SUPERFOOD FOR BABIES

How overcoming barriers to breastfeeding will save children's lives

NO CHILD BORN TO DIE

Save the Children

Front cover: Ana Cristina with her newborn daughter Tainá, at hospital in Petrolina, Brazil. After Tainá was born premature, nurses helped Ana Cristina to breastfeed and look after her daughter. Tainá put on weight and made good progress. (Photo: Genna Naccache/Save the Children)

A mother and baby at a nutrition awareness-raising session, supported by Save the Children, in Pakistan (Photo: Ayesha Vellani/Save the Children)

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We save children's lives. We fight for their rights.
We help them fulfil their potential.

Authors and acknowledgements

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Other colleagues at Save the Children greatly supported the research: Michel Anglade, Pia MacRae, Patricia Norimarna, Yang Ruikan, Louise Sampson, Carmina Sarmiento, Alison Donnelly, Karin Lapping, Ashley Jones, Arshad Mahmood and the Save the Children Pakistan team.

We are also very grateful for the substantial insights and support of experts who contributed to this report: Annelies Allain, Dr Dai, Velvet Escario-Roxas, Ines Fernandez, Arun Gupta, Francesco Branca, Bridget Fenn, Alyssa Klein, Lida Lhotska, Pamela Mbele, Jessica Meeker, James Njiru, Rebecca Norton, Dr Perera, Anna Taylor and Terri Wafwafwa.

Particular thanks go to Patti Rundall and Mike Brady of Baby Milk Action, the UK branch of IBFAN.

Published by
Save the Children
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London EC1M 4AR
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First published 2013

© The Save the Children Fund 2013

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Typeset by Grasshopper Design Company
Printed by Page Bros Ltd.

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BREASTFEEDING SAVES LIVES

THE STORY IN NUMBERS

THE BIG PICTURE: HOW MANY CHILDREN ARE DYING?

6.9 MILLION

6.9 million children under five died in 2011.

14,000

Since 1990, the number of children dying a year has come down by 5 million – that's 14,000 fewer children dying every day.

THE POWER OF THE FIRST HOUR

830,000

We estimate that 830,000 deaths could be avoided if every baby were breastfed within the first hour of life.

FIRST HOURS

In the first hours and days after childbirth a mother produces the first milk, called colostrum – the most potent natural immune system booster known to science.[1]

22%

It's estimated that 22% of newborn deaths could be prevented if breastfeeding started within the first hour after birth, and 16% if breastfeeding started within the first 24 hours.[2]

3 TIMES

An infant given breast milk within an hour of birth is up to three times more likely to survive than one breastfed a day later.[3]

SIX MONTHS' PROTECTION

15 TIMES

Infants who are not breastfed are 15 times more likely to die from pneumonia and 11 times more likely to die of diarrhoea than those who are exclusively breastfed for the first six months of life.[4]

1.4 MILLION

An estimated 1.4 million child deaths in 2008 were as a result of 'sub-optimal' breastfeeding – ie, where babies were not exclusively breastfed and where breastfeeding did not continue into the second year.[5]

14 TIMES

A study in Brazil found that infants who were not breastfed at all had a 14 times greater risk of death than those who were exclusively breastfed, while those who were partially breastfed had a four times greater risk of death.[6]

92 MILLION

Worldwide, 92 million children under six months of age – two out of three babies – are either artificially fed or fed a mixture of breast milk and other foods.[7]

BABY BUSINESS

$25 BILLION

The baby milk formula business is worth $25 billion (or £16 billion).

31%

The baby-food industry as a whole is set to grow by 31% by 2015, with most of that growth concentrated in Asia.

ABBREVIATIONS AND ACRONYMS

ANC	antenatal care
BFHI	Baby-Friendly Hospital Initiative
BINGO	business interest non-governmental organisation
BMS	breast-milk substitute
EBF	exclusive breastfeeding
EU	European Union
IBFAN	International Baby Food Action Network
IFE	infant feeding in emergencies
ILO	International Labour Organization
IYCF	infant and young child feeding
NCT	National Childbirth Trust
NGO	non-governmental organisation
PINGO	public interest non-governmental organisation
RUTF	ready-to-use therapeutic foods
SUN	Scaling Up Nutrition
WHA	World Health Assembly
WHO	World Health Organization

EXECUTIVE SUMMARY

In the last two decades there has been huge global progress in reducing child mortality. Five million fewer children died in 2011 than in 1990. The world is nearing a tipping point, the time at which the eradication of preventable child deaths becomes a real possibility.

There is still a long way to go to achieve that goal. One-third of child deaths are still attributable to malnutrition; the reduction in malnutrition rates has been proceeding at a stubbornly slow pace. Unless malnutrition is tackled it threatens to become the 'Achilles' heel' of development, holding back progress in other areas. We must also tackle the unacceptably high number of newborn deaths: while overall child mortality rates are falling, a larger proportion of deaths now occur within the first month of life.

Breastfeeding saves lives. It's the closest thing there is to a 'silver bullet' in the fight against malnutrition and newborn deaths.

THE POWER OF THE FIRST HOUR

Breast milk is a superfood. In the first hours and days of her baby's life the mother produces milk called colostrum, the most potent natural immune system booster known to science.[1] Research for this report estimates that 830,000 newborn deaths could be prevented every year if all infants were given breast milk in the first hour of life.

It is not only through the 'power of the first hour' that breastfeeding is beneficial. If an infant is fed only breast milk for the first six months they are protected against major childhood diseases. A child who is not breastfed is 15 times more likely to die from pneumonia and 11 times more likely to die from diarrhoea.[2] Around one in eight of the young lives lost each year could be prevented through breastfeeding,[3] making it the most effective of all ways to prevent the diseases and malnutrition that can cause child deaths.[4]

But breastfeeding is undervalued. This report finds that progress made in increasing breastfeeding rates in the 1980s (as a result of initiatives such as Baby-Friendly Hospitals and agreement on the International Code of Marketing of Breast-milk Substitutes) has stalled. Global rates of breastfeeding have remained below 40% for the past 20 years as breastfeeding has slipped down the list of political priorities. In some countries, particularly in east Asia and the Pacific, the number of breastfed children is starting to fall.

After years of neglect, malnutrition is starting to get the attention it deserves, with initiatives including the Scaling Up Nutrition (SUN) movement, the 1,000 Days Partnership and the G8's New Alliance for Food Security and Nutrition. The year 2013 will be crucial, with the UK hosting a 'hunger summit' as part of its G8 presidency. This gives a unique opportunity to address the question of child malnutrition, including promoting the vital role of breastfeeding. In addition, Ireland is holding the European Union (EU) presidency, which will focus on nutrition, and SUN is gathering momentum in 33 countries across the world. It is vital that plans in each of these countries include protection, support and promotion of breastfeeding. We must seize these opportunities to make a difference and accelerate progress towards the goal of ending preventable child deaths in our generation.

THE FOUR BARRIERS TO BREASTFEEDING

This report examines the reasons behind the lack of progress in improving breastfeeding rates and especially the four major barriers that prevent mothers from breastfeeding their babies.

1. COMMUNITY AND CULTURAL PRESSURES

Despite clear evidence that early and exclusive breastfeeding is the best way to care for newborns, many mothers in poor countries are given bad advice or are pressurised into harmful alternatives. Common practices include denying the newborn colostrum and giving other foods or liquids before starting breastfeeding.

Many women are not free to make their own decisions about whether they will breastfeed, or for how long. In Pakistan, a Save the Children survey revealed that only 44% of mothers considered themselves the prime decision-maker over how their children were fed. Instead it is often husbands or mothers-in-law who decide.[5]

It is important to recognise the contribution a woman is making to the future of her child, her family, her village and her country's economy by breastfeeding. Projects that seek to address community power dynamics while promoting more helpful behaviours, through a variety of efforts, including mass media campaigns, support groups and interpersonal communication, can be useful – especially if they empower young women by changing communities' views of breastfeeding and also target fathers and grandmothers and other influential community members.

2. THE HEALTH WORKER SHORTAGE

Owing to a chronic shortage of health workers, one-third of infants are born without a skilled birth attendant present.[6] As a result, the opportunity for new mothers to be supported to breastfeed in the first few hours is lost. Our analysis of data from 44 countries[7] found that women who had a skilled attendant present at birth were twice as likely to initiate breastfeeding within the first hour.

Human and financial resources are needed to scale up the support mothers get from health workers.[8]

Countries that support infant feeding practices have shown that it is possible to rapidly increase the rates of early initiation and exclusive practice of breastfeeding. The Baby-Friendly Hospital and Community Initiative, launched in 1991 by WHO and UNICEF, is among the most successful of these programmes.

3. LACK OF MATERNITY LEGISLATION

Returning to work after the birth of a child is difficult for any mother and may mean that continuing to breastfeed is very challenging. Three areas of national policy play a key role in a woman's ability to breastfeed: maternity leave, financial protection to help maintain the family's income while the mother is not working, and workplace provisions to allow breastfeeding to continue once a mother returns to work. To promote exclusive breastfeeding, women must be provided with sufficient paid maternity leave – in line with the international minimum of 14 weeks and working towards 18 weeks' leave with at least two-thirds pay – but the majority of poor countries do not meet this standard. Once a mother returns to work, there must be policies in place that require employers to provide paid breaks and private places where women can breastfeed or express milk so that they are able to continue breastfeeding.

Women in informal employment also face problems in continuing to breastfeed when they return to work, as they are often unable to take their children with them to the fields to farm or to do household chores such as collecting firewood and water. For these women, state grants and social protection (in the form of social security payments or cash benefits) that are not dependent on formal maternity leave arrangements are even more important.

4. THE BIG BUSINESS BARRIER

While there is a recognised need for certain infants to be formula-fed, there has long been concern that the marketing activities of some manufacturers has led to infant formula being used unnecessarily and improperly, ultimately putting children at risk. In 1981, the World Health Assembly adopted a set of standards known as The International Code of Marketing of Breast-milk Substitutes, and has since adopted a number of subsequent resolutions that have developed and updated the original provisions.* 'The Code' regulates marketing tactics that can

* For the purposes of this report, any reference to 'the Code' should be taken to refer to The International Code of Marketing of Breast-milk Substitutes and its subsequent resolutions, which have the same status.

undermine breastfeeding, including advertising, free samples, targeting mothers and health claims on packaging. While some companies have created global monitoring and reporting systems, in many cases they are not being implemented in practice and there continue to be too many examples of violations of the Code by some breast-milk substitute companies. Among the most worrying violations is the alleged targeting of health workers with encouragement to promote the companies' products to mothers of young infants.

Growth in the baby food market is increasingly dependent on emerging economies. The shift in the economic centre of gravity has created new lucrative markets in countries with a growing middle class. Meanwhile, sales are stagnating in Europe and North America, as a result of declining birth rates and increased interest in breastfeeding.

Strong legislation can restrict the marketing activities of breast-milk substitute (BMS) companies. During research for this report we found evidence of lobbying by the industry that we believe could serve to weaken legislation on the Code in a number of countries. It is our understanding that BMS companies have put corporate competition aside to form groups to influence national governments. We question the true intention of these groups, some of which have pseudo-scientific titles that could be misleading and are presented as nutrition associations.

RECOMMENDATIONS

This report is a call to action for the world to rediscover the importance of breastfeeding and for a commitment to support mothers to breastfeed their babies, especially in the poorest communities in the poorest countries. It calls for world leaders, international institutions and multinational companies to take action to ensure that every infant is given the life-saving protection that breastfeeding can offer.

All countries should put breastfeeding at the centre of efforts to improve infant and child nutrition, and should develop specific breastfeeding strategies as well as including breastfeeding in their nutrition strategies. Countries that are developing plans as part of the SUN movement should ensure that they address all of the obstacles identified in this report that deter optimal breastfeeding practices.

To overcome harmful practices and tackle breastfeeding taboos, developing country governments must fund projects that focus on changing the power and gender dynamics in the community to empower young women to make their own decisions. They need to include fathers and husbands, grandmothers and local leaders in their work. Governments should invest in programmes to address breastfeeding that include high-quality, professional national communications and media campaigns to spread messages about the benefits of breastfeeding, well-targeted support for communities, and measures for tackling the obstacles to good practice.

To achieve the goal of every birth being attended by a skilled health worker, governments must work to **make the health system stronger to protect, promote and support breastfeeding**. This should include allocating adequate resources to long-term health worker training, recruitment, support and retention and ensuring that all healthcare providers have strong policies in place that protect breastfeeding. International donors should support these efforts by increasing funding for projects that support breastfeeding. The UK prime minister's 'hunger summit' ahead of the G8 leaders meeting in the UK provides the ideal opportunity for leaders to put nutrition, including breastfeeding, at the top of the agenda and to fill the funding gap.

All governments should **introduce nationwide breastfeeding-friendly policies and legislation**. They should provide maternity leave in line with the International Labour Organization (ILO) minimum recommendation of 14 weeks of paid leave but working towards best practice of 18 weeks.[9] Governments should also provide financial protection for six months in the form of cash transfers, state grants or maternity benefits to all breastfeeding women in both the formal and informal sectors, and require that employers make provisions for breastfeeding women in the workplace.

In order to **improve breast-milk substitute industry practices** we need a two-pronged approach that requires change from within industry while also seeking to tighten national regulation in the countries where they operate. BMS companies and those working on their behalf should adopt a code of conduct regarding their engagement with governments and open up their lobbying activity for public scrutiny through a public register of meetings regarding the International Code.

Whistleblowing procedures must be strengthened, and to ensure that the Code is understood and enforced at every level, responsibility for

preventing Code violations should be built into the job description of the company's most senior representative in every country. The job description of the company's most senior representative in every country, whether that is a company office or distributor, should include ensuring that no Code violations occur in the area they are responsible for. That person should be held accountable under the terms of their employment and be held personally responsible in law for any violations of the Code. A member of the board should be made accountable for ensuring that the company does not violate the Code and for managing a robust auditing system.

At the same time, all governments must enshrine the International Code and subsequent resolutions into law and ensure that it is independently monitored and enforced and complemented by additional measures. For example, while the International Code states that companies must include health warnings and details of the benefits of breastfeeding, in practice these warnings are usually small and unobtrusive. To strengthen the power of these warnings, national laws should specify that health warnings should cover one-third of any BMS packaging. In order to hold companies accountable at a global level the UN should create an effective body to monitor reports of, and rule on, Code violations, and should publicly disclose, in detail, all Code violations. The operating costs of this body, which should work with national regulatory bodies to penalise companies, could be covered by a combination of donor funding and fines issued to BMS companies for Code violations.

PHOTO: CAROLINE TRUTMANN/SAVE THE CHILDREN

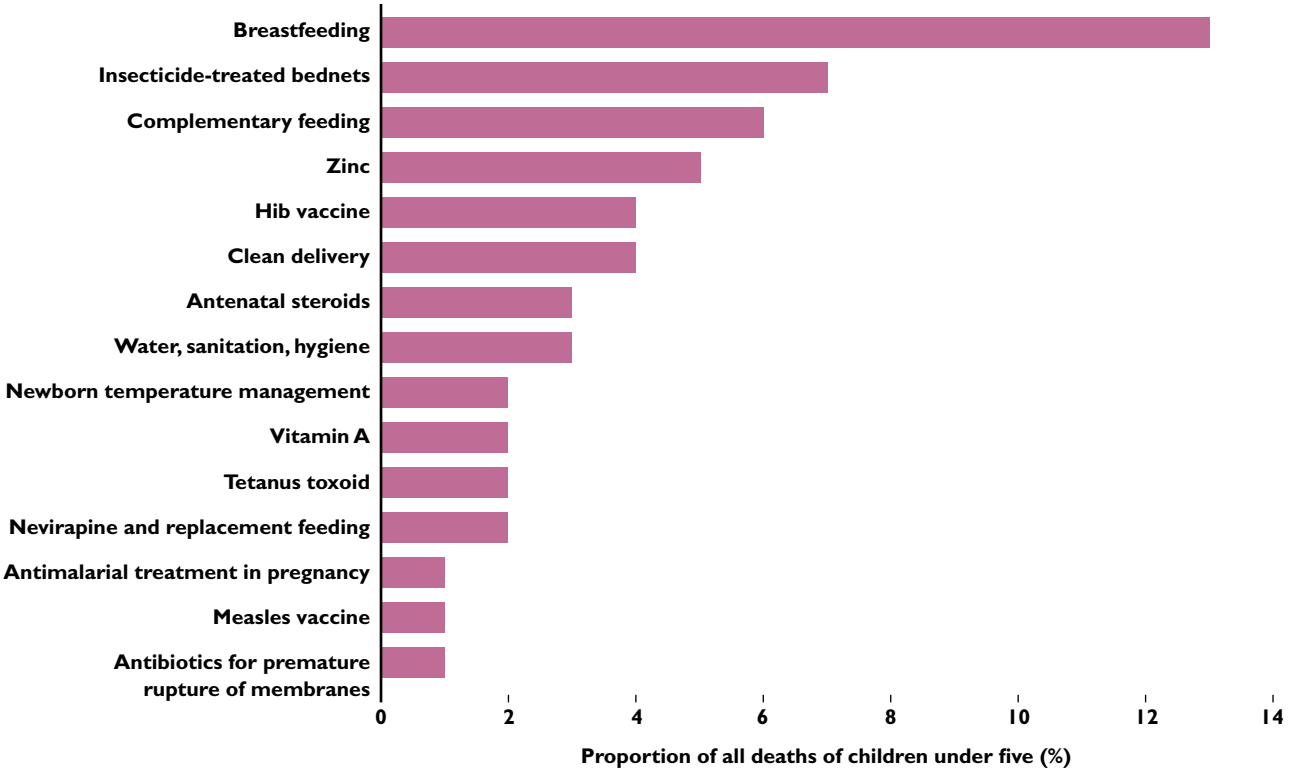
Nurse Koletha teaches Mwajuma how to breastfeed her one-day-old baby boy at the Lindi Regional Hospital, Tanzania

INTRODUCTION

In the last two decades there has been great progress at the global level in reducing child mortality. Five million fewer children died in 2011 than in 1990 and we are now reaching a tipping point where preventable child deaths could be eradicated in our lifetime. Between 2010 and 2011 we saw the biggest annual reduction in child deaths ever recorded, showing that global efforts are paying off. Ours could be the generation to eradicate preventable child death.

But there is still a lot to do to reach that point and breastfeeding is key to unlocking further progress. Malnutrition was the underlying cause of around one-third of the almost 7 million child deaths in 2010. It has become the Achilles' heel of child survival as, while rapid progress has been made on other fronts such as immunisation, progress in reducing malnutrition has remained stubbornly slow. At the same time, as the child death toll falls, a greater proportion of deaths are among newborn babies – currently, two in five children under five who die are under one month old. Breastfeeding has a strong impact on both reducing malnutrition and protecting children in their first 28 days and beyond – it is the closest thing there is to a 'silver bullet' to save these children's lives. To achieve our goal that within our lifetime no child will be born to die from a preventable cause, we must put breastfeeding at the centre of our efforts.

FIGURE 1. PROPORTION OF UNDER-FIVE DEATHS THAT COULD BE PREVENTED THROUGH UNIVERSAL COVERAGE WITH INDIVIDUAL INTERVENTIONS IN 42 COUNTRIES



Source: Jones, G et al., 'How many child deaths can we prevent this year?' *Lancet Child Survival Series*, 2003, 362:65-71

It is common knowledge that breastfeeding a baby is good for his or her health. Breast milk is a superfood. In the first hours and days of her baby's life the mother produces milk called colostrum, the most potent natural immune system booster known to science.[1] Research for this report estimates that 830,000 newborn deaths could be prevented if every infant were given breast milk in the first hour of life. Breastfeeding gives an infant significant protection against pneumonia and diarrhoea, which are two major causes of deaths of children in poor countries. If we can ensure that every infant is given breast milk immediately after birth and is fed only breast milk for the first six months, we can greatly increase the chance that they will survive and go on to fulfil their potential. Around one in eight of the young lives lost each year could be prevented through breastfeeding,[2] making it the most effective of all ways to prevent the diseases and malnutrition that can cause child deaths.[3]

But breastfeeding is undervalued. The world is in danger of forgetting just how important this universal, free and wholly beneficial practice is. Previous progress in increasing the rates of breastfeeding has slowed down. The global proportion of children exclusively breastfed for six months increased from 32% in 1995 to 39% in 2010[4] – an improvement of just over 1.5% a year.

In the 1980s and early 1990s there was significant progress in improving the number of infants who were breastfed. Global initiatives such as the UNICEF and World Health Organization Baby-friendly Hospital Initiative and the International Code of Marketing of Breast-milk Substitutes showed that, with political will and dedicated resources, it was possible to achieve dramatic improvement. However, since then, attention has slipped. In the last two decades, breastfeeding has dropped down the global agenda and fallen lower in the priorities of national governments. At the same time, according to industry analysts Euromonitor, "The [baby food] industry is fighting a rearguard action against regulation [on advertising and promotion of breast-milk substitutes] on a country-by-country basis."[5]

However, other, more recent developments are also significant. After years of neglect, malnutrition is starting to get the attention it deserves. The Scaling Up Nutrition movement is gathering momentum in 33 countries across the world. It is vital that plans in each of these countries include protection, support and promotion of breastfeeding. In 2010, the US and Irish governments launched the 1,000 Days Partnership, highlighting the need to focus on the critical first 1,000 days of a child's life from conception through pregnancy to the age of two. In 2012, world leaders attending the G8 summit held in the USA recommitted themselves to SUN and launched the New Alliance for Food Security and Nutrition. And 2013 is set to be a crucial year, with the UK hosting a hunger summit as part of its G8 presidency. In addition, Ireland is holding the EU presidency, which will focus on nutrition and the SUN movement. We must seize these opportunities to make a difference and accelerate progress towards the goal of ending preventable child deaths in our generation's lifetime.

This report is a call to action for the world to rediscover the importance of breastfeeding and to demonstrate a commitment to supporting mothers to breastfeed their babies, especially in the poorest communities in the poorest countries. It calls on world leaders to take action to ensure that every infant is given the life-saving protection that breastfeeding can offer.

In the next chapter, we set out the evidence for how breastfeeding saves children's lives, showing just how vital early initiation and six months' exclusive breastfeeding is to an infant. Chapter 2 then tracks the current global trends and the rates of breastfeeding in different parts of the world, and provides examples of countries that have made significant improvements and those that are lagging behind.

The four subsequent chapters then focus on the barriers to further global progress and the major social, cultural and political obstacles that are preventing mothers from breastfeeding their infants. Reasons vary from country to country – and indeed from woman to woman – but the report identifies four main barriers:

1. **Community and cultural pressures.** Many women face extreme pressures from their family or their community to feed their infants in ways that are traditional in their society, but which can be harmful. Husbands, other family members, and community leaders may have such a significant influence over young mothers that it prevents them from making their own informed decisions about how to feed their infants. The chapter calls for empowerment of young women and widespread knowledge-sharing on the benefits of breastfeeding, as crucial to transforming breastfeeding practices.

2. **The health worker barrier.** Lack of access to fully skilled and well-supported health workers means many new mothers give birth either completely alone or without proper support. As well as the immediate danger this poses to themselves and their infants, it means that these women do not get the information and support that they need. Many women are missing out on antenatal checks, support during and immediately after birth, and post-natal visits that would be a source of advice and information about good practices in breastfeeding.
3. **Lack of maternity legislation.** Even when women are supported to breastfeed by their families and health workers, returning to domestic and work duties while continuing to breastfeed is very difficult. The report calls for every country to ensure minimum maternity leave entitlements of 14 weeks, with an aim to increase the leave to the recommended 18 weeks. It also calls for financial support, making sure there are appropriate provisions for breastfeeding women in the workplace and finding ways to cater for those who are in informal employment.
4. **Bad corporate behaviour.** The marketing and lobbying practices of many companies that manufacture breast-milk substitutes are still undermining breastfeeding. Despite the fact that some companies have created global monitoring systems, they are not being systematically implemented in practice. There continue to be too many examples of companies violating the International Code of Marketing of Breast-milk Substitutes and adopting various tactics to attract new mothers to use their products in order to increase their market. The report specifically calls for an end to industry lobbying for the watering down of legislation on BMS marketing and for some BMS companies to stop targeting health workers.

With examples of best practice and case studies, the report offers targeted solutions that have been proved to work. We conclude by arguing that much more emphasis must be given to breastfeeding as part of global efforts to improve child survival. We make recommendations for all actors including policy-makers in low-income countries, donor governments, companies that manufacture substitutes for breast milk and the multilateral institutions and processes that are under way in 2013. All of these players have a responsibility to take action on breastfeeding and achieve the progress needed. If the right steps are taken we could see an end to preventable child deaths in our lifetime.

Fahida with her one-day-old baby girl at a rural health centre in Tanzania

1 HOW BREASTFEEDING SAVES CHILDREN'S LIVES

Breastfeeding is an amazing way to protect newborn babies and infants; quite simply, it saves lives. Breast milk is a superfood for babies and a powerful, natural antidote to hunger and disease.

Breastfeeding ensures babies get all the energy, nutrients and water they need to develop and it also keeps the infant safe from life-threatening dangers such as unclean water or bacteria in food. To minimise the risks of infections and other illnesses, infants should begin breastfeeding within the first hour of life and continue to breastfeed exclusively – that is, without any other foods or liquids – for six months, and then with complementary food for up to two years and beyond.[1]

THE POWER OF THE FIRST HOUR

The first hours and days of an infant's life are the most dangerous – this is when they are at their most vulnerable and prone to infection. Of the almost 7 million children who died in 2011, around 30% died within the first week of life. This critical period is also when a mother produces the first milk, called colostrum – a highly nutritious substance full of vital antibodies that strengthen a baby's immune system. It is, to all intents and purposes, a child's first vaccination – and often makes the difference between life and death. Colostrum is the most potent natural immune system booster known to science[2] and should be given to the infant as soon as possible.

Save the Children estimates that 830,000 infant deaths in developing countries could be prevented if every baby were given breast milk, and only breast milk, in the first hour. Using two studies from Ghana[3] and Nepal,[4] we calculated the effect that increasing the current rate of early initiation[5] to 100% would have if all other factors remained the same. Infants who are not breastfed within an hour are 86.5% more likely to die during the neonatal period – the first 28 days of life – than those who are breastfed.[6]

The study in Ghana found that 16% of neonatal deaths could be prevented if all infants were breastfed within 24 hours of birth, and 22% if breastfeeding started within the first hour of life.[7] The study in Nepal found that an infant given breast milk within an hour of birth

COLOSTRUM – THE FIRST IMMUNISATION

As well as being rich in antibodies and immune system-boosting cells, colostrum helps the infant's intestines to mature and function effectively. The protective substances it contains make it more difficult for bacteria and allergens to attack the baby's throat, lungs and intestines. Colostrum has a laxative effect, helping infants pass their first early stools and prevent jaundice. The colostrum gradually changes into mature milk during the first two weeks after birth but the disease-fighting properties of breast milk do not disappear.

There is only a small amount of colostrum and its consistency is thick, which helps the newborn learn to swallow slowly and breathe at the same time. This ensures that the infant's stomach – which is only the size of its fist – is not overfilled, which can happen with other liquids commonly given, such as water, cow's milk or tea, and can result in the baby not being able to digest the excess.

SUMMARY OF WHO AND UNICEF RECOMMENDATIONS ON BREASTFEEDING

- All infants should be put to the breast within an hour of birth (known as early initiation).
- All infants should be exclusively breastfed for the first six months of life. 'Exclusive breastfeeding' is defined as giving no other food or drink – not even water – except breast milk. It does, however, allow the infant to receive oral rehydration salts (ORS), drops and syrups (vitamins, minerals and medicines).[9]
- From six months, infants and young children should be given nutritionally adequate and safe foods that complement breastfeeding.
- Breastfeeding should continue for up to two years of age or beyond.
- In the rare cases where a mother is unable to breastfeed her child, WHO and UNICEF recommend making a choice from the following alternatives in this particular order: the mother's own breast milk fed from the breast; mother's milk given from a cup; breast milk from a wet nurse or from a human milk bank; or a breast-milk substitute fed from a cup, which is a safer method than using a feeding bottle and teat.[10]
- An infant is a child under one year old.

is up to three times more likely to survive than one breastfed a day later. Infants who are not breastfed until they are two days old are more than four times more likely to die.[8]

The World Health Organization (WHO) has recommended that a newborn baby should suckle from the mother's breast as soon as possible, ideally within the first hour after birth. However, as the next chapter shows, far too many newborns miss out on this vital help.

SIX MONTHS' PROTECTION

Breast milk provides all the energy, nutrients and liquid that an infant needs for the first six months of its life. In fact, studies have shown that the nutritional make-up of a mother's breast milk adapts according to her infant's individual needs at that time for his or her development. So it is important that infants are not fed any other foods or water, as this can interfere with this natural supply-and-demand mechanism.

PROTECTION FROM DISEASE

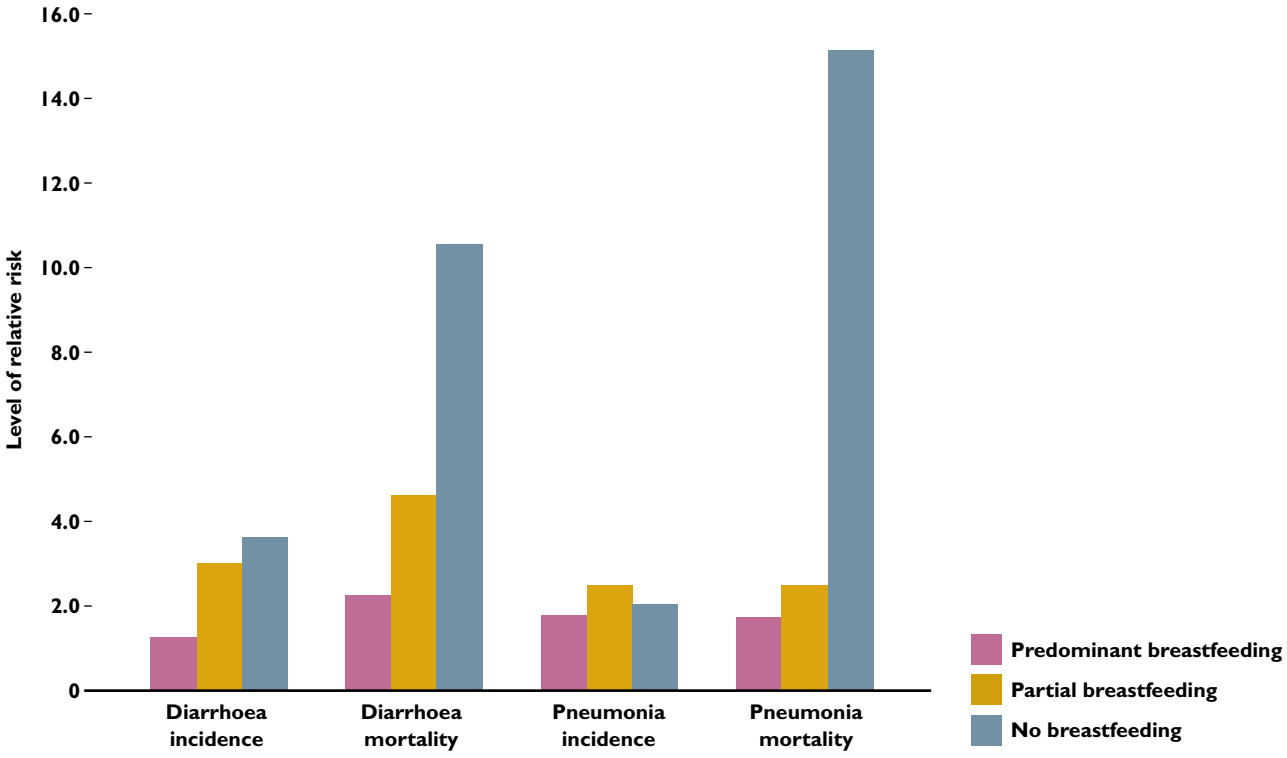
Exclusive breastfeeding is particularly important in low-income countries where there is a high risk that food contains bacteria or parasites and that water is contaminated. Exclusive breastfeeding greatly reduces the risk that a baby is exposed to life-threatening infectious diseases through the feeding of other liquids and foods.

A study in Brazil that compared feeding practices found that infants who received some foods or liquids in addition to breast milk were four times more likely to die than those who received only breast milk. Infants who received no breast milk at all were 14 times more likely to die.[11]

One of the life-saving properties of breast milk is the protection it can give children from pneumonia and diarrhoea – the two leading causes of child deaths in developing countries. Infants who are not breastfed are 15 times more likely to die from pneumonia and 11 times more likely to die of diarrhoea than children who are exclusively breastfed.[12]

Pneumonia and diarrhoea can both be a result of infection caused by bacteria, viruses or parasites. A review of studies that examined the link between breastfeeding and these two causes of death found that the protection came from three components of breast milk. These three life-saving components were identified as: oligosaccharides, which are a type of sugar that can stop bacteria attaching to cells; lactoferrin, which kills bacteria and viruses; and antibodies that boost the immune system and protect the child from infection.[13] In addition to being effective in preventing pneumonia in the first place, breastfeeding can shorten the length of time a child is ill if they do contract it.[14]

FIGURE 2. RELATIVE RISK OF INCIDENCE AND MORTALITY FROM DIARRHOEA AND PNEUMONIA FOR PREDOMINANT, PARTIAL AND NON-BREASTFED INFANTS AGED 0–5 MONTHS COMPARED WITH BREASTFED INFANTS



Note: Relative risk of incidence of and mortality from diarrhoea and pneumonia for partial breastfeeding and not breastfeeding; compared with that for exclusive breastfeeding among infants aged 0–5 months. A relative risk of 1.0 indicates the same risk incurred as for exclusively breastfed children. Relative risks above 1.0 indicate increased risk.

Source: UNICEF (2012) *Pneumonia and Diarrhoea: Tackling the deadliest diseases for the world's poorest children*

PREVENTING MALNUTRITION

Malnutrition is an underlying cause of one-third of child deaths, and our analysis[15] has demonstrated that breastfeeding has a significant impact on childhood nutrition status. Failure to ensure early initiation was linked to an increase – by up to one-fifth – of the likelihood of a child being wasted.[16] And failure to achieve exclusive breastfeeding was associated with a 10% increase in the risk of a child being wasted.[17] Malnutrition and diseases such as pneumonia and diarrhoea work in a deadly cycle. A malnourished child is more likely to suffer from disease, and the more they suffer from disease the more likely they are to be malnourished. Inadequate food intake leads to weight loss and a weakened immune system, which means that childhood diseases will be more severe and will last longer. This in turn leads to a loss of appetite.

UNIVERSAL BENEFITS

It is clear that the protection provided by breastfeeding applies whether a child has been born to a wealthy family in a rich country or born to an impoverished family in a poor country. In Spain, risk of admission into hospital for infection in the first year of life was five times higher among infants (born into upper-middle-class, educated, urban families) who were never breastfed, compared with infants breastfed for four months or more.[18] In the USA, a study estimated that children who were never breastfed were 24% more likely to die of infection, injury and other causes in the post-neonatal period (defined as from 28 days to one year) than those who were breastfed.[19]

Research compiled by WHO suggests that children who are not optimally breastfed have a higher risk of asthma, diabetes, coeliac disease, ulcerative colitis and Crohn's disease and potentially a higher chance of becoming obese in childhood and adolescence.[20] There is also a growing body of evidence that links feeding an infant with liquids other than breast milk with risks of

cardiovascular disease.[21] Breastfeeding has also been linked to cognitive development. A meta-analysis of 20 studies showed that breastfed children scored on average 3.2 points higher in cognitive function tests than those who were formula-fed.[22]

As well as helping a mother bond with her baby, breastfeeding has short- and long-term benefits for the mother's health. Immediately after birth, the suckling action of the baby releases a hormone called oxytocin. This hormone not only releases milk to the baby, it produces contractions in the uterus that prevent postpartum haemorrhage. Exclusive breastfeeding can often mean a woman's periods do not return for several months, which conserves iron stores in her body and can act as a natural contraceptive, thus helping to space pregnancies. Healthier birth spacing, where mothers delay conceiving until 36 months after giving birth, could prevent 1.8 million deaths of children under five a year – around a quarter of annual child deaths.[23]

The process of producing milk can use up to 500 calories per day and help women lose weight after pregnancy.[24] And in the longer term, there is evidence that the risk of breast and ovarian cancer is smaller among women who have breastfed.It is now estimated that breastfeeding for six to 24 months throughout a mother's reproductive lifetime may reduce the risk of breast cancer by up to 25%.[25, 26]

In the poorest countries, where child mortality rates are driven by lack of access to sufficient nutritious food, high rates of poverty, prevalence of diseases and lack of access to healthcare, breastfeeding is a vital way to help children survive and develop. Increasing optimal breastfeeding will help to drive down the rates of children dying before their fifth birthday. It is therefore a top priority. However, as the next chapter shows, breastfeeding is not being prioritised in the poorest countries of the world.

PHOTO: LOUISE DYRING NIELSON/SAVE THE CHILDREN DENMARK

Winnie and her three-week-old daughter, Diana Rose, at an evacuation centre set up after tropical storms hit Laguna province in the Philippines. In emergencies, children – and particularly babies – are at greater risk of sickness and malnutrition. Here at the centre Winnie took part in a Save the Children breastfeeding training session.

2 THE GLOBAL BREASTFEEDING PICTURE

Despite universal consensus that breastfeeding is the best way to give a child a healthy start in life, and a wealth of solid evidence of the critical role it plays in reducing child mortality, only 37% of children globally are exclusively breastfed for the first six months of life and only 43% are breastfed within the first hour of life.[1] What is shocking is that despite significant efforts in global policy and initiatives for over 20 years [2] to improve breastfeeding rates, the global rate of exclusive breastfeeding has stayed below 40%.

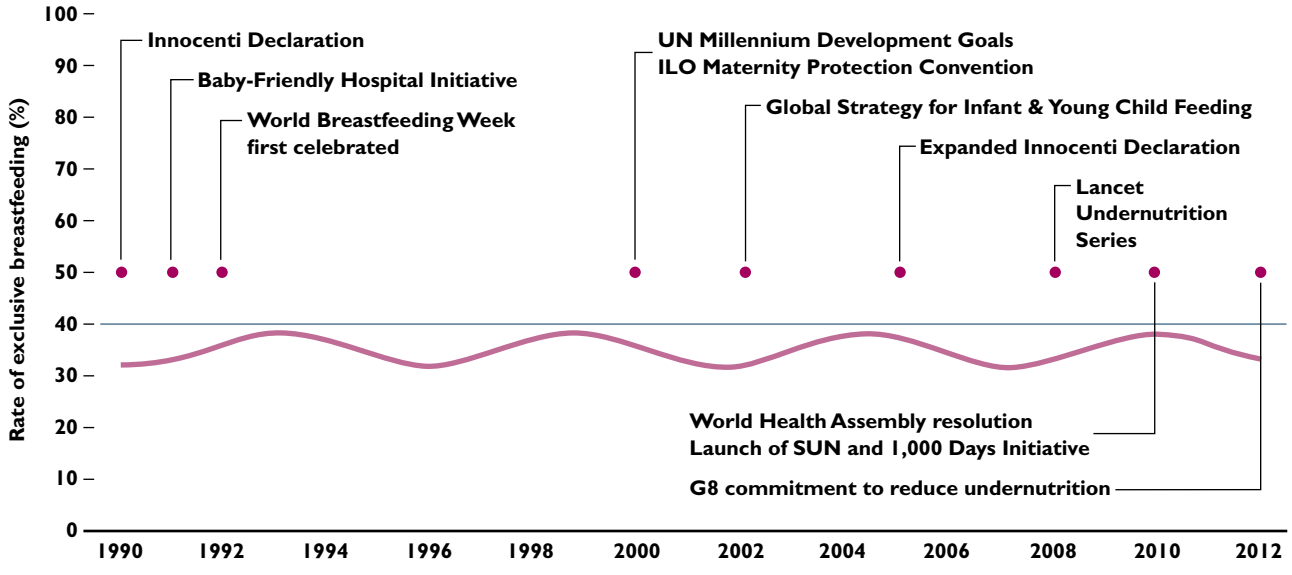
Member states meeting at the World Health Assembly in 2012 adopted a global target for at least 50% of infants under six months of age to be exclusively breastfed by 2025, requiring an increase of at least 2.5% a year. This can be done – rapid and substantial increases in exclusive breastfeeding rates, often exceeding the proposed global target, have been achieved in individual countries in all regions,[3] yet this progress needs to be made across all countries.

GLOBAL TRENDS: REGIONAL VARIATION

This global stagnation conceals varied trends within countries and regions. History has shown that much rapid progress on improving breastfeeding rates is possible. Sri Lanka, for example, saw a dramatic increase in its exclusive breastfeeding rate from 17% in 1993 to 76% in 2007; Cambodia's exclusive breastfeeding rate was just 12% in 2000 but it had increased to 74% by 2010; Ghana's rose from a low level of 7% in 1993 to 63% in 2008.[5] A total of 27 countries[6] have seen exclusive breastfeeding rates increase by more than 20 percentage points in ten years.[7]

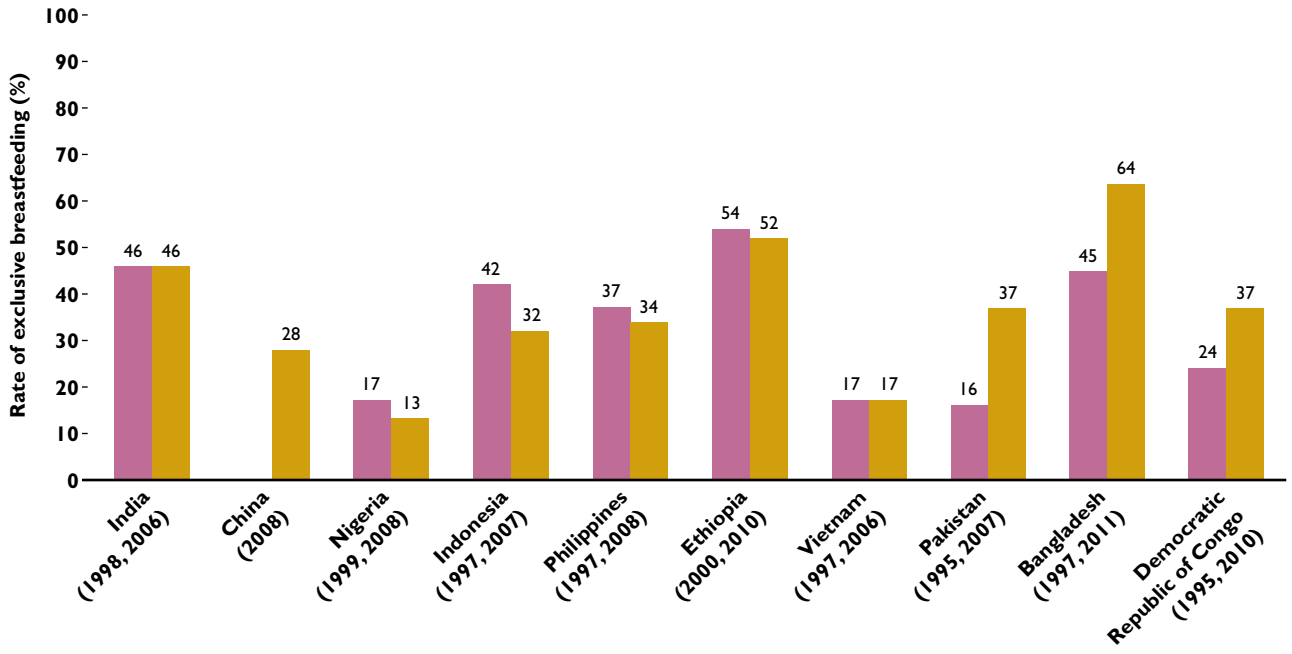
The fact that rates in some of the countries with the largest populations have stalled or even declined has contributed to the global stagnation and has masked progress by smaller countries. According to the most recent available national data, two-thirds of the 92 million children who are not exclusively breastfed

FIGURE 3. GLOBAL TRENDS IN RATE OF EXCLUSIVE BREASTFEEDING



Note: Comparable global trend data is not available for each of the above points during the period 1990–2012; however, in that period, global rates only increased from 32% to 39%.[4]

FIGURE 4. RATES OF EXCLUSIVE BREASTFEEDING ACCORDING TO NATIONAL SURVEYS



The ten countries where two-thirds of children who are not exclusively breastfed live

Source: UNICEF, World Breastfeeding Conference, 2012[8]

live in just ten countries. Seven of these countries (India, China, Nigeria, Indonesia, Philippines, Ethiopia and Vietnam) have made no progress on improving exclusive breastfeeding, despite having some of the highest burdens of child mortality (see page 4).

The region that is the biggest cause for concern is east Asia and the Pacific. UNICEF recently reviewed the declining rate of exclusive breastfeeding in the region and found that the overall rate, which in 2006 was 45% including China[9] or 32% excluding China, had fallen to 29% for the whole region in 2012.[10] This region is the area where the baby food industry is targeting the greatest proportion of its resources (see Chapter 6).[11]

INCOME, EDUCATION AND BREASTFEEDING RATES

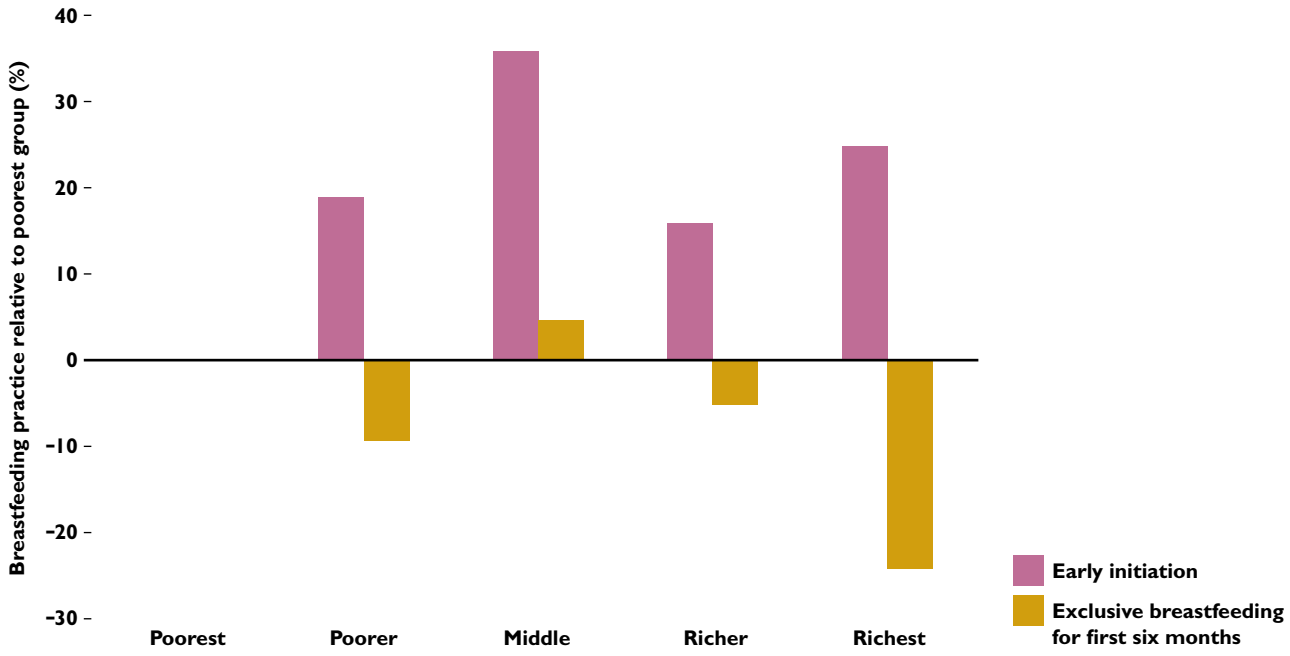
BREASTFEEDING RATES BY INCOME LEVEL

New analysis commissioned by Save the Children has reviewed global infant feeding practices and found a number of interesting trends within the global statistics. We analysed data from 44 countries with among the highest global rates of maternal and child mortality (monitored in *Countdown to 2015*[12]).[13] The research found that there were significant disparities in rates of breastfeeding depending on the wealth of the household, when looking at the population divided into five groups in terms of income (wealth quintiles). National average breastfeeding rates are able to conceal inequity in rates according to the mother's or family's income.

Poorer households were less likely to initiate breastfeeding early than those in higher income groups. Those in the wealthiest fifth of the population were 25% more likely to follow the short-term good practice of early initiation. The second-richest group were 16% more likely to do so. This trend was revealed after analysis controlling for other factors such as the skill level of their birth attendant, and which household member has control over spending decisions, factors that also differ significantly between income groups.

Conversely, the poorest are more likely to exclusively breastfeed than the richest. The richest population group is 24% less likely than the poorest group to exclusively breastfeed for the first six months.[14] A study of infant feeding in Bangladesh backed these findings, showing that while richer households were more likely to initiate breastfeeding within the first hour of birth, higher socio-economic status meant it was more likely an infant would not continue to be exclusively breastfed.[15] These findings suggest that the lifestyle of wealthier women can increase the use of infant formula, but they also show that women of all wealth groups can face distinct difficulties in breastfeeding.

FIGURE 5. WEALTH AND BREASTFEEDING



Note; The figure shows odds ratios of breastfeeding practices, by wealth quintile. Results are gained through logistic regression, controlling for parents' education; ANC, delivery, and PNC skill level; age at marriage; ownership of TV and radio; country-level IMR and birth rate.

BREASTFEEDING RATES BY LEVEL OF EDUCATION

The disparity in breastfeeding is particularly pronounced among uneducated mothers, who are 19% less likely to initiate breastfeeding early and 13% less likely to exclusively breastfeed than mothers who had completed primary education.[16] These findings are supported by wider evidence. Studies conducted in Uganda[17] and Nigeria[18] found that a mother's education was an important factor associated with exclusive breastfeeding. Women who have had no education may be more likely to follow traditional social practices in which giving an infant colostrum is often considered taboo (see Chapter 3).

However, our study also found that having had a higher level of education (above primary) can actually negatively affect breastfeeding practices: women with higher levels of education were less likely to exclusively breastfeed than those who only attended primary school. Similarly, studies in Ghana[19] and Ethiopia[20] found that mothers who reported having primary schooling were more likely to breastfeed exclusively than those with higher schooling levels. As the study from Ethiopia suggested, this could be due to a correlation between higher education levels and employment, as well as greater exposure or susceptibility to advertising of breast-milk substitutes.

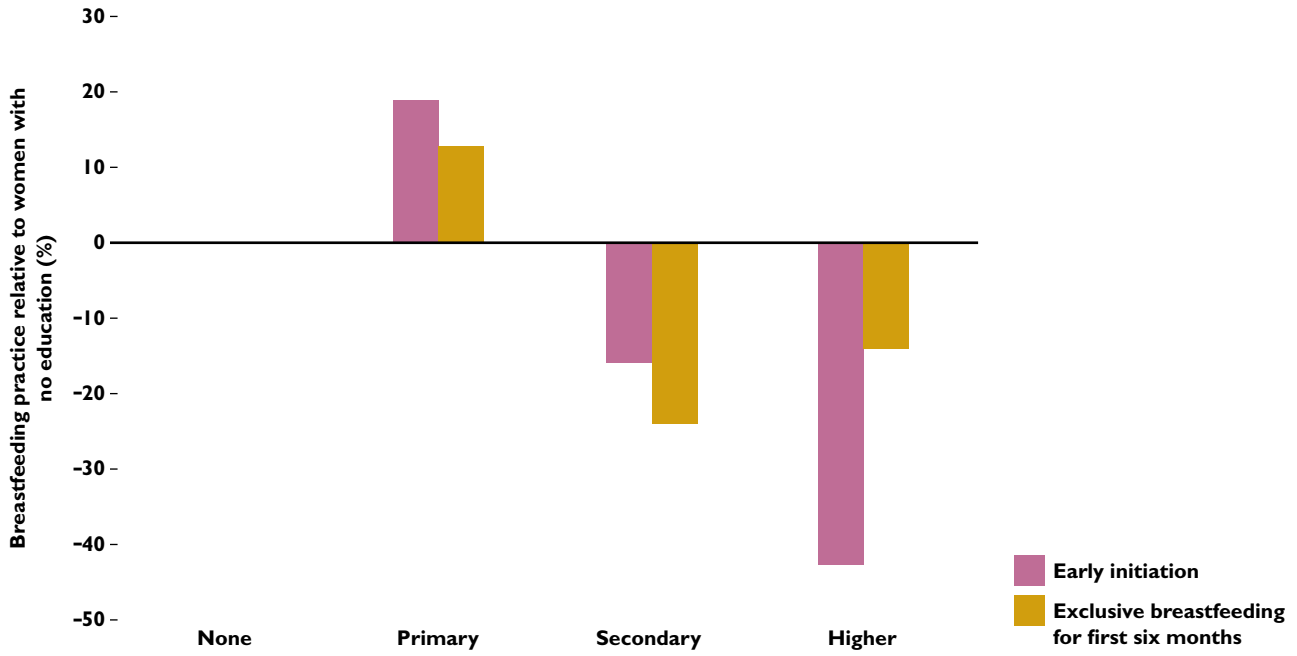
VARIATIONS IN BREASTFEEDING RATES BETWEEN COUNTRIES

Lack of international and national attention to breastfeeding is a key underlying reason for the stagnation of breastfeeding rates. There has been little effective action on the world stage since the 1980s and early 1990s. The introduction of the International Code of Marketing of Breast-milk Substitutes in 1981 (see Chapter 6) and the Baby-Friendly Hospital Initiative in 1991 (see Chapter 4) brought about an increase from levels of around 14% in 1985[21] to their current levels, but since these global initiatives were first introduced, progress has almost stalled.

The global average, moreover, can give a misleading picture: there are substantial differences in rates of both early initiation and of exclusive breastfeeding between countries. In several of the countries analysed by Save the Children, rates of early initiation and exclusive breastfeeding are very much lower than the average. As can be seen in Table 1, four countries have exclusive breastfeeding rates lower than 5%.

Sri Lanka sets the global standard for having the right policies in place to protect and promote breastfeeding and is near the top of the list for both early initiation and exclusive breastfeeding. The country has a strong health infrastructure and a breastfeeding training programme for health workers. Almost every birth

FIGURE 6. EDUCATION AND BREASTFEEDING



Note: Odds ratios of breastfeeding practices, by maternal education level. Results for early initiation only are gained through logistic regression, controlling for wealth category; ANC, delivery, and PNC skill level; age at marriage; ownership of TV and radio; country-level IMR and birth rate. Results for exclusive breastfeeding are not controlled for these factors due to colinearity.

TABLE 1: RATES OF EXCLUSIVE BREASTFEEDING AND EARLY INITIATION

EXCLUSIVE BREASTFEEDING (%)[22]				**EARLY INITIATION (%)**			
Top ten		**Bottom ten**		**Top ten**		**Bottom ten**	
Rwanda	85	Djibouti	1	Samoa	88	Mexico	18
Sri Lanka	76	Suriname	2	Tunisia	87	Democratic People's Republic of Korea	18
Solomon Islands	74	Chad	3	Timor-Leste	82	Burkina Faso	20
Cambodia	74	Côte d'Ivoire	4	Mauritania	81	Cameroon	20
Malawi	72	Tunisia	6	Mongolia	81	Botswana	20
Burundi	69	Algeria	7	Sri Lanka	80	Belarus	21
Peru	68	South Africa	8	Honduras	79	Senegal	23
Nauru	67	Belarus	9	Eritrea	78	Côte d'Ivoire	25
Democratic People's Republic of Korea	65	Somalia	9	Nauru	76	Somalia	26
Bangladesh[23]	64	Dominican Republic	9	Myanmar	76	Pakistan	29

Note: The rates are given for the top ten and bottom ten countries for which data were available for analysis.

Source: UNICEF, *State of the World's Children 2012*

takes place in a hospital or health centre, and 90% of births take place in the 71 hospitals in the country that offer specialist care for newborns and have been designated Baby-Friendly Hospitals. In addition, the Sri Lankan Ministry of Health demonstrates its commitment by hosting a monthly meeting of the Committee on Promotion, Protection and Support of Breastfeeding and the Marketing of Designated Products, where government, academics and representatives of the relevant UN agencies review violations of the International Code.[24]

Malawi is one of only three African countries in the top ten for exclusive breastfeeding. Its early initiation rate is 56%. Despite poor legislation on maternity leave for women in formal employment, Malawi has achieved great progress in all other areas of support to breastfeeding mothers. It has done this through strong policies and full adoption of the International Code of the Marketing of Breast-milk Substitutes into its legislation, with monitoring and enforcement of the Code. In addition, the country's health professionals receive guidelines and training on appropriate maternity care, and there is nationwide coverage of infant and young child feeding support services, together with community-based support and a national campaign on the importance of breastfeeding.[25]

Despite significant improvements, from a low point where only 3% of babies were breastfed exclusively in 1994 to now, when around 25% are exclusively breastfeeding and 20% are breastfed within the first hour, Burkina Faso is still near the bottom of both tables. Bottle-feeding rates are low, but the country faces huge challenges in overcoming traditional feeding practices, and many infants are given water and other foods alongside breast milk. Support for the Baby-Friendly Hospital Initiative has also waned, from 19 certified hospitals in the early 1990s to the current situation where not one remains.

Mexico is also falling behind. While the country has officially adopted a national breastfeeding policy it has no plan of action to implement it, and the training that health workers receive on the best way to feed infants is inadequate. The national strategy for communicating the benefits of breastfeeding is weak; messages have been found to contain inaccurate information and the campaign has not been active in the past year. In addition, women have shorter maternity leave than is internationally recommended and are not entitled to take paid breaks to breastfeed when they return to work.[26]

Much of the data on breastfeeding trends is out of date and some countries have not measured their rates of breastfeeding for over a decade. This is illustrative of the problem that breastfeeding is not given the political time, energy or resources it needs. As the management adage states, "what gets measured, gets done", and this lack of monitoring and accountability could certainly be a contributing factor to the persistent low rates of breastfeeding.

BREASTFEEDING RATES IN DEVELOPED COUNTRIES

In the UK, 81% of mothers initiate breastfeeding early[27] (defined in this context as within the first 24 hours).[28] This highlights a steady increase from 62% in 1990 and 76% in 2005.[29] However, according to the 2010 survey, only 5% of babies were still breastfed at five months (up from 3% in 2005).[30]

In Norway, in 2010, 92% of infants were exclusively breastfed at one week of age. However, similar to the situation in the UK, this had declined to 10% exclusive breastfeeding at six months.[31] This is despite an extensive and positive breastfeeding tradition in Norway and a maternal leave system that supports the possibility to breastfeed.

In the USA, there has been a steady increase in the rate of exclusive breastfeeding at six months of age, from 10.3% in 2003 to 16.3% in 2009. Early initiation rates in 2009 reached 77%.[32]

3 EMPOWERING MOTHERS TO BREASTFEED THEIR BABIES

Despite centuries of knowledge that early and exclusive breastfeeding is the best way to care for newborns and infants,[1,2,3] evidence shows that poor and even harmful feeding practices are very common, including in low-income countries where breastfeeding is even more important. This shows that there are serious barriers and disincentives that prevent women, families and communities from doing what is best for their infants. Women need to be empowered to adopt the feeding practices that can save their infants' lives.

The benefits of breastfeeding go back as far as human history. Breastfeeding has been essential for the survival and development of human beings. That it has become devalued is a result of the way that societies have developed. Infant feeding practices are shaped by power and gender relations, by shifting work patterns, and by the pressure to follow cultural, religious and social norms.

Identifying the reason for these obstacles is crucial if they are to be removed. Attempts to change behaviour through simply publishing advertisements or handing out information and advice will be ineffective unless there is an understanding of the deep social and political factors that govern behaviour, and the will to work towards changing them. These factors are intimately connected with the way that societies treat women, and young women in particular. They also reflect the fact that the rights and well-being of very young children are rarely the priority for a society, but under existing human rights agreements it can be argued that governments already have an obligation in international law to protect the right of the mother and child to breastfeeding.[4]

This chapter will begin by outlining the traditional, cultural and social obstacles to breastfeeding and their prevalence, before explaining how they can be overcome.

COMMON INAPPROPRIATE FEEDING PRACTICES

There are many common practices that go against the recommendations for optimal breastfeeding:

1. DENYING THE NEWBORN THE FIRST MILK

As discussed earlier, the first milk produced immediately after birth – the colostrum – is specially tailored to start the newborn breastfeeding, to meet its nutritional needs and to contain powerful antibodies to help it fight infection (see box on page 4). Despite this, in many cultures it is discarded. Studies in India found that the reasons included religious belief (63.6%), followed by the reasons (in approximate equal proportions) that it was thick, it was unclean, and its removal helped the child to suckle more easily.[5] In Afghanistan, many people believe that colostrum should be discarded because it has been in the breast for 9–10 months.[6] In Niger, tradition dictates that colostrum is dangerous for infants and thrown away, depriving them of the protection they need most.[7]

2. GIVING OTHER SUBSTANCES BEFORE BREASTFEEDING STARTS

Other foods or liquids are often given to an infant as a first feed before breastfeeding is started. These 'pre-lacteal feeds' are often water, herbal teas or sugared water, animal milk or ghee. These substances actually reduce the appetite and thirst of the baby that are essential for it to suckle effectively, and they greatly increase the risk of infections. In Pakistan 62% of infants born in urban areas receive pre-lacteal feeds, and that figure is 5% higher among rural infants.[8] Many Pakistani mothers believe that pre-lacteal feeds are necessary to clean the intestines of the newborn and because breast milk is insufficient.[9] In India, family and religious customs prescribe the giving of pre-lacteal feeds to remove meconium (the earliest stools of an infant) from the gut.[10,11] The practice was found to be most prevalent among illiterate mothers, those

within lower social classes and those who gave birth at home.[12] In Burkina Faso, infants are often fed a concoction of roots, leaves and bark, cooked with tea, which is given to them as early as the first day of life.[13]

3. ASSUMING THAT BREASTFEEDING CANNOT BE RE-ESTABLISHED

After the 2005 Pakistan earthquake, rapid assessments found several barriers were preventing women from breastfeeding. One of these was the belief that once stopped, breastfeeding cannot be re-established and that tired and malnourished mothers cannot breastfeed.[14] The same phenomenon is seen in maternity care in hospitals. In some cases it may be necessary to temporarily supplement the baby's intake with formula milk, but often mothers are not given enough advice, support and encouragement to continue to express milk so that they can resume breastfeeding.

4. FEAR OF BREASTFEEDING IN PUBLIC

Many women in industrialised countries will be familiar with the challenge of breastfeeding in public, but in countries where a woman's ability to breastfeed is controlled by religious, traditional and social practices, that challenge can be significantly greater. Many women in Afghanistan are unable to breastfeed if they do not have a private space in which to do so.[15] In parts of Ethiopia there is a belief that some people possess the 'evil eye', meaning they are able to lay curses on others. One study found that most women believed that exposure to an 'evil eye' could harm their baby and would not breastfeed in places where they could not properly shield and protect their infant.[16] Women and their infants are watched over by family members for the first 40 days of the infant's life in order to protect them.[17]

5. BELIEF THAT BREAST MILK IS INSUFFICIENT

An assessment in Kenya found that grandmothers recommended giving cow's milk to the baby when it is two weeks old and water by the time it is one month old, in order to make the baby healthier or help it pass a stool. By 2–3 months, they encourage the giving of a thin porridge of maize and fruit juices.[18] A study of breastfeeding mothers in Nigeria found that the main reason that women felt unable to breastfeed exclusively included (in approximate equal measure): the perception that their infants continued to be hungry after breastfeeding, maternal health problems, fear of infants becoming addicted to breast milk, pressure from the mother-in-law, pains in the breast, and the need to return to work.[19]

WOMEN'S EMPOWERMENT AND BREASTFEEDING

It is important to ensure that the whole community is fully aware of best practices and of how these can be supported, in order to succeed in increasing rates of immediate and exclusive breastfeeding. For this reason, education and information-giving, coupled with counselling and support mechanisms, are all important activities. However, the underlying reason why women and communities do not follow ideal practices is much more than lack of information or support. At root, it is often the low status of young women in their homes and communities and their lack of power to choose alternatives that are driving poor practices and the persistence of incorrect traditional beliefs. This includes women's lack of access to education and information.

Many women are not free to make their own decisions about whether they will breastfeed or for how long. In Pakistan, a survey of mothers of infants under six months old undertaken by Save the Children in 2012 revealed that only 44% of mothers considered themselves the prime decision-maker regarding the way that their children were fed. When asked to specify the main decision-maker on issues related to the infant's feeding practices (up to six months of age), 22% of mothers said it was other relatives (primarily the mother-in-law) and the rest cited health professionals or traditional birth attendants.[20]

A woman's decision will be heavily influenced by her husband and his family. A husband may need a young mother to return to work as soon as possible, whether in formal employment or informal work that generates income for the family, such as farming or selling, often alongside household work and responsibilities. It is often the father who determines whether the infant is breastfed and, if so, for how long. Fathers interviewed in Kenya said that they did not believe that exclusive breastfeeding for six months was feasible, owing to women having multiple responsibilities that require separation from their infants and because the mother's diet is insufficient for them to produce enough milk.[21]

In Sierra Leone, nearly half (47%) of women reported that their husband made the decisions about their own healthcare, mainly by himself.[22] In some societies there is a post-partum taboo whereby sexual relations are forbidden between a husband and a wife while the wife is breastfeeding. This may result in the husband taking on another wife or mistress which in turn puts pressure on the mother to preserve her marriage by giving up breastfeeding.[23]

PHOTO: AYESHA VELLANI/SAVE THE CHILDREN

MISSING OUT

Karam and her husband, from Punjab in Pakistan, have six children. The family struggles to survive. "Poverty is the only life we know," she says. "I don't know of a life where your needs are met." Karam's youngest child, Raeesa, who is three months old, is showing signs of malnutrition.

Karam says that babies in her neighbourhood are not generally breastfed for their first three days, and so they miss out on the mother's colostrum. Instead, newborn babies are fed cow's milk and *ghutti* – a paste of seeds, herbs and petals that have been cooked together – which is believed to "cleanse their stomachs".

OVERCOMING THE BARRIERS

Frequent and regular breastfeeding is essential to keep milk flowing, and it is a significant demand on a mother's time. Women are often under extreme pressure to return to domestic duties or employment as quickly as possible after birth, which may curtail the period of exclusive breastfeeding. One solution to this, discussed in Chapter 4, is to ensure legal protection and financial support for new mothers. Another is to provide skilled supportive health workers to promote breastfeeding, as discussed in Chapter 3.[24] But underlying that is a need for husbands, families, communities, employers, local authorities and governments to properly recognise the significance of the contribution that a woman is making to the future of her child, her family, her village and her country's economy by breastfeeding her child.

PROJECTS TO ADDRESS CULTURAL BARRIERS

Improving feeding practices in the community requires social and behaviour change communication strategies that lead to changes in norms and values. These can come in a number of forms, as outlined below. For these strategies to be successful they must address not only the individual behaviours of the mother, but the beliefs of those who influence her: health workers, family members, elders and community members. Many programmes fail because they were targeted only at mothers, on the mistaken assumption that it is they who are responsible for the nutrition of the family, when often other members of the family have equal or even greater decision-making powers, particularly when it comes to infants.[25]

It is critical that programmes working to address inappropriate feeding practices are based on a clear understanding of the factors that influence the community. For example, in the Philippines, Save the Children infant and young child feeding (IYCF) programmes in Muslim communities use verses from the Qur'an and quote Muslim leaders who assert that the last Prophet was wet-nursed.

Campaigns

Many countries have launched national campaigns to inform and educate women and the wider community about the importance of breastfeeding and improving IYCF practices. These may include the use of media channels – TV, radio, video, magazines, newspapers, advertisements, billboards or posters. Such campaigns have far greater impact when combined with direct work with communities, including counselling, group education or support groups and community activities. It is important that information and motivational material reaches families and the community, as well as mothers.[26]

Countries' campaigns and communication strategies will be most effective if they are implemented nationally and with consistent and up-to-date messages that are tailored for different groups within the population. The World Breastfeeding Trends Initiative found that while all but two of the 51 countries they assessed engaged in some form of programme or campaign activity about how to feed infants and young children, only 15 had comprehensive national strategies.[28] The lack of a national strategy often leads to confusion, as the public hear different messages and many women live in remote areas that are not reached by any kind of messaging at all.

World Breastfeeding Week is seen in Ethiopia, Kenya and elsewhere as an opportunity for appropriate feeding messages to be widely publicised. However, it is important that this week-long focus does not leave

SUCCESSFUL MEDIA CAMPAIGN IN BANGLADESH

The Bangladesh Infant and Young Children Feeding (IYCF) programme is using a national media education and awareness campaign with TV and radio spots to generate demand for IYCF services and to create a supportive environment. Six TV commercials were aired, each representing a different stage of childhood. They covered early initiation, the misguided perception of insufficient milk and the involvement of fathers. This media campaign is also being supported by 15,000 frontline community health workers who are carrying out IYCF activities, including counselling and support. The programme is ongoing, but it is expected to lead to an additional 800,000 infants under six months old being exclusively breastfed, with reported rates increasing from 43% to 65% in programme areas. It will also lead to nearly 300,000 fewer children under five being stunted and a 10% reduction in anaemia among children 6–23 months old.[27]

INNOVATIVE APPROACHES IN BRAZIL

Brazil is one of the most impressive success stories in infant feeding in recent decades, thanks to innovative programmes and a dedicated effort by the government, non-governmental organisations (NGOs) and the private sector. Breastfeeding duration increased from an average of 5.5 months in 1989[29] to 14 months in 2006.[30] The 1986 DHS survey measured the rate of exclusive breastfeeding (EBF) up to four months as 3.6%. In 2006, the rate of EBF up to six months had risen to 40%.[31]

In 1980 a mass media campaign was launched with national and state-level coordination. A message encouraging mothers to breastfeed for at least six months was spread through 100 television channels, 600 radio stations, sports lottery tickets, water, telephone and energy bills, bank statements and newspaper articles, and through the more traditional scientific meetings. The campaign reached millions of households.[32] It led into a second campaign with the key messages including: "Continue breastfeeding, every woman can", "You can produce enough milk", "Your breasts will not drop if you breastfeed", "You can breastfeed and work", and "Make up your own mind".[33]

A network of 270 human milk banks has been set up where specially trained firefighters or milk bank employees go to the expressing mother's home to collect donated milk to be given to infants who were not able to be breastfed.[34] The National Network of Human Milk Banks in Brazil is considered the largest in the world, with national and international recognition. In Brasilia, one local hospital reported that infant deaths had decreased by 50% after just one year of the programme.[35]

The Breastfeeding-friendly Postman Programme trained nearly 40,000 postmen to provide information on breastfeeding to pregnant women and mothers with babies as they went door-to-door delivering mail.[36]

Finally, in Ceara state, a radio show called 'Family Talks' was set up as an experiment to spread community health messages. It features discussions with families on a wide range of topics that include childcare, nutrition and breastfeeding. By 2008 Family Talks had been picked up by 62 radio stations throughout Ceara state.[37]

gaps in information, education and communication for the remaining 51 weeks of the year. An understanding of breastfeeding needs to be incorporated into school curricula, medical training and paramedical courses consistently throughout the year.

Talking to fathers

In Ethiopia, Alive & Thrive[38] has been working with fathers on issues around infant feeding practices. Its research found that fathers make most of the household-level decisions and are viewed as the 'owners' of family resources. Alive & Thrive worked with a marketing firm to develop and test a campaign to target them. Materials include counselling handbooks to be used by health extension workers,[39] a child nutrition card for families to track their child's feeding against recommended guidance, TV and radio adverts, a radio drama serial, a 50-minute entertainment video and a music video. All materials are culture-specific and produced in local languages. The TV adverts used farming analogies to link good feeding practices to farming practices that fathers were familiar with – for example, feeding the colostrum, which is usually done in the case of calves. One husband remarked during the research for the project: "What I can do for my crops and cattle, I can do for my children."

In Kenya, researchers found that men listen to men, and it was suggested that using trained male facilitators, such as other fathers, could be important for spreading sources of information.[40]

In Ghana, a programme that used existing community networks and a wide range of partners found that breastfeeding practices could be improved on a large scale in a relatively short space of time. The project focused on training and behaviour change communication using radio programmes, print media, counselling, community events and mother-to-mother support groups. Over four years approximately 500 radio broadcasts were made. Fathers were seen as a priority audience and were given the message that a wise father encourages exclusive breastfeeding so their babies grow up to be healthy, strong and intelligent.[41]

In Nicaragua, a new drive to improve rates of exclusive breastfeeding includes promoting 'Breastfeeding-friendly homes' that aim to change gender roles. The project will develop a counselling programme for couples and families on how to support breastfeeding mothers, by ensuring that they are the first to eat, and by sharing childcare and household chores.[42]

Influential grandmothers

Grandmothers were also found to be open to combining new practices with old ones, even if this meant abandoning certain traditions.[43] The Grandmother Project has been set up in several countries including Djibouti, Mali, Mauritania and Senegal. Programmes have dealt with various aspects of women's and children's health by forming multigenerational groups to analyse community problems and identify collective actions that can lead to positive and sustainable changes within their own cultural systems, including infant feeding practices.

Supporting a mother includes helping a woman build confidence before, during and after childbirth. This is done through activities such as support groups, individual or group counselling, home visits, and ensuring that women have access to necessary information and assistance. Mother support is especially important in areas where home delivery is common.

Community groups

Large-scale community programmes aiming to improve breastfeeding practices were implemented in Bolivia, Ghana and Madagascar.[44] In each country hundreds of community members were trained, alongside health workers, in order to saturate the community with clear messages. The chief goal was to equip service providers and community volunteers with the right skills needed to persuade mothers to change their infant-feeding behaviour. Mass media was also employed, including a nationwide radio campaign in Bolivia. Over three to four years, early initiation increased by 18% in Ghana and Bolivia and from 35% to 78% in Madagascar. Exclusive breastfeeding increased in all three countries, with the greatest increase again shown in Madagascar (from 46% to 68%).

PHOTO: SEBASTIAN RICH/SAVE THE CHILDREN

Bishnu, a subsistence farmer from Nepal, with her five-month-old son Abhijit.

4 THE HEALTH WORKER CRISIS AND ITS IMPACT ON BREASTFEEDING

Health workers are vital in supporting a mother to breastfeed – before the birth and especially in the first hours and days of an infant's life. Save the Children's analysis of data from 44 countries[1] found that the presence of a skilled birth attendant increases the likelihood that an infant will be breastfed immediately and exclusively for six months. Women who had a skilled attendant present at birth were twice as likely to initiate breastfeeding within the first hour.

The analysis showed that the presence of unskilled people, such as traditional birth attendants, was correlated with much smaller increases in the likelihood of early initiation of breastfeeding. This suggests that these attendants, often older women in the community who traditionally help mothers to give birth but are not formally trained or certified, are less likely to give correct advice. In India in 2009, a survey reported that only 48% of women had received any information on breastfeeding during pregnancy and only 17% had received support from a health worker.[2]

It is not just the support needed at birth that is critical to the mother and infant. The Save the Children analysis found that mothers who attended antenatal care sessions run by a skilled practitioner were 18% more likely to initiate breastfeeding early and to exclusively breastfeed for six months than mothers who did not.

As many mothers all over the world will know from experience, breastfeeding does not necessarily come naturally. Fear and stress can temporarily inhibit production of the hormone oxytocin, which is responsible for the 'let-down reflex', meaning that milk is not released. This reaction may be evolutionary, from times when a rapid flight from danger required lactation to cease and only to re-start when safety had been found. Reassurance and support to the mother at such times are critical so that she can continue breastfeeding.

This is as much the case for women in developing countries as it is for women in richer countries such as the UK or the USA. The difference for women in poorer countries is that they are much less likely to have attended prenatal sessions or to have a midwife, nurse or doctor present when they give birth to provide support, and hence the importance of breastfeeding is even greater.

Whether the infant is born at home or in a health centre also has a strong influence on breastfeeding practices. In India infants born in health facilities were twice as likely to be breastfed in the first hour as those born at home and in Tanzania, early initiation rates were 57% for those born in health facilities compared with 38% for those born at home.[3]

Save the Children's research in Pakistan found that 84% of mothers were advised about breastfeeding by health professionals, but 84% of mothers also reported that they had been advised to use formula milk or other milk or drinks or food for infants under six months of age. Over half of this advice came from doctors or nurses, a problem discussed further in Chapter 6.[4] It is therefore critical that these health professionals are trained in optimal feeding practices for infants.

THE GLOBAL SHORTAGE OF HEALTH WORKERS

There is a global shortage of about 350,000 midwives, which is part of a wider global shortage of around 3.5 million health workers (see box on page 21). As a result, more than four in ten infants are delivered without any skilled assistance.[5] This poses an immediate risk to the life of the mother and her baby because of the dangers of childbirth, but it also means

PHOTO: CAROLINE TRUTMANN/SAVE THE CHILDREN

MOTHER NATURE'S RECIPE

Basilija (pictured, right) has been a midwife at a rural health centre in Tanzania for five years. She has seen how babies who aren't exclusively breastfeed for six months are at greater risk of life-threatening illnesses like pneumonia and diarrhoea.

"When a baby isn't exclusively breastfed for the first six months, many problems can occur. They can get diarrhoea or they might suffer from indigestion," she says. "Mothers who don't exclusively breastfeed expose their newborn babies to the risk of infection, because of where food is prepared. On the other hand, breast milk is safe and provides newborn babies with enough vitamins and minerals to help build up their immune system.

"Here at the health centre we start educating women when they're pregnant about the importance of exclusive breastfeeding," Basilija continues. "After they give birth we keep teaching them about its importance and how to take care of their babies. One of the challenges we face is that some mothers start giving their babies water or other foods instead of breast milk – they think that breastfeeding isn't enough for their children. But we're doing our best to raise awareness of the importance of exclusive breastfeeding."

the mother is less likely to receive the help she needs to breastfeed immediately, and the important advice required on exclusive breastfeeding until the child is six months old. In many countries, the majority of infants are born at home, rather than in a health centre. In 2008 in sub-Saharan Africa, south Asia and south-east Asia, more than 70% of all births of the poorest 40% of the population took place at home.[6]

ENSURING HEALTH WORKERS CAN SUPPORT BREASTFEEDING

Many countries have shown that it is possible to increase the rates of breastfeeding and support appropriate infant feeding practices. A number of these activities, run by health workers and overseen by ministries of health in developing countries, are described below and offer lessons for successful practice.

Health workers' direct support to mothers

The Lancet Series on Maternal and Child Undernutrition emphasised the importance of breastfeeding counselling, as one of the top three interventions that will improve infant and young child nutrition.[8] Indian mothers who had received antenatal counselling had greater awareness of breastfeeding than those who had not and were more likely to practise exclusive breastfeeding.[9] These findings are substantiated by similar studies in Nigeria.[10,11]

Women who were given post-natal care by someone who was unskilled and had not had sufficient training were 25% less likely to be exclusively breastfeeding than women who had no post-natal care at all. This suggests that those unskilled practitioners, such as traditional birth attendants, were giving poor advice and potentially reinforcing harmful local attitudes and taboos.

While most Nigerian women breastfeed, fewer than 2% do so exclusively for even four months, and early initiation is often low.[12] An intervention to train health extension workers to give breastfeeding support led to 47% of infants being breastfed within 30 minutes of delivery, compared with only 4% in the control area. Following the intervention, many more health workers recommended exclusive breastfeeding and avoidance of pre-lacteal feeds, compared with the control area.[13]

Baby-Friendly Hospital Initiative

The Baby-Friendly Hospital Initiative (BFHI) was launched in 1991 by WHO and UNICEF in an effort to implement practices that protect, promote and support breastfeeding. To be designated 'baby-friendly' a maternity centre must implement the Ten Steps to Successful Breastfeeding (see Appendix 2). More than 20,000 hospitals in 156 countries have achieved BFHI status and proved to be effective in increasing exclusive breastfeeding rates. In China, breastfeeding rates doubled in rural areas and increased from 10% to 47% in urban areas after two years of BFHI implementation.[14] In Cuba, exclusive breastfeeding rose from 25% to 72% in the six years after the introduction of the BFHI.[15,16]

Nicaragua was the first country to successfully certify the Baby-Friendly Hospital Initiative at the national level. By 2005, 77% of all hospitals were certified,

THE GLOBAL HEALTH WORKER CRISIS

The World Health Organization (WHO) has said that the minimum recommended number of health workers – doctors, nurses and midwives – is 23 per 10,000 population or one for every 435 people. There are more than 60 countries with a critical shortage of health workers; two-thirds of these countries are in Africa. Sierra Leone, for example, has two health workers for every 10,000 people.

There are many reasons for this health workforce crisis. Health workers have tough working conditions; staff shortages mean they are overworked, while a lack of money for the health service means they are underpaid. This chronic underinvestment in health also means health facilities lack the basic equipment and medicines workers need to do their jobs and there are few opportunities for training, education and career development. Countries do not have the facilities to educate sufficient numbers of health workers and many of those they do train will go abroad to seek a better standard of living. Remote rural areas and neglected urban areas face particular challenges as few health workers are willing to work there.[7]

THE WORLD'S FIRST BABY-FRIENDLY STATE

In 2002, Kerala, India, was declared the world's first 'baby-friendly state' after 80% of its maternity hospitals were given BFHI status. Rates of initiating breastfeeding within the first day of an infant's life were 92% compared with the national average of 37.1%.[17] Random reviews of BFHI hospitals in Kerala found that breastfeeding practices were being followed systematically and that in 85.7% of cases the infants had remained with their mother since delivery – as recommended, to ensure early initiation and optimal breastfeeding. Furthermore, none of the hospitals was found to be displaying or distributing any advertisement, promotional or educational materials carrying the name of any infant formula or its manufacturers.[18]

and exclusive breastfeeding rates had increased from 6% in 1998 to 31% in 2001. The Ministry of Health achieved this by enforcing a legal framework concerning exclusive breastfeeding and by ensuring that every single person working in health institutions – including drivers, clerks and janitors – was trained. Despite this, five years after the certification, lack of continued investment meant that only one hospital was still certified as baby-friendly under the BFHI.[19] In 2012, however, there was renewed political will to revitalise hospitals and communities that were previously certified.[20]

Global momentum for the BFHI project now appears to be stalling: many hospitals were never fully drawn into the project because of a lack of available funding, and many of those that were have not been monitored or reassessed since their initial designation.[21] In Pakistan, the BFHI was launched with the support of development partners, but weak commitment from the government meant that the initiative reached only a few hospitals.[22] A similar situation exists in Nigeria, where only 4.8% of hospitals have been designated baby-friendly.[23]

UNICEF is promoting the BFHI beyond hospitals to health workers in other settings such as health centres and clinics, and is pushing for the Ten Steps to Successful Breastfeeding to be used in all maternity units. To be accredited, a healthcare centre has to ensure all staff are aware of a written breastfeeding policy and that they have received appropriate training so that it will be properly implemented. Pregnant women and mothers should in turn be taught about the benefits of breastfeeding and supported to initiate and maintain breastfeeding. Cooperation between healthcare staff, breastfeeding support groups and the local community is also an essential element of the initiative.

SPECIAL CIRCUMSTANCES

There is a need for two further types of programmes that give special consideration to breastfeeding as part of a wider response to specific circumstances: those around mothers living with HIV; and situations in the wake of humanitarian crises. Both are discussed below.

HIV and infant feeding

Infant feeding in the context of HIV is complex, as the risk of passing the virus from mother to child must be balanced against the increased risk of the infant dying from a disease (eg, pneumonia or diarrhoea) if he or she is not breastfed. Recommended feeding practices should support the greatest likelihood of HIV-free survival of children, while not harming the health of mothers. Many studies in countries that include Botswana, India, Malawi, South Africa and Uganda have found that even in the absence of antiretroviral (ARV) interventions, there is still higher mortality among non-breastfed children than among children whose HIV-positive mothers breastfed properly.[24] When ARV drugs are available, the risk of transmitting the virus through breast milk is even lower.

In 2010, new guidelines on HIV and Infant Feeding recommended that governments decide on a single national public health recommendation depending on the epidemiological, child survival and HIV situation in their respective countries. Accordingly, national guidelines may recommend either exclusive breastfeeding while the mother receives ARV treatment or that she avoids breastfeeding.[25] The former option is the one favoured by most developing countries.

Eight out of ten health professionals in Ethiopia would strongly defend both their promotion of replacement feeding and their silence regarding exclusive breastfeeding as an infant feeding option for HIV-positive mothers.[26] In Kenya, to help eliminate mother-to-child transmission (MTCT) of the virus,

PHOTO: GENNA NACCACHE/SAVE THE CHILDREN

SIMPLY THE BEST

Joice is from Bahia state in eastern Brazil. Her daughter, Laura, was born premature and she was kept in a neonatal unit for 45 days. During this time Joice was unable to breastfeed. Instead, she had to express milk and feed it to Laura from a bottle, supplemented as necessary with milk from the 'milk bank' (see page 17). Joice found it hard not to be able to breastfeed – she knew about the benefits of breastfeeding for children's health and development.

However, in spite of this difficult start, Joice did go on to breastfeed successfully. When Laura came out of the incubator she was transferred to a centre that practises 'kangaroo care'. This technique of caring for premature babies emphasises the importance of skin-to-skin contact with the parents. Thanks to the support of health workers, Laura started to breastfeed within days.

"Mothers often worry that their breast milk won't be enough to sustain their babies," says Joice. "That's why many of them end up feeding them with formula milk. The health team here has taught me that the more milk I give, the more I'll have, and this helps your child to grow up healthy."

UNICEF launched a 'Mother–Baby Pack' initiative in 2010 as part of the Maisha MTCT-free Zone Initiative.[27] As less than half of all pregnant women in Kenya complete four antenatal visits and more than half of women do not give birth in health facilities, this initiative aims to reach women who would otherwise fall through the cracks.

Infant Feeding in Emergencies (IFE)

In emergencies there is often a breakdown in national or agency policies related to infant feeding, as companies and donors rush to provide goods and services and send countries products that are not needed and that may actually harm breastfeeding and other infant feeding practices. Any donations of breast-milk substitutes and related products such as bottles and teats should be collected and stored until UNICEF or the designated coordinating agency, together with the government – if functional – develops a plan for their safe use or destruction.[28] Should there be a need for breast-milk substitutes it is usually far better to source them within the region to ensure labels are in the correct language. Distribution of breast-milk substitutes must be done in a carefully targeted way.

Key information on how infants and young children are being fed should be collected during routine rapid assessment procedures. Health, nutrition and community workers should be trained according to national or agency guidelines, to promote, protect and support optimal feeding practices as soon as possible after the onset of an emergency. Child feeding/caring areas should be set up where necessary to provide individual support to mothers and infants who require it.[29]

In the 2008 conflict in Gaza there was an untargeted distribution of breast-milk substitutes and more than one-quarter of mothers received infant formula during or immediately after the conflict, including mothers who were breastfeeding. Nearly half the mothers received other breast-milk substitutes and some received baby bottles. Roughly 50% of mothers reported that they reduced their frequency of breastfeeding during this time.[30]

NO CHILD OUT OF REACH

Save the Children is campaigning for every child to be in reach of a health worker. A key part of this is the role that health workers must play in supporting women to breastfeed. This requires global and political action at the highest level to recruit more health workers with appropriate skills, make better use of existing health workers to reach the most vulnerable families, ensure that all health workers are paid a fair wage, and deliver more funding for healthcare – and in a more effective way.

A 2010 report reviewing ten areas[31] of infant feeding policies and programmes in 33 countries found that achieving optimal breastfeeding practices was not a priority for any of these countries. In addition, in many of them, information was either lacking or out of date, making it difficult to assess the situation.[32] This report found that infant and young child nutrition had not been successfully integrated into health and nutrition systems in the countries surveyed. Enthusiasm for successful schemes like the Baby-Friendly Hospital Initiative had not been maintained.

As well as taking action to ensure that health workers are in place to support breastfeeding and that they are properly trained and equipped, governments need to give attention to how the state can do more to remove the barriers and enable women to breastfeed.

5 MATERNITY PROTECTION: LACK OF LEGISLATION TO ENABLE MOTHERS TO BREASTFEED

Political will and social support for breastfeeding have a strong influence over whether and how long women are able to breastfeed.

Returning to work after the birth of a child is difficult for any mother, regardless of her circumstances, and it can often mean that continuing to breastfeed exclusively for the recommended six months becomes very challenging. Therefore, national policies related to employment and maternity, the financial support on offer from the government and the attitude of those in power all play a key role in a woman's decision to breastfeed.

This chapter outlines the type of support available for breastfeeding mothers, drawing on new comparative research into national legislation that affects breastfeeding, carried out for Save the Children by international law firm Freshfields Bruckhaus Deringer LLP.

Women who are not employed in the formal sector – for example, those working on family farms or small traders – often do not benefit from the protection provided by employment and maternity policies. In developing countries where the burden of child mortality is highest, these women make up a larger share of the workforce; thus, protecting their ability to breastfeed must also be a priority. The latter section of this chapter will consider the particular vulnerabilities of women in this situation, and what can be done to support them.

MATERNITY LEGISLATION AND STATE GRANTS

In order to reduce the barriers to breastfeeding that women can face as a result of work pressures, the state can provide various forms of support and protection, including:

- maternity leave and employment rights
- financial protection in the form of state grants, social protection, or benefits
- policies and provisions to support breastfeeding in the workplace.

The new Save the Children research commissioned for this report examined maternity protection in the 36 low-income countries with the highest number of malnourished children. It looked at whether maternity leave in these countries met the International Labour Organization's (ILO's) minimum standards, the extent to which the state provided financial protection and whether its policies made provision for breastfeeding women at the workplace. Highlights of the research are outlined below and a full overview is in Appendix 3.

MATERNITY LEAVE

The importance of appropriate length of maternity leave is critical not just for the infant and for the continuation of breastfeeding, but for the mother's health.[1] In 2000, the ILO recommended that countries endeavour to provide women with 18 weeks' maternity leave, but no less than 14 weeks.[2] Many countries are still falling well short of the minimum standard and most are failing to meet best practice.

THE ILO CONVENTION

Global standards on maternity protection are overseen by the International Labour Organization (ILO), a United Nations agency that brings together governments, employers and workers. In 2000 it adopted the Maternity Protection Convention 183 and Recommendation 191, to ensure that women's work does not threaten the health of the woman or her children and that having a baby does not compromise her economic and employment security. The Convention and subsequent Recommendation provide for:

- a minimum of 14 weeks' maternity leave, with a recommendation for states to endeavour to provide 18 weeks
- cash benefits amounting to not less than two-thirds of their previous salary (to be provided through compulsory social insurance or public funds and not by an employer)
- the right to one or more daily breaks, or a daily reduction in hours of work, to allow for breastfeeding
- medical and maternity care provided by qualified healthcare providers
- protection of pregnant and breastfeeding women and their children from any workplace risks to their health
- protection from dismissal and discrimination and entitlement to return to a former position with breastfeeding support on return to work (eg, private spaces for breastfeeding or expressing milk, flexible scheduling for breastfeeding mothers, childcare, etc).

The length of time provided for maternity leave varies widely from country to country. Even 18 weeks is not long enough to allow a woman to breastfeed exclusively for six months (or 26 weeks) at home, and many rich countries therefore have considerably more generous maternity leave policies. At the top end of the scale is Sweden, which provides 480 days of parental leave that can be taken by either parent at any point until the child is eight years old.[3] The UK provides for up to 52 weeks of maternity leave with maternity pay contributions coming from employers and the state budget.[4] In Norway there is provision for 47 weeks' parental leave on full pay, or 57 weeks on 80% pay. In both cases the father has to take 12 of the total number of weeks allowed. There is a cash-for-care system for children aged 13–23 months who are not in day care, with subsidies provided by the government.[5]

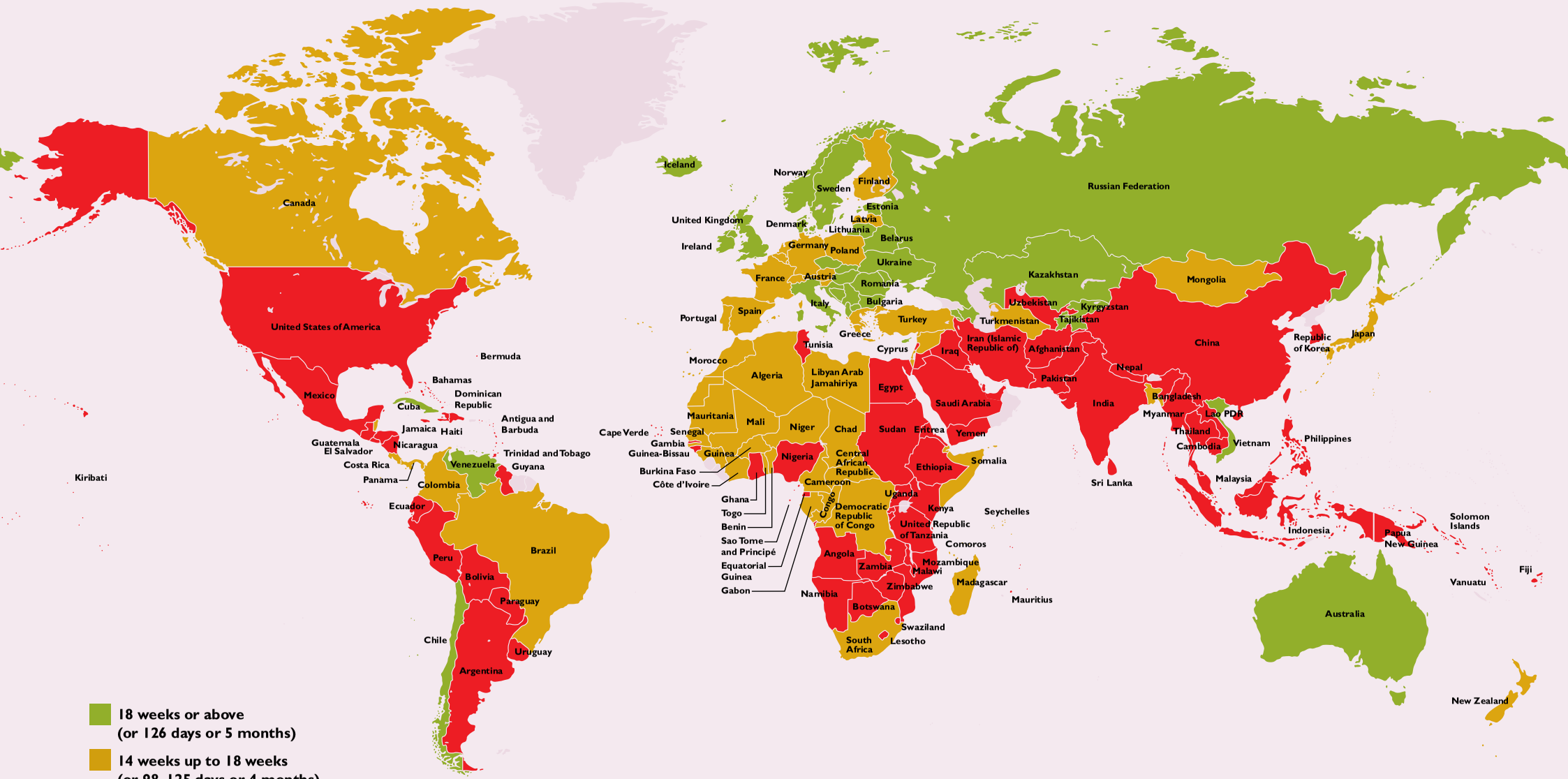
Save the Children's latest analysis in 36 low-income countries found that all countries' legislation provided some form of maternity leave. However, only Vietnam, which provides six months' maternity leave, exceeded the recommended allowance of 18 weeks. Only ten countries met the minimum standard of 14 weeks.[6] At the bottom end of the table were Malawi and Sudan, which provided only eight weeks' leave; Mozambique, Iraq, the Philippines and Yemen all allowed less than nine weeks. In addition to this analysis, we have learned that in October 2011 Chile increased its maternity leave from three to six months[7] and in 2011 Bangladesh increased maternity leave to six months for government sector workers, though this has yet to filter down to private sector employees. In India, employees of central government receive six months but state government employees still receive only 90 days' maternity leave, while maternity leave for private sector employees is left to the discretion of the employer.[8]

A comparison of 38 industrialised countries revealed that all but one met the minimum standard of 14 weeks' leave (the exception being the USA with 12 weeks) and that 18 met or exceeded the recommended duration of 18 weeks.

In June 2012 Vietnam's National Assembly made a landmark decision to extend paid maternity leave from four to six months – a bold departure from other maternity leave policies in south-east Asia.[9] Women working in the public sector are entitled to 100% of their salary for the time that they are on leave.[10] It is notable that it is compulsory for women to have at least two months' rest after the birth, and longer if they are not certified as fit to return to work at that time.[11] It must be pointed out, however, that while this legislation is a positive step by the Vietnamese government, the exclusive breastfeeding rates remain very low, at 17%.[12] Hence, other aspects of support to mothers of newborns are essential, as described in this report.

The map opposite demonstrates the differentiation of maternity protection in the world.

MATERNITY LEAVE AROUND THE WORLD



Note: In India, maternity leave for central government employees is six months, for state government employees 90 days, and in the private sector is at the employer's discretion.

FINANCIAL PROTECTION

Financial support from the state that helps a mother to maintain the family's income level during the early months of her child's life can alleviate some of the pressure to return to work immediately. This support normally comes in the form of maternity pay or benefits but can also take the form of state grants to enable breastfeeding. Again, despite the ILO recommendation that governments provide women with at least two-thirds of their salary, countries were found to provide very different levels of financial support. The balance between how much of the costs were covered by the state budget and how much by employers also varied from country to country.

Save the Children's analysis looked at the percentage of a woman's salary that would be paid while she was on maternity leave. The analysis found that 28 of the 36 low-income countries paid 100% of the woman's salary for the duration of the maternity leave – either shared by the government and employer or paid fully by either one. Of the remaining countries, only Nigeria and Cambodia paid less than half the woman's salary.

In the industrialised group only five of the 38 countries failed to meet the two-thirds standard (Canada 55%, Czech Republic 60%, Greece 50%, Japan 30% and Slovakia 55%). In two countries (Australia and Denmark) maternity pay was funded by employers, and the USA did not provide data.[13]

In rare instances, countries have provided financial support that specifically rewards or incentivises women who breastfeed. Angola has national legislation that provides state grants for lactating women in addition to the normal maternity benefits that are available to all women.[14] To qualify for these breastfeeding cash payments, women must have contributed social security payments for at least three of the last 12 months; have the birth certificate of the newborn; and have met the vaccination schedule established by the Ministry of Health. India is considering similar grants for lactating women as part of the Food Security Bill proposals currently going through parliament.[15]

WORKPLACE POLICIES

Once a mother returns to work, policies are needed that require employers to provide paid breaks and private places where women can breastfeed or express milk. In countries where maternity policies do not provide for the full six months recommended for exclusive breastfeeding, these provisions are even more important. If a woman works close to home it may be possible for the infant to be brought to her place of work to be fed, or alternatively childcare facilities should be considered.

This is part of a wider change that is needed within many societies to ensure that women are valued within the workplace and that employers are not able to discriminate against women because of pregnancy. Governments must ensure that employers are supported to make these provisions in order that they do not act as a disincentive to employ women.

Save the Children's research shows that more than 20 of the 36 low-income countries legislated for paid breaks for lactating mothers at the workplace. In 19 of the 36 countries there is a law in place allowing for paid breaks at work. In Vietnam, in addition to 60 minutes' paid rest in order to breastfeed at their workplace each day, enterprises that employ a high number of female employees should provide childcare centres and kindergartens or assist with part of the costs of child care.[16] Nigeria allows women to take up to one hour a day off work in order to breastfeed, but fails to state whether this is to be paid.[17]

SUPPORTIVE POLICIES AND LAWS

A government's responsibility to protect breastfeeding does not end there. Other laws can be implemented relating to the healthcare industry, education, taxation and financial incentives to support breastfeeding and in employment law. For example, the Philippines' Act 100028 requires the Department of Education to integrate breastfeeding education into the curriculum at all educational levels, including elementary, high school and college levels. The same Act, passed in July 2009, requires certain health and non-health facilities to create lactation stations which provide breastfeeding mothers with a place to breastfeed. The Act provides tax incentives to establishments providing such accommodation. Violators, by contrast, are required to pay fines for failing to provide the minimum standard for lactation stations. Mongolia and Estonia prohibit dismissal from the time of pregnancy until the child is three years old.[18] In 2004,

the Scottish Parliament passed the Breastfeeding Act. Under the Act, a person who interferes with a mother in the act of breastfeeding her child in a place that she is otherwise lawfully allowed to be may be fined up to £2,500.[19] Similar laws exist in British Columbia (Canada), Taiwan and Australia.

Alongside all this is the importance of integrating the International Code of Marketing of Breast-milk Substitutes and other subsequent relevant resolutions into national law.

Brazil is an example to other countries in many aspects of its law, and the Ministry of Health has been referred to as a pioneer in developing breastfeeding policy.[20] One example comes from the industrial city of São José dos Campos in São Paulo state, a city with more than 400 factories, where the health secretariat introduced counselling for mothers to teach them how to express and store breast milk before they return to work. It also includes training for childcare providers – such as childminders or grandparents – on how to cup-feed expressed breast milk in the mother's absence. The city council also provides crèche facilities for female employees with children up to five years of age.[21]

WOMEN WORKING IN THE INFORMAL SECTOR

The 'informal sector' includes jobs like street vending, domestic work, casual labour or agricultural work and is a major source of employment and income for women. The ILO has said that more women are in informal employment than formal employment and that more women than men are in informal employment.[22] These women may be from households living in poverty, as earnings from informal employment are likely to be low and unreliable. The ILO Maternity Protection Convention ostensibly applies to "all employed women, including those in atypical forms of dependent work", but according to UNICEF the compensation frameworks in many jurisdictions do not apply to women working "in the informal economy and in rural farming who often lead the most economically fragile lives".[23]

Strong policies and practices in the formal sector of employment help to set standards and norms which can help to advocate for similar policies to apply to those in other modes of employment. However, for many women, their informal employment is not covered by formal arrangements including employment benefits (such as sick pay or annual leave) or national labour legislation, including maternity policies. The most recent World Breastfeeding Trends report showed that of the 51 countries reviewed[24] only 17 had any provisions for mothers working in the informal and agricultural sectors. In Angola, women who work outside the regulated sector and are not paying social security are not eligible for state grants. Thus, breastfeeding women who are in informal employment are not sufficiently protected by the state but are still subject to pressure to return to work.

Women in informal employment also face problems in continuing to breastfeed when they return to work, as they are unable to take their children with them to the fields to farm or to do household work such as collecting firewood and water.

For these women, state grants and social protection that are not linked to formal maternity leave are even more important. These forms of financial support allow women to maintain their household income while they are breastfeeding and relieve some of the pressure to return to work immediately. This sort of financial support for breastfeeding is a clear indication of a government's commitment to improving nutrition and the extent to which it values the role being performed by mothers.

PROTECTION FOR WOMEN IN INFORMAL EMPLOYMENT

In India, the government has started providing conditional cash transfers to women working in the informal sector who have infants up to the age of six months. The scheme, currently in 52 of the 393 districts, is conditional upon a number of requirements including women attending antenatal care clinics, receiving breastfeeding counselling and exclusively breastfeeding. It has now been extended so it reaches every woman in the two states of Assam and Orissa. The amount of cash given has been increased from 4,000 Indian rupees to 6,000 rupees ($110), paid in three instalments, and in Assam women with infants up to the age of nine months are now covered.[25] Another example in India is the Self-Employed Women's Association, an insurance scheme for casual labourers that includes maternity benefits and reimburses mothers for a proportion of their loss of income and medical expenses.[26] In Bangladesh social security provides maternity benefits for self-employed women and casual labourers, though in practice coverage is very limited.[27]

In some countries, poverty alleviation programmes that are not traditionally associated with or specifically designed to improve breastfeeding have seen positive results on infant nutrition.

In Mexico, the Progresa-Oportunidades cash transfers were targeted at poor families and used for increasing access to education and to health facilities. The cash transfers were given to mothers to empower women at the household and community level. The result was a positive change in behaviour towards girls and greater support for pregnant and breastfeeding women, in terms of attitudes and an increased entitlement to health services.[28]

The Red de Protección Social cash transfer programme in Nicaragua, launched in 2000, provided all households that met certain conditions with a cash payment designed to increase their access to food. One of these conditions was that family members had to attend health and nutrition workshops that included education on childcare and breastfeeding.[29]

PROMOTING BREASTFEEDING IN MYANMAR

In Myanmar, Save the Children has been protecting breastfeeding mothers in rural and urban settings and in the formal and informal sectors. We provided mothers with cash grants so they could stay at home and breastfeed during the crucial first months. All the recipients were active members of mothers' support groups where they were able to get information and advice about nutrition. We also involved the wider community in some sessions to ensure that messages about breastfeeding reached influential people, such as local leaders, who could help to achieve changes within families. The project resulted in over 90% of the targeted mothers reporting that they had breastfed exclusively.[30]

In rural areas we trained a group of experienced mothers to act as breastfeeding counsellors to other mothers facing difficulties. This programme also included a project to support women to establish gardens at home, and a fresh food voucher scheme for pregnant and breastfeeding women. The result was an increase in early initiation rates from 50% to 90% and an increase in exclusive breastfeeding rates from 9% to 45%.

In the peri-urban area around the capital Yangon we are working with employers to strengthen the maternity provisions for working mothers and to provide breastfeeding spaces in the workplace. We are encouraging employers and mothers to participate in the government's social protection schemes and are helping to shape government policies on maternity.

6 BREAST-MILK SUBSTITUTE COMPANIES FACING CONFLICT OF INTEREST

The global baby food industry is estimated to be worth more than $36 billion and that figure is predicted to rise by 31% by 2015. The lion's share of this is the sale of milk formula, which accounts for $25 billion.[1]

While there is a recognised need for some infants to be formula-fed in certain cases, there has long been concern that the marketing and promotion activities of some manufacturers has led to breast-milk substitutes being used unnecessarily and improperly, ultimately putting children at risk. The risk is amplified in lower-income countries where women have less access to clean water to prepare formula and are often unable to afford sufficient amounts of the product to keep their baby well fed. Regulation of these marketing practices is often weaker in these countries, where governments generally do not have the power to hold large companies to account.

Save the Children believes that breast-milk substitute companies face an inherent conflict of interest because their rival product, breast milk, is both superior and free. Putting all other corporate or social aims of these companies aside, it is in the commercial interests of breast-milk substitute manufacturers to undermine breastfeeding and thus limit the use of the rival product.[2]

THIRTY YEARS OF REGULATION, BUT VIOLATIONS CONTINUE

In 1981, the World Health Assembly (WHA) responded to a long-running international campaign by civil society and health advocates by adopting a set of minimum standards to promote and protect breastfeeding and ensure breast-milk substitutes are used safely if needed. The standards, adopted by the WHA – the world's highest-level body that sets global health policies – are known as The International Code of Marketing of Breast-milk Substitutes or, more simply, 'the Code'. Since then the WHA has adopted a number of additional subsequent resolutions that update and develop the provisions of the Code (See Box below and Appendix 4).

The Code is designed to regulate "inappropriate sales promotion" of breast-milk substitutes, and instructs signatory governments to ensure the implementation of its aims through legislation.[3] The Code is not legally binding unless it has been enshrined into a country's national law but, independent of this, the Code states that relevant companies should abide by it and regard themselves responsible for monitoring their marketing practices according to the principles and aim of the Code, and take steps to ensure that their conduct at every level conforms.[4] This means that where national law is not as strong as the Code, BMS companies should still adhere to the Code. In addition, the UN Convention on the Rights of the Child 1989 speaks of the need to "ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition [and], the advantages of breast-feeding".[5]

There is evidence that since the introduction of the Code, in those countries that have adopted it, some BMS manufacturers have improved their approach. In those countries, some of the more blatant violations (such as free samples of breast-milk substitutes to new mothers) have reduced significantly. However, in those countries where regulation is weak, evidence suggests that violations continue. Even where the Code has been adopted, it appears that many BMS companies are finding new ways around it, and are utilising loopholes such as marketing 'follow-on formula'.[6]

Some BMS companies have taken steps in the right direction by creating their own internal management procedures for monitoring and reporting Code violations, including whistleblowing policies and online reporting forms. Furthermore, the corporate social responsibility activities of some of the parent companies of BMS manufacturers are highly developed and play a valuable role.

However, it is clear that the industry is not doing enough to ensure compliance with the Code and has yet to go through a change in mindset. The WHA response to these challenges has been to adopt additional resolutions to the Code in order to strengthen it in the face of new marketing tactics and to close the loopholes that have been utilised by some manufacturers.[7]

Thirty years after the launch of the Code, the global situation for breast-milk substitute sales and marketing has changed, but is no less concerning. There is fresh evidence that, in practice, despite the introduction of high-level company policies and guidelines, violations of the Code and resolutions are still widespread. Save the Children researched practices in more than a dozen countries in order to prepare this report and found recent evidence to suggest multiple violations by many breast-milk substitute companies, their subsidiaries and distributors. Some of the most concerning examples of violations include the apparent targeting of health workers.

At the same time, the most obvious global trend is that BMS companies are increasingly focusing their efforts on emerging markets, such as China, India and south-east Asia. Evidence suggests that this new focus is often accompanied by BMS companies seeking to influence governments in these countries to weaken national policies and legislation.

SUMMARY: INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES[8]

Since the Code was introduced in 1981 a number of subsequent WHA resolutions have been adopted – including as recently as 2012 – which have aimed to keep pace with development in marketing and science. These are listed in Appendix 4, alongside a fuller explanation of the Code.[9] The subsequent resolutions have the same status as the 1981 Code.

A breast-milk substitute is any product that represents a partial or total replacement for breast milk. This can include food and beverages such as: infant formula, other milk products, cereals for infants, vegetable mixes, baby teas and juices, and follow-up milks. The Code also applies to feeding bottles and teats.

MAIN POINTS

- No advertising of breast-milk substitutes and no other promotion of products, ie, no product displays, posters or promotional materials.
- No free samples to mothers, their families or health workers. No free or low-cost supplies to any part of the healthcare system.
- Marketing personnel should not seek direct or indirect contact with pregnant women or mothers of infants and young children (children up to three years of age).
- No gifts to health workers.
- Product information must be factual and scientific.
- Labels must state the superiority of breastfeeding and [give] a warning about health hazards.
- Labels must be written in the local language.
- No pictures of infants, or other pictures or text idealising the use of infant formula.

THE PROBLEM WITH BREAST-MILK SUBSTITUTE PROMOTION

Breast-milk substitute companies are normally multi-million-dollar operations with huge marketing budgets. Nestlé SA is the global leader in baby food with a 23% share of the market, followed by Danone which, since acquiring Royal Numico, has 14%. Mead Johnson is third with 11% of the global market.[10]

The Code includes provisions on a number of marketing tactics that when used to promote breast-milk substitutes can directly or indirectly undermine breastfeeding. This includes direct advertising, giving free samples, targeting mothers and printing spurious health claims on packaging. Breast-milk substitute companies that use these tactics are violating the Code. Naren Kaimal, an advertising executive who has been working for the Breastfeeding Promotion Network of India, said: "Promotion of breast-milk substitutes is very clever. It portrays the product as something aspirational, turning it into a status symbol and attempting to convince women that they could not have made a better choice for their baby. It also plays with perceptions around nuclear families – that it is a convenient product for working women who have little time off work."[11]

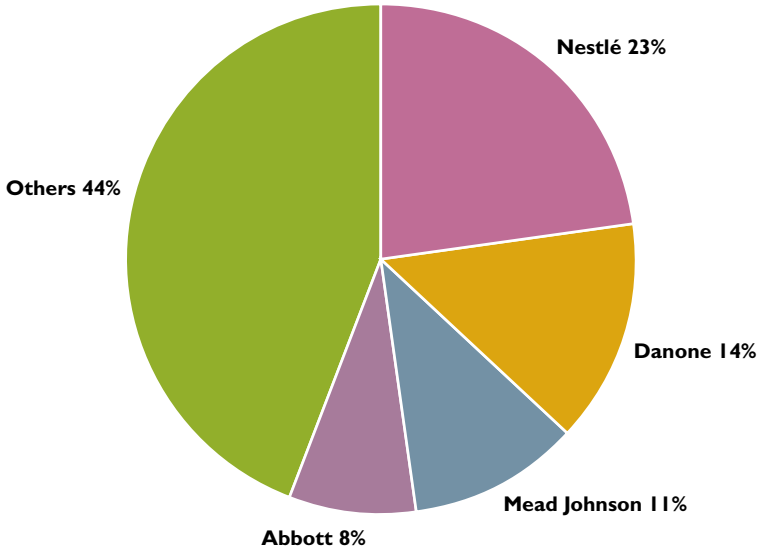
ADVERTISING

BMS companies use a variety of advertising messages to market their products, often appearing to make the use of breast-milk substitutes seem aspirational.

Save the Children research in six cities in China[12] found that 16 of the 35 food stores surveyed promoted breast-milk substitutes, for example, through salespeople, posters and gifts, and hence in our view violated the Code. In Pakistan[13] we found that 11% of mothers interviewed reported seeing or reading about a promotional campaign by BMS companies, mainly at a clinic or hospital.[14]

Some of the more misleading marketing campaigns over the years have included health claims for which there is little scientific evidence. The UK Scientific Advisory Committee on Nutrition (SACN) in 2007 explained why such claims are inappropriate, saying: "We find the case for labelling infant formula or follow-on formula with health or nutrition claims entirely unsupportable. If an ingredient is unequivocally beneficial as demonstrated by independent review of scientific data it would be unethical to withhold it for commercial reasons. Rather it should be made a required ingredient of infant formula in order to reduce existing risks associated with artificial feeding."[15] In 2010, the European Food Standards Agency ruled that Danone did not have sufficient evidence to justify a claim that the 'Immunofortis' ingredient in its baby formula products strengthened an infant's immune system;[16] subsequently, Danone said that the Immunofortis shield logo trademark would no longer be used on products manufactured after the end of 2012.[17]

FIGURE 7. GLOBAL BABY FOOD COMPETITIVE LANDSCAPE 2009



BRAND RECOGNITION

The Code states that there should be no advertising to the general public of products within the scope of the Code,[18] so some BMS companies are finding ways to promote their brands through other channels. Giving mothers or health workers branded gifts – for example, teddy bears with formula company logos, is a subtle way of raising brand awareness and creating an association of trust.[19] But providing gifts that may promote the use of breast-milk substitutes is in itself a violation of the Code and evidence suggests the practice is still widespread. Our recent survey in Pakistan (see Appendix 1) reported that one-fifth of health professionals surveyed said they had received gifts from representatives of BMS companies. These included prescription pads, calendars, pens and note pads. Over half of these gifts were reported to have been Nestlé-branded and the rest to have carried other companies' brands, including the Japanese firms Morinaga and Meiji.

Save the Children research in China found that a quarter of mothers surveyed said they had received gifts, mostly from the representatives of BMS companies (two-thirds), and from health workers. A survey in Laos in 2012[20] showed that all of the nurses and doctors who reported a contact with an infant formula sales representative said they had received gifts[21] and 66.7% of shop keepers and 63.6% of mothers who had had contact with sales representatives also reported receiving gifts. A survey in Ecuador in 2012[22] found that more than half of the health centres surveyed said they had been given products or merchandise by formula companies and more than half said they had also received unsolicited donations of bottles and teats from formula manufacturers.

BRANDING DANGER

The possible dangers of potentially misleading branding were highlighted by an article published by the *British Medical Journal*. The article was in response to reported cases of malnutrition in Laos in 2008 among infants who had been fed coffee creamer.[23] According to the article, the product used in those cases was reported to be Nestlé's Bear Brand coffee creamer, which at the time carried a logo of a cartoon baby bear being held by its mother in what appears to be the breastfeeding position. The largest ingredient in Bear Brand coffee creamer was sugar.

The BMJ conducted a survey examining what it called the "misperceptions and misuse" of the Bear Brand coffee creamer among paediatricians and consumers in 84 villages across the country. It revealed that 18% of those surveyed had fed the coffee creamer to their infants at an average age of five months, 39% of consumers believed that the Bear Brand logo coffee creamer was good for infants and 6.5% thought it was a replacement for breast milk. Although the label on the Bear Brand coffee creamer packaging contained a warning that it was not to be used as a breast-milk substitute, 80% of those surveyed said that they had not read it.[24] The study, published in the BMJ, concluded that the sale of coffee creamer with this logo had placed the health of infants at risk.

Nestlé has since amended the logo to a mother bear holding a glass and has publicly stated that it has discontinued production of the beverage creamer for commercial reasons.[25]

THE FOLLOW-ON FORMULA CONTROVERSY

It has been claimed that follow-on formula was invented in an attempt to circumvent the requirements of the Code.[27] When the WHA became aware of this claim it issued a resolution stating that "providing infants with specially formulated milks (so-called 'follow-up milks') is not necessary".[28] Although ostensibly for infants over six months old, marketing and branding for follow-on formula can be almost indistinguishable from those for infant formula. This can lead to it being used for younger infants for whom it is unsuitable owing to its high mineral content. Although WHO is yet to confirm its position, UNICEF, the [UK's] National Childbirth Trust (NCT), the International Baby Food Action Network (IBFAN), Baby Milk Action (the UK member of IBFAN) and Save the Children agree that follow-on formula should be regulated by the Code since the milk part of the infant's diet is meant to be made up of breast milk up to the age of two years or beyond, and the Code classes a breast-milk substitute as "any food being marketed or otherwise presented as a partial or total replacement for breast milk".

An additional new report published in November 2012 states that there is scientific evidence that follow-on milks are "dispensable" and "serve as breast-milk substitutes, hence their marketing should respect appropriate standards".[29]

TARGETING MOTHERS

Breast-milk substitute companies use numerous techniques to introduce their products and build loyalty among parents, and in many cases they cast themselves in the role of trusted advisers. In the UK and other rich countries, many formula companies have online baby clubs to develop relationships with mothers and build loyalty to a brand. In developing countries, where internet use is lower, the approach to mothers is more often made in person, but the objective is arguably the same. To protect mothers from being provided with information that comes from a source with an inherent conflict of interest, the Code forbids BMS companies from having direct contact with pregnant women or mothers.[26]

However, our research in China found that 40% of mothers interviewed said that they had been contacted directly by baby food companies' representatives; half of them had been contacted in hospitals and over one-third by phone. Seventy-nine per cent of these mothers said the representatives had recommended their companies' products or given them free samples. In this survey in China, the brands mentioned by mothers who said they had been contacted directly by baby food companies' representatives were Dumex (Danone), Abbott, Enfamil (Mead Johnson), Wyeth, Nestlé, Friso, Ausnutria and Yi-li (listed in order of the frequency which they were mentioned by those surveyed).

FREE SAMPLES

If new mothers are given free samples to feed to their babies it can start a vicious circle that undermines their own ability to breastfeed. An infant satiated with formula may demand less breast milk, so the mother produces less, and that can result in her losing confidence in her ability to breastfeed. Save the Children's research in China found that 40% of the mothers interviewed said they had received formula samples. Of these samples 60% were said to be provided by baby food company representatives, and over one-third were said to be given by health workers.[30] The mothers interviewed for the survey reported that samples were provided by (in order of frequency): Dumex (Danone), Enfamil (Mead Johnson), Wyeth, Abbott, Nestlé, Friso, Ausnutria and Bei-yin-mei.[31]

A nationally representative survey commissioned by Save the Children in Pakistan in 2012[32] shows that one in ten health professionals surveyed said that their health facility had received free samples of breast-milk substitutes, teats or bottles in the previous six months; half of the free samples were said to be of infant formula. Among all those respondents who said they had received a sample, 68% said that the sample had been manufactured by Nestlé.[33]

ECONOMIC COSTS OF INFANT FORMULA

The cost of regularly buying formula can put a great strain on a family's budget, even in developed countries. In lower-income countries, it is only the richer families who can afford formula and who have access to the clean water and facilities needed to prepare the formula safely. In Nicaragua, low-income families who feed their children breast-milk substitutes spend 27% of their household budget every month on breast-milk substitutes, compared with 4.5% spent by high-income families.[34]

If women who cannot afford it are encouraged to formula-feed – for example, through free samples – they may be too poor to continue buying sufficient quantities of formula and may not get the support needed to re-start breastfeeding. In this situation women have reported feeding their infants with over-diluted formula, which is likely to lead to the infant falling prey to infections.

A study from the Philippines showed that after adjusting for income and non-milk family expenditures, the average formula-purchasing Philippine family spent an additional $0.30 on medical expenditure for every $1 spent on formula. This was two-and-a-half times as much as that spent by families who did not buy formula.[35]

TARGETING HEALTH WORKERS

One of the most concerning dimensions in the continued violations of the Code is the reported targeting of health workers – doctors, nurses and midwives – by some breast-milk substitute companies. Unlike advertising or free gifts, these violations can be committed without leaving any evidence. Our research suggests that many BMS companies view health workers as a direct link to new mothers and infants who can recommend their products – the presumed rationale being that once a mother begins using a product recommended by their health worker, they are more likely to continue using the same brand.

The market research body, Euromonitor, recommends that infant formula companies highlight the protective qualities of breast milk in order that local health authorities come to regard them as valid partners in promoting infant nutrition and health. The Euromonitor report states that this relationship could be used "to gain access to public health channels such as hospitals and surgeries, which are very important to baby food sales in developing countries".[36]

Save the Children's research in Pakistan[37] found that almost one-third of health professionals interviewed said they had been visited by a representative of BMS companies. Among these health professionals, 74% said they had been visited by Nestlé and 30% by the Japanese company Morinaga. The health professionals surveyed said that the purpose of more than one-third of these visits was to provide information to pregnant women.[38] Only 7% of the visits were said to be at the request of the health professionals or authorities.[39]

As outlined in Chapter 3, health workers are often underpaid and poorly trained and are working in very difficult conditions with little or poor-quality equipment. Continuing education for midwives is limited and incomes are low. These conditions leave midwives and other health workers vulnerable to influence from those who might seek to use their proximity to mothers of infants and young children, including in relation to the promotion of infant formula to mothers.

In August 2012, Wyeth LLC, a subsidiary of Pfizer, agreed to a settlement in which it paid a sum of more than $18.9 million to the US Securities and Exchange Commission (SEC) in respect of various alleged violations of the US Foreign and Corrupt Practices Act by its subsidiaries. Wyeth, a subsidiary of Pfizer since October 2009, was charged by the SEC with – among other things – providing cash payments, travel incentives and gifts (eg, smartphones) to state-employed doctors, midwives and other healthcare providers through its subsidiaries in several countries over the period 2005 to 2010. The SEC alleged that payments and incentives were offered by Wyeth subsidiaries in order to influence healthcare professionals to recommend Wyeth's nutritional products, to ensure that Wyeth products were made available to new mothers at hospitals, and to obtain information about new births that could be used for marketing purposes. Wyeth subsidiaries were also accused of concealing the true nature of those transactions. The settlement was reached without any admission or denial of the allegations by Wyeth and was approved by federal court.[40, 41]

Nestlé completed the acquisition of Pfizer Nutrition on 30 November 2012. Pfizer had been seeking to sell

the nutrition/baby formula business that it acquired in a takeover of Wyeth, in October 2009. Save the Children recognises and welcomes Pfizer's decision to divest itself of this section of its business, and its decision to voluntarily disclose the above matters to the SEC.

REWARD SCHEMES FOR MIDWIVES

Sari Husada,[44] a BMS company acquired by Danone in 2007, has been cultivating relationships with midwives in Indonesia for several years through its various 'Srikandi' programmes.[45] These programmes aim to build brand loyalty and trust among health workers, including midwives. Evidence published by IBFAN in 2010 and seen by Save the Children suggests that the Srikandi scheme provided midwives with incentives of money and foreign travel in return for selling formula.[46] The evidence suggests that Srikandi midwives were given monthly criteria including providing details of babies born and buying a certain amount of formula and that midwives could get financial rewards, invitations to scientific seminars and tourism trips, depending on how long they remained in the scheme. Some of the free trips on offer were said to be a pilgrimage to Mecca.[47] Danone has said that this Srikandi programme has been terminated.[48]

However, Danone has since launched a new Srikandi Academy, in 2011. The stated aim of the project is to "help junior midwives establish practices in rural areas".[49] But a business case for the project presented in January 2012 suggests that this may not be the only aim. It states that "Health Care Professionals (midwives especially) are of course key endorsers / brand ambassadors for our products!"[50]

LOW BREASTFEEDING RATES IN INDONESIA

Indonesian law states that all infants should be exclusively breastfed for the first six months of life[42] and that anyone who stands in the way of this will be fined up to 100m rupiah ($11,000) and sentenced to up to a year in prison. However, only 32% of infants are exclusively breastfed up to six months and 44% are breastfed in the first hour of life.[43]

EMERGING MARKETS: THE NEW FRONTLINE FOR SALES OF BREAST-MILK SUBSTITUTES

The above examples from Indonesia, China and elsewhere suggest a shift in strategy for breast-milk substitute companies. The substantial growth in the baby food market is increasingly dependent on emerging economies. Retail trend analysts predict that the future success of global baby food companies "will hinge on their performance in the increasingly lucrative Asia Pacific market" and that is played out by the company's own reports.[51] Danone Baby Nutrition sales[52] grew 10.7% in 2011, thanks in large part to markets in Asia, which account for 40% of its business. Mead Johnson reported sales growth for Asia/Latin America of 26% that year while its North America/ Europe sales increased by just 3%.[53]

The explanation for this change is twofold. The shift in the economic centre of gravity has created a proliferation of new lucrative markets with a growing middle class. This means many more women are entering the workplace who may find it difficult to continue breastfeeding because of restrictive maternity provisions (see Chapter 4). Meanwhile, sales are stagnating in Europe and North America because of declining birth rates and increased interest in breastfeeding. Heinz, for example, announced plans to close its Nurture Baby Milk UK operations (where it had 2% market share) in 2010[54] and to launch its formula business in China, where it will spend $30 million to develop its infant formula business in 450 cities.[55]

WEAK NATIONAL LEGISLATION: IMPUNITY FOR BREAST-MILK SUBSTITUTE COMPANIES?

Part of the attraction of emerging markets may lie in the fact that many countries currently have only weak regulations and enforcement regarding the marketing of breast-milk substitutes. Only 37 countries have adopted the entirety or most of the Code's provisions. A total of 103 member states have implemented at least part of the Code in their national law, and it has been drafted in a further 14 (see Appendix 5).[56]

National regulation can make a significant difference in formula sales. The case of India and China, the two largest emerging economies, is a case in point. There

is a huge disparity in the retail value of formula sales between China, which has weak enforcement, and India, which has implemented the Code and where enforcement is relatively strong.[57] China issued a national regulation in 1995 forbidding advertising and promotion of 'stage one' formula but reports suggest that it was widely ignored and punishments were limited to warnings and fines.

India has been stricter in enforcing its laws. On 1 August 2012, the Food and Drug Administration (FDA) in Haryana state, near Delhi, raided a Nestlé factory in Samalkha for allegedly using inappropriate graphics on milk substitutes meant for infants. The FDA seized consignments of infant milk substitutes, which the FDA Commissioner Rakesh Gupta said had graphics depicting a feeding bottle along with advertisements for other products, which are prohibited for infants below two years under the drugs law. The raids, he said, came after the FDA (within whose power it is to determine that labels are non-compliant and confiscate products[58]) had sent a notice to Nestlé in this regard,[59] although Nestlé claims not to have received any written communication of the FDA's concerns. A Nestlé spokesperson denied any violations,[60] and Nestlé India has said it is now revising BMS labels.

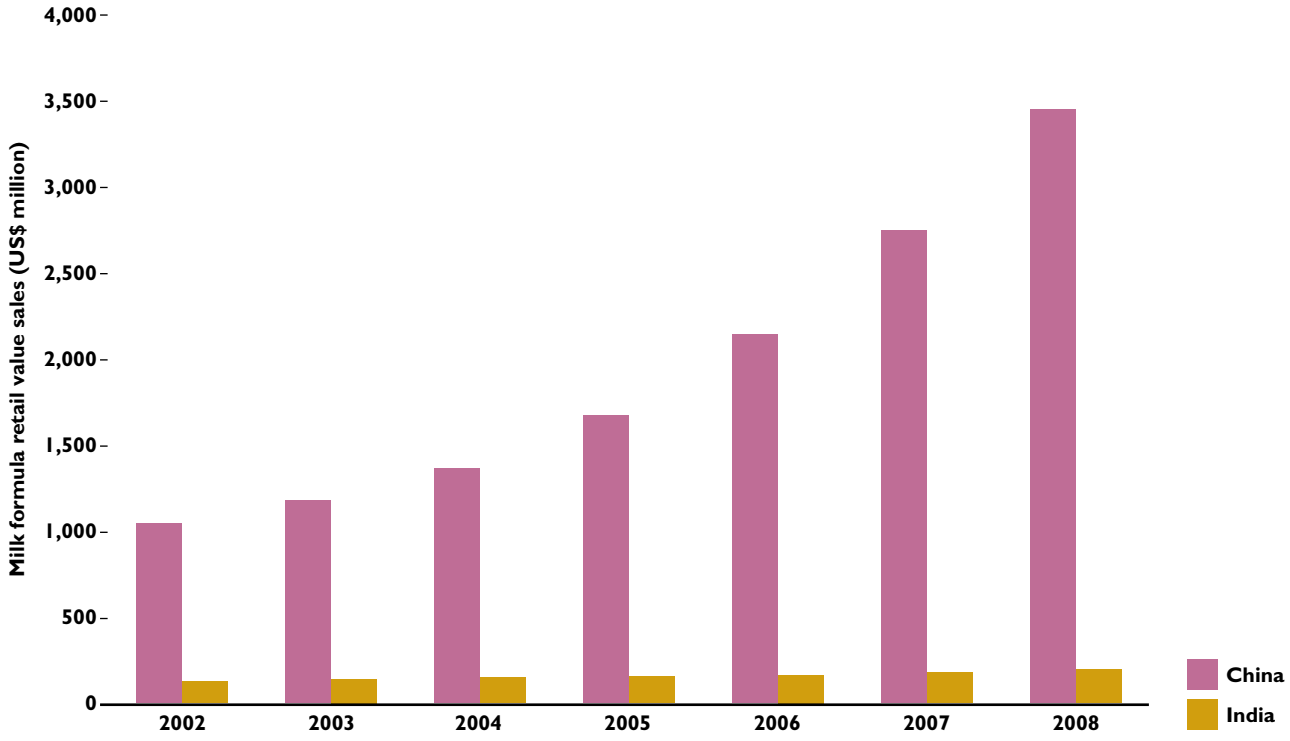
In another case, Nestlé India was charged by a court in Delhi in March 2012 for allegedly violating the country's infant formula labelling laws. The charge, which relates to a complaint filed by the Association for Consumers Action on Safety and Health in 1994, was denied by Nestlé.[61] The case is ongoing.

INDUSTRY LOBBIES TO WEAKEN LEGISLATION

Strong country legislation can put a brake on the worst examples of code violations and seriously restrict the marketing activities of BMS companies, and thus their ability to make profits. An increasing number of countries are passing strong laws to regulate companies and enshrine the Code into national law. Vietnam passed new legislation in June 2012, Kenya in September 2012 and South Africa in December 2012.

Companies may feel that with marketing regulations coming into force in some developing countries, "short-term maximisation of market share is a crucial goal", as once laws are in place it becomes more difficult for new entrants to take sales away from established brands.[62] Therefore, it is no surprise that in several countries where regulation concerning the Code is being considered or has recently been passed, some BMS companies have been lobbying

FIGURE 8. THE IMPACT REGULATION CAN HAVE ON MILK FORMULA SALES



to weaken it. They appear to be putting corporate competition aside to form groups to influence national governments. Furthermore, as will be examined in more detail below, the real intentions of these groups are unclear. While we acknowledge that the industry has a valuable role to play in policy-making, it should be as transparent as possible to ensure there is no undue influence on governments and legislative processes. We believe the use of pseudo-scientific titles and the way these groups are presented as nutrition associations or neutral non-industry organisations could be misleading. There is evidence to suggest that breast-milk substitute companies are coming together as non-governmental organisations, or NGOs, a term normally reserved for not-for-profit bodies. The term can also apply to business groups but these companies may be using that ambiguity to their advantage. For this reason, health advocates such as IBFAN encourage the use of the terms that distinguish between business interest NGOs (BINGOs) and public interest NGOs (PINGOs).

In the Philippines, a dispute over proposed legislation controlling BMS marketing has divided parliament. The Filipino 'Milk Code' was originally created in 1986[63] and is seen as a gold standard legislation, as it incorporated the Code and all the provisions of its subsequent WHA resolutions at the time of their adoption, and has influenced other Asian countries to improve their own laws. After the introduction of this gold standard bill, sales of infant formula in the Philippines dropped.[64]

However, a new bill proposed by congress, which includes amendments to the Milk Code, is perceived as an attempt to weaken the current regulations.[65] Although the new bill would strengthen the penalties issued to companies for violations, it would reduce the scope of the national regulations from the current 0–36 months to just 0–6 months. It would allow donations of breast-milk substitutes in emergencies and samples of breast-milk substitutes to be distributed in healthcare facilities, and give sales and marketing staff of BMS companies access to health workers.[66]

There has been strong opposition to this bill, known as the 'Monster Bill' to its opponents, with UNICEF, WHO and the Philippines' Department of Health condemning it in a statement in September 2012.[67] Breastfeeding advocates in the Philippines, including Save the Children's Philippines office,[68] have also strongly stated their opposition. Ines Fernandez, lead convener of the Philippines Save the Babies Coalition, said the bill undermines breastfeeding and indulges milk manufacturers. "The true intention of the Breastfeeding Promotion and Infant Formula Regulation Bill is to water down the Milk Code," she added.

The bill is backed by the Infant and Paediatric Nutrition Association of the Philippines (IPNAP), a lobby body consisting of Nestlé, Mead Johnson, Abbott, Fonterra, and Wyeth, who issued a position paper that said it was "a progressive piece of legislation".[69] The Filipino Department of Trade and Industry has echoed the BMS companies in a statement saying that the Philippines could lose $400 million in investment projects from BMS companies if the law is not passed.[70]

The bill was heard by the House Committees on Trade and Industry, and the legislative process has involved consultation with a wide range of stakeholders, including the government, industry and civil society.

In June 2012, the Government of Vietnam voted to extend the ban on advertising of breast-milk substitutes for infants from up to six months to up to 24 months, including feeding bottles and teats, as well as other food for infants of less than six months. This new law was passed with more than 90% of the vote. However, the decision was taken despite apparent substantial lobbying for an opposite outcome. In June 2012 the US Embassy in Hanoi urged the Chairman of Vietnam's National Assembly not to extend a ban on advertising formula milk products to children up to two years old. In a letter copied to three ministers in Vietnam's government, the US Chargé d'Affaires said: "Several US companies have contacted the US Embassy regarding their serious concerns over the proposed ban, as it 'could have a significant negative impact on their business in Vietnam'. We share their concerns."[71] However, the law was extended despite the pressure, thus reducing risks for Vietnamese children.

Kenya successfully resisted the pressure of industry lobbying as the Breast-milk Substitutes (Regulation and Control) Act that was passed in September 2012 rejected nine proposed amendments that ministers said would "negate the spirit of the bill which is to encourage breastfeeding".[72] One of the rejected amendments would have allowed health

workers to receive gifts, scholarships and samples of complementary food product from a manufacturer or a distributor.[73] The Kenyan government has adopted the Code's provisions in spite of industry pressure.

South Africa's national legislation to implement the Code was passed in December 2012 to replace its previous code that was voluntary and unenforceable. Securing the law was a nine-year process, which suffered many setbacks including lobbying from BMS companies. The baby food industry raised many concerns over the draft regulations, which they claimed went beyond the scope of the Code, were unconstitutional, placed restrictions on access to information and went beyond the Minister's authority. They formed a new business interest organisation, which lobbied for amendments to the South African regulations.[74]

THE INDUSTRY IN DISGUISE?

There is a concerning trend for these industry groups to be formed in a way that lacks transparency. Their names can make the intention and membership of these groups unclear and at first glance they may appear to be acting solely in the interests of child nutrition rather than representing industry interests. For example, the Asia Pacific Infant and Young Child Nutrition Association is an organisation whose membership is made up entirely of breast-milk substitute companies. Save the Children believes that companies should be fully transparent about their activities and publicly accountable to their customers, shareholders and the governments of the countries in which they work. The table below lists a number of such bodies that Save the Children encountered during its research.

BUSINESS INTERESTS AND WHO

We are also concerned over the potential influence of interest groups that are in official relations with WHO.[82] Such bodies include The International Special Dietary Foods Industries Federation, an umbrella group of national and international food industry associations,[83] and the International Life Sciences Institute (ILSI), a multi-stakeholder, nonprofit organisation whose stated mission is to "provide science that improves public health". While ILSI's Board is comprised of at least 50% public sector representatives, 70% of its funding comes from support

TABLE 2: EXAMPLES OF INDUSTRY ASSOCIATIONS AND THEIR ACTIVITIES

Organisation	Membership	Examples of activities
Asia Pacific Infant and Young Child Nutrition Association (APIYCNA)	Set up in 2010 by Abbott Nutrition, Danone Asia Pacific, Fonterra Co-operative Group Limited, Friesland Campina, Nestlé Nutrition, Mead Johnson Nutrition and Wyeth Pharmaceuticals (Pfizer). Headquartered in Singapore.[75]	Has previously hired MCI Singapore – a global association, communications and event management company – to set up the association, prepare for its WHO meeting and lobbying with local associations with the industry.[76]
Hong Kong Infant and Young Child Nutrition Association (HKIYCNA)	Set up in May 2011 after Hong Kong announced plans to review its regulations on BMS marketing. Abbott Laboratories Limited, Danone Baby Nutrition (HK) Limited, FrieslandCampina (Hong Kong) Limited, Mead Johnson Nutrition (Hong Kong) Limited, Nestlé Hong Kong Limited and Wyeth (Hong Kong) Holding Company Limited[77]	Has issued position statement and submissions to legislative council that are unsupportive of the proposed new Hong Kong Code. Commissioned a survey that showed 80% of mothers said the prohibition of marketing of infant formula over six months was unnecessary.[78] Placed ads in Hong Kong daily newspapers saying: "Help Mothers Make the Right Choice: Many mothers cannot breastfeed for various reasons. Moms can only make an informed choice and choose the best for their babies if a wide range of information is available to them."[79]
Infant and Paediatric Nutrition Association of the Philippines (IPNAP)	Member companies are: Abbott Laboratories, Fonterra brands, Mead Johnson Nutrition, Nestlé and Wyeth.[80]	Has been supporting revisions to the Milk Code that are perceived as an attempt to weaken the current regulations.[81]

from its members who include Abbott Nutrition, Fonterra, Mead Johnson, Nestlé, and Danone,[84] among many other food, pharmaceutical and biotechnology companies. The status of official relations means that these bodies have the ability to attend certain meetings, access documents and influence certain processes. In 2002, the WHO's Civil Society Initiative report said that there were "insufficient safeguards" on conflict of interest and "a lack of systematically accumulated knowledge about the sponsors and the interest groups behind individual NGOs".[85] Member States have recently called on WHO to protect the integrity of its public policy decision-making and ensure that this is transparent. A draft policy paper regarding WHO's official relations with NGOs was discussed at the 2013 Executive Board meeting. IBFAN, the Conflict of Interest Coalition and other NGOs are calling for clear distinctions to be made between BINGOs and PINGOs, and for a clear differentiation to be made between their policies, norms and standards.

THE WAY FORWARD

Putting a stop to all Code violations will need serious reform within breast-milk substitute companies and significant changes to the way their activities are regulated. We believe that BMS companies have an inherent conflict of interest and must change their promotion and activities accordingly. In many cases we consider this means no less than a complete overhaul of their approach to the way they do business.

At present there is no regulatory system operating at the international level for when national measures are lacking or ineffective. The fact that there are still examples of Code violations suggests that some BMS companies are failing to effectively monitor themselves[86] and even where national legislation does exist, in many cases it has failed to designate a responsible or effective monitoring authority[87] that is transparent and truly independent.[88] WHO has said that there are shortfalls in operational guidance on the Code and its application, enforcement and monitoring, and that gaps in health worker training and public knowledge of the Code must be filled.[89] Currently, responsibility for the monitoring and enforcement of the Code is divided among governments, manufacturers and distributors, and NGOs.[90] Member States must report to WHO on their implementation of the Code, but WHO plays no direct role in monitoring and enforcing the Code.

For the Code to be effective there need to be firm regulations in place within each country. There is evidence of good legislative practice by countries. In Botswana the government trains staff to monitor Code compliance and national regulations include imprisonment for violations. In India violators are subject to a prison term of up to three years and/or a fine, and commentators suggest that companies are conforming.[91] The responsibility for Code monitoring in India is shared with four NGOS, who have brought complaints that led to actions in Indian courts against BMS companies.[92, 93]

Fiji is one of only four countries in the world[94] to regulate on the advertising of food products, including infant formula and other complementary foods, for children up to the age of five years. These regulations were introduced in 2010 after rising rates of malnutrition and micronutrient deficiencies were recorded in the country. The challenge the country now faces is in monitoring any violations.

Some countries have gone even further to regulate the practices of BMS companies. In Iran, formula is available only by prescription and the tins must carry a generic label with no pictures or promotional messages. In India tins of infant formula must carry a conspicuous warning about the potential harm caused by artificial feeding, placed on the central panel of the label. In Papua New Guinea, the sale of feeding bottles, cups, teats and dummies is strictly controlled, and there is a ban on advertising these products in the Philippines.[95]

THE ROLE OF FTSE4GOOD

FTSE4Good is an ethical investment index in the UK that seeks to encourage companies to improve their policies, practices and accountability. For the last ten years it has been trying to find a practical way forward to unlock the current stalemate on the issue of BMS marketing and to incentivise firms to make progress on their application of the Code, but has attracted criticism for the way it has gone about that process.

FTSE4Good works by requiring firms listed on the index to improve their ratings over time on a range of social and environmental issues, from bribery and corruption to climate change. In this way, it differs from other indices in that it does not exclude firms that fail to comply with all the elements of the Code; instead, it includes firms, but uses the threat of exclusion from the index as a way of driving change.

Until 2003, baby food manufacturers were automatically excluded from the index because of evidence of Code violations. However, to include BMS firms in its approach to changing corporate behaviour, FTSE4Good brought in a new policy in 2003. In order to qualify for inclusion on the FTSE4Good index, a firm must demonstrate that it has put in place management systems that will eventually lead to Code compliance, rather than having to demonstrate actual compliance.[96]

In 2006 Novartis, the parent company of Gerber, the market leader in complementary foods in the USA, became the first company to meet the FTSE4Good BMS marketing criteria and entered the index. The following year Gerber was taken over by Nestlé. For three years no BMS manufacturer featured on the index, with some commentators claiming that this was because Nestlé did not comply with FTSE4Good standards.

Despite considerable effort by FTSE4Good staff to work with companies to get them to the point where they could comply, no companies were successful in meeting the criteria. This led FTSE4Good to conclude that the criteria were too stringent to serve as an incentive for companies to improve their practices.

In 2010 FTSE4Good produced another set of BMS marketing criteria,[97] which focus on BMS firms operating in 149 'higher-risk' countries (thus designated for their higher rates of child malnutrition and mortality). The approach has been criticised, as companies that systematically violate the Code and resolutions can now be admitted on the basis of their own presentation of their marketing policies and management systems.[98]

The revised FTSE4Good criteria suggest that some parts of the Code are not so vital to children's health and so are allowable in 'low-risk' countries. This approach has attracted widespread criticism.[99] Critics argue that the new standard is weaker than the Code, which is designed to be applied internationally and be a minimum standard.

The assessment criteria have also been criticised. Nestlé was admitted to the FTSE4Good Index in March 2011. A later review in September 2011 maintained Nestlé's position in the index on the basis of assessments in India and Zambia. This move has met with criticism in the light of reports of Code violations in both countries.

Although the FTSE4Good standard is not as powerful as the legislative application of the International Code, if BMS companies were assessed against more robust criteria according to the Code, the process that FTSE4Good has established has the potential to become a useful element in a global action plan to put an end to examples of Code violations by BMS manufacturers.

CONCLUSIONS AND RECOMMENDATIONS

Action is needed now to unlock the life-saving potential of breastfeeding. Save the Children estimates that if every child started breastfeeding within the first hour it could save 830,000 young lives, thus reducing the global burden of child mortality by 12%. Exclusive breastfeeding of all children up to the age of six months would protect them from diseases such as pneumonia and diarrhoea and save even more children.

While breastfeeding is preventing millions of deaths and helping to reduce health inequalities, there is great unlocked potential to be gained by enabling more mothers to breastfeed their babies. It is of huge concern that breastfeeding rates have remained so low, particularly in low-income countries where the practice can make such a huge difference to child survival. In the last 15 years, progress on improving breastfeeding rates has been extremely slow. The barriers to breastfeeding are many, they are complex and they can be difficult to overcome. But, as this report has shown, they are not insurmountable.

Women face four main barriers to breastfeeding their infants: the influence of cultural and religious feeding practices; limited access to good-quality healthcare; insufficient support from the state; and inappropriate marketing practices by BMS companies. As the recommendations below will demonstrate, there are effective actions that could be taken by governments, multilateral institutions, breast-milk substitute manufacturers and others to overcome these barriers.

For many women a combination of some or all of these above factors will influence their ability to breastfeed their children. The impact of these four hurdles varies dramatically between countries and within countries and among different wealth groups. Hence countries need to review the following recommendations within their own contexts and prioritise accordingly.

RECOMMENDATIONS

Countries should put breastfeeding at the centre of efforts to improve infant and child nutrition and should develop specific breastfeeding strategies as well as including breastfeeding in nutrition strategies. Countries that are developing plans as part of the Scaling Up Nutrition (SUN) movement should ensure that they address all of the obstacles identified in this report, which deter optimal breastfeeding practices.

OVERCOME HARMFUL CULTURAL AND COMMUNITY PRACTICES AND TACKLE BREASTFEEDING TABOOS

Many women are prevented from making their own decisions about whether and how long to breastfeed and are heavily influenced by traditional feeding practices that can be harmful to infants (see Chapter 3). In Pakistan, for example, fewer than half of the mothers we surveyed said they were able to make decisions about the way their children were fed.

The first step in overcoming these traditions is to address the power dynamics in a community that explain why women are often unable, rather than unwilling, to follow the best advice. Fundamental changes are required in many societies to bring gender equality for women. Changing these dynamics is not just about providing the right information at the right time in the right way. It requires social and behaviour change that can empower women to challenge traditional practices.

- Projects to improve breastfeed rates should include the entire community, especially fathers, who traditionally have not been targeted. Developing country governments must recognise this in order to achieve impact on the ground. Local leaders, grandmothers and wider communities must all be involved. Successful projects are those that use multiple strategies to address key decision-makers. These strategies must address the power dynamics that govern breastfeeding practices and the most effective projects are those implemented by the community itself.

- Governments should increase investment in sustained national communications campaigns and programmes to spread messages about the benefits of breastfeeding. The example of Brazil shows the scale of impact these can have. These media should include high-quality, professional TV, radio, social media, newspaper, magazine and billboard advertising, as well as community-level work such as counselling and peer support groups. Such comprehensive programmes should be included in SUN country-costed plans currently being drafted, and should be supported by funding from developing country governments and donors.
- Governments should put women's empowerment at the heart of their work around breastfeeding promotion, protection and support. They must recognise that unless they ensure that women are free and able to make their own choices, breastfeeding rates will not improve.[1]

MAKE THE HEALTH SYSTEM STRONGER TO PROTECT AND PROMOTE BREASTFEEDING

Because of the chronic shortage of health workers, many women in developing countries give birth at home without skilled help, or in a health facility where the health workers are over-stretched and under-trained. One-third of babies are born without a skilled birth attendant present. As a result the opportunity for new mothers to be supported to breastfeed in the first few hours is lost. Human and financial resources need to be substantially increased to allow a scale-up of the tools that are already available to enable strong, effective programming.[2]

- Governments must address the global health worker crisis in order to achieve improved breastfeeding rates. They must allocate adequate resources to long-term health worker training (including training on the benefits of breastfeeding and how to support mothers to breastfeed), recruitment, support and retention, and remove financial barriers that prevent women from accessing healthcare.
- In order that progress can be monitored and evaluated and so that decisions can be based on strong evidence, infant and young child feeding indicators should be recorded and reported in government health information systems.
- All healthcare providers, whether private or state, must have strong policies in place that protect breastfeeding. These should include policies that ensure mother and baby are kept together after delivery as much as possible, that employees are well trained in breastfeeding promotion, protection and support including during emergencies, and that skills are kept up to date with refresher training. These policies must be supported and enforced at the most senior level and must be regularly monitored with frequent spot checks to maintain high standards.
- International donors should increase funding for projects that support breastfeeding as part of broader country plans to reduce malnutrition under the Scaling-Up Nutrition movement. Those plans will require funding from developing countries and from donors. The UK prime minister's Hunger Summit ahead of the G8 leaders' meeting in the UK provides the ideal opportunity for leaders to put nutrition, including breastfeeding, at the top of the agenda and fill the estimated $10bn funding gap.

INTRODUCE AND ENFORCE CONSISTENT NATION-WIDE BREASTFEEDING-FRIENDLY POLICIES AND LEGISLATION

Working women may struggle to continue breastfeeding when they return to work if the environment and working conditions are not supportive. Policies that protect both their employment and their ability to give their infants the best start in life must be put in place and backed up by national legislation where appropriate. Governments need to review their own policies and legislation and ensure that mothers have the right protection through maternity leave and benefits.

- Every country should immediately bring their maternity leave policies into line with the International Labour Organization (ILO) minimum recommendation of 14 weeks and work towards the recommendation of 18 weeks. Maternity leave provided must be paid at a minimum of two-thirds of the woman's salary, but preferably at 100%.[3]

- For new mothers who are not employed within the formal sector, states should provide social protection in the form of cash transfers, state grants or benefits in order to maintain the household income while they are breastfeeding. These should be available to all women who are breastfeeding who do not otherwise benefit from paid maternity leave, for the first six months of their infant's life.

IMPROVE BMS INDUSTRY PRACTICES

There continue to be too many examples of some BMS companies violating both the spirit and the letter of the International Code of Marketing of Breast-milk Substitutes and subsequent resolutions. The Code was designed to prevent baby food manufacturers from inappropriately marketing and distributing their products and has been in place for 30 years. Yet, as evidence regularly collected by an active civil society suggests, Code violations continue, with many infant formula companies conducting marketing and lobbying practices that, we believe, put children at risk.

To achieve change we need a two-pronged approach that directly targets the breast-milk substitute industry while seeking to tighten the regulative and legislative frameworks in which it operates. Significant improvements are needed across a number of dimensions: transparency, accountability, internal practices and external regulation.

- Governments can make a significant impact on the number of Code violations by strengthening their national laws and prosecuting any violations. Many countries – including India, Fiji, Vietnam, Botswana and South Africa – have successfully enshrined strong laws on BMS marketing that make Code violations either a criminal or a civil offence and are using these laws to hold companies to account and penalise them where necessary.
- While the International Code states that companies must include health warnings and details of the benefits of breastfeeding, in practice these warnings cover a small proportion of packaging, are written in small type and are designed to be unobtrusive. To strengthen the power of these warnings, national laws should specify that health warnings should cover one-third of any breast-milk substitute packaging.
- Breast-milk substitute companies should adopt and implement a business code of conduct regarding their engagement with governments in relation to breast-milk substitutes legislation. Companies should include a public register on their website that outlines their membership of national or regional industry bodies or associations, any meetings where the WHO Code or breastfeeding is discussed, and details of any public affairs or public relations companies they have hired, alongside the nature of this work. Any associations (such as nutrition associations or working mothers' associations) that receive funding from infant formula companies should be required to declare it publicly. In addition to this information being made publicly available on the websites of individual companies, the International Association of Infant Food Manufacturers should publish a consolidated record of this information, updated on a quarterly basis.
- To improve accountability, the employees of BMS companies must be held personally responsible for adherence to the Code. The job description of the company's most senior representative in every country, whether in a company office or that of a distributor, should include responsibility for ensuring that no Code violations occur in the area for which they are responsible. That person should be held accountable under the terms of their employment and be held personally responsible in law for violations of the Code. A member of the board should manage a robust auditing system and should be made accountable for ensuring that the company does not violate the Code.
- The fact that some violations of the Code are being brought to the attention of infant formula companies through outlets such as IBFAN's *Breaking the Rules, Stretching the Rules* report rather than through internal mechanisms suggests that their whistleblowing policies are not fit for purpose.[4] Whistleblowing procedures must be strengthened to provide all staff in all countries with access to easy-to-use confidential advice from an independent body to which they can report violations.

- In order to hold companies accountable at a global level, the UN should mandate WHO to create a body to monitor reports of Code violations or strengthen existing bodies such as IBFAN. That body should have the power to rule on Code violations and work with national regulatory bodies to issue penalties including fines based on the size of the violation and the size of the company's turnover. The operating costs of this body could be covered by a combination of donor funding and the fines issued.
- To encourage companies to improve their policies, practices and accountability, FTSE4Good should, by 2015, extend its criteria for the inclusion of a BMS company on its index to include the company's activities in all countries, rather than just those countries listed as higher risk, and should bring its criteria into line with the International Code and resolutions. It should assess company practices in selected countries against the Code and resolutions, as well as the company's own policies.

APPENDICES

APPENDIX 1 – METHODOLOGIES

METHODOLOGY USED FOR DHS ANALYSIS TO ASSESS THE IMPACT OF DIFFERENT VARIABLES ON EARLY INITIATION OF BREASTFEEDING AND EXCLUSIVE BREASTFEEDING

The various factors – social, economic, and relating to access to services – that were investigated are outlined in the table below.

Indicator	**Description of variable**
Household wealth quintiles	Ordinal (1, poorest to 5, richest)
Mother's educational status (grade)	Ordinal (none, primary, secondary+)
Antenatal care (ANC) indicators: Skill level of ANC provider Number of times attended ANC Number of tetanus toxoid injections received	 Binary: by whom (skilled, unskilled) Binary (0, 1+) Binary (0, 1+)
Delivery care coverage	Binary; 0 = delivered at home; 1 = government facility or private facility
Post-natal coverage	Binary, yes:no (by skilled carer within one week) Binary, yes:no (any PNC, within one week
Skill level of attendant at birth	Binary: by whom (skilled, unskilled)
Ever had a child that died Sex of child that died	Binary – yes:no Ordinal – yes (boy, girl):no
Child still breastfed at 11 months	Binary; yes:no
Child still breastfed at 23 months	Binary; yes:no
Child stunted	Binary
Child wasted	Binary
National indicators (imputed as that at time of survey from UNDP)[1]	
Mortality indicators Neonatal; infant and under-five mortality rates	Deaths expressed per 1,000 live births Neonatal (first 28/30 days); infant (up to one year); under five (up to five years)
Adolescent birth rate	Number of births to women ages 15–19 per 1,000 women ages 15–19 – at time survey was done
Life-expectancy at birth	Number of years a newborn infant could expect to live if prevailing patterns of age-specific mortality rates at the time of birth stay the same throughout the infant's life

Data were used from Demographic Health Surveys from 44 countries which have high rates of maternal and child mortality and which are monitored in *Countdown to 2015*. Of these countries, six had had surveys carried out between 2000 and 2004, 23 between 2005 and 2007, and 15 between 2008 and 2011. Data for children of different ages between birth and five months were not available from Pakistan, Indonesia, the Philippines, Vietnam, Chad and Congo, so exclusive breastfeeding rates were not calculated here.

The data from these 44 countries were combined into a pooled dataset, weighted for country population size. Chi-squared methods were used to investigate the importance of categorical variables, while logistic regressions were used to investigate imputed national figures (such as mortality rates). Logistic regressions were also used to control for effects of other variables.

METHODOLOGY FOR SAVE THE CHILDREN BREASTFEEDING AND CODE VIOLATION SURVEY (PAKISTAN), OCTOBER 2012

TARGET GROUPS FOR GATHERING INFORMATION

Target 1: Mothers of infants up to six months of age who were living in large cities, towns and villages of Pakistan.

Target 2: Health professionals who have contact with pregnant women or mothers of young infants serving in large cities, towns and villages of Pakistan.

Target 3: Information items on infant feeding in government/private/NGO-run healthcare facilities that see pregnant women or mothers of young infants.

GEOGRAPHIC SCOPE

Spread across four provinces of Pakistan. Three clusters were selected:

Cluster 1: Metropolitan cities: these are the three main urban centres that together constitute 13% of the population of the country. They are: Karachi, Lahore and Rawalpindi/Islamabad. Eighty urban census circles were selected from the list of all census circles in these three cities by 'probability proportionate to size' method.

Cluster 2: Large cities and towns: the Population and Housing Census provides a list of all cities in Pakistan that have a population above 100,000 (in total there are 68 such cities in Pakistan). Within these cities there are urban census circles and census blocks. The Census also provides a list of all smaller cities in Pakistan (which have a population of less than 100,000). In total there are 394 such small cities and towns. These cities also have urban census circles and census blocks. The survey randomly selected 80 urban census circles in large cities and small towns of Pakistan using the 'probability proportionate to size' method.

Cluster 3: Rural areas: the rural areas have an administrative hierarchy of Province, District, Tehsil, Qanoon Goh Halqa, Patwar Circle and Mauza/ Revenue Village.

In order to select random locations from this cluster/rural areas, total locations (N=200) were distributed among the four provinces: Punjab, Sindh, Khyber-pakhtoon-khwa and Balochistan, according to their share of the total rural population of Pakistan. Within each province, the designated number of locations was selected from a list of all the Mauzas/ Revenue Villages in that province by 'probability proportionate to size' method.

SAMPLING

Multistage cluster sampling.

Total sample size: 4,800 (2,400 of Target 1, 1,200 of Target 2, 1,200 of Target 3)

TOOLS

Structured questionnaires (translated and pre-tested in Urdu, the national language)

MODE

Face-to-face in-house interviews with Targets 1 and 2; Target 1 in household and Target 2 at the health facility

Observation by enumerator for Target group 3 using structured form

APPENDIX 2 – PROMOTING SUCCESSFUL BREASTFEEDING[2]

THE TEN STEPS TO SUCCESSFUL BREASTFEEDING

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all healthcare staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one half hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practise rooming-in – allow mothers and infants to remain together – 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

APPENDIX 3 – A MOTHER'S WORKING ENVIRONMENT: MATERNITY LEGISLATION AND STATE GRANTS

The chart below identifies the following:

Column 1 identifies the extent to which a state has legislation that provides for the provision of a grant from the state for lactating women (ie, further payments over and above the recovery of a woman's salary while on maternity leave);

Column 2 identifies the extent to which a state has legislation that provides a woman who has returned to work with a paid break from work to nurse her child;

Column 3 identifies the extent to which a state has legislation that provides for maternity leave, and the length of such leave;

Column 4 identifies the extent to which a state has legislation that provides that a nursing mother will have her wages paid during her maternity leave, the percentage of those wages that will be paid and the extent to which the government or the employer will bear the burden of those wages; and

Column 5 identifies whether a state's maternity leave meets or exceeds the International Labour Organization's (ILO's) minimum standard of 14 weeks' leave. (N.B. Column 5 does not establish whether a jurisdiction is fully compliant with Convention No. 183, but just whether the maternity leave of 14 weeks is available. A "Yes" denotes that the jurisdiction has 14 weeks of maternity leave available. Each jurisdiction may, however, have varying restrictions on the availability of such leave which would make it otherwise non-compliant with ILO's Convention No. 183; however, this falls outside the scope of the chart.)

The cells marked with an "X" highlight the fact that, on the basis of our general research, the specific issue is not addressed by the legal framework of the relevant jurisdiction or covered in any of the publicly available information that we have reviewed.

Country	**(1) Legislation providing for state grants for lactating women**	**(2) Legislation on paid breaks for lactating women at the workplace**	**(3) Legislation providing for maternity leave**	**(4) Percentage of salary to be paid while on maternity leave**	**(5) Duration of maternity leave meets requirements of International Labour Organization (14 weeks)**
Africa					
Angola	Yes	Yes	Yes[2] (90 days)	100% (employer)	No
Burkina Faso	No	Yes	Yes (14 weeks)	100% (government pays social security and employer pays difference between social security and wage)	Yes
Burundi	No	Yes	Yes (12 weeks)	100% (50% employer, 50% social security)	No

Country	(1) Legislation providing for state grants for lactating women	(2) Legislation on paid breaks for lactating women at the workplace	(3) Legislation providing for maternity leave	(4) Percentage of salary to be paid while on maternity leave	(5) Duration of maternity leave meets requirements of International Labour Organization (14 weeks)
Africa *continued*					
Cameroon	Yes	Yes	Yes (14 weeks)	100% + pre-natal grant (National Social Insurance fund)	Yes
Côte d'Ivoire	No	Yes	Yes (14 weeks)	66.66% (employer)	Yes
Democratic Republic of Congo	No	Yes	Yes (14 weeks)	66.66% (employer)	Yes
Egypt	No	Yes	Yes (12 weeks)	100% (25% employer, 75% social security)	No
Ethiopia	No	No	Yes (90 days)	100% (employer)	No
Ghana	No	Yes	Yes (12 weeks)	100% (employer)	No
Kenya	No	No	Yes (12 weeks)	100% (employer)	No
Madagascar	No	Yes	Yes (14 weeks)	100% (50% employer, 50% social security)	Yes
Malawi	No	No	Yes (8 weeks)[3]	100% (employer)	No
Mali	No	No	Yes (14 weeks)	100% (social security)	Yes
Mozambique	No	Yes	Yes (60 days)	100% (social security)	No
Niger	No	Yes	Yes (14 weeks)	100% (50% employer, 50% social security)	Yes
Nigeria	No	X	Yes (12 weeks)	50% (employer)	No
South Africa	No	No	Yes (16 weeks)	Up to 60% (unemployment insurance fund)	Yes
Sudan	No	No	Yes (8 weeks)	100% (employer)	No
Uganda	No	No	Yes (8 weeks)	100% (employer)	No
United Republic of Tanzania	No	Yes	Yes (84 days)	100% (social security)	No
Zambia	No	No	Yes (12 weeks)	100% (employer)	No
Latin America					
Guatemala	No	Yes	Yes (84 days)	100% (33.33% employer, 66.66% social security)	No
Peru	No	Yes	Yes (90 days)	100% (social security)	No

continued overleaf

Country	(1) Legislation providing for state grants for lactating women	(2) Legislation on paid breaks for lactating women at the workplace	(3) Legislation providing for maternity leave	(4) Percentage of salary to be paid while on maternity leave	(5) Duration of maternity leave meets requirements of International Labour Organization (14 weeks)
Asia					
Afghanistan	No	No	Yes (90 days)	100% (employer)	No
Bangladesh	No	No	Yes (12 weeks)	100% (employer)	No
Cambodia	No	Yes	Yes (90 days)	50% (employer)	No
India	Yes	Yes	Yes (12 weeks)	100% (employer)	No
Indonesia	No	Yes	Yes (3 months)	100% (employer)	No
Iraq	No	Yes	Yes (62 days)	100% (employer)	No
Myanmar	No	No	Yes (12 weeks)	66.66% (social security)	No
Nepal	No	Yes	Yes (52 days)	100% (employer)	No
Pakistan	No	No	Yes (12 weeks)	100% (employer)	No
Philippines	No	No	Yes (60 days)	100% (social security)	No
Turkey	No	No	Yes (16 weeks)	66.66% (social security)	Yes
Vietnam	No	Yes	Yes (18 weeks)	100% (social security)	Yes
Yemen	No	No	Yes (60 days)	100% (employer)	No

APPENDIX 4 – THE CODE AND A REVIEW OF WHO RESOLUTIONS SUPPORTING THE CODE

SUMMARY: INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES

Aim: To protect and promote breastfeeding by ensuring appropriate marketing and distribution of breast-milk substitutes.

Scope: Breast-milk substitutes, when marketed or otherwise represented as a partial or total replacement for breast milk. These can include food and beverages such as: infant formula, other milk products, cereals for infants, vegetable mixes, baby teas and juices, and follow-up milks. The Code also applies to feeding bottles and teats. It also protects and supports those who are not breastfed by ensuring that their caregivers are provided with correct information, eg, through labelling specifications.

Advertising: No advertising of above products to the public.

Samples: No free samples to mothers, their families or health workers.

Healthcare facilities: No promotion of products, ie, no product displays, posters or distribution of promotional materials. No use of company-paid personnel. Health authorities are encouraged to promote breastfeeding, discourage use of infant formula and ensure that only authorised personnel demonstrate to pregnant mothers the correct use of formula and the potential hazards of its use.

Health workers: No gifts or samples to health workers. Product information must be factual and scientific. Distributors and manufacturers should disclose to the employers of healthcare workers any contributions made in-kind, and must not take on any type of educational role unless granted government permission.

Supplies: No free or low-cost supplies of breast-milk substitutes to any part of the healthcare system.

Information: Information and educational materials must explain the benefits of breastfeeding, health hazards associated with bottle-feeding, the difficulty of reverting back to breastfeeding, the costs of using infant formula and, where applicable, the proper use of infant formula.

Labels: Product labels must clearly state the superiority of breastfeeding, the need for the advice of a health worker and a warning about health hazards, and be written in the local language. No pictures of infants, or other pictures or text idealising the use of infant formula.

Products: Unsuitable products, such as sweetened condensed milk, should not be promoted for infants. All products should be of a high quality,[4] have expiration dates, and take account of the climatic and storage conditions for the country where they are used.

A number of subsequent WHA resolutions adopted in the intervening years addressed and continue to address the marketing of breast-milk substitutes as described below.

Adapted from: International Code Documentation Centre/IBFAN Penang, PO Box 19, 10700, Penang, Malaysia

ADDITIONAL RESOLUTIONS SUPPLEMENTING THE CODE

As previously noted, a number of World Health Assembly resolutions have been adopted in the intervening years to supplement the Code and provide greater guidance and clarity as to its interpretation:

(f) 1981: Resolution 34.22 emphasises adherence to the Code as a *minimum standard* to which states should adhere, and urges signatories to implement the Code in their territories via legislation, regulation or other measures.

(g) 1982: Resolution 35.26 recognises that commercial advocacy of breast-milk substitutes can contribute to increased artificial feeding. The Resolution reinforces previous calls to signatory states to implement and monitor the Code.

(h) 1984: Resolution 37.30 requests that the Director-General of WHO work with Member States to implement and monitor the Code. The Director-General was also asked to examine further the promotion and use of unsuitable foods for children.

(i) 1986: Resolution 39.28 urges Code signatories to ensure that in those cases where breast-milk substitutes are required, they are provided through normal channels and not freely or at a reduced price. Further, the Resolution calls on Member States to refrain from promoting any food or drink before breastfeeding (potentially interfering with breastfeeding), and deems follow-up milks "not necessary".

(j) 1988: Resolution 41.11 requests the WHO Director-General to provide legal and technical assistance to Member States in their transposition of the Code into appropriate national norms.

(k) 1990: Resolution 43.3 highlights the WHO/UNICEF statement on "protecting, promoting and supporting breastfeeding: the special role of maternity services". The Resolution further urges signatories to ensure that all national legislation and health policy fully expresses the stated aims and principles of the Code.

(l) 1992: Resolution 45.34 reaffirms the Code's role as a *minimum standard* and, building on the aforementioned statement of Resolution 43.3, welcomes the adoption of the WHO/UNICEF 'baby-friendly' hospital initiative, whose focus is the positive role that health services play in the protection, promotion and support of breastfeeding.

(m) 1994: Resolution 47.5 reiterates previous calls to end "free or low cost supplies", and extends the scope of this provision to the entirety of the healthcare system. This call has the practical effect of superseding Article 6.6 of the Code. The Resolution also provides practical guidelines on the provision of breast-milk substitutes in emergency situations.

(n) 1996: Resolution 49.15 calls on governments to ensure that: complementary foods are not marketed so as to undermine the exclusive use of breastfeeding; healthcare professionals are not put in situations of conflict of interest and, crucially, that the monitoring of the Code and subsequent WHA Resolutions is conducted in an independent and transparent manner free from commercial influence.

(o) 2001: Resolution 54.2 establishes an international recommendation time frame of six months for exclusive breastfeeding, at which stage it calls for the introduction of safe or appropriate foods until a child reaches two years of age.

(p) 2002: Resolution 55.25 endorses the Global Strategy on Infant and Young Child Feeding. This strategy advocates national policies that aim to create environments that protect, promote and support beneficial child feeding methods. It mandates that baby food producers comply with the Code and appropriate national provisions and ensure a uniform quality of their products. Further, the Resolution recognises the role of correct infant feeding in reducing the risk of obesity.

(q) 2005: Resolution 58.32 requests that signatories ensure that health claims for breast-milk substitutes are not permitted unless specifically allowed by law, and that states should be aware of the potential risks of contamination of formulas (and that this risk is correctly labelled) and ensure that this information is conveyed accordingly through label warnings. The Resolution further reiterates the need to ensure that child healthcare professionals' financial support or backing does not create conflicts of interest.

(r) 2006: Resolution 59.11 requests that Member States take measures to ensure that any response to the HIV pandemic (at the time) does not compromise compliance with the Code.

(s) Resolution 59.21 in the same year reiterates a request for ongoing WHO technical assistance to states to better enable them to implement and monitor the provisions of the Code.

(t) 2008: Resolution 61.14 endorses the action plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases. The Resolution includes the promotion of breastfeeding and complementary feeding as examples of key interventions to reduce risk factors for non-communicable diseases.

(u) Resolution 61.20 in the same year again urges signatories to improve efforts to monitor and enforce those national measures taken to implement the Code, and to avoid conflicts of interest in so doing. Importantly, the Resolution calls for an investigation of the safe use of donor milk through human milk banks for those children in need and for whom milk sources are otherwise unavailable.

(v) 2010: Resolution 63.14 calls on Member States to implement recommendations aimed at reducing the impact of marketing of 'junk' foods to children, and to follow guidelines to restrict such marketing where appropriate (for example, schools).

(w) Resolution 63.23 in the same year compels states to strengthen their degree of implementation into national legislation of the following documents: the Code, the relevant WHA Resolutions, the Global Strategy on Infant and Young Child Feeding, the Baby-Friendly Hospital Initiative and the Operational Guidance for Emergency Relief Staff and Programme Managers on Infant and Young Child Feeding in Emergencies. It also specifies that health and nutrition claims shall not be permitted, except where specifically provided for, in relevant Codex Alimentarius standards or national legislation.

(x) 2012: Resolution 65.6 requests WHO to provide clarification and guidance on the inappropriate promotion of foods for infants and young children cited in Resolution 63.23, taking into consideration the ongoing work of the Codex Alimentarius Commission and to "develop risk assessment, disclosure and management tools to safeguard against possible conflicts of interest in policy development and implementation of nutrition programmes consistent with WHO's overall policy and practice".

(y) The Special Rapporteur on the Right to Food calls on countries committed to 'scaling up nutrition' to "begin by regulating the marketing of commercial infant formula and other breast-milk substitutes, in accordance with WHA resolution 63.23, and by implementing the full set of WHO recommendations on the marketing of breast-milk substitutes and of foods and non-alcoholic beverages to children, in accordance with WHA resolution 63.14". He also called for "a clear exit strategy to empower communities to feed themselves". In such circumstances, "when ecosystems are able to support sustainable diets, nutrition programmes, policies and interventions supporting the use of supplements, ready-to-use therapeutic foods (RUTF), fortificants and infant formulas are inappropriate and can lead to malnutrition, and the marketing of these food substitutes and related products can contribute to major public health problems".

APPENDIX 5 – PROVISIONS OF THE CODE IN NATIONAL LAW

Thirty-seven countries have adopted the entirety or substantial entirety of the Code's provisions: Afghanistan, Albania, Bahrain, Benin, Botswana, Brazil, Burkina Faso, Cameroon, Cape Verde, Costa Rica, Dominican Republic, Fiji, Gabon, Gambia, Georgia, Ghana, Guatemala, India, Iran, Lebanon, Madagascar, Maldives, Mozambique, Nepal, Pakistan, Palau, Panama, Peru, Philippines, Saudi Arabia, Sri Lanka, Tanzania, Uganda, Uruguay, Venezuela, Yemen, Zimbabwe.

Forty-seven countries have adopted laws that encompass many of the Code's provisions: Argentina, Austria, Azerbaijan, Bangladesh, Belgium, Bolivia, Cambodia, Czech Republic, China, Colombia, Denmark, Egypt, Djibouti, Finland, France, Germany, Greece, Hungary, Indonesia, Ireland, Italy, Jordan, Kyrgyzstan, Lao PDR, Latvia, Luxembourg, Malawi, Mali, Mexico, Netherlands, Nicaragua, Niger, Nigeria, Norway, Oman, Poland, Portugal, Papua New Guinea, Senegal, Slovenia, Sweden, Spain, Tajikistan, Tunisia, United Kingdom, Vietnam, Zambia.

Nineteen countries have laws that include few provisions of the Code: Algeria, Armenia, Canada, Chile, Democratic Republic of Congo, Cuba, Estonia, Ethiopia, Guinea, Guinea-Bissau, Israel, Japan, Macedonia, Mongolia, Paraguay, Qatar, Turkey, Turkmenistan, United Arab Emirates.

Eleven have adopted all or a substantial proportion of the Code's provisions through voluntary, non-binding measures: Australia, Ecuador, Honduras, Kenya, Kuwait, Malaysia, New Zealand, South Africa, Swaziland, Thailand, Trinidad & Tobago.

Eight countries have adopted some of the Code's provisions through provisions through voluntary, non-binding measures: Bhutan, Guyana, Hong Kong, Jamaica, South Korea, Liberia, Singapore, Switzerland.

Fourteen have a draft law in place: Bosnia/ Herzegovina, Burundi, Congo, Côte d'Ivoire, El Salvador, Haiti, Iraq, Malta, Moldova, Morocco, Namibia, Rwanda, Sierra Leone, Togo.

Fourteen are studying how best to implement the Code: Angola, Belarus, Croatia, Eritrea, Lesotho, Lithuania, Mauritania, Mauritius, Myanmar, Romania, Russia, Slovakia, Syria, Uzbekistan.

Two have taken some steps to eliminate the supply of free or reduced-price breast-milk substitutes: Libya, Sudan.

Six countries have taken no action to implement the Code: Central African Republic, Chad, Somalia, USA, Iceland, Kazakhstan.

No information exists on the remaining countries: Bulgaria, Equatorial Guinea, North Korea, Netherlands Antilles, Niue, São Tomé & Principe, Ukraine.

ENDNOTES

HOW BREASTFEEDING SAVES LIVES: THE STORY IN NUMBERS

[1] Uruakpa, F, 'Colostrum and its benefits: a review', *Nutrition Research*, 2002, 22, 755–767, Department of Food Science, University of Manitoba, Winnipeg, Manitoba, R3T 2N2, Canada.

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INTRODUCTION

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1 HOW BREASTFEEDING SAVES CHILDREN'S LIVES

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4 THE HEALTH WORKER CRISIS AND ITS IMPACT ON BREASTFEEDING

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CONCLUSIONS AND RECOMMENDATIONS

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SUPERFOOD FOR BABIES

How overcoming barriers to breastfeeding will save children's lives

Breastfeeding is an amazing way to protect babies. Quite simply, it saves lives. It's the most effective approach to preventing the diseases and malnutrition that cause child deaths.

But breastfeeding is undervalued. Progress made in the 1980s in increasing breastfeeding rates has almost stalled. And in some countries, it's in reverse.

Superfood for Babies is a global call to action to rediscover the importance of breastfeeding and to support mothers to breastfeed their babies – especially in the poorest communities in the poorest countries.

The four major barriers that prevent mothers from breastfeeding are examined: community and cultural pressures; the shortage of health workers; lack of maternity legislation; and inappropriate promotion of breast-milk substitutes.

This report then puts forward a series of recommendations to governments, international institutions and multinational companies to act to ensure that every infant is given the life-saving protection that breastfeeding can offer.

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