State of the Code in Africa

Implementation, Monitoring and Enforcement of the International Code of Marketing Breastmilk Substitutes and subsequent World Health Resolutions in 32 countries served by IBFAN Africa

IBFAN Africa in collaboration with the International Code Documentation Centre

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and subsequent World Health Assembly Resolutions
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International Baby Food Action Network
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Foreword

The African region, particularly Sub-Saharan Africa, stands out globally for not being on track to meet Millennium Development Goal 4 of reducing child mortality by 2015. Malnutrition, compounded by HIV and AIDS, as well as lack of access to clean water and sanitation infrastructure, contributes to the high morbidity and mortality of infants and young children.

With the Lancet 2013 Series reporting that optimal breastfeeding of infants and young children has the potential to prevent over 800,000 deaths (13% of all deaths) in children under five in the developing world, there is a strong justification for IBFAN Africa to work on promotion, protection and support of breastfeeding. No other intervention has the highest impact on the survival of infants and gives them the normal start in life that they are entitled to. We know now that breastfed children have at least six times greater chance of survival in the early months than non-breastfed children and that an exclusively breastfed child is 14 times less likely to die in the first six months of life than a non-breastfed child. Breastfeeding drastically reduces deaths from acute respiratory infection and diarrhoea, two major child killers (Lancet 2008).

The Lancet figures are compelling and give evidence to the fact that breastfeeding is vitally important for the survival, growth and healthy development of infants and young children. Yet, Code monitoring undertaken by IBFAN groups shows that infant and young child health is constantly under threat from marketing practices of profit seeking baby food companies. Unless there are legal measures at the national level to regulate the marketing behaviour of powerful companies, there will be no level playing field for breastfeeding promotion and support including appropriate complementary feeding. This conviction has strengthened our resolve to work on a coherent regional approach as well as country-specific solutions for the protection of infant and young child health. Parents and caregivers must be able to make Infant and Young Child Feeding (IYCF) decisions free from commercial influence.

IBFAN Africa realises that no single approach would suffice to improve infant and young child health in the region. However, looking at the issue from the rights perspective, there is a duty on our part to tackle the man-made problem of unethical marketing of foods for infants and young children. The implementation, monitoring and enforcement of national measures which give effect to the International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly Resolutions (the Code) have time and again been identified as an area of priority action. It is one of many strategies IBFAN Africa works on to ensure that our children not only survive but thrive. Working in tandem with IBFAN Africa, many countries in the region have already introduced comprehensive laws but, with the exception of a few, monitoring and enforcement remain a problem in most countries. IBFAN Africa is therefore undertaking this project to assess existing legal and policy frameworks in the countries we serve. We need to see how countries are faring with Code implementation and where there are already laws in place, whether they are being monitored and enforced. This landscape review will help us identify gaps and hopefully with the cooperation and commitment of countries in question, plans can be made to address those gaps.

For this important exercise, we are pleased to be collaborating with our sister organisation, the International Code Documentation Centre (ICDC) which has consistently been supporting IBFAN Africa in its Code work. We hope this project will enable IBFAN Africa to serve the region better. ■

Joyce Chanetsa
Regional Coordinator
(October 2008 - April 2015)
IBFAN Africa

Executive Summary

This publication provides an insight into the progress of Code implementation, monitoring and enforcement for 32 Sub-Saharan countries served by IBFAN Africa. In alphabetical order, they include: Angola, Botswana, Burundi, Cameroon, Cape Verde, Eritrea, Ethiopia, the Gambia, Ghana, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, São-Tomé & Príncipe, Seychelles, Sierra Leone, Somalia, South Africa, South Sudan, Sudan, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

In evaluating the progress of countries, the Code and subsequent World Health Resolutions are used as benchmark standards. Unless indicated otherwise, all references to the term "baby food companies" cover also feeding bottles and teats companies and the term “Code” means “the International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly Resolutions”. A summary of Code provisions appears at pages 8-9.

The information procured for the Country Reports came from different sources. Details of Code implementation processes and analysis of national laws are from ICDC archives. Selected data from international agencies are reproduced in the country profiles to give some perspective to the vagaries of Code implementation and the role politics, economics and institutions play in policy development. To facilitate this publication, IBFAN Africa requested its constituents for country updates – response rate was low- so while attempts have been made to publish the most recent information, there could be developments that were missed and any feedback will be welcome. We tried to be comprehensive but some events and developments had to be edited out due to space constraints. Any mistake in reporting remains the author’s.

A "Code Barometer" is specially designed for this publication to graphically indicate the State of the Code in each country we are reporting on.

Doing this publication we were glad to note that in Sub-Saharan Africa, many countries subscribed to the text of ICDC’s Model Law when translating the Code into national measures. Still there are falterers and non-starters and the capacity in drafting good laws requires strengthening. In almost all countries covered by this publication, the strong baby food industry lobby against regulation emerged as the main barrier in Code implementation.

As many government officials working on the Code can testify, adopting a national measure is just a first step. All too often, unrelenting efforts by forces linked to the baby food industry threaten Code-based laws although professing support for breastfeeding. Where political commitment is not strong and where there are changes in priority and allegiances, the Code invariably suffers. There are laws which are being revised backwards and laws which lie forgotten because implementation, monitoring and enforcement have become inconvenient. By and large though, African countries are receptive to the idea of introducing strong laws for the protection of child health. The Code survived in Africa despite being battered by political, economic and social struggles in most countries in the region.

While Code implementation fares moderately well, monitoring and enforcement are weak areas in the African Code landscape. After putting laws in place, the challenge arises of getting the necessary political commitment and support to ensure compliance. As elsewhere in developing countries, capacity building of government officials tasked with the responsibilities of monitoring and enforcement requires attention as well as resource allocation. Otherwise, national measures will not be accorded the sanctity that must accompany all laws. The review of the State of the Code in individual countries will highlight the areas where ongoing support from IBFAN Africa and other agencies is needed. ■

Introduction

In 1981, the International Code of Marketing of Breastmilk Substitutes[1] was adopted by the World Health Assembly (WHA), the forum of Member States that governs the World Health Organization (WHO). WHA resolution 34.22 stressed that adoption of and adherence to the Code is 'a minimum requirement' and Member States are expected to give effect to the principles and aim of the Code 'in their entirety'.

The Preamble to the Code highlights:

a) that inappropriate feeding practices lead to infant malnutrition, morbidity and mortality in all countries;
b) that improper marketing of breastmilk substitutes and related products contribute to these major public health problems; and
c) that the vulnerability of infants and the risks involved in the unnecessary and improper use of breastmilk substitutes means that the marketing of breastmilk substitutes requires special treatment.

These statements became the foundation for the Code.

For the Code to take legal effect at the national level, it must first be translated into legislation, regulations or other suitable measures appropriate to the social and legislative framework of the implementing country.[2] As the Code was adopted as a minimum requirement, Member States may adopt additional or stronger provisions but they must not omit or dilute any of its provisions. This point is often missed when the Code gets translated into national measures in all regions, including Africa. Countries often fail to realise that the Code is a result of negotiation and compromise between parties representing opposing interests. In many places, texts are not as strong as they should be. Where the opportunity arises, IBFAN advocates for measures which are stronger than the Code.

African laws that are precise and up-to-date (e.g. South Africa, Botswana) are described in more detail to encourage other governments to emulate.

There are many subsequent WHA resolutions[3] adopted since 1981 which further clarify and extend[4] certain provisions of the Code. When implementing the Code nationally, Member States must incorporate these subsequent WHA resolutions to keep up with evolving marketing trends and the latest scientific knowledge. As WHA resolutions on infant and young child nutrition are adopted every two years, Member States with existing Code measures should, where appropriate, strengthen them or adopt new measures.[5] Unfortunately, this is very often overlooked. A summary of Code provisions read in conjunction with subsequent WHA resolutions appears on pages 8-9.

There are a few other important points to take into account regarding Code implementation:

> **One,** the Code alone will not improve breastfeeding rates. While there is a correlation, it is neither direct nor immediate. For breastfeeding rates and ancillary health indicators to improve, protection from inappropriate marketing must be augmented by other approaches such as quality breastfeeding education for health workers and women; supportive health services and community programmes and good maternity protection. What the Code does, is to keep out commercial competition so that breastfeeding promotion can thrive.

[1] www.who.int/nutrition/publications/code_english.pdf
[2] Code Article 11.1; all African countries present when the Code was tabled at the WHA in 1981 voted in favour of it.
[3] For a full listing of subsequent World Health Resolutions on infant and young child feeding, go to www.who.int/nutrition/topics/wha_nutrition_iycn/en/index.html
[4] The International Code of Marketing of Breast-Milk Substitutes: frequently asked questions, p.6, WHO 2008.
[5] Global strategy for infant and young child feeding, p.16, WHO 2003.

Two, the Code does not prohibit the availability and sale of breastmilk substitutes. Instead, it prohibits and restricts certain marketing activities and directs health authorities to encourage and promote breastfeeding by providing objective and consistent information. It empowers parents and caregivers to make informed decisions on IYCF, free from commercial pressures. More importantly, the Code determines that health workers, very often the conduit to mothers, should not be used for the purpose of promoting baby feeding products.

Three, the Code serves to protect breastfeeding as well as infants who are artificially fed by requiring appropriate labelling of products and warnings on information materials to minimise health risks. To prevent unsuitable and inappropriate products from being used to feed infants and young children, the Code contains provisions on the labelling of such products.

As of end 2014, 14 countries in Africa have adopted legally binding measures encompassing all or nearly all provisions of the Code and subsequent WHA resolutions. Another 10 have adopted legally binding measures encompassing many provisions of the Code and subsequent WHA resolutions. Of this total, 17 (70.8%) are countries served by IBFAN Africa. Together with the International Code Documentation Centre (ICDC), IBFAN Africa has supported Code implementation in each of these 17 countries either directly or through national groups. This is an impressive figure but IBFAN Africa serves 32 countries in the region. With 15 more countries still having some way to go with the Code, work must continue. (See Table 1 for a listing of the stages countries have reached). ■

Why breastfeeding is important?

Breastmilk is a living substance that from birth to full six months of age fulfils all of a baby's nutritional requirements. It contains antibodies that help protect the baby against many common illnesses such as perinatal infections, acute respiratory infections and diarrhoea. Besides clear short-term benefits for child health, there is now evidence[1] to suggest that breastfeeding has many long-term benefits in adulthood including the prevention of obesity.[2] WHO recommends **exclusive breastfeeding** until a baby is six months old and **continued breastfeeding** for up to two years or beyond with the addition of nutritious complementary foods.

It should be emphasised that breastfeeding confers immeasurable benefits upon children after six months of age. It provides the natural and complete food[3] a child can have between six months and two years. Even though breastmilk alone may no longer be enough for the child's nutritional needs after six months and appropriate complementary foods need to be added gradually to the child's diet, it continues to provide living cells and immuno-protective factors which help to reduce both the rates and severity of infections during 6 to 24+ months. No commercial baby food contains these protective factors.

There are documented cases of deaths resulting from severe malnutrition when babies are given inappropriate substitute products instead of breastmilk.[4] Even when babies do not die, the irreversible consequences of malnutrition are causative factors in the perpetuation of poverty.[5] This is something resource poor countries that face developmental challenges should always consider when formulating their policies. ■

[1] Horta, B.L., et. al., "Evidence on the long-term effects of breastfeeding: systematic review and meta-analyses", WHO 2007.

[2] Singhal A, et. al., "Nutrition in infancy and long-term risk of obesity: evidence from 2 randomized controlled trials." Am J Clin Nutr., Sep 29 2010.

[3] One study, Dewey K.G. "Nutrition, growth, and complementary feeding of the breastfed infant", Pediatr Clin North Am. 2001 Feb; 48(1):87-104 reported that between the ages of 12-24 months, just half a litre of breastmilk provides the child with the following: energy (29% of its requirements), protein (43%), calcium (36%), vitamin A (75%), folate (76%), vitamin B12 (94%) and vitamin C (60%).

[4] See Barennes, H. et al, "Misperceptions and misuse of Bear Brand coffee creamer as infant food: national cross sectional survey of consumers and paediatricians in Laos", BMJ 2008;337:a13792.

[5] Repositioning nutrition as central to development: A strategy for large-scale action, World Bank 2006.