Whatever happened to Health for All?

Ups and downs of protection of breastfeeding, regulation of transnational corporations and Health for All

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Foreword

The Health for All strategy that was agreed in the Alma Ata Declaration in 1978 is already thirty years old, but its principles of social justice and solidarity are ever more relevant. In 2008, it is urgent to renew our international commitment to Primary Health Care while taking into account the new realities and knowledge of today.

What is needed is a regeneration of the comprehensive primary health care approach to guarantee the highest attainable standard of health for all the peoples of the world. The global financial crisis has shown the vulnerability of ordinary people everywhere to market forces beyond their control, directly affecting their ability to access and afford health care. The global food security crisis has provoked food riots because people cannot afford to feed themselves and their families. The already measurable effects of climate change compound these threats to food sovereignty. The scandal of contaminated milk in China has shown the global nature of the food safety crisis with the same contaminant found in products all over the world, and particularly in powdered baby milk. Each of these crises affects vulnerable people most seriously: infants and young children are at highest risk.

One by one, these crises have demonstrated the weakness of market-based solutions and have underscored the urgency of providing adequate protection to the world's peoples to safeguard their health, safety and livelihoods. Sustainable, affordable solutions already exist, but may be threatened by market forces seeking to place private profit above public health. Breastfeeding can be seen as one of the cornerstones of Health for All, but optimal breastfeeding practices have been steadily eroded. To attain the Millennium

Development Goals of a two-third reduction in under-five child mortality, breastfeeding practices need to be revitalised using the protective primary health care approach.

Successive crises have shown that it is critical to adopt and enforce an effective regulatory framework. The International Code of Marketing of Breastmilk Substitutes was adopted by the World Health Assembly in 1981 to protect breastfeeding against marketing practices that undermine it. Subsequent food safety measures were adopted by the Codex Alimentarius Commission to lessen the risks of industrially processed baby milks. Nonetheless, these risks cannot be totally eliminated and industry influence remains strong in this standard-setting forum.

Since 1978, public-interest NGOs have expanded into an energetic and active movement, working to protect public health and emphasising the importance of the public sector approach. However, business-interest NGOs have grown in number in the past 30 years. They continue serving to advance the corporate aims of those businesses whose interests they represent through the current trend toward so-called public-private partnerships.

Public-interest groups such as the International Baby Food Action Network, IBFAN, are committed to join hands with governments to implement low-cost and sustainable solutions and to follow a strategy that has at its core the basic principles of Primary Health Care. IBFAN warns against the influence of business interests, either direct or thinly veiled under public-private partnerships, in policy setting and programme implementation. Such partnerships cannot provide sustainable solutions based on the Alma Ata principles.

Alison Linnecar, International Coordinator, IBFAN - GIFA

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Much has been written about the need to protect, promote and support breastfeeding, to increase the chances of survival and healthy development of children. Much has been said about the role breastfeeding plays in improving the health of mothers and its positive impact on family, community and national economies.

This article will try not to repeat what has been so eloquently expressed by fellow activists, researchers[1] and UN staff, although some overlaps are inevitable. It will focus on the protection of breastfeeding in the global and UN context. It will argue for public forces to come together, once again, to advance the agenda, which has a unique potential to facilitate the comprehensive achievement of children's and women's right to health.

Why Protect Breastfeeding?

The scientific evidence is unambiguous: early, exclusive breastfeeding for six months, followed by appropriate complementary feeding practices, with continued breastfeeding for

[1] For example: Andrew Chetley: The politics of baby foods: Successful challenges to an international marketing strategy, London, Frances Pinter, 1986; Annelies Allain: IBFAN: On the cutting edge. Uppsala: Dag Hammarskjöld Foundation, 1991; Gabrielle Palmer: The politics of breastfeeding, London, Pandora Press, 1993 (updated version planned for 2009); Judith Richter: Holding corporations accountable: Corporate conduct, international codes and citizens action, London and New York, Zed Books, 2001

up to two years or beyond, provides the key building block for child survival, growth and healthy development[2]. It is also the most cost-effective health strategy with respect to infant survival and health[3]. Besides having a major positive influence on the short- and long-term health of each human being, breastfeeding affords important health benefits to mothers who practise it.

Yet, this optimal feeding pattern is still a rare phenomenon both in the industrialized and developing countries alike. Only about one third of all infants in developing countries are exclusively breastfed for the first six months of life[4]. Malnutrition has been responsible, directly or indirectly, for 60% of the 10.9 million deaths annually among children under five years of age. Two-thirds of these deaths, which are usually associated with inappropriate feeding practices, occur during the first year of life.

To improve the situation, vigorous efforts at international and national level to protect, promote and support breastfeeding are required. Many people understand the concepts of 'promotion' and 'support', but question why breastfeeding needs 'protection'.

The answer is relatively simple. Once a society recognizes the crucial importance of breastfeeding, it has a responsibility to protect pregnant and lactating women from any negative influences and remove obstacles that could adversely affect this practice. One such influence is the unscrupulous marketing practices of the

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[2] For example: Child survival: The Lancet, July 5 2003. Vol. 362 (65-71)
[3] The World Bank: Directions in Development: Repositioning Nutrition as Central to Development - A Strategy for Large-Scale Action, pp. 34-35. Washington, 2006
[4] Progress for children, UNICEF, 2007

manufacturers of infant formula and other baby foods. This leads both directly and indirectly to artificial feeding, a suboptimal, and often dangerous way of feeding infants and young children.

The negative impact of marketing practices on child health was recognized decades ago and the international community has been taking steps ever since, sometimes forward and sometimes backward, on the way towards finding solutions to this problem. All these steps have been taken within a broader political context. In this publication, we will concentrate on the protection of breastfeeding, positioning it in the historical political context of the past 30 years, the time that has elapsed since the Alma Ata Declaration on primary health care was adopted.

Alma Ata and the New International Economic Order (NIEO)

Thirty years ago, in September 1978, the Alma Ata International conference on primary health care[5] took place. Primary health care was adopted as the policy model for global health. The outcome document, the Alma Ata Declaration, adopted this holistic approach, which emphasizes human rights and social and economic dimensions of health and well-being. It shifted the focus from cure to the prevention of ill health.

[5] Primary health care is "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination" (Alma Ata international conference definition)

Already the preamble to the World Health Organisation's Constitution declared that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." [6] the Declaration reaffirms this statement and positions health care firmly in a social framework whereby the promotion and protection of people's health are viewed as essential to sustained economic and social development. It argues for the recognition that such a focus on primary public health makes a key contribution to a better quality of life for all humans and in so doing enhances the possibility of world peace.

Primary health care was highlighted as the key strategy so that all peoples of the world could attain a level of health that would permit them to lead a socially and economically productive life as part of development within the spirit of social justice. The conference declared health[7] a fundamental human right and adopted as a worldwide goal the attainment of the highest possible level of health for all by the year 2000.

Proper nutrition together with maternal and child health care were emphasized among the key elements of the primary health care approach. Thus, although not explicitly mentioned, breastfeeding clearly was part of this strategy.[8]

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[6] World Health Organisation, Constitution, in Basic Documents, 46th ed., WHO 2007

[7] WHO defines health "a state of complete physical, mental, and social well being, and not merely the absence of disease or infirmity" WHO, Constitution of the World Health Organization, entered into force 1948,

[8] In the late 70s, research and knowledge about breastfeeding was scarce and the risks of artificial feeding not widely understood. Even the activists

The Alma Ata Conference took place in the political context of the New International Economic Order (NIEO), formally adopted by the 6th Special session of the General Assembly in April 1974. NIEO was a set of proposals developed during the 1970s by formerly colonized countries in the developing world. The main aim was to revise the existing international economic system to make it more favourable to the Third World countries, as they were then called[9]. The entitlement of developing countries to regulate and control the activities of transnational corporations (TNCs) within their territories was one of the key principles of the NIEO.

Strategies to make the TNCs more accountable had been discussed since the 1960s. At the international level this agenda was pursued by the former colonies which were experiencing and therefore analysing the negative impact of TNCs on the development, health and well-being of their people. It is therefore not surprising that in order to protect infants and young children from dying, the repeated calls to stop the harmful practices of the TNCs that manufactured and marketed baby foods formed a strong part of the debate about the necessity for the regulation of TNCs' activities.

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believed it was only a question of hygienic conditions and that artificial feeding had no adverse effects in rich societies.

[9] Third World as a term was used to capture the self-awareness of newly emerging nations in Africa, Asia and Latin America wishing to develop an economy and society different from the 'models' presented by the Western capitalist countries (First World) and the state socialist countries of Eastern Europe (Second World). In Ankie Hoogvelt: Multinational Enterprise; An encyclopaedic Dictionary of Concepts and terms Macmillan reference Books, Macmillan Press , 1987

The Code is born …after an elephantine gestation [10]

A year after the Alma Ata Conference, the 1979 UNICEF/WHO Meeting on Infant and Young Child Feeding triggered the process of creating a policy framework to protect, promote and support breastfeeding. The regulation of the marketing practices of the manufacturers of infant formula and other breastmilk substitutes became the centrepiece of the proposed code. It was at the end of this meeting that the International Baby Food Action Network (IBFAN) was formed as a network of NGOs that would follow up that particular recommendation of the meeting. When WHO and UNICEF initiated and coordinated the drafting of the International Code on Marketing of Breastmilk Substitutes, IBFAN was among the four parties (UN, governments, industry and NGOs) involved.

After four drafts, tough negotiations and several compromises, the World Health Assembly[11] adopted the International Code of Marketing of Breastmilk Substitutes in 1981. The Code was adopted as a minimum standard. Since then, it has been followed by thirteen WHA resolutions on infant and young child feeding.

It is important to note two points about the changing political context in which the Code was adopted:

1/ By 1980 the NIEO was no longer high on the world's agenda and the neoliberal economic order started surfacing as the "pensée

[10] The elephant's gestation period is 22 months. The Code was born after 18 months of risky pregnancy.

[11] World Health Assembly (WHA) is the world's highest health policy setting body and is composed of health ministers from member states (currently 193). WHA has its regular sessions once a year in Geneva.

unique", bringing with it strong opposition to legally binding regulations. During the 1980s under the influence of US President Ronald Reagan and UK Prime Minister Margaret Thatcher, a philosophy of a 'there is no alternative' approach to market economics came to achieve global domination.

2/ Although at the end of the 1970s there were at least 30 proposals for codes or guidelines to regulate business and protect consumers, only a few were adopted during the 1980s, all in a weakened and non-binding form. A strong lobby against the development of binding and effective codes of conduct for the TNCs was so successful that further attempts to get strong codes in other fields, for example the environment, were blocked. Even the Code of Marketing of Breastmilk Substitutes suffered because of this shift in economic and political thinking. The Code was adopted by the WHA only as a recommendation rather than as a stronger enforceable international measure, which its protagonists had originally intended. Nevertheless, even as a recommendation it still carried strong moral and ethical weight.

GOBI: Taking a pragmatic approach---or compromising Health for All?

UNICEF adopted a selective primary health care approach, a model proposed as an 'interim strategy' towards implementation of Health for All[12]. At its core were key interventions that were low cost, feasible to implement, with proven efficacy and considered to be

[12] J. Walsh and K. Warren: Selective Primary Health Care: An Interim Strategy for Disease Control in Developing Countries, *New England Journal of Medicine* 301, no. 18 (1979): 967–974

synergistic. These interventions were organized in a 'strategy package' as GOBI (Growth monitoring, Oral rehydration, Breastfeeding and Immunisation). The combination of these four interventions was deemed to be able to save 20,000 children from dying each day. GOBI quickly became GOBI-FFF with Food supplementation, Female education and Family spacing added later.

Box 1: GOBI as described in the UNICEF's State of the World's Children

GROWTH MONITORING
- which could help mothers to prevent most child malnutrition before it begins. With the help of a U.S. 10-cent growth chart, and basic advice on weaning, most mothers could maintain their child's healthy growth - even within their limited resources. More than 200 different growth charts are used in over 80 countries.

ORAL REHYDRATION
- which could save most of the more than 4 million young children who now die each year from diarrhoeal dehydration. One out of every 20 children born into the developing world dies due to dehydration brought on by ordinary diarrhea, before reaching the age of 5. It is the biggest single cause of child deaths in developing countries. Previously, the only effective treatment for dehydration was the intravenous feeding of a saline solution - a cure beyond the physical and financial reach of most of those who need it. Now a child can be rehydrated by drinking a solution of salts, sugar and water administered by the mother in the child's own home. Most of these children could be saved by this simple Oral Rehydration Therapy (ORT). It is one of the simplest but most important breakthroughs in the history of science.

BREAST-FEEDING
- which can ensure that infants have the best possible food and a considerable degree of immunity from common infections during the first six months of life. For infants, breast-milk is more nutritious, more hygienic, and provides a degree of immunity from infection. For the mother, breast-feeding is economical - but it also makes heavy demands on her energy, time, and freedom of movement.

IMMUNIZATION
- which can protect a child against measles, diphtheria, whooping cough, tetanus, tuberculosis, and polio. At present, these diseases kill as estimated 5 million young children a year, leave 5 million more disabled, and are a major cause of child malnutrition.

[1] James P. Grant, former Executive Director of UNICEF, State of the World's Children 1982-83 (Oxford University Press, 1982)

GOBI was rather favourable to breastfeeding, selecting it clearly as an essential intervention and UNICEF undertook the work on the **"B"** with all its complexities, including support for implementation and monitoring of the Code. This was a critically important step towards a much needed comprehensive approach to infant and young child nutrition since at that time no coordinated strategies to protect, promote and support breastfeeding had existed.

The UNICEF Executive Director, Mr. James P. Grant (1980 – 1995), explained the importance of protecting mothers and babies from aggressive marketing: *"Among the main causes of that decline [in breastfeeding rates] has been the spread of artificial infant milk whose manufacturers looked outward from the stagnating markets of the industrialized countries in the 1960s and 70s and saw the potential of increasing sales among the large and rising infant populations of the developing world. And to a mother whose confidence may already be low in the face of more ' scientific' ideas and more 'modern' products imported from other cultures, even the most innocent promotions - ' for those who can't breastfeed' or ' for*

mothers with insufficient milk' - can create the anxiety which is one of the major causes for breastfeeding's decline". [13]

Implementation of the Code: From the moment of its adoption by the World Health Assembly national implementation of the Code in the form of enforceable laws or directives became an uphill struggle. The USA, which had initially supported the Code process, underwent its own political changes when a new government took over. The USA was the only country to vote against the Code's adoption. Lobbying by the baby-food industry and a new philosophy of deregulation led to the sabotaging vote. It may be that this last-minute reversal of support undermined the resolve of other nations to implement the Code rapidly and effectively.

Criticism of GOBI and the effect on breastfeeding protection

After the launch of GOBI in 1982, the critics soon gave their opinions. Those supportive of the NIEO principles and the Alma Ata Declaration's objectives saw GOBI as a reductionist approach. They viewed its pragmatism as a dangerous compromise. They argued that the selective approach undermined the original intention of the Alma Ata Declaration which was to address the underlying social, economic and political causes of poor health. Others, who yearned to abolish NIEO or any movement and action based on its principles, such as implementation of Health for All, argued that UNICEF was biased in favour of NIEO. They claimed that in implementing the GOBI strategy, UNICEF had overstepped, even violated, its mission.

[13] James P. Grant, ExDir UNICEF, State of the World's Children 1982-83, Oxford University Press, 1982

It is worth examining one of these critics' arguments with direct relevance to the protection of breastfeeding.

In 1983, The Heritage Foundation, an American conservative 'think tank'[14], prepared a background document [15] for the US Congress which expressed serious reservations regarding both UNICEF's GOBI strategy and in particular UNICEF's efforts to push for implementation and monitoring of the Code:

"In the recently published UNICEF report on The State of the World's Children, Director Grant places full blame for the alleged decline in breastfeeding in developing countries on the multinational infant formula manufacturers", asserted the Heritage Foundation. Referring to the before mentioned statement of James Grant, they accused UNICEF of ignoring "other evidence and reasons for the changes in breastfeeding habits in the developing countries" and challenged the need for any mandatory code. The Heritage Foundation's document claimed that:

[14] Founded in 1973, The Heritage Foundation is a think tank that defines its mission as follows: "to formulate and promote conservative public policies based on the principles of free enterprise, limited government, individual freedom, traditional American values, and a strong national defence." http://www.heritage.org/About/ (accessed 12 September 2008)

[15] Roger A. Brooks, UNICEF, beware—dangerous shoals ahead: backgrounder #287
http://www.heritage.org/Research/InternationalOrganizations/bg287.cfm Accessed 14.8.2008

"*The majority of infant formula companies believe that there is a need for guidelines governing the promotion of infant formula in developing countries*". [16]

"These firms have written their own industry codes and regulations which, in fact, predate the WHO code. Yet UNICEF, perhaps for political reasons, seems determined to castigate the industry".

The paper continues: "*If UNICEF continues to move in this direction, it will find itself compromised by the reflexive anti-Western rhetoric and anti-free market arguments that have undermined other U.N. agencies."*

Since UNICEF's funding depended (and continues to depend) on voluntary contributions from both governments and non-governmental sources, with the USA being an established and important contributor, this last statement could have been interpreted by the agency's leadership as an implicit threat. The following statement made the stance more explicit:

"Few Americans would oppose their government's providing useful aid and support to needy children in developing countries or to UNICEF's relief and rehabilitation efforts throughout the developing world. But in light of UNICEF's increasing involvement in monitoring (the Infant Formula Marketing Code which the U.S government has opposed, and WHO's "Essential Drug Program") and the growing trend toward politicizing the UNICEF agenda, the U.S must consider

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[16] The Code applies globally but ever since its adoption, infant food manufacturers have been trying to create an understanding that it applies only for developing countries. The Heritage Foundation said it in 1983 and 25 years later we still hear the same misinterpretation, as if children and their mothers in industrialized nations did not merit any protection.

more carefully the effectiveness of UNICEF programs and the benefit to the United States of continuing to support them."

Did this Heritage Foundation paper make an impact? Was there other 'behind the scenes' pressure from politicians or directors of TNCs? We may never know. What is known is that UNICEF has never embarked vigorously on any programme or initiative of global Code monitoring.

Any takers for monitoring?

> *"We thought that when the Code was passed the manufacturers and marketing people would do the right thing. Unfortunately, little has changed."*
> *Nancy Jo Peck, former Scientific Advisor to IBFAN*[17]

IBFAN launched its monitoring of company compliance with the Code after realizing that governments were unlikely to engage in systematic national monitoring. IBFAN also became aware that no UN agency was committed to keeping proper records of Code breaches.

Since 1982, IBFAN's reports *Breaking the Rules* and *State of the Code by Company* have regularly drawn the attention of governments, the UN agencies, the infant feeding industry and the general public, to the fact that the most vulnerable consumers still, 27 years after Code's adoption, continue to lack protection from unethical marketing practices.[18] IBFAN's monitoring results have been

[17] Quoted in *BFHI News* Jan-Feb 1999

[18] IBFAN Code monitoring reports (accessed 13 September 2008): http://www.ibfan.org/site2005/Pages/article.php?art_id=298&iui=1

supported by other types of monitoring as well as by research findings.[19]

From the beginning, IBFAN assisted governments with Code implementation by providing legal services and by reporting on national implementation in its *State of the Code by Country*. Progress was slow and opposition strong. Might there be other powerful arguments that could tip the balance in favour of babies' protection?

Human rights— a new approach to accountability?

In 1989, the UN General Assembly adopted the Convention on the Rights of the Child (CRC), now signed and ratified by all member states but two (USA and Somalia). The CRC is the most ratified international convention and represents a breakthrough in global consensus over a moral and ethical issue. Article 24 of the CRC mentions specifically the importance of breastfeeding as part of the child's right to the highest attainable standard of health. It was this exceptional document that placed breastfeeding high on the human rights agenda.

This was excellent news for mothers and babies especially because the CRC carries more than moral and ethical weight: it is legally binding for the governments that ratified it. The CRC Committee regularly reviews the progress countries are making towards meeting their obligations as stipulated in the Convention. The CRC Committee

[19] Examples of other sources reporting Code violations: Cracking the code. Interagency Group on Breastfeeding Monitoring (IGBM). London, IGBM, 1997; Awareness and reported violations of the WHO International Code and Pakistan's national breastfeeding legislation: a descriptive cross-sectional survey. International Breastfeeding Journal 2008, 3:24 doi:10.1186/1746-4358-3-24

is a group of independent experts who interpret the CRC articles[20]. The Committee has since recognized that "implementation of the Code by States Parties is a concrete measure towards the realisation of parents' right to objective information on the advantages of breastfeeding and, thus, to fulfilling the obligation of article 24." [21] The CRC Committee has on many occasions recommended to countries under review to implement or strengthen national implementation of the Code[22].

Bringing the Code into the human rights arena profoundly changes the way in which the Code violators must be seen.

> *"Those who make claims about infant formula that intentionally undermine women's confidence in breastfeeding are not to be regarded as clever entrepreneurs just doing their job but as human rights violators of the worst kind".*
>
> Stephen Lewis, former UNICEF's Deputy Executive Director, 1999

The Innocenti Declaration[23]

In 1990, under the leadership of Sweden, policy-makers from 31 governments and seven international agencies met in Florence and developed the *Innocenti Declaration on Protection, promotion and*

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[20] For example: Elaine Petitat-Côté, Child Rights and Health: NGOs making a difference, IBFAN-GIFA, Geneva, 2005

[21] R. Hodgkin, P. Newell, *Implementation Handbook for the Convention on the Rights of the Child*, UNICEF, 2002, 762 p. (p. 357).

[22] For example in the Philippines (2005), where a CRC recommendation led to the development of strong regulations implementing the national law or in the United Kingdom where it led to the strengthening of some provisions of the national law.

[23] For full text of the Innocenti Declaration see: http://www.unsystem.org/scn/archives/scnnewsextractsmay91/ch3.htm#The%20Innocenti%20Declaration%20on%20the%20Protection,%20Promotion%20and%20Support%20of%20Breastfeeding

support of breastfeeding. The declaration is a major conceptualisation of four key areas for government action to protect breastfeeding. These 'operational targets' are:

- Effective national coordination of breastfeeding protection activities
- The transformation of protocols and routines in maternity wards and hospitals in order to overcome constraints and achieve a high standard of care supportive of breastfeeding in health care services. (The Baby-Friendly Hospital Initiative [BFHI] was one strategy devised to achieve this goal.)
- The implementation of the Code
- Maternity protection legislation for all working women.

Baby Friendly Hospital Initiative (BFHI)

In response to the second target of the Innocenti Declaration's targets, UNICEF and WHO launched BFHI in the early 1990s. The BFHI is based on ***"The Ten steps to successful breastfeeding***"[24], a summary of the WHO/UNICEF guidelines for maternity care. The 10 Steps are minimum global criteria for maternity care that protects breastfeeding, which also form the standard for assessment of maternity services. Facilities have to fulfill all Ten Steps to attain the status of a Baby-Friendly Hospital. BFHI status is designed to ensure the provision of the conditions, skills and support to enable mothers to breastfeed and to guarantee the same for safer artificial feeding

[24] Joint WHO/UNICEF Statement Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services, (WHO,1989)

for the minority of babies who cannot be breastfed.[25] The role of maternity facilities and staff is to protect breastfeeding. Therefore in order to achieve BFHI status, hospitals must also comply fully with the Code and ban any promotion of breastmilk substitutes, bottles or teats, or the distribution of free infant formula[26].

The mid 1990s: the dark ages of breastfeeding protection

With the establishment of the Code, the Innocenti Declaration, the CRC process and the Baby-Friendly Hospital Initiative, conditions seemed to be favourable for the creation of a global environment in which mothers would receive all the support needed to breastfeed their children. Regulating commercial influence and addressing social pressures could do much to protect a woman's confidence that the feeding bottle and artificial milk are unnecessary.

These steps to progress were hampered by the HIV/AIDS pandemic. The fact that some babies could contract HIV through being breastfed led to one of the most painful dilemmas of public health. Breastfeeding, until then increasingly appreciated for saving lives and improving the health prospects of babies and their mothers, came to be regarded as a culprit, a dangerous thing to do. [27]

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[25] There are now more than 20,000 Baby-Friendly facilities in 152 countries. The impact of the Initiative on the duration of exclusive breastfeeding for 6 months and on the health of babies has been proven.

[26] BABY-FRIENDLY HOSPITAL INITIATIVE: Revised, Updated and Expanded for Integrated Care, UNICEF/WHO 2006 http://www.unicef.org/nutrition/files/BFHI_Revised_Section1.pdf accessed 15.8.2008

[27] While most HIV-positive mothers will not transmit HIV to their infants, transmission of HIV virus from the HIV-positive mother to her child may

Moreover, the increasing number of regions exposed to complex emergencies, be it man-made calamities such as war or natural disasters, brought about further challenges to breastfeeding. Far too often the immediate response to an emergency was – and continues to be -- shipments of infant formula, bottles and baby foods. This happens despite the fact that it is well-documented that artificial feeding in these circumstances dramatically increases the risks of child disease and death. Both NGOs and UN agencies running programmes in the contexts of HIV and emergencies (often both) observed the exploitation of these situations for the promotion of artificial feeding either directly by infant food TNCs or by governments supportive of this industry.

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occur either during pregnancy, delivery or through breastfeeding. The transmission rate, without administration of antiretroviral drugs (ARV), is determined to be 5 - 10% during pregnancy and 10 – 20% during the approximate 24-hour period of labour and delivery (the single time point of greatest risk). The risk of transmission through breastfeeding is estimated at 5 - 20%, if a baby were to be breastfed for two years. Transmission through breastfeeding is more likely if a woman becomes infected with HIV during the breastfeeding period. The risk of HIV transmission through breastfeeding can be significantly lowered by exclusive breastfeeding. Further reduction of this risk is likely to be achieved if infants receive antiretroviral (ARV) prophylaxis and/or mothers receive ARV treatment. Mixed feeding in young infants carries a higher risk of HIV transmission. Guidance on HIV and infant feeding in the context of refugees and displaced populations, UNHCR, 2008.

All this controversy was happening in the midst of an increasingly vexatious debate on the appropriate duration of exclusive breastfeeding[28].

Scientific evidence and a consensus among many infant feeding experts had led to the adoption of a WHA Resolution WHA47.5 (1994), which recommended "about six months" of exclusive breastfeeding. This replaced the four-to-six month statement in the 1990 Innocenti Declaration which was agreed before new evidence had been found. Despite this fact the industry - and those supportive or intimidated by them - persisted with 4-6 months. Two months worth of sales profits were at stake. Exclusive breastfeeding for 6 instead of 4 months represents a large financial loss to the companies when global sales are calculated.

The public health experts, public interest NGOs[29] and UNICEF, all of whom promoted the World Health Assembly position, had before them an almost ten-year uphill struggle trying to implement a policy to which the entire world had already officially agreed.

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[28] Exclusive breastfeeding: an infant receives only breastmilk and no other liquids or solids, not even water, with the exception of drops or syrups containing vitamins, mineral supplements or medicines.

[29] Public-interest NGOs (PINGOs) is a term referring to NGOs whose primary goal is to further public agendas, such as environment, health and welfare of children, women's agenda. They are distinctly different from so called BINGOs (business–interest NGOs), whose primary goal is to further business profit-making agenda. A BINGO example would be the International Association of Infant Food Manufacturers (IFM) with their front NGO, the International Society of Dietetic Food Industries (ISDI).

The turning of the tide

The struggle to combat the many constraints to breastfeeding protection during this critical period has been happening simultaneously on several fronts:

- Limitation of the damage caused by the HIV dilemma
- Strengthening the protection of breastfeeding in emergencies
- Defense of the optimal age of 6 months of exclusive breastfeeding

Researchers in South Africa undertook the first ever analysis to look at the possible impact of breastfeeding patterns[30] on HIV transmission. They discovered that exclusive breastfeeding protected against the transmission of HIV. This was not a surprise to breastfeeding experts who had long been advocating this type of analysis, which would distinguish between infants of HIV-infected mothers who were exclusively breastfed and those only partially breastfed. It was known that exclusive breastfeeding was important for maturation of the intestinal mucosa and that introduction of infant formula or any food to young infants might cause micro

[30] In addition to exclusive breastfeeding, WHO defines:
Predominant Breastfeeding: a feeding pattern which requires that the infant receive breast milk (including milk expressed or from wet nurse) as the predominant source of nourishment. It allows the infant to receive liquids (water and water-based drinks, fruit, juice, oral rehydration solution), ritual fluids and drops or syrups (vitamins, minerals, medicines).
[Any] Breastfeeding: a feeding pattern that requires that the infant receive breast milk and allows the infant to receive any food or liquid including non-human milk.
Exclusive and predominant breastfeeding categories together constitute *full breastfeeding*.

bleeding of the gut or other negative effects which, they suspected, were likely to facilitate the virus crossing through the baby's gut wall. The first South African studies were thus important breakthroughs making it essential to limit the damage caused by promotion of artificial feeding for babies born to HIV-infected mothers. Those who had been unable to accept the facts that a few bottles of infant formula could disrupt breastfeeding and cause infection were now confronted with evidence that promotion of these products was indeed a matter of life and death.

The systematic approach to policy and capacity building in the area of infant feeding in emergencies (IFE) has been led by the IFE Core Group. This interagency body was formed in 1998 with IBFAN – GIFA as one of the founding members[31]. The IFE Core Group has been successful, in increasing the understanding of the importance of the avoidance of donations and industry interference in order to protect breastfeeding when it is most essential to save life. These principles, contained in *The Operational Guidance on Infant and Young Child Feeding in Emergencies*, have been adopted by some UN and government agencies and large NGOs operating in emergencies. They are also incorporated in the UNICEF - led Nutrition Cluster of the UN Inter-agency Standing Committee (IASC). [32]

The implementation of the 6 months exclusive breastfeeding policy was important not only in the public health arena. In the area of

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[31] Other members are: UNICEF, UNHCR, WHO, WFP, Emergency Nutrition Network, CARE USA, Save the Children UK and Action Contre la Faim.

[32] The Nutrition Cluster of the Inter-Agency Standing Committee is a United Nations initiative to improve the effectiveness and predictability of humanitarian response in the area of nutrition. There are 11 sector-based clusters and 4 on cross-cutting issues

workplace protections, in 2000, a new International Labour Organisation (ILO) Convention on Maternity Protection number 183 together with Recommendation number 191[33] was adopted by the three constituent parties of the ILO Conference: governments, employers' and employees' organisations. These documents lay out international standards for maternity leave and breastfeeding breaks in the workplace. The stipulated minimum length of maternity leave is, however, only 14 weeks in the Convention and 18 weeks in the Recommendation. They thus do not sufficiently support six months of exclusive breastfeeding and continued breastfeeding. However, since maternity leave and breastfeeding breaks are still inadequate in many countries, the adoption of the 2000 ILO Convention presents an important political reminder to governments that legislation must be improved. Such standards provide crucial benchmarks for politicians and campaigners struggling to make changes within countries.

Finally in 2001, a WHO-convened scientific expert consultation concluded that 6 months of exclusive breastfeeding must be the global public health recommendation. Their findings endorsed previous knowledge that babies given other food before six months were more likely to get ill and/or die. Subsequently, this recommendation was endorsed by that year's World Health Assembly in its resolution 54.2.

The turn of the millennium looked hopeful for the revival of breastfeeding, improving the prospects for mothers and their babies

[33] There are three ILO Maternity Protection Conventions (No 3 1919; No 103, 1952; No 183, 2000) and two Maternity Protection Recommendations (No 95, 1952, No 191 2000)

and entire families. Interesting developments were also taking place at UN level.

The international context of the millennium

In September 2000, a UN headquarters meeting of world leaders adopted the United Nations Millennium Declaration, committing their nations to renewed efforts to reduce extreme poverty. They also set eight time-bound targets with a deadline of 2015, known as the Millennium Development Goals (MDGs). The MDGs range from halving extreme poverty to reducing maternal and child mortality and halting the spread of HIV/AIDS.

The MDGs are praised as a strategy that has galvanized unprecedented efforts to meet the needs of the world's poorest. However, all these good intentions notwithstanding, critics of the approach explain that the MDGs pose a danger of verticalisation and fragmentation of policies and programmes. They emphasize that MDGs have been taking the development work away from the promising "sector-wide approaches"[34], promoted in the late 90s.

[34] "Sector-Wide Approach (SWAp) is a method of working that brings together governments, donors and other actors within any sector. It is characterized by a set of operating principles rather than a specific package of policies or activities. The approach involves movement over time under government leadership towards: broadening policy dialogue; developing a single sector policy (that addresses private and public sector issues) and a common realistic expenditure program; common monitoring arrangements; and more coordinated procedures for funding and procurement." If SWAps were ever to be taken up again, for them to be effective they would have to give far greater prominence to women's health and human rights issues. http://www.sti.ch/health-systems-support/the-swap-website.html Accessed 20 August 2008

Although breastfeeding does not figure specifically as one of the MDGs, analysis of the goals highlights the role breastfeeding protection, promotion and support can play towards achievement of every single one of the Goals (see Annex 1).

In 2002, building on these initiatives, WHO/UNICEF launched The Global Strategy for Infant and Young Child Feeding to "*revitalize world attention to the impact that feeding practices have on the nutritional status, growth, development, health, and thus the very survival of infants and young children.*" The Strategy was adopted by all WHO member states and represents further commitment for strengthening of the protection of breastfeeding through enforceable legal measures based on the Code.

And while the Global Strategy calls for innovative alliances to implement the Code, it also clearly delineates in its paragraph 44 the appropriate roles for manufacturers and distributors of industrially processed foods intended for infants and young children. It assigns them two basic responsibilities:

- to meet specific quality, safety, and labelling standards set by the Codex Alimentarius and the Codex Code of Hygienic Practice for Foods for Infants and Children,
- and with regard to the International Code of Marketing of Breast-milk Substitutes: to ensure that their conduct, at every level conforms to the Code, subsequent relevant Health Assembly resolutions, and national measures that have been adopted to give effect to both.

Why does the Global Strategy emphasise these explanations of the roles of the infant feeding industry? Both WHO and UNICEF had long experience of both overt and hidden pressures from industry to weaken or subvert public health policy so as to shape it in favour of

commercial interests. The tobacco debate provided a glaring example of industry influence on policy-making. Both UN agencies were aware of the need to avoid situations of conflict of interest which would increase the risk of undue baby food industry influence on those individuals and institutions responsible for public policies and programmes.

Many professionals working in the field of health are conscious about how difficult it is to protect personal and institutional integrity when interacting with powerful for-profit actors.

> "*There are many health professionals and public officials who fulfill their duties with absolute integrity. Overall, however, statistical evidence indicates that financial interests are known to sway professional judgment. Even professionals who are aware of a conflict of interest tend to underestimate the extent to which it affects their judgment and behaviour.*[35] *For example, many physicians think that they cannot be influenced by small gifts from companies. Yet a great body of research on the link between gifts and samples from pharmaceutical companies and prescribing behaviour shows that even insignificant tokens tend to affect physicians' judgment and induce them to prescribe products of the gift-giving company*."
>
> Judith Richter, Independent researcher, 2005[36]

The adoption of the Global Strategy raised expectations that increased funding for infant and young child feeding would follow this political commitment. A golden age for breastfeeding seemed to be arriving.

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[35] Dana, J. & Loewenstein, G. (2003). A social science perspective on gifts to physicians from industry. JAMA, 290 (2), pp. 252-255

[36] Judith Richter: Conflicts of Interest and Policy Implementation. Reflections from the fields of health and infant feeding. IBFAN-GIFA, June 2005

2000: WHO's new Corporate Strategy

Unfortunately, the Global Strategy was developed at a time when WHO embarked on implementation of its new *Corporate Strategy*. Presented to the WHO Executive Board in January 2000, the Strategy made "negotiating and sustaining national and global partnerships" into a 'core function' of the WHO Secretariat.[37] The very same month, the Commission on Macroeconomics and Health[38] was established by Dr. Gro Harlem Brundtland, then WHO's Director General. WHO took the Commission's final report[39], with its economic focus and global public-private partnership policy model, as a blueprint for health, consigning the Alma Ata Declaration to the history books once and for all and paying mere lip service to the notion of Health for All[40]. The Commission dismissed WHO Member States' concerns about conflicts of interest as unnecessary constraints to "more flexible working approaches".

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[37] For detail see Judith Richter: Public-Private Partnerships and International Health Policy-making; How can public interests be safeguarded? pg. 76-81, Ministry for Foreign Affairs of Finland, Helsinki 2004

[38] The Commission on Macroeconomics and Health was to assess the place of health in global economic development. It comprised 18 of the world's leading economists, public health experts, development professionals and policy-makers, under the Chairmanship of Professor Jeffrey Sachs of Harvard University.

[39] Macroeconomics and health: investing in health for economic development. Geneva, World Health Organization, December 2001

[40] For example, the work done by WHO-EURO office on Health for All in the 21st century (Health 21 – health for all in the 21st century, European health for all series No.6, WHO 1999) was discarded.

The Peoples' Health Movement (PHM) issued a public comment on some of the central issues in the report[41]. Among others, PHM expressed great concern over the promotion of the public-private partnership scheme:

"The report recommends a series of measures at the international level to complement its vision of healthy development … including the development of more public-private partnerships focused on tackling disease. Given the reservations we have raised about disease-specific measures and the lack of evidence to show that these global public private partnerships contribute to longer-term system sustainability, WHO and national governments should be wary about supporting their further development."

By 2005, implementation of the Global Strategy was still slow; the funding base decreasing rather than increasing. This trend continued in the face of much new research which repeatedly highlighted and added to the knowledge that improving breastfeeding practices was the single most effective intervention to save infant lives and improve infant health[42].

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[40]http://www.who.int/macrohealth/events/civil_society_asia/en/phm_comment_on_cmh.pdf accessed 11 November 2008

[42] In July 2003, the Bellagio Child Survival Study Group estimated that 13% of under-five deaths could be prevented by optimal breastfeeding and 6% by improved complementary feeding practices (The Lancet, July 5 2003. Vol. 362: 11-17). About 50-60% of under-five mortality is caused by malnutrition due to inadequate complementary foods and feeding following on poor breastfeeding practices.

In order to renew interest in and foster implementation of the Global Strategy, a UN/NGO coalition[43], led by UNICEF, embarked on a process to take stock of past achievements, to present current challenges and to define priority actions for all key actors. This process culminated in November 2005 in Florence with the adoption of a second Innocenti Declaration on Infant and Young Child Feeding, endorsed in 2006 by the 33rd annual session of the UN Standing Committee on Nutrition (UNSCN) and welcomed by the 2006 WHA.

The Call for Action contained within the 2005 Innocenti Declaration follows a human rights approach in delineating the obligations and roles for all actors in the protection, promotion and support of breastfeeding.

The UN/NGO coalition was conscious of the need for innovative alliances to accelerate effective interventions in countries with a high burden of child deaths. At the same time, aware of the potential pitfalls of public-private partnerships, the coalition argued that: *"The global partnerships, alliances and collaborations should be fully transparent and consistent with accepted principles for avoiding conflicts of interest and should support all the targets of the Declaration to provide a strong force for positive change*." [44]

[43] NGO participants: IBFAN, ILCA, La Leche League, The Academy for Breastfeeding Medicine, WABA, Wellstart International. UN participants: UNICEF and WHO.

[44] http://www.unicef-irc.org/homepages/files/documents/f_7.pdf accessed 20 August 2008

Are Public-Private Partnerships good for infant and young child feeding?

The Alma Ata Declaration appealed to its signatories to work towards Health for All in a "spirit of partnership". This was during the time of the Cold War and the statement was an appeal for actors to transcend the very real political rifts of the time and to bring all relevant sectors to work together. The right and duty of the people to participate in planning and implementation of their health care was a key element.

The rallying call of "a spirit of partnership" came to take on a profoundly different meaning in the 1990s when the word 'partnership' came to signify joint initiatives between UN agencies and non-state actors, increasingly from private sector. These initiatives have tended to go beyond technical and financial relationships and include policy-related collaboration.

In the late 1990s, as the trend to public-private partnerships was becoming established, IBFAN-GIFA observed their formation and the development of the WHO Guidelines on Interaction with Commercial Enterprises. IBFAN criticized such problematic statements as "*The general principles of partnership building should be established on the basis of mutual respect, trust, transparency and shared benefit*". The IBFAN network's experience of TNC behaviour led its leading analysts to believe that such respect and trust must be earned. That is to say, any commitment by a UN agency to enter into a relationship with the private sector must be based on a serious and meticulous investigation of the track record of each particular

company, industry sector, and/or business association. [45] This had not been done by WHO.

In 2003, a specialist on PPPs wrote[46]: "*Today, there is hardly any UN agency that does not actively promote and seek out some sort of partnership between itself and the corporate sector. The International Baby Food Action Network (IBFAN) and other citizen groups and networks have been gravely concerned that uncritical acceptance of this policy trend of 'partnership' with business is detrimental to efforts to promote human rights, including the right to the highest attainable standard of health. They fear that this policy paradigm may run counter to attempts to hold corporations accountable to society by means of legally-binding regulation and other public actions*".

These concerns are as relevant today as they were five years ago. Some infant food manufacturers, aware of the benefits provided by this policy model are using the public-private partnership structures to become involved in policy processes and programmes on infant and young child feeding, regardless of the roles assigned to them by the Global Strategy and the 2005 World Health Assembly Resolution[47].

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[45] In Judith Richter: We the peoples or we the corporations. Critical reflections on UN-business "partnership", IBFAN-GIFA, 2003 http://www.gifa.org/files/wearethepeople.pdf accessed 20 August 2008

[46] idem.

[47] The 2005 WHA resolution 58.32 on infant and young child feeding has further reaffirmed these important principles when it urged the Member States to:

IBFAN and other NGOs are increasingly apprehensive about the public-private partnerships which started off as UN-business partnerships and are now becoming independent of the UN. These quasi policy-makers and programme-implementers are not bound by UN policy processes, ethical principles or guidelines and therefore are not obligated to follow them. This means that the democratic accountability of the UN is being undermined. Carefully worked out policy decisions agreed by world health representatives of all member states at the World Health Assemblies may be easily subverted without redress.

An example is that of the Global Alliance for Improved Nutrition (GAIN), a public-private partnership launched in 2002. GAIN was presented as *"an alliance of international public, private and civic organisations committed to improving health, cognitive development and productivity in developing countries through the elimination of vitamin and mineral deficiencies – especially deficiencies of vitamin A, folic acid, and iron.*" The main aim of this "*alliance of public and private sector partners"* was to *"leverage cost-effective food fortification initiatives*" to achieve this goal.[48]

Despite its name encompassing the whole field of nutrition, GAIN initially focused its activities on the issue of micronutrients. However, this soon changed. In January 2008, GAIN announced a US$38 million grant from the Bill & Melinda Gates Foundation to fight malnutrition in young children. In GAIN's own words: *"GAIN will use the grant to*

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(1) ensure that financial support and other incentives for programmes and health professionals working in infant and young child health do not create conflicts of interest;

[48] Press release, 5 May, Global Alliance for Improved Nutrition. www.gainhealth@org/pressrelease.asp, quoted in Judith Richter 2003

work with a range of stakeholders to promote breastfeeding, create an enabling environment for appropriate feeding practices, and work to increase access to nutritious foods for infants and young children between 6 and 24 months of age."[49]

Aware of the lack of sustained funding for breastfeeding protection, promotion and support, the reader might now feel elated to learn that money for breastfeeding and appropriate complementary feeding is finally available. Why should anyone complain?

However, such elation might wane when the reader learns that this global health initiative follows the Bill Gates model of PPPs which requires industry membership on governing boards. In the case of GAIN, the CEO of Danone, one of the world's largest baby food manufacturers is on its board and the company is listed as an active working partner with GAIN. The company profile on the GAIN website does not mention Danone's significant place in the baby food market.[50] [51] Nor does it mention Danone's failure to comply with the Code. Is this a chance omission?

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[49] GAIN Newsletter May 2008. http://www.gainhealth.org/gain-newsletter-may-2008 accessed 20 August 2008

[50] http://www.gainhealth.org/danone accessed 20 August 2008

[51] Danone is the second largest world manufacturer of baby foods (following Nestlé). It wholly owns Blédina, the biggest supplier of baby food in France dominating 45% of the market and a Code violator. Blédina also sells directly to 55 other countries and controls big market shares in sub-Saharan Francophone Africa and in the Middle East.
Danone has recently bought over another infant food manufacturer and violator of the Code, NUMICO. IBFAN called on Danone to make fundamental changes in the marketing tactics of the dozen baby food companies it now owns but without success. Breaking the rules, stretching the Rules, IBFAN-ICDC, 2007 Accessed 20 August 2008

Yet, in an article in the June 2008 issue of *Development Outreach* (a flagship magazine of the World Bank)[52], GAIN's Executive Director wrote that only companies that will among other things prioritize in "*investing in understanding and **complying** with international standards and codes of conduct such as the WHO International Code of Marketing of Breastmilk Substitutes*" will be successful in the markets that deliver food to the poor.

GAIN marked its involvement the new field by issuing its first ever press release on infant and young child feeding [53] on the occasion of World Breastfeeding Week in August 2008. The troubling part of the press release is what it does not say. It lists a wide range of measures needed to support mothers in breastfeeding but nowhere does it mention the need for protecting mothers and their babies from commercial pressures. Is this a chance omission?

It is of note that GAIN's website states its working method is to: "Use markets to deliver improved nutrition, based on public health objectives"[54].

India's protest

Like other global PPPs, GAIN is replicating its model at national level. The GAIN Business Alliance India was launched in March 2007. In

[52] Marc Van Ameringen, Berangère Magarinos and Michael Jarvis: Business and Malnutrition: Opportunities and challenges for the food industry in reaching the poor, Development outreach World Bank October 2008, http://www1.worldbank.org/devoutreach/index.asp?id=494 Accessed 10 December 2008

[53] http://www.gainhealth.org/give-children-a-golden-start-%E2%80%93-support-mothers accessed 20 August 2008

[54] http://www.gainhealth.org/overview accessed 20 August 2008

April 2008, GAIN introduced in India its Infant and Young Child Feeding (IYCF) programme and proposed to launch officially an IYCF Alliance, which had been under discussion for some time[55].

This effort met with strong protest from 19 national public interest organisations working in the areas of health, development, gender, education and nutrition, including Breastfeeding Promotion Network of India, Jan Swasthhya Abhiyan and All India Drug Action Network. These organisations staged a demonstration in front of the room where the future allies held their meeting. Not all the invitees were there. Some had decided to join the demonstrators. Others, including a WHO representative who had been invited to chair the meeting, stayed away because they may have wanted to avoid the controversy. [56] The demonstrating organisations were concerned about the conflict of interest created by the involvement of the multinational Danone as well as of some local business partners. One such was the Indian branch of Wockhart, a global pharmaceutical and biotechnology company. Wockhart had acquired Farex infant formula and had been breaking the Indian Code law[57]. The demonstrators protested against the increasing interference from manufacturers to influence policies on infant and young child feeding and nutrition. They challenged the purpose and wisdom of forming the GAIN IYCF Alliance, whose main aim seemed to be the creation of markets for its business partners.

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[55] Organisations listed as potential members of the Alliance were India's Ministry of Women and Child Development, Ministry of Health and Family Welfare, Ministry of Food Processing a many national and international agencies incl. UNICEF, WHO, DFID and individual experts.
[56] T.K.Rajalakshmi: The food question, Frontline, May 9, 2008.
[57] India translated the Code into the Infant Milk Substitutes, Feeding Bottles and Infant Foods Act.

GAIN's claim (quoted above) to prioritise Code compliance is an interesting statement. These words cannot become deeds if even the closest of GAIN's business partners consistently flouts the Code and shows no indication of behaviour change. There is no indication of such leadership. During IBFAN's written exchanges and discussions with Danone in 2008, the company would not give any assurances that it would rectify the situation.

Sustainable alternatives to GAIN and similar public-private partnerships

The jibe that it is easier to criticize than to provide alternative solutions is often valid. However in this particular case, the solution already exists. There is no need to invent a new wheel because a very good wheel already exists and is kept hidden at the back of the garage. It is called the Health for All philosophy and approach.

The time is ripe for revisiting Alma Ata. IBFAN has the vision that the 30th anniversary of the Alma Ata Declaration will not be a mere celebration but a true revival of the Health for All policy that was agreed upon back in 1978[58]. With the current uncertainties of the 21st century, its human rights approach to primary health care could not be more timely, more necessary or more urgent.

As the unfolding worldwide economic crisis shows, we still need effective national and international regulation of powerful economic actors. We need to regain the understanding that interactions between public-interest and business-interest actors need a clear delineation of roles, and clear and legally enforceable conflict of

[58] Primary health care remains the best tool to achieve Health for All, PHM, June 2008

interest rules.“Human rights principles, as widely accepted global norms, should provide a basis for these rules and a guide for clarifying roles.”

Surely this is also the time for a major public health effort to implement all the components of protection, promotion and support of breastfeeding and optimal young child feeding. Political and social support from civil society and governments can and must be mobilized. If this simple solution to protect the world’s most vulnerable cannot be achieved, what hope is there for the rest of humankind?

Annex 1

Contribution of Early and Exclusive Breastfeeding, continued breastfeeding with complementary feeding and related maternal nutrition to the Millennium Development Goals

MDGs	Goals and Targets	Contribution
Goal 1	Eradicate extreme poverty and hunger	Breastfeeding significantly reduces early childhood feeding costs, and exclusive breastfeeding halves the cost of breastfeeding [1]. Exclusive breastfeeding and continued breastfeeding for two years is associated with reduction in underweight [2] and is an excellent source of high quality calories for energy. By reducing fertility, exclusive breastfeeding reduces reproductive stress. Breastfeeding provides breast milk, serving as low-cost, high quality, locally produced food and ensures sustainable food security for the child.
Goal 2	Achieve universal primary education	Breastfeeding and adequate complementary feeding are prerequisites for readiness to learn 3. Breastfeeding and quality complementary foods significantly contribute to cognitive development and capacity. In addition to the balance of long chain fatty acids in breast milk which support neurological development, initial exclusive breastfeeding and complementary feeding address micronutrient and iron deficiency needs and, hence, support appropriate neurological development and enhance later school performance.
Goal 3	Promote gender equality and empower women	Breastfeeding is the great equalizer, giving every child a fair start on life. Most differences in growth between sexes begin as complementary foods are added into the diet, and gender preference begins to act on feeding decisions. Breastfeeding also empowers women: • increased birth spacing secondary to breastfeeding helps prevents maternal depletion from short birth intervals, • only women can breastfeed thus breastfeeding enhances women's capacity to feed children • breastfeeding increases focus on the need to consider women's nutrition (although women's right to adequate food should not depend on whether they breastfeed of not!)
Goal 4	Reduce child mortality	By reducing infectious disease incidence and severity, breastfeeding could readily reduce child mortality by about 13%, and improved complementary feeding would reduce child mortality by about 6% [4]. In addition, about 50-60% of under-5 mortality is caused by malnutrition due to inadequate complementary foods and feeding following on poor breastfeeding practices [5] and, also, to low birth weight. The impact is increased in unhygienic settings. The micronutrient content of breastmilk, especially during exclusive breastfeeding, and from complementary feeding can provide essential micronutrients in adequate quantities, as well as necessary levels of protein and carbohydrates.

Annex 1

Contribution of Early and Exclusive Breastfeeding, continued breastfeeding with complementary feeding and related maternal nutrition to the Millennium Development Goals

MDGs	Goals and Targets	Contribution
Goal 5	Improve maternal health	The activities called for in the Global Strategy on Infant and Young Child Feeding include increased attention to support for the mother's nutritional and social needs. In addition, breastfeeding is associated with decreased maternal postpartum blood loss, breast cancer, ovarian cancer, and endometrial cancer, as well as the probability of decreased bone loss post-menopause. Breastfeeding also contributes to the duration of birth intervals, reducing maternal risks of pregnancy too close together, including lessening risk of maternal nutritional depletion from repeated, closely-spaced pregnancies. Breastfeeding promotes return of the mother's body to pre-pregnancy status, including more rapid involution of the uterus and postpartum weight loss (obesity prevention).
Goal 6	Combat HIV/AIDS, malaria, and other diseases	The risk of transmission of HIV through breastfeeding can be significantly lowered by exclusive breastfeeding. Further reduction of this risk is likely if infants receive Anti-retroviral prophylaxis and/or mothers receive ARV treatment. Mixed feeding in young infants carries a higher risk of HIV transmission[6].
Goal 7	Ensure environmental sustainability	Breastfeeding is associated with decreased milk industry waste, pharmaceutical waste, plastics and aluminum tin waste, and decreased use of firewood/fossil fuels for alternative feeding preparation [7], less CO_2 emission as a result of fossil fuels, and less emissions from transport vehicles as breastmilk is locally produced.
Goal 8	Develop a global partnership for development	The Global Strategy for Infant and Young Child Feeding fosters multi-sectoral collaboration, and can build upon the extant partnerships for support of development through breastfeeding and complementary feeding. In terms of future economic productivity, optimal infant feeding has major implications.

Adaptation of a table presented by the Breastfeeding and Complementary Feeding Working group at the 31st annual session of the UN Standing Committee on Nutrition (UNSCN), 2005

[1] Bhatnagar, S., Jain, N. P. & Tiwari, V. K. Cost of infant feeding in exclusive and partially breastfed infants. Indian Pediatr. 33, 655-658 (1996).

[2] Dewey, K. G. Cross-cultural patterns of growth and nutritional status of breast-fed infants. Am. J. Clin. Nutr. 67, 10-7 (1998).

[3] Anderson, J. W., Johnstone, B. M. & Remley, D. T. Breast-feeding and cognitive development: a meta-analysis. Am. J. Clin. Nutr. 70, 525-35 (1990).

[4] Jones, G. et al. How many child deaths can we prevent this year? Lancet 362, 65-71 (2003).

[5] Pelletier, D. & Frongillo, E. Changes in child survival are strongly associated with changes in malnutrition in developing countries. J. Nutr. 133, 107-11

[6] HIV and Infant Feeding:Update based on the technical consultation, Geneva 25-27 October, 2006, WHO 2007

[7] Labbok M. Breastfeeding as a women's issue: conclusions and consensus, complementary concerns, and next actions. IJGO 1994; 47(Suppl):S55-S61

Notes:

ABOUT IBFAN

The International Baby Food action Network is a coalition of voluntary organizations in both developing and industrialized nations, working for better child health and nutrition through the PROTECTION, SUPPORT and PROMOTION OF BREASTFEEDING and the elimination of irresponsible marketing of breastmilk substitutes. IBFAN was founded in October 1979 and now counts over 200 groups in about 100 countries around the world. The network was involved in the development of the *International Code of Marketing of Breastmilk* Substitutes and is committed to seeing marketing practices everywhere change sustainably for the better. IBFAN has successfully assisted governments in Code implementation and as well has used company campaigns and adverse publicity to press manufacturers into respecting their obligations under the Code. IBFAN also assists in programs and interventions to promote and support breastfeeding, such as the Baby-Friendly Hospital Initiative (BFHI).

ABOUT IBFAN-GIFA

The Geneva Infant Feeding Association (GIFA) was founded in 1979 and serves as a liaison office with international agencies and organizations. It also hosts a coordination office for Europe. From its original solidarity work with the Southern partners, IBFAN activities in Europe expanded from the Western part also to the countries of Central and Eastern Europe, making the network one of the most successful NGO movements in that region. IBFAN-GIFA works on a variety of issues related to protecting breastfeeding: Human Rights/Child Rights, HIV/AIDS and infant feeding, infant feeding in emergency situations, maternity protection, contaminants in baby milk, sponsorship, conflict of interest and others.