

Code Essentials 3: Responsibilities of Health Workers under the International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly Resolutions.

Writers

Yeong Joo Kean
Megan Jessica Bardsley
Constance Ching

Editor

Annelies Allain

Researcher

Jane Tang

Design & Layout

Meliana Tjia

Production Assistant

Komala Ramalingam
Tan Hooi Choo

© ICDC Penang, Malaysia, April 2018

No part of this publication may be reproduced
without the permission of the publisher.

ISBN 978-983-9075-33-5

Published by

IBFAN Sdn Bhd
PO Box 19, 10700 Penang, Malaysia
Tel: +60 4 890 5799
Email: code@ibfan-icdc.org
www.ibfan-icdc.org

Printed by

Visual Pro Creative Sdn. Bhd., Penang

First Edition February 2009

Second Edition April 2018

Suggested citation

IBFAN-ICDC (2018). Code Essentials 3: Responsibilities of Health Workers under the International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly resolutions. Penang: IBFAN S/B.

Acknowledgments

We wish to thank Dr JP Dadhich for reviewing the parts on HIV, and to Maryse Arendt and Elisabeth Sterken for their input regarding BFHI. We are grateful to the following people who contributed to the first edition of this publication: Dr. Lida Lhotska, Dr. Adriano Cattaneo, Allesandro Iellamo and the late Dr. Audrey Naylor.

Contents

Preface.....	i-ii
Background to the International Code	1
A brief history	1
Adoption of the Code	2
Relevance of the Code today	2
Overview of the Code	4
Giving effect to the Code	5
Understand the Code	5
How the Code affects health workers, health care facilities and professional associations	6
Why breastfeeding is important	8
Breastfeeding after the first six months	8
Key messages from The Lancet Series on Breastfeeding.....	9
Reduced healthcare costs from increased breastfeeding	10
Scope of the Code	11
Interpreting Article 2	11
Complementary foods.....	12
What is meant by "foods for infants and young children" in the 2016 Guidance.....	13
Handling information and educational materials	13
Need for unbiased information free of commercial influence	15
Manipulated information.....	16
How to evaluate company materials.....	16
Information to health professionals	18
Shifting the perspective on the "benefits and superiority of breastfeeding".....	19
When formula is necessary.....	19
Dealing with the problem of intrinsic contamination of powdered infant formula.....	20
Forbidden business in the health sector	21
How promotion is channelled through the health care system	23
'Educating' mothers.....	24
Supplies – Free now, pay later.....	25
Donations of equipment and materials	26
Dangerous liaisons: The health worker-industry relationship	27
Minimising the impact of commercial promotion.....	28
Myths of small gifts	29
Samples for professional evaluation or research	30
Problems with sponsorship and disclosures.....	31
Understanding conflicts of interest	32
What the phrase "welcomes with appreciation" in WHA 69.9 [2016] means?	32
Drawing the line between the unacceptable and the permissible	33
Taking a stand against sponsorship of events	34

Code watch by health workers	36
Why monitor	36
Available monitoring tools.....	36
What to look for in health facilities	37
What to look out for where health workers are concerned.....	38
Reporting on Code violations	38
Monitoring under the 2016 Guidance.....	38
HIV, breastfeeding and the Code	39
Risk of HIV infection in infants and young children.....	39
New guidelines on HIV and infant feeding.....	39
The Code, HIV and infant feeding.....	41
Role of health workers	41
BFHI and the Code	42
Foundation for breastfeeding in health facilities.....	42
Ten steps to successful breastfeeding (revised 2018)	42
Annexes	
1. The International Code: a 10-point Summary	44
2. Relevant WHA resolutions on Infant and Young Child Nutrition: summary.....	45
3. Quick and Easy Monitoring Form	46

"If breastfeeding did not already exist, someone who invented it today would deserve a dual Nobel Prize in medicine and economics. For while "breast is best" for lifelong health, it is also excellent economics. Breastfeeding is a child's first inoculation against death, disease, and poverty, but also their most enduring investment in physical, cognitive, and social capacity."

Hansen, K. (2016). Breastfeeding: a smart investment in people and in economies. *Lancet*, 387, 416.

Preface

For hundreds of thousands of years, breastfeeding has been the biologic norm for feeding our infants and for ensuring their survival. The wide-ranging benefits of breastfeeding mirror the sophisticated nature of breastmilk itself. It is a living substance which fulfils all of a baby's nutritional requirements from birth to six months and breastfeeding continues to confer benefits on infants and young children between six to 24 months and beyond. Breastmilk contains a huge range of bioactive molecules that play a key role in healthy microbial colonisation, in protection against infection and inflammation and also in organ development. In addition breastmilk is dynamic; its composition changes through the breastfeeding period, diurnally, and even within feeds. Breastmilk is safe, clean, always at the right temperature, inexpensive and nearly every mother has more than enough for her baby.

Given the above, it is perhaps unsurprising that no breastmilk substitute can equal breastmilk, whether in terms of nutrition, enzymes, growth factors, hormones, immunologic properties, infant growth and development outcomes or in maternal outcomes. The benefits of breastmilk and breastfeeding simply cannot be replaced or replicated.

Unfortunately, breastfeeding is nowadays not the societal norm. In many settings, modern feeding alternatives have meant that the importance of breastmilk and breastfeeding has been undermined. The fact that marketing of breastmilk substitutes negatively impacts breastfeeding is well documented. Likewise, the fact that a large proportion of marketing expenditure by manufacturers and distributors of breastmilk substitutes, feeding bottles and teats is devoted to the health care system and health workers is well established.

Health workers must recognise their role in promoting and protecting breastfeeding. They are a primary source of trusted information for pregnant women and mothers, and decisions on infant feeding are often made on their advice. The attitude of health workers towards the marketing practices of manufacturers and distributors, and how they interact with these companies, influence the advice they give. This in turn impacts on how successfully mothers initiate and maintain breastfeeding.

Many health workers are unaware of the existence of the Code. Those who are aware about the Code find difficulty in piecing it together with subsequent World Health Assembly resolutions. Hence, they are unable to establish an appropriate position to take when confronted with commercial practices that undermine breastfeeding.

Code Essentials 3: Responsibilities of Health Workers under the International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly resolutions (CE3)

is written to address this difficulty. CE3 sets out how health workers should operate. It shows they have the responsibility to not only promote and support breastfeeding but to also protect it by rejecting all forms of commercial activities designed to undermine it.

CE3 also makes a strong case for health workers to avoid situations which may give rise to conflicts of interest due to the position of trust they hold with their patients. Professional associations that provide focus and support for health workers in the area of maternal and child health will find CE3 illuminating, especially if they try to steer away from conflicts of interest.

ICDC published the original version of CE3 in 2009 with the support of UNICEF East Asia and Pacific Regional Office (EAPRO) and the WHO Western Pacific Regional Office. This second edition is made possible with the continued support of UNICEF EAPRO. Although intended for the Asia Pacific region, CE3 is useful in all parts of the world, as the Code and subsequent World Health Assembly resolutions are universal.

Readers are advised to check if there is a national Code-based law in their country to determine the full extent of their roles and responsibilities under national legislation, if any. Where there is no such law, the minimum standards set by the Code and resolutions should form the basis of best practice policies in all health care settings and the ethical guidelines of health workers' associations.

IBFAN-ICDC
Penang
April 2018

This is the third in a series of four booklets on the International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly resolutions. Each one can stand on its own and is aimed at different categories of users.

Code Essentials 1: *Annotated International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions.*

Code Essentials 2: *Guidelines for Policy Makers on Implementing the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions.*

Code Essentials 3: *Responsibilities of Health Workers under the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions.*

Code Essentials 4: *Complying with the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions - A guide for Regulators and Compliance Staff.*

"Breastmilk substitutes are a multi-billion-dollar industry, the marketing of which undermines breastfeeding as the best feeding practice in early life. No new interventions are needed—the Code is an effective mechanism for action. However, much greater political commitment is needed to enact and enforce relevant, comprehensive legislation and national investment to ensure implementation and accountability. Without these commitments, agreed principles of responsible marketing will continue to be violated."

Rollins, N. C., Bhandari, N., Hajeebhoy, N., Horton, S., Lutter, C. K., Martines, J. C., ... & Group, T. L. B. S. (2016). Why invest, and what it will take to improve breastfeeding practices?. *The Lancet*, 387(10017), 491-504.

Background to the Code

A brief history¹

The link between the promotion of breastmilk substitutes and the declining rate of breastfeeding worldwide. Increases in infant undernutrition, morbidity and mortality were not directly associated with the decline in breastfeeding.

Dr. Cicely Williams, a paediatrician working in Singapore in the late 1930s, was the first health professional to make the link. In 1939, she addressed the Rotary Club with a hard-hitting speech entitled **"Milk and Murder."** She decried the promotion of sweetened condensed milk, and stated that **"misguided propaganda on infant feeding should be punished as the most criminal form of sedition and these deaths should be regarded as murder."**

Dr. Williams later became the first Director of Maternal and Child Health of WHO, and was one of the first proponents of the importance of breastfeeding. Despite Dr. Williams' efforts, it took another 50 years before breastfeeding became an acceptable topic for government action.

In the aftermath of World War II, sales of breastmilk substitutes, feeding bottles and teats flourished. Mistaken ideas about infant feeding were spread among health professions, which resulted in a general loss of belief in the importance of breastfeeding for infant, child and adult health. The social construct that artificial feeding was the norm, and as good as or better than breastfeeding, spread from industrialised nations, and set the stage for an alarming and persistent global trend.

The growing popularity of choosing formula feeding over breastfeeding brought dire consequences to the health and well-being of infants and young children. Particularly in developing countries, the fall in breastfeeding rates brought with it increased malnutrition, morbidity and mortality. Despite illnesses and deaths, governments were providing free or low-cost supplies of infant formula through state and welfare distribution systems, being influenced by the health profession's misperception that breastmilk substitutes were scientifically equal to breastmilk or that many mothers could not breastfeed.

Industrialised countries were somewhat buffered from the acute negative effects of formula feeding because of improvements in the supply of water, sanitation and housing in the 1950s. Widespread access to health services and rapid medical treatment also meant that most babies could withstand the mortality risks of artificial feeding, albeit at a high cost to the healthcare system.

In the 1960s, the early warnings by Dr. Cicely Williams began to be echoed by others in the health care profession, namely **Dr. Derrick Jelliffe** of the Nutrition Institute in Jamaica. He coined the term **"commerciogenic malnutrition"** to describe the impact of industry marketing on infant health.

In 1974, a British charity, War on Want, published **"The Baby Killer"**, a report on the consequences of commercial promotion of breastmilk substitutes in the developing world. A Swiss non-governmental organisation (NGO), Arbeitsgruppe Dritte Welt, subsequently published a German translation but changed the title into *Nestlé Tötet Babies* (literal translation "Nestlé Kills Babies").

1. This part is a modified summary from Sokol, E. (2005). *The Code Handbook*, 2nd Edition. Penang, Malaysia: IBFAN S/B.

Nestlé filed a libel suit against the NGO, which attracted global publicity and dramatically raised awareness around the issue. Two years and many hearings later, Nestlé dropped three of the four charges but maintained the libel suit on the title of the book. The NGO was found guilty of libel because there was no proof that Nestlé killed babies in the criminal sense. The judge imposed a mere token fine, and warned Nestlé to change its marketing practices.

The years that followed saw increasing public attention to the promotion of breastmilk substitutes. There was press and media coverage, professional discussions, a law suit in the United States involving Mead Johnson and highly publicised US Senate Hearings. A long-standing boycott against Nestlé, the world's largest baby food manufacturer, began in the late 1970's and continues until this day.

Adoption of the Code

Following this ground swell of action, WHO and UNICEF jointly hosted an international meeting on infant and young child feeding in October 1979. The participants of the 1979 Meeting, including industry representatives, adopted by consensus a **Statement on Infant and Young Child Feeding and Recommendations**. One of the most significant recommendations states:

“There should be an international code of marketing of infant formula and other products used as breastmilk substitutes.”

The significance the participants accorded to the impact of marketing is evident in another one of the recommendations, which states:

“There should be no marketing or availability of infant formula or weaning foods in a country unless marketing practices are in accord with the national code or legislation if these exist, or, in their absence, with the spirit of this Meeting and the recommendations contained in this report or with any agreed international code.”

The 1979 meeting was followed by debates and negotiations with experts, governments, NGOs and industry around the drafting of a code of marketing. The final text of the Code was a compromise among differing interests. It is thus weaker than the ideal, and some articles and definitions are open to interpretation, even today.

The Code was adopted by resolution WHA 34.22 at the World Health Assembly (WHA) in 1981. It represents an important milestone as it established a set of minimum standards for responsible marketing.

Every even year, the WHA discusses infant nutrition and adopts resolutions that clarify or extend on issues covered in the Code. Like the Code, they are recommendations of the WHA, and thus the Code and resolutions must be considered together.²

Relevance of the Code today

The Code is just as relevant today, if not more, than when it adopted in 1981. Knowledge on the importance of infant and young child nutrition, particularly breastfeeding, has vastly surpassed what was known in 1981. For a long while after the Code was adopted, the recommendation for exclusive breastfeeding was four to six months. There was resistance to extend the period of exclusive breastfeeding to six months even though there was ample scientific evidence to support a "six months" recommendation mainly because manufacturers and distributors saw the original recommendation as an important window for marketing.

This controversy ended in 2001 when the WHA,³ after much debate, adopted resolution WHA 54.2 which sets the optimal period of exclusive breastfeeding unequivocally at six months.

2. The International Code of Marketing of Breastmilk Substitutes: Frequently Asked Questions (2017 Update), Geneva, Switzerland, World Health Organization; 2017. The resolutions are WHA 35.26, 37.30, 39.28, 41.11, 43.3, 45.34, 46.7, 47.5, 49.15, 54.2, 55.25, 58.32, 59.11, 59.21, 61.20, 63.23, 65.6, 69.9. There is also a decision adopted on maternal, infant and young child nutrition in 2014, WHA 67(9) that focused on indicators to achieve global nutrition targets including Code implementation. Under Article 23 of the WHO Constitution, the normative weight given to resolutions and decisions is the same.

3. Retrieved from http://www.who.int/nutrition/topics/WHA54.2_jygn_en.pdf.