

# ibfan case studies



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using international tools to  
stop corporate malpractice

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- does it work?

# Using international tools to stop corporate malpractice - does it work?

Checks and balances in the global economy

January 2004

International Baby Food Action Network



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## Checks and balances in the global economy

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# Executive Summary

Globalisation is sometimes portrayed as a recent phenomenon, yet over 100 years ago the baby food industry was already an international business, with Swiss pioneer Nestlé exporting its cereal milk food, *farine lactée*, to Latin America and the Dutch East Indies and, soon afterwards, opening factories in its target markets.

Over 60 years ago health campaigners began to notice the impact on health of the aggressive promotion of breastmilk substitutes, at that time products such as sweetened condensed milk as well as what we now call 'formulas'.

More than 20 years ago the International Baby Food Action Network (IBFAN) was formed, bringing together campaigners working to control the marketing of breastmilk substitutes. Two years later they had their tool, the **International Code of Marketing of Breastmilk Substitutes** (the Code), adopted by the World Health Assembly (WHA) in 1981, the first attempt to regulate an entire industry sector at a global level.

In these days of email lists it is easy to forget that for decades international networks were built and functioned with only post, telephone and, later, fax. IBFAN has effectively counterbalanced the power of some of the world's largest companies as they have lobbied at the WHA and country by country as they have attempted to use their economic and political influence to undermine national implementation of the measures adopted by the WHA.

Sometimes the industry was victorious and the regulatory route was set aside in favour of 'voluntary codes'. Sometimes the health advocates won, bringing in strong regulations, even criminal law with powers of imprisonment.

The baby food issue has long been a case study for those studying public relations and those working to achieve international standards and corporate accountability in their own area of interest. To produce this report, IBFAN asked groups in a diverse range of countries (Case Study countries) to look back over the history of infant feeding in their countries, to ask *'how did you get where you are today?'* and *'what went right and what went wrong?'* And *'what are your recommendations to others?'* This resulted in a series of rich reports from Belgium, Bolivia, Brazil, England, India, Mexico and Kenya, which are drawn on here to give a sense of the realities faced by campaigners on the ground confronted on the one hand with the needless illness or death of their neighbours' children and on the other with powerful companies caring more for profit. There is something of their frustration and determination, their commitment, professionalism and imagination.

As set out in Section 1, it is evident that it has taken concerted marketing activity over decades to create bottle-feeding cultures and that now in mature markets, such as Belgium and England, bottle feeding is seen almost as a lifestyle, rather than a health choice. Even in countries where breastfeeding predominates, such as Bolivia and Kenya, the baby food marketing messages are causing mothers to doubt their ability to breastfeed and a surprising number are using feeding bottles, often with unsuitable substances inside them.

The Case Study countries were selected for a mixture of practical reasons and because of the different types of implementation represented, as described in Section 2. India has a strong law, where non-governmental organisations (NGOs) are sanctioned to file cases in the courts. Brazil's strong law is enforced by the country's health inspectorate and consumer protection bodies. Belgium and England have



**IBFAN received the Right Livelihood Award in 1998.**

The citation states:

*'In the face of the enormous power of the multinational companies which dominate the world infant baby food market, IBFAN has continued to find means to mobilise people effectively to press their governments for action, to undertake citizen monitoring of compliance with the recommendations of the World Health Assembly, and to stimulate self-reliance and effective action at the grassroots level.'*

followed policies adopted by the European Union (EU), the free trade area to which both belong and which has only introduced some aspects of the Code and Resolutions in regulations. Kenya, Mexico and Bolivia have all principally followed the route of voluntary codes of conduct agreed with industry.

In all countries the industry has lobbied for narrow implementation of the Code and Resolutions, preferably as a voluntary code, rather than in binding legislation, and has attempted to influence government policy setting with tactics such as sponsoring the research on which policy is based and the health worker bodies represented on government committees. Where industry has failed, it is in large part due to the work done by NGOs in monitoring and exposing company marketing activities and raising awareness of the need for strong measures, taking the Code and Resolutions as minimum requirements. In India and Brazil, legislation has been progressively strengthened to give the broad protection seen today. Within the EU, the calls of the health lobby and the European Parliament brought about some changes to the policies of the unelected Commission, but not full implementation of the Code and Resolutions. In the member states of Belgium and England (as part of the UK), industry arguments for deregulation won out over health concerns. In Mexico, Bolivia and Kenya, governments have followed the industry line.

The Case Studies considered the systems in place to monitor and enforce the Code and subsequent Resolutions. As might be anticipated, the nature and spread of violations differs substantially, depending on the national regulations and the efforts taken to expose violations. India's strong laws have stopped much of the promotion of breastmilk substitutes, but companies are aggressively promoting complementary foods, something now banned by the latest legislation, introduced in 2003. Brazil has less violations than most countries, though inappropriate promotion of whole milks and sponsoring of health worker bodies are particular concerns. The authorities in Belgium and England take what action they can, but are constrained by narrow legislation and lack of resources. Bolivia's voluntary code is being made to work to some extent by the IBFAN group's monitoring and exposure of malpractice. Mexico, with its voluntary code and strong industry lobby, is awash with violations such as free supplies of breastmilk substitutes in hospitals. In Kenya, companies use problems such as HIV and national emergencies to push breastmilk substitutes and promote to mothers through the health care system.

Where advertising and promotion of breastmilk substitutes, feeding bottles and teats, are prohibited alongside initiatives to promote breastfeeding, year-on-year increases in breastfeeding rates are being achieved, which leads to reduced infant mortality and morbidity. In Brazil, for example, rates of exclusive breastfeeding at 4 months of age have been increasing at 4 percentage points per year. In Kenya, where the industry has little market, but aggressively promotes all the same, breastfeeding rates are declining.

Section 3 draws together the key elements of IBFAN's strategy: a virtuous cycle of campaigning for and achieving science-based international standards, working for their implementation at national level and then monitoring them to ensure they are followed and to feed back weaknesses.

Section 4 looks at how similar strategies could be applied to other campaigns. For many working in other areas, the fashion of entering into 'partnership' with companies to develop codes of conduct is passing owing to bitter experience, and legislative routes are looking more attractive. Achieving checks and balances on some of the world's most powerful companies does not come about by accident - it takes dedicated campaigning. Sometimes over decades.

# Introduction

The world's economies and financial systems are becoming increasingly international and interconnected. In the accompanying process of economic and trade liberalisation, some companies have also become more international in their scope and operations. Are there sufficient and effective checks and balances operating on these companies in a global economy to ensure that their practices do not harm or conflict with people's well-being? What can governments and civil society groups do to ensure that transnational companies (TNCs) are accountable not only to their shareholders or owners but also to the people whose lives are affected by their operations? How can such companies be persuaded or obligated to act in a socially responsible manner?

Those concerned with infant and child health and survival have long contended with these questions. Concern about the sometimes-fatal effects of the marketing practices of companies that manufacture and distribute breastmilk substitutes led to the first international measure to regulate the activities of a whole industry sector at a global level.

## The international tools for regulating the marketing of breastmilk substitutes

The marketing of breastmilk substitutes has long been a concern. In 1939 paediatrician Dr Cicely Williams (later the first head of the World Health Organisation's Maternal and Child Health Services) made a speech entitled '*Milk and Murder*' to business members of the Singapore Rotary Club, highlighting the impact of the promotion of sweetened condensed milk on infant health<sup>1</sup>:

*If you are legal purists you may wish me to change the title of this address to Milk and Manslaughter. But if your lives were embittered as mine is, by seeing day after day this massacre of the innocents by unsuitable feeding, then I believe you would feel as I do that misguided propaganda on infant feeding should be punished as the most miserable form of sedition, and that these deaths should be regarded as murder...*

In the 1960s and 1970s, health professionals and civil society groups began to speak out more widely about the consequences for infant health, growth and survival of replacing breastfeeding with artificial feeding. Scientific studies were conducted and demonstrated the link between the marketing and promotion of artificial baby foods, inappropriate feeding, infection, malnutrition and death, exacerbated by the non-promotion of breastfeeding.

An international boycott of the leading baby milk company, Switzerland-based Nestlé, shareholder actions and US Senate hearings all helped to create pressure for the international regulation of the marketing and promotion strategies of the baby food industry (see, 'International pressure for regulation', page 16). Pressure culminated in 1981 when the *International Code of Marketing of Breastmilk Substitutes* was adopted by the Member States of the World Health Organisation (WHO) at their annual World Health Assembly (WHA).

**Nestlé 'milk nurses' (sales representatives dressed as nurses) promoting infant formula at a clinic in apartheid South Africa.**





Resolution 34.22, which ushered in the Code, urges all Member States:

*to give full support to the implementation of the provisions of the International Code in its entirety*

and

*to translate the International Code into national legislation, regulations or otherwise suitable measures.*

The Code, and the subsequent Resolutions adopted by the WHA to clarify its interpretation and to address changes in marketing practices and scientific knowledge, enjoy equal status and together can be used to protect consumers from the marketing practices of baby food companies which mislead mothers and discourage them from breastfeeding. Breastfeeding alongside appropriate complementary feeding is an essential safeguard for an infant's immediate and long-term health. The World Health Organisation currently recommends<sup>2</sup> ***'exclusive breastfeeding for the first six months of life, and with nutritionally adequate and safe complementary feeding through introduction of safe and adequate amounts of indigenous foodstuffs and local foods while breastfeeding continues up to the age of two years and beyond.'*** The aim of the Code and Resolutions is to protect infant and young child health through removal of commercial pressures in the area of infant feeding (see, *Summary of the provisions of the International Code and Resolutions*, page 20). The Code does not proscribe the sales of breastmilk substitutes, but it governs their marketing. It is equally designed to protect infants who are artificially fed.

Today, 24 countries have implemented most of the Code and Resolutions by means of a law, decree or other legally enforceable measure.

Another 52 governments have enacted many or some of the provisions of the Code and Resolutions in law. Some 23 governments have implemented the entire Code and Resolutions as a voluntary measure or national policy without the force of law. Some governments have a draft law pending adoption while others are still considering what to do. The case studies suggest that both enforceable and voluntary measures can be effective provided they are properly and independently monitored.

Despite these achievements, breastfeeding and infant health are as much under threat now as they were in the late 1970s. The baby feeding and pharmaceutical industry maintains a powerful influence in the many fora where decisions affecting infant feeding are made: the annual WHA; the FAO/WHO Codex Alimentarius Commission; the Economic and Social Council of the United Nations (ECOSOC); the UN Conference on Trade and Development (UNCTAD); the World Trade Organisation (WTO); the International Labour Organisation (ILO); the European Commission, the European Parliament and the EU Advisory Committees; national governments; regional and local authorities; and health authorities.

In recent years, the United Nations (UN), and two agencies in particular, WHO and the UN Children's Fund, UNICEF, have come under pressure from the baby feeding industry to participate in partnerships and to drop the protection and promotion of breastfeeding from their agendas. At the same time, industry has lobbied governments to adopt weak voluntary agreements to implement the Code and Resolutions rather than strong legislation, and to include the industry in all discussions and monitoring bodies.

Legislation and other measures brought in at national level have been under an

additional threat since WTO was established in 1995. WTO promotes trade between nations and requires governments to remove barriers to trade. Barriers may include legislation deemed by WTO to be unnecessary. WTO looks to the standards developed by an expert committee called the Codex Alimentarius Commission to determine whether national legislation relating to food standards is justified on scientific grounds. Industry has long played a dominant role in the Commission and lobbies against bringing its standards into line with the Code and subsequent, relevant WHA Resolutions.

## Country Case Studies

Once the Code was adopted in 1981 by the WHA, governments had a responsibility to implement it in national measures in their countries. In 2001, the International Baby Food Action Network (IBFAN) commissioned case studies from a diverse range of countries to examine the effectiveness of different methods of implementation and the pressures leading to those methods being chosen.

The Case Studies from Belgium, Bolivia, Brazil, England\*, India, Kenya and Mexico present the history of infant feeding in each country and analyse the scope, independence, transparency, effectiveness and means of empowerment provided by the Code and Resolutions and instruments such as the 1990 *Innocenti Declaration* and the UN's *Convention on the Rights of the Child*. The Case Studies also examined efforts to promote and support breastfeeding, and conclude that without protecting breastfeeding these efforts are undermined.

This report draws from the national Case Studies to describe and analyse the range of activities made to protect breastfeeding during the past century using the international tools achieved through decades of campaigning. It provides valuable lessons on what works and what diverts time and resources.

(\*The Case Study looked specifically at the infant feeding situation in England, which is one country in the United Kingdom.)

*This picture tells two stories: most obviously, about the often fatal consequences of bottle-feeding; more profoundly, about the age-old bias in favour of the male. The child with the bottle is a girl – she died the next day. Her twin brother was breastfed. This woman was told by her mother-in-law that she didn't have enough milk for both her children, and so should breastfeed the boy. But almost certainly she could have fed both children herself, because the process of suckling induces the production of milk.*

*'Use my picture if it will help', said the mother. 'I don't want other people to make the same mistake.'*

Extract from the United Nation's Subcommittee on Nutrition News May 1991



**Every 30 seconds a baby dies because it was not breastfed.**

An artificially-fed child is denied the anti-infective properties of her mother's breastmilk and is at risk of infection from unsafe water and poor hygiene. Where water is unsafe an artificially-fed child is up to 25 times more likely to die as a result of diarrhoea than a breastfed child.

Poverty may lead some parents to over-dilute formula to make it last longer, or use cheaper whole milks, unprocessed animal milks or cereals once they have decided, or been persuaded, not to breastfeed. Some infants die of respiratory infections. Others from diarrhoea, dehydration and malnutrition.



# 1. Why regulate the marketing of breastmilk substitutes?

Commercial breastmilk substitutes were originally produced on an industrial scale by Swiss company Nestlé, which claims that its founder, Henri Nestlé, made the first breastmilk substitute, *farine lactée*, in 1867<sup>3</sup>. Within seven years, the company was selling 500,000 boxes of 'Nestlé Milk Food' in Europe, the United States, Argentina, Mexico and the Dutch East Indies<sup>4</sup>. So began the commercial assault on breastfeeding cultures and the creation of bottle-feeding cultures, which in some countries is only now beginning to be reversed. According to the World Health Organisation (WHO) and the UN Children's Fund (UNICEF), 1.5 million infants die each year because they are not adequately breastfed<sup>5</sup>. WHO recommends that infants be exclusively breastfed for 6 months with continued breastfeeding for up to 2 years of age or beyond.

## Mature mass markets in Europe

The Case Studies examined the history of infant feeding. Belgium and England could be classified as mature markets, as breastfeeding rates have remained static at a low level for decades. Figures published for Belgium in 1995 suggest that just over half (52%) of babies are breastfed at birth, about one-third (33%) at 3 months (but not necessarily exclusively), one-fifth (21%) at 4 months and down to 18.4% at 6 months<sup>6</sup>. Infants not breastfed provide custom for the baby food companies. A Government infant feeding survey for England in 2000<sup>7</sup> revealed that while 71% of infants were breastfed at birth, 39% of these were given infant formula exclusively by 4 to 10 weeks. Only 22% of all babies in England were receiving any breastmilk at 6 months of age. In 1997, the artificial baby milk market in England alone was worth £150.9 million (US\$240 million) while the baby food market (excluding milks) was worth £157 million (US\$250 million)<sup>8</sup>.

Belgium and England could be classified as mature markets.

In Belgium, only 33% of babies are still receiving breastmilk at three months.

In England 30% of babies are artificially-fed from birth.

## Wet nurses replaced by formula in Belgium

The creation of the market for breastmilk substitutes has been complex, and has both responded to, and driven, fashion. The Belgian Case study summarises one historical perspective (*Source : Histoire de l'allaitement, Infor-Allaitement, Belgium*):

*During the 19th century, industrialization led to an increase in the number of women working away from their home or farm and many babies were fed by wet-nurses, usually far from their family. Wet nurses often took too many babies at the same time (and gave food other than breastmilk too early), were very poor and lived in very difficult social conditions, factors contributing to infant mortality. Colostrum [the first breastmilk produced, which provides immediate protection against infection] was considered dangerous and thrown away. At the end of the 19th century, moralists and doctors began to encourage breastfeeding, colostrum was given to babies and public medical consultations for infants and children took place. Breastfeeding was encouraged, especially for poor mothers. At the same time, to discourage fostering and to keep the infant with the family when a mother was working away, artificial feeding using animal milk was developed and with it equipment for giving the milk to babies. The use of unprocessed milk and unhygienic conditions contributed to infant mortality. The health services tried to educate women to sterilize the bottles and the milk was pasteurized. At the beginning of the 20th century, day nurseries began to appear and after the Second World War, the wet nurses disappeared. At the same time, the infant formula industry grew and marketed their products towards health workers as something scientific and measurable. During the 50's and 60's, the feminist*

*movement linked bottle-feeding with freedom for women. Breastfeeding was seen by some as slavery. In the 70's, interest in ecological issues prompted a renewal of interest in breastfeeding.*

## Health costs in industrialized countries

Gastroenteritis associated with artificial feeding is estimated to cost the health care system in England US\$56 million per year.

About 100 premature babies die each year in England as a result of not receiving breastmilk.

Even in industrialized countries, infants who are artificially fed are at greater risk of many diseases including gastroenteritis, otitis media (ear infection), necrotising enterocolitis (serious damage to the intestinal tract), respiratory infection, urinary tract infection, childhood obesity and allergies<sup>9</sup>. With universal access to health care, infant mortality rates in Belgium and England are low at 6 deaths per 1,000 live births. In Belgium 14% of all infants under 1 year have reported respiratory tract or lung infections while one-fifth of children between the ages of 1 and 3 years are hospitalised at some point<sup>10</sup>. In England, one Government report<sup>11</sup> stated that, for gastroenteritis alone, the rate of hospital admissions for artificially fed babies is five times more than that for breastfed babies. Each of these in-patient stays costs about £1,200 (US\$1,920). Breastfeeding would reduce these costs substantially. The report concludes that *'If all babies were breastfed this would be equivalent to almost £300,000 (US\$480,000) a year for the average district or £35 million (US\$56 million) for the country as a whole'* – about one-fifth of the money made from sales of artificial milks in the country.

It has been estimated that 500 pre-term babies in England suffer from necrotising enterocolitis each year because they are artificially fed, and 100 of these babies die<sup>12</sup>.

## Expansion into developing countries in the 20th century - the cases of Brazil and Mexico

The multinational baby food industry entered Brazil in 1912

Indiscriminate advertising first targeted mothers.

Paediatricians later became the focus of promotion, free supplies and gifts.

The baby food industry spent many decades developing the market for breastmilk substitutes in Brazil and Mexico. The tactics used will be explained here in some detail to demonstrate how breastmilk substitutes have been marketed to replace breastfeeding, not simply to fill a need for those infants who, for whatever reason, cannot be breastfed. The next section will show how efforts to reverse the decline in breastfeeding have taken different paths in these two countries.

The Brazilian Case Study drew on a book by sociologist Paulete Goldenberg which documents the history of infant feeding companies in Brazil<sup>13</sup>.

At the beginning of the 20th century when advertisements in Brazil mentioned breastfeeding, they extolled it as an exemplary way to nourish a child. For example, Guinness beer was promoted as good for breastfeeding mothers. This began to change in 1912 when Nestlé began selling its condensed milk and *farine lactée* (produced in Switzerland and known as *farinha lactea* in Brazil) in Rio de Janeiro. Within a decade, it began to manufacture in São Paulo, and by 1928, was producing its milks, *Ninho* and *Lactogen*. By 1946, it had three factories producing powdered milk in the Rio de Janeiro - São Paulo axis.

Advertising and other forms of promotion have been key to creating a market for baby foods the world over. The first advertisement for infant feeding milk products in Brazil ran in 1916 in the popular magazine, *A Cigarra*. The first Nestlé advertisement, also in this magazine, highlighted that it produced powdered milk in Brazil (rather than importing it from Switzerland) and promised low-price products that were 'fresher' and 'richer' than imported milks. During the 1930s, the advertisements introduced the idea that these products were scientifically formulated, and stressed that internationally renowned paediatricians recommended them.

During the 1940s, as Nestlé's increased production of powdered milk in Brazil, advertising and promotion intensified. New promotional themes were introduced: 'rich in nutrients', 'prevents gastrointestinal upset', 'the best results in the world obtained in normal infants' and 'bacteriologically pure.' (It is still a common misconception that powdered milk is sterile, which it is not.) The companies played upon a mother's understandable insecurities by presenting powdered milk as an excellent alternative should a mother experience a 'failure' or 'lack' of breastmilk.

At the end of the 1940s and the beginning of the 1950s, doctors began to figure as the competent professionals mothers should trust when making infant feeding decisions. In one advertisement in a Brazilian medical journal, a mother is depicted taking her child to a paediatrician with the word 'confidence' emblazoned across the advert, suggesting both the mother's relationship with the professional and her trust in the brand of products he prescribes.



**'Confidence' in the doctor and Nestlé products, but not her ability to breastfeed.**

*Nestlé advertisement targeted at healthworkers, 1948*

By the 1960s and 1970s, publicity became more explicit. The figure of a mother as the source of nutrition almost disappeared, substituted by that of a feeding bottle and a doctor. When she did appear in advertisements, a mother was portrayed only as a source of emotional care for her child, thereby associating the brand name of an infant formula with this sentiment. Advertisements described powdered milk as enriched with a high level of nutrients, such as proteins, vitamins, minerals and other additives – and thus a superior food to breastmilk.

Advertising in paediatric journals and magazines was just one part of the industry's marketing strategy aimed at getting these powerful interlocutors between mothers and manufactures on their side. Company representatives made their presence – and their products – known to health professionals by making routine visits to health service units, distributing attractive pamphlets, offering free samples and give-aways (posters, prescription pads, pens) and giving other substantial donations such as enough powdered milk and cereal to supply a paediatrician's own children for their first year.

In the 1970s, the companies developed other marketing strategies: industry sponsorship and promotion of scientific congresses, courses and meetings; financial support for journals; running competitions for research; and distributing scientific information of their own. Medical and scientific articles published under company auspices began to stress the need to administer artificial infant feeding as soon as a baby was born.

Gradually, artificial infant feeding became characterised as a normal activity and one within medical competence. In turn, this characterisation subliminally introduced the idea that powdered milks could not only substitute for a mother's milk, but could also supplement it, reinforcing the notion that today's mother is incapable of satisfying her child through breastfeeding.

Health service units played an important role in promoting powdered milk. They distributed it through their supplementary feeding programmes in the mother and child groups that had become the focus of public health policies in the 1930s. Paediatric services increased the number of milk kitchens and developed training for personnel and mothers in preparing feeding bottles. From 1950 to 1973, the number of tins of milk distributed leapt from 198,654 to 733,141. Health service donations of powdered milk were restricted to only a part of a family's needs for infant formula so as not to be overly paternalistic. This practice, however, meant that families had to buy the rest of the formula themselves and thereby helped create a consumer market among lower income people.

From the 1950s, the health service was co-opted to distribute free powdered milk - but mothers had to pay for it when they left hospital.

Maternity units in hospitals were involved in marketing artificial milks. They facilitated direct contact between company representatives and mothers in the crucial post-natal period when lactation is becoming established. Up to the mid-1970s, all mothers received a free tin of powdered milk when they left the hospital, whether they were breastfeeding or not. Other practices that undermine breastfeeding – the existence of nurseries, taking children away from their mothers, prescriptions for artificial milk – all stimulated consumption.

In the State of Bahia nearly 50% of infants stopped breastfeeding at three months of age.

Poor mothers are more likely to use unsuitable whole milks if they are not breastfeeding.

The effects of all these practices persist to this day as breastfeeding statistics show. Figures gathered in 1994 from the State of Bahia, a semi-arid rural area in North-East Brazil, suggest that nearly 92% of children were breastfed at birth, but by the age of 3 months, about half of them (45.1%) had already stopped, while at 6 months, only one-third (35.4%) were being breastfed<sup>14</sup>.

Poorer mothers in particular were replacing breastmilk with unsuitable artificial milks. A 1997 study in Ouro Preto, a region 100 kilometres from the Minas Gerais state capital of Belo Horizonte in South-East Brazil, indicated that among mothers using powdered milks for infant feeding, over two-thirds (70%) of the poorer families (those whose income was less than half the minimum per capita daily wage) tended to buy powdered whole milk rather than infant formula<sup>15</sup>.

Multinational baby food companies entered Mexico almost a century ago.

The health care system was used to distribute powdered milk.

Free supplies remain widespread.

Less than half of infants are still receiving any breastmilk at 6 months of age.

Transnational infant food companies set up business in Mexico at about the same time as they did in Brazil. Similarly Government authorities contributed in bringing about the decline in breastfeeding. The Social Security Institute for Government employees from 1959 and the Mexican Social Security Institute from 1973 for other employees, provided mothers with 36 cans of formula during her baby's first six months. About half of this was whole milk, most of the rest, modified milk and a small amount, soya-derived milk. Although this welfare provision was supposedly intended for mothers unable to breastfeed, the Case Study notes the opinion of health campaigners interviewed that it stemmed from a political and economic decision made by the executives of the social assurance bodies, union leaders and the companies.

The health care system in Mexico, as elsewhere, has long been a route for promoting baby milks by giving out free supplies. A study conducted in the 1980s by the Nestlé Infant Formula Audit Commission of marketing practices in Mexico found that hospitals were flooded with free supplies which reached the majority of mothers<sup>16</sup>. This Commission was presented as independent of Nestlé, but the company blocked publication of the report until 1991 and then disbanded the Commission. The extent of free supplies in Mexico was a factor leading to the development of the UNICEF Baby Friendly Hospital Initiative in 1991, which institutionalises a ban on company donations.

Of the 2.7 million children born in Mexico every year, about 85% of babies start breastfeeding and about 44% are still breastfeeding at 6 months<sup>17</sup>. On average, babies that are not breastfed have at least three serious episodes of diarrhoea a year and one of the episodes is likely to be treated in hospital at a cost of US\$179 per case<sup>18</sup>.

The baby milk market in Mexico, a country of 98 million people, is estimated to be worth US\$672 million per year<sup>19</sup>. Nearly half (44%) the salaried working population in Mexico earns double the daily minimum wage (US\$3.73), yet bottle feeding a child for their first six months with infant formula costs 65% of this salary<sup>20</sup>.

Infant mortality of children under 1 year old is a common indicator of a country's level of 'development'. In the year 2000, the mortality rate for children under 5 in

Mexico was 29 per 1,000 live births and 24 per 1,000 live births for infants under 1 year old<sup>21</sup>. Most of these deaths are attributed to intestinal and respiratory infections, from which artificially-fed infants are more likely to suffer.

## The impact of promotion in Bolivia and Kenya where the market for formula is small

In Bolivia breastfeeding is still perceived as the best and most natural way to feed newborn babies, particularly among the 70% of the country's 8.1 million inhabitants – more than two in three people – estimated to be living in poverty (51% of the urban population and 94% of the rural)<sup>22</sup>. Most poor Bolivians have difficult, sporadic or no access at all to adequate health and education services. Almost all babies (96.6%) are breastfed at birth, the average duration of exclusive breastfeeding is 3.9 months and the average duration of breastfeeding overall is 18 months<sup>23</sup>.

Poverty is a major barrier to the infant food companies, but despite the long duration of breastfeeding, one-quarter of mothers in Bolivia use feeding bottles for infants under the age of 1, mimicking what is promoted as the 'ideal'<sup>22</sup>. Mothers living in poverty are likely to over-dilute formula or use unsuitable whole milks or animal milks<sup>24</sup>.

Infant mortality is 60 deaths per 1,000 live births while child mortality is 77 deaths per 1,000 live births<sup>25</sup>. Of the deaths of all children under 5, about one-third (35.7%) are due to acute diarrhoeal diseases and one-fifth (20.4%) to acute respiratory infections<sup>26</sup>. Breastfed infants are at less risk of suffering from these illnesses<sup>27,28</sup>.

The annual Bolivian market for infant formula and other baby foods is estimated to be between US\$1 and 3.5 million<sup>29</sup>. It has been estimated that the country will lose US\$57 million over the next decade if children continue not to be exclusively breastfed for the first 6 months<sup>25</sup>.

As in Bolivia, breastfeeding is still perceived positively in Kenya, a country of some 28 million people, one-third of whom are children under the age of 9<sup>30</sup>. Most indigenous cultures in the country have encouraged and promoted breastfeeding in different ways. In some cultures, children would be breastfed after the age of 5. This positive perception of breastfeeding has been changing in recent decades. A 1980s study concluded that many mothers were using artificial food because of the aggressive marketing of breastmilk substitutes, lack of social support, the influx of Western culture, messages about HIV transmission through breastfeeding, and urbanisation<sup>31</sup>.

Mothers interviewed as part of the Case Study claimed they had stopped breastfeeding because *'they didn't have enough milk'*, because *'the baby refused to suck'* or because *'the baby was too big and needed other foods.'* Some mothers from higher social classes regarded infant formula as more fashionable - *'it is the trend of the world.'* Some mothers had stopped breastfeeding because they feared it would cause their breasts to sag.

According to the Ministry of Health, only 18% of infants under 4 months old were being exclusively breastfed in 1995 while only 16% were predominantly breastfed. The average duration of breastfeeding was 21 months. Duration is longer in rural areas. 18% of mothers bottle-fed their infants before they were 4 months old, often with maize porridges and animal milks because only wealthy women can afford infant formula<sup>32</sup>.

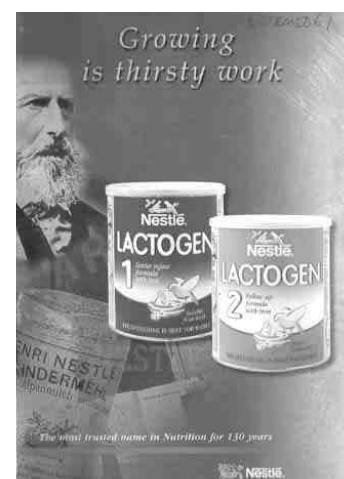


### Milking every penny

Poor mothers unable to afford infant formula may over-dilute it or buy cheaper alternatives, such as *Nido* whole milk. In many countries this is displayed alongside the infant formula in infant feeding sections of pharmacies and supermarkets as the above picture shows. This picture, from Argentina, is from Nestlé's own *Sustainability Review*<sup>33</sup>. The company refuses to stop the practice.

In Kenya the average duration of breastfeeding is 21 months. But mothers are increasingly reporting breastfeeding 'problems' and bottle-feeding is seen as the modern way.

18% of mothers bottle-feed, but most cannot afford infant formula.



**Growing is thirsty work** – the message on a present-day leaflet for Nestlé *Lactogen* found in a rural clinic in Botswana.



## India - marketing having an impact

In India, 37% of infants are exclusively breastfed at 4 months.

The Indian Case Study is not so detailed on the historical development of the market for breastmilk substitutes. The impact can be seen, however, in the results of a 1998 study which found that the number of infants receiving artificial milk in the first month of life was 10.9% and in the fourth month was 55.3%<sup>34</sup>.

In India breastfeeding is generally perceived as a good thing. Almost every woman breastfeeds her child. The percentage of infants who are exclusively breastfed at 4 months is 37%, a rate that drops to 19.4% by 6 months, although the rates tend to be higher in rural areas than in urban ones<sup>35</sup>.

Interestingly, Indian Government surveys show that working women tend to breastfeed their children for a longer period than women who do not work. It has been suggested that breastfeeding is generally viewed positively and that working mothers may be more conscious of providing the benefits of breastfeeding for their infants to make up for the time of separation<sup>35</sup>.

## International pressure for regulation

**IBFAN** - the International Baby Food Action Network

**NGOs** - Non-Governmental Organisations

**UN** - the United Nations

**UNICEF** - the United Nations Children's Fund

**WHA** - the World Health Assembly

**WHO** - the World Health Organisation

Also see the Glossary

The World Health Assembly (WHA) adopted the *International Code* in 1981<sup>36</sup>. This was the culmination of several years of activities in various fora, all of which created pressure and helped to stimulate action to regulate the marketing of baby foods internationally<sup>37</sup>. Groups and individuals from several of the Case Study countries were actively involved in building up this pressure.

Concerns about the effects of the infant food industry's marketing practices had been mounting during the 1960s and 1970s and voiced in statements made at UN meetings.

A key turning point involved a UK charity, War on Want, which went on to be a founder of Baby Milk Action, and a founding member of IBFAN. In 1974, War on Want published a booklet entitled *The Baby Killer* which exposed the aggressive marketing practices of the leading baby food companies<sup>38</sup>. This introduced the concept of regulating the marketing of breastmilk substitutes. Twenty thousand copies were sold. A Swiss group, Third World Action, translated the book into German and changed the title to *Nestlé Kills Babies*. Nestlé sued the group for libel over the allegations of irresponsible marketing, but towards the end of a two-year trial dropped all charges except that against the title. The company won this one charge on the grounds that it was not guilty of 'killing' as it did not set out or intend to kill babies. The judge gave the defendants, the members of Third World Action, token fines and warned Nestlé to change its marketing practices, particularly in developing countries, to avoid future accusations of 'immoral and unethical conduct'.

In the United States, groups lodged shareholder resolutions with companies in attempts to obtain information about marketing strategies. One group, an order of Catholic nuns, filed a lawsuit against Bristol Myers for giving misleading information to its shareholders. In 1977, the Infant Formula Action Coalition was formed and launched a consumer boycott of Nestlé, which spread to a wide range of groups across the world. In 1978, in response to these actions, the US Senate held a public hearing on the promotion of breastmilk substitutes in developing countries which added to the calls for marketing regulations.

These events put pressure on the World Health Organisation (WHO) to look for an international solution to an international problem. WHO and UNICEF held a meeting in 1979 addressing infant and young child nutrition to which representatives



**The baby killer**

War on Want's 1974 booklet brought the impact of unsafe artificial feeding to public attention.

from governments, industry, UN agencies and NGOs and relevant experts were invited. The meeting concluded by asking WHO and UNICEF to prepare an international code governing the marketing of breastmilk substitutes.

Towards the end of this meeting, representatives from six NGOs decided to form a network to work on the issue of artificial feeding, to monitor corporate activity relating to infant food and to share this information as widely as possible – so the International Baby Food Action Network (IBFAN) was born.

After the 1979 WHO/UNICEF meeting, two of the Case Study countries were already taking action to investigate regulating the baby food industry: Brazil and India. Brazil instigated discussions through the Pan American Health Organisation. The Indian Government set up a working group comprising representatives of all concerned ministries/departments, specialised bodies, the infant food industry, voluntary organisations and UN agencies. Its task was to explore the whole gamut of issues concerning the production, marketing and promotion of infant foods in India and to work out the principles of legislation. Anwar Fazal, a founder member of IBFAN and Dr. R.K. Anand, an Indian paediatrician and member of the Consumer Guidance Society, went on to conduct press conferences throughout South-East Asia, starting with India, to draw attention to the deterioration in infant feeding and the marketing practices of the baby food industry. Their work meant that the governments of several countries were aware of the issue when they attended the 1981 World Health Assembly. India not only voted in support of the Code at the WHA, but Prime Minister Indira Gandhi spoke out forcefully at the WHA for the need for such a Code.

The passage of the Code through the World Health Assembly adoption process was not easy. It was fiercely opposed by the United States of America, which indicated it would not support its adoption as a Regulation, which would have given it a status in international law requiring its adoption by WHA Member States. A political decision was taken to adopt it instead as a Recommendation and to include strong wording in Resolution 34.22 under which it was adopted calling on Member States to implement it in its entirety as a minimum requirement. In the event, the United States still voted against its adoption, the only country to do so.

The Code calls for a review every two years of the progress made by Member States in implementing it in national measures. These are prepared by the Director General of WHO. The World Health Assembly in these years has generally adopted a subsequent Resolution, referencing the Code and other relevant Resolutions, to address questions of interpretation and changes in scientific knowledge or company marketing activities. The United States has supported these Resolutions since 1994<sup>39</sup>.

The **International Code** and the subsequent, relevant Resolutions are the principal international tools for holding the baby food industry to account.

## The World Health Assembly

The Assembly discusses infant and young child feeding issues every two years to address questions of interpretation of its marketing requirements and changes in scientific knowledge and company marketing strategies.



## 2. National experiences of using the tools

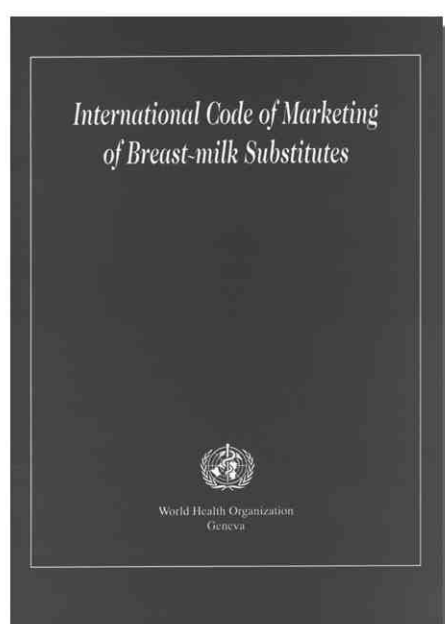
Regulating the marketing of breastmilk substitutes is part of the broader campaign to reverse the decline in breastfeeding and to ensure breastmilk substitutes are used safely if necessary. In addition information needs to be disseminated on the importance of optimal infant feeding: exclusive breastfeeding for the first six months of life followed by the introduction of complementary feeding and continued breastfeeding into the second year of life and beyond. Mothers require support to overcome any difficulties they may have and social constraints, such as unsupportive working conditions, need to be addressed. This report focuses on the marketing of baby foods.

The preamble to the Code states: *'the marketing of breastmilk substitutes requires special treatment, which makes usual marketing practices unsuitable for these products.'*

Getting the 1981 World Health Assembly (WHA) to adopt the *International Code* was a major success for all those concerned about infant survival. The next challenge was to encourage WHA Member States to implement the Code and the subsequent, relevant Resolutions within their countries and to call companies to account. National governments can make the Code effective by implementing it via national legislation, or equivalent measures, and by providing mechanisms to monitor and enforce it. Companies are required to abide by the Code's provisions independently of government action. Non-governmental organisations (NGOs) are called on to report violations.

After an overview of the provisions of the Code and Resolutions, this section examines the different forms of government implementation in the Case Study countries.

The Case Study countries were selected for practical reasons and to give a selection of different types of implementation. India has a strong law, where NGOs are sanctioned to file cases in the courts. Brazil's strong law is enforced by the country's health inspectorate and consumer protection bodies. Belgium and England are influenced by their membership of the European Union, the free trade area to which both belong and which has only introduced some aspects of the Code and Resolutions in regulations. Kenya, Mexico and Bolivia have all principally followed the route of voluntary codes of conduct agreed with industry.



### ***The International Code of Marketing of Breastmilk Substitutes***

The Code, adopted in 1981, is backed by the moral authority of the world's highest health policy setting forum - the World Health Assembly, made up of government health ministers. Later given status in international law through the *Convention on the Rights of the Child*.

## Summary of the provisions of the *International Code and Resolutions*

The aim of the *International Code of Marketing of Breastmilk Substitutes* is to:

*contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breast-feeding and by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.*

The Code defines breastmilk substitutes as '*any food being marketed or otherwise represented as partial or total replacement for breast-milk, whether or not suitable for that purpose*'.

The Code also covers the marketing of feeding bottles and teats because their use can interfere with breastfeeding.

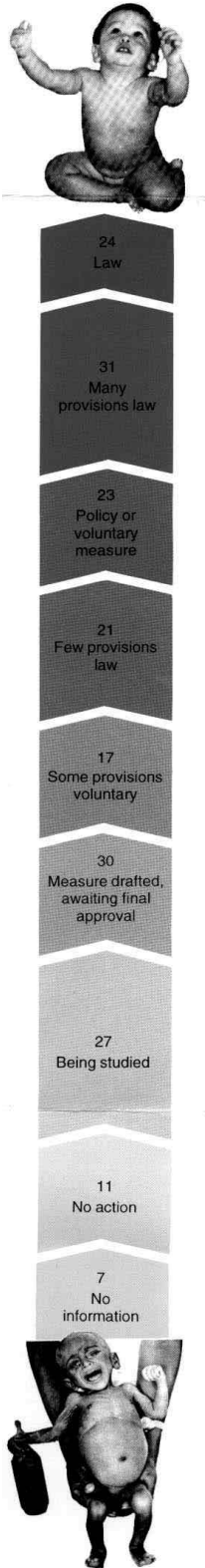
The Code's specific provisions, as clarified by subsequent World Health Assembly Resolutions, can be summarised as follows:

1. No advertising or other form of promotion of breastmilk substitutes, feeding bottles or teats to the general public.
2. No pictures of infants or other pictures or text on labels idealising artificial feeding or undermining breastfeeding. Labels must state clearly the superiority of breastfeeding and must include preparation instructions and a warning about the health hazards of inappropriate preparation.
3. Information and educational material on infant feeding must explain the benefits and superiority of breastfeeding, the health hazards associated with artificial feeding, and the difficulty of reversing the decision not to breastfeed. Information about the feeding of infants must include details of the social and financial implications of artificial feeding. The materials may not contain pictures or text that idealise artificial feeding, nor may they refer to a product brand name.

4. No free samples, direct or indirect, to mothers. No free supplies in any part of the health care system.
5. No contact between marketing personnel and pregnant women or mothers of infants and young children.
6. No promotion of products within the health care system, including no free or low-cost formula, other breast-milk substitutes or feeding-bottles and teats.
7. Product information for health professionals must be limited to scientific and factual matters.
8. No gifts to health workers; samples of breastmilk substitutes may be given for research and evaluation purposes only.
9. Care should be taken to avoid conflicts of interest regarding financial support. Some take this clarification of the Code to mean that financial support from baby food companies should be refused, as it gives rise to a conflict of interest. Some refer only to the original wording in the Code, which requires that manufacturers should disclose any contribution made to health workers for fellowships, study tours, research grants, attendance at professional conferences and the like; as should recipients.
10. Unsuitable products should not be promoted for babies. Complementary foods should not be promoted for use before 6 months of age and marketing should not undermine breastfeeding.

The *International Code* also requires corporate responsibility. Article 11 specifies that:

*independently of any other measure taken for implementation of this Code, manufacturers and distributors of products should regard themselves as responsible for monitoring their marketing practices according to the principles and aim of this Code, and for taking steps to ensure that their conduct at every level conforms to them.*



## Current state of implementation of the Code and Resolutions

The International Breastfeeding Action Network (IBFAN) set up the International Code Documentation Centre (ICDC) in Malaysia in 1986 to monitor the Code, to analyse the laws and measures introduced by governments and to rate them according to scope and strength.

### ICDC classifications<sup>40</sup>

#### Level 1: Law

These countries have enacted legislation encompassing all or nearly all provisions of the *International Code* and the clarifications and additions from subsequent WHA Resolutions.

#### Level 2: Many Provisions Law

These countries have enacted legislation encompassing some, but not all provisions of the *International Code* and Resolutions.

#### Level 3: Policy or voluntary measure

In these countries, the government has adopted a voluntary code or health policy encompassing all, or nearly all, provisions of the *International Code* and Resolutions. There are no enforcement mechanisms.

#### Level 4: Few provisions law

In these countries, the government has adopted only a few provisions of the *International Code* and Resolutions as law.

#### Level 5: Some provisions voluntary

In these countries, the government has adopted some, but not all provisions of the *International Code* and Resolutions as a voluntary code or health policy. There are no enforcement mechanisms.

#### Level 6: Measure drafted, awaiting final approval.

#### Level 7: Being studied

#### Level 8: No action

#### Level 9: No information

### State of the Code

IBFAN's International Code Documentation Centre trains legislators and tracks progress in implementing the Code and Resolutions.

**Belgium** - Level 2 (many provisions law)

1993 law - A Royal Decree modifying a former Royal Decree of 18 February 1991 about foodstuffs for special purpose, amended in 1997.

**Scope:** Infant formula and follow-on formula.  
Permits advertising of follow-on formula to the general public.

**Bolivia** - Level 3 (policy or voluntary measure)

1984 voluntary regulation and 1992 voluntary agreement with industry. Legislation pending (level 6).

**Scope:** Breastmilk substitutes  
Bans promotion.

**Brazil** - Level 1 (most provisions law)

1988 law *Regulations on the marketing of foods for infants* revised in 1992 as *Brazilian Regulations for the Marketing of Products for Infants* further revised in 2002, as three Regulations: *Technical regulation for pacifiers, teats, feeding bottles and breast protectors*; *Technical regulation for marketing of foods for infants and young children*; *Policy on the promotion of foods for infants and young children to the general public and health professionals*.

**Scope:** Products for children to 3 years of age, feeding bottles, teats, pacifiers, nipple shields.  
Bans promotion.

**India** - Level 1 (most provisions law)

1992 law, *Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act*, came into force 1 August 1993. 2000 *Cable Television Networks (Regulation) Act*. 2003 *Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Amendment Bill*.

**Scope:** Products for children to 2 years of age, feeding bottles and teats.  
Bans promotion.

**Kenya** - Level 3 (policy or voluntary measure)

1983 voluntary code, *Kenya Standard Code of Marketing of Breastmilk Substitutes*.

**Scope:** Breastmilk substitutes.  
Bans promotion.

**Mexico** - Level 2 (many provisions law)

1991, 1995, 2000, voluntary agreements between government and National Board of Manufacturers and Distributors of Breastmilk Substitutes. Many code provisions in different laws, but these have been neglected in favour of the voluntary agreements.

**Scope:** Infant formula and complementary foods.  
Permits advertising and promotion of infant formula.

**UK (which includes England)** – Level 2 (many provisions law)

1995 *Infant Formula and Follow-on Formula Regulations*. Amended in 1997.

**Scope:** Infant formula and follow-on formula.  
Permits advertising of follow-on formula to the general public and infant formula in the health care system.



## Key facts - India

Population	1,025,096,000
Under 5 mortality rate/1000	93
Infant mortality rate/1000	67
GNI per capita (US\$)	460
Life expectancy at birth	64
% Exclusively breastfed (<6 months)	37
% Breastfed with complementary foods (6 - 9 months)	44
% Still breastfeeding (20 - 23 months)	66
% of population using improved drinking water sources	95 (urban) 79 (rural)
% of population using adequate sanitation facilities	61 (urban) 15 (rural)

State of the World's Children 2003,  
UNICEF (most figures 2001)

## India – powers of imprisonment

In India, the process of introducing legislation to regulate the marketing of breastmilk substitutes began even before the 1981 adoption of the *International Code*. Prompted by the 1979 WHO/UNICEF Joint Meeting, the Government set up a working group within the Ministry of Social Welfare in February 1980, which included all sectors involved with infant feeding, including the baby food industry. Dr R. K. Anand of the Consumer Guidance Society of India, who went on to become a prominent member of IBFAN, joined the sub-group examining the production, marketing and promotion of infant foods to work out a suitable code as the basis for legislation.

From the outset, the baby food industry, led by Nestlé, worked hard to frustrate the introduction of legislation. It promoted the idea of a voluntary code implemented by the manufacturers themselves, although this had already been rejected by the WHA during years of wrangling before 1981. The industry drafted its own version of the Code and circulated it to members of the Government's Committee looking at the issue of regulation, which included two members sponsored by Nestlé. The company offered large donations to the Indian Academy of Paediatricians, whose then President was a member of this Committee. Although the Indian Government had been active since the late 1970s in supporting international regulation of infant formula marketing, this industry activity in the country managed to stall the introduction of a law.

NGOs, however, capitalised on subsequent WHA Resolutions urging Code implementation. The Voluntary Health Association of India (VHA) and the Association for Consumer Action on Safety and Health (ACASH) launched awareness-raising campaigns and held meetings with health professional associations, NGOs, government officials and ministers. They also contacted international agencies and participated in the international boycott of Nestlé. All these efforts eventually led to the lower house of parliament, the Rajya Sabha, passing a Bill in 1986, but before it could become law, the upper house, the Lok Sabha, adjourned and the Bill lapsed.

It took another six years of lobbying and campaigning, particularly meeting directly with parliamentarians, before the NGO efforts were successful. An Independent Member of Parliament, Ram Naik, tabled a private member's bill in 1992, which the government took up as its own in the next Parliament. The *Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act* (the IMS Act) of 1992 came into force on 1 August 1993. It implements most of the Code's provisions, but addresses only infant milks and feeding bottles and not complementary foods. It completely prohibits manufacturers and distributors of artificial feeding products from contacting pregnant women and mothers of infants. It bans promotion in health care facilities. It provides major powers to confiscate products and prescribes high fines if a company wants to retrieve its confiscated goods. It also provides for criminal sanctions and penalties.

Complaints about infringements can be filed by government food inspectors and, unusually, by several designated NGOs: the Central Social Welfare Board; the Indian Council for Child Welfare; ACASH; and the Breastfeeding Promotion Network of India (BPNI). The Government bodies have not made any attempt to carry out systematic monitoring. The IBFAN groups, ACASH and BPNI, monitor on an ad hoc basis and publish reports on their findings. IBFAN monitoring reveals that the law is being broken and several legal actions have been filed by ACASH against companies, including Nestlé. Whereas other companies (Johnson and Johnson, Wockhardt) have apologised for their violations and changed their practices, Nestlé



### Breastfeeding 'just isn't convenient'

Advertisements such as this one (*India Today*, August 1980) which blatantly discouraged breastfeeding, were common in India before the IMS Act came in. Companies have become more subtle over the years, but the message is the same (see right).

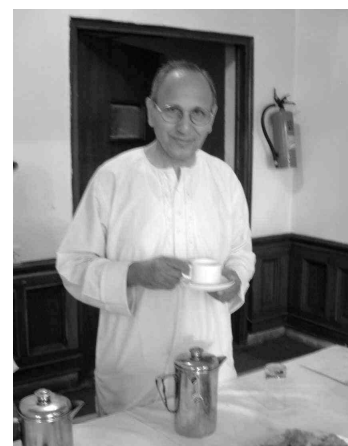
is challenging the law itself, particularly its provisions giving NGOs the powers bring cases to court. ACASH brought the case under the IMS Act because Nestlé did not put the required warning notice **'Mother's milk is best for babies'** in Hindi on its infant formula labels and the English text was a modified version of that required by the law. Nestlé has filed a Writ Petition against the 1992 IMS Act, arguing that it has resulted in the company being 'harassed'. Nestlé's challenge also attacks several articles of the Act that directly implement the **International Code**. For example, in line with the Code, the IMS Act requires a warning on labels that products should only be used on the advice of a health worker. Nestlé is challenging this, claiming that anyone should be allowed to advise mothers.

Companies continue to undermine breastfeeding by promoting cereals heavily, often using images of very young babies and giving an age of use that is too young. This has led to inappropriate use of these products as breastmilk substitutes. The 1994 the WHA Resolution attempted to address this, stating that complementary feeding should be **'fostered from about 6 months of age'**. This was reiterated by the 2001 Resolution, which stresses the importance of exclusive breastfeeding for the first 6 months. Campaigners have used these Resolutions in their campaigning and were invited to participate in a Government task force which resulted in amendments in 2003 tightening up loopholes in the law. These ban promotion of all foods for babies up to 2 years of age and ban company sponsorship of health worker events, something some professional societies had already put into their policies.

Indian campaigners have lobbied to stop the national Doordarshan television station from showing advertisements that were prohibited by the 1992 Act, and were successful after two years. But Nestlé's interference and influence over Doordarshan staff meant that advertising started up again until 2000 when the **Cable Television Networks (Regulation) Amendment Act** was amended on 8 September 2000, banning advertisements for infant milk substitutes, feeding bottles and infant foods on cable television networks, which reach almost 40 million homes in India.

As controls on the aggressive marketing of infant milks gradually take effect companies (principally Nestlé) have stepped up their promotion of milks to be consumed by children from one to three years old as these were not covered by the national regulations until 2003.

Some companies in India have set up telephone call centres providing family counselling on nutrition, an action which IBFAN groups believe is motivated by the desire to establish a good company image in the minds of customers. Companies are also moving into cause-related marketing by sponsoring various functions at schools such as sports or annual days linked to sports and children's health.



**Dr. Raj Anand**

A founder member of IBFAN, who worked for the introduction of the Code itself, Dr. Anand helped to convince colleagues that it is better for paediatricians to pay for their own lunch than take money from the baby food industry for congresses.

### Promotion of complementary foods

Company promotion like the examples below from 2002 and 2003, are subtler but still undermine breastfeeding and indigenous foods, using health claims and idealised images of slightly older babies.

India's law, which was revised in 2003, outlaws all such promotion until the child is two year old. IBFAN is assisting the Government in getting companies to finally comply.



## Key facts - Brazil

Population	172,559,000
Under 5 mortality rate/1000	36
Infant mortality rate/1000	31
GNI per capita (US\$)	3,060
Life expectancy at birth	68
% Exclusively breastfed* (4 months)	42
% Breastfed with complementary foods (6 - 9 months)	30
% Still breastfeeding (20 - 23 months)	17
% of population using improved drinking water sources	95 (urban) 53 (rural)
% of population using adequate sanitation facilities	84 (urban) 43 (rural)

State of the World's Children 2003,  
UNICEF (most figures 2001)  
\*Progress of Nations 1999,  
UNICEF(see page 39)



### The Gerber baby

Gerber called in US government support to pressure the Guatemalan authorities to allow it to use its baby logo despite a legal ban on baby pictures. But in Brazil...

## Brazil – building ever stronger regulations

Like India, Brazil was lobbying for the international regulation of baby food marketing practices even before the World Health Assembly (WHA) adopted the *International Code* in 1981. In 1979, for instance, the Government had already initiated a wide-ranging discussion on the theme with the support of the Pan-American Health Organisation (PAHO) and UNICEF.

After 1981, a National Executive Technical Group for the Promotion of Breastfeeding began working out how to adopt the Code in national law in accordance with the country's international commitment. That same year, the Government put forward two proposals to prohibit the advertising of powdered milks on radio and television and to regulate the presentation, promotion and advertising of breastmilk substitutes, but they were not approved. The Judicial Department of the Ministry of Health judged the measures improper because they contained items already covered by existing legislation.

In 1985, IBFAN Brazil (formed in 1983), conducted its first training on how to monitor the industry's compliance with the Code, the main function of the IBFAN international network. A new committee was created in 1987 within the National Institute of Food and Nutrition of the Ministry of Health to re-ignite the question of how to regulate compliance with the Code in Brazil. The committee comprised both governmental and non-governmental institutions, industry and non-profit groups: the Ministries of Health and Agriculture, the Brazilian Association of Food Industries, the Advertising Self-Regulating Council, the Brazilian Paediatric Society, the Brazilian Nutrition Federation, the Brazilian Association of Postgraduates in Health Collective, the National Division of Food, the National Confederation of Commerce, the National Consumer Defence Council, UNICEF and IBFAN.

Just over a year later, on 20 December 1988, the National Council of Health of the Ministry of Health approved the *Normas de Comercializacao de Alimentos para Lactentes (Regulations on the Marketing of Foods for Infants)*. This was rated at the time as being a full implementation of the Code and Resolutions. In 1992, following widespread discussion about revising the law with various sectors of civil society and with IBFAN, the *Norma Brasileira para Comercializacao de Produtos para Lactentes (Brazilian Regulations for the Marketing of Products for Infants)* came into effect, with even stronger provisions. In November 2002, a set of three more regulations were passed, two under the responsibility of the health inspectorate and one, concerning health worker ethics, is under the Ministry of Health. The new rules encompass all baby foods for children up to 3 years of age, feeding bottles, teats, dummies and nipple shields, removing many of the loopholes exploited in the past by companies. Company production or sponsorship of educational materials is also prohibited.

In Brazil, IBFAN has monitored the national regulations and the *International Code* and Resolutions since 1985. Its monitoring focuses primarily on Brazil's legislation as this is stricter than the Code and Resolutions in many areas and it gives more detailed requirements for the text of warnings. The IBFAN Brazil network used to carry out monitoring exercises every two years until 1997 when, following an evaluation of its work, it made monitoring an ongoing activity, enabling action against infringements to be taken more promptly. The data are collected and published in IBFAN's annual monitoring reports which document the principal violations of the national regulations and the names of the products and companies responsible for them. To gain greater support and to protect IBFAN members legally, reports of violations are generally sent directly to the Ministry of Health. Since 1997, a monitoring co-ordinator (or co-ordinators) has been elected at IBFAN Brazil's General Assembly for one year to co-ordinate activities and produce the report.

IBFAN conducts training courses on how to monitor the regulations for Government as well as non-government personnel. UNICEF's support has been fundamental for these activities and during the months of discussion in the 1980s that led to approval of the national regulations in 1988. IBFAN Brazil's training consists of a basic programme of 32 hours usually carried out over four days, the minimum time the network thinks is necessary to understand the national regulations and to learn how to monitor compliance. It has prepared some basic materials for these training events including a set of overhead transparencies and instructions on how to conduct training. This material has been distributed to all IBFAN groups and to five Breastfeeding Reference Centres (established by the Government since 1985 in health institutions that have demonstrated a strong commitment to promoting and supporting breastfeeding and that have a tradition of training). The majority of IBFAN members are known specialists in breastfeeding, and thus are often invited to give presentations at conferences and to take part in training, occasions they use to disseminate information about the national regulations and the *International Code* and Resolutions.

The Ministry of Health has also supported training activities. In 1999, it assumed responsibility for conducting training courses throughout the country, but still relies on the support and experience of IBFAN to do this. The Government's Health Inspectorate and the consumer protection authority, PROCON, also monitor the national regulations, although not necessarily very effectively. IBFAN tries to encourage these Government organisations to get involved, however, because they have the power to warn and punish companies that do not comply with Brazil's laws. Authorities in one city, Florinopolis, have exercised their power to confiscate products from the shelves if they do not comply with the regulations.

Interviews conducted for the Case Study revealed that in the 1980s IBFAN was initially regarded as a radical organisation, but that it had taken this stance to ensure that infant health was put on the public agenda. One interviewee who works for the Ministry of Health, for instance, commented that in the mid-1980s IBFAN was very combative, giving a negative impression of the NGO (*'a group of extremists'*). But for this interviewee, contact with the more 'ideological' ideas promoted by IBFAN changed his mind about breastfeeding issues in the country and prompted him to look again at issues affecting women and maternity. He came, he said, to realise that social issues had to be addressed as factors in encouraging breastfeeding.

Brazil has been a leading voice on the international stage for protecting infant health. Representatives of both Government and NGOs interviewed for the Case Study point to the important role of NGOs not only in representing the country internationally, but also in briefing Government delegates that participate in international fora and assemblies. It has ended up being the responsibility of NGOs such as IBFAN to provide Government representatives with the information and knowledge that will enable them to defend the interests of groups working to support breastfeeding and to regulate infant feeding.

Some interviewees in the Case Study highlighted the 'dangerous' relationship between the large companies and medical professional societies, especially the Brazilian Paediatric Association. According to one NGO representative, paediatricians often know about the national regulations only through the industry. This gives the industry the opportunity to promote its own interpretation of the regulations and to justify their marketing activities. Historically, paediatricians and the Paediatric Society have been major targets of the companies, for instance being given financial support to attend or hold professional congresses. Although paediatricians are the preferred target, Nestlé, in particular, also courts other professional bodies such as those of nutritionists and speech therapists.



### Gerber's missing baby

Gerber's idealizing baby logo does not appear on products in Brazil.



### Step by step

IBFAN Brazil's programme of continuous monitoring has demonstrated how marketing practises change, requiring revisions to legislation. The latest regulations have been expanded to cover feeding products for children up to 3 years of age, including infant formulas, follow-on formulas, 'growing up formulas', specialised formulas, feeding bottles, teats and pacifiers. Labelling and other requirements are included for whole milks, complementary and other foods and breast protectors. 'Ministry of Health warning' notices are defined for each type of product, including the text size and presentation. Baby food sponsorship of events must be clearly declared and event organiser are responsible for ensuring that no promotion occurs. Company representatives are not permitted to move around health facilities.

## Key facts - Belgium

Population	10,264,000
Under 5 mortality rate/1000	6
Infant mortality rate/1000	5
GNI per capita (US\$)	23,340
Life expectancy at birth	68
% Breastfed at birth*	52
% Breastfed at 3 months*	33
% Breastfed at 6 months*	18.4
% of population using improved drinking water sources	-
% of population using adequate sanitation facilities	-

*State of the World's Children 2003, UNICEF (most figures 2001) except \* (see reference 5).*

## Belgium and England - in line with EU Directives

In Belgium, two groups are IBFAN members. VZW Borstvoeding (Breastfeeding NGO) supports and advises women on breastfeeding, particularly when they have problems, through a network of 51 trained and experienced women giving training or answering dedicated telephone lines. It reaches out to health workers and pregnant women through leaflets, newsletters and public events, all on a shoestring budget. The VZW Vereniging Begeleiding en Bevordering van Borstvoeding (VBBB - Association for Supporting and Promoting Breastfeeding) does similar work, but also training and lobbying. It assesses hospitals before they embark on the UNICEF Baby Friendly Hospital Initiative. It has received public money for its work.

Baby Milk Action is the member of IBFAN for the UK (which includes England). It was founded in 1977 as a coalition of individuals and groups (including the National Childbirth Trust, Health Visitors Association, OXFAM and War on Want) who came together to campaign against the unethical marketing of breastmilk substitutes, primarily in the developing world. Baby Milk Action was a founding member of IBFAN when it was formed in 1979 at the WHO/UNICEF meeting on Infant and Young Child Feeding. Following that meeting, Baby Milk Action joined other European groups to lobby for the adoption of marketing regulations.

Shortly after the Code was adopted in 1981 by the World Health Assembly (WHA), the European Parliament adopted a Resolution of its own calling for the incorporation of the Code into a Directive, the name given to European Union (EU) laws. The Parliament, however, has limited powers within the EU. More power, particularly in formulating Directives, lies with the European Commission, a body of appointed representatives, and the Council of Ministers, made up of representatives of Member States. The Commission began looking at drafting a Directive the following year, but based it on industry interpretations rather than the Code itself. IBFAN's coordinated lobbying of the European Parliament, and partner NGOs through the European region, resulted in the Parliament voting overwhelmingly for the Directive to be brought in line with the **International Code**. The Commission responded by accepting the majority of the amendments proposed. But it was not until 1991, after yet another struggle with the Commission over wording on free supplies and advertising, that the Directive was finalised, with the Commission making key concessions in the final stage. Over 1000 NGOs had joined in the lobby, and the resulting Directives, although limited in scope and full of loopholes are still seen as an important victory for health. Member States had a legal obligation to bring it into national legislation within three years. While the minimum standards set by the Directives are much narrower than the Code and Resolutions, they do make reference to the **International Code** and critically, do not prevent Member States from fully implementing these measures if they choose to do so. An Export Directive was adopted in 1992.

## Belgium

The Belgian law, introduced in 1993, is weaker than the European Directive: it covers infant formulas, but not follow-on formulas nor bottles and teats. Marketing directed at the medical profession is permitted. The law was amended in 1997 to encompass the risks of babies developing allergies as a result of bottle-feeding, and to prohibit samples and free supplies of breastmilk substitutes and other promotional items being given to mothers and their families, even if they requested them. However, free samples and supplies are permitted for infants that **'have to be fed on infant formula'**. This clause has been interpreted broadly by the industry to mean any child not being breastfed; resulting in a health care system awash with free supplies, something only recently addressed.

In Belgium, the baby food industry has set up its own industry grouping: the Association Belge du Secteur de l'Alimentation de l'Enfance et des aliments Diététiques (ABSAED), which has had discussions with Government ministries but which has no voice in the national breastfeeding committee. The companies produce glossy 'information' booklets and distribute 'Pink Boxes' of samples to pregnant women in hospitals and 'Baby Boom Baskets' of follow-on formulas and complementary foods to women's homes when their babies are 3 months old.

There is no national monitoring scheme for the Code and Resolutions in Belgium. Monitoring the implementation of the country's narrower 1993 law is carried out by inspectors from the Foodstuff Inspection Department of the Ministry of Public Health, but usually only when a complaint has been made. This seems to be because there are so few inspectors: 20 for a country of 10 million people to cover all sectors where food is provided – industry, restaurants, hospitals, shops – in all, 230,000 points need to be monitored. Until recently, the food inspectors have not been able to check whether maternity wards and community services distribute breastmilk substitutes free of charge. But it is public knowledge that nearly all maternity wards do so in contravention of the 1993 law. The national IBFAN Belgium report for 1997 stated that at least 86% of Flemish maternity wards distributed free samples to mothers, while 82% of Walloon maternity wards have agreements with the infant formula industry<sup>41</sup>.

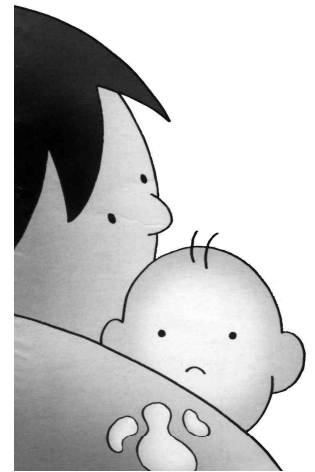
The Minister of Public Health has sent letters to hospitals reminding them that it is illegal to distribute free samples or supplies of breastmilk substitutes, but there has been little change. At the beginning of 2001, the Minister met with the infant formula industry and came to a voluntary or 'gentleman's agreement' on the practice. Soon after, she mentioned in Parliament the possible introduction of sanctions for infringing the law.

In the spring of 2001, food inspectors checked for the presence or distribution of free samples of breastmilk substitutes in six health care service units (primary care units and maternity wards) and passed on four charges to the office of the public prosecutor. All these violations incurred the sanction of an administrative fine; all have been paid. This was the first time that such action had been taken and more checks are believed to be planned. Significantly, according to a member of the Foodstuff Inspection Department, the practices within the offending maternity wards do seem to have changed.

The health risks of artificial feeding were tragically demonstrated in 2002. Nestlé was compelled to recall a batch of **Beba 1** infant formula after it was implicated in the death of a 5-day-old boy from meningitis. The formula was found to be infected with the bacteria *Enterobacter sakazakii*.

## England

Campaigning within the UK (of which England is part) had begun long before the EU Directives were adopted, initially prompting industry to devise a voluntary Code which described current marketing practices and did little to halt promotion. Indeed its existence diverted attention and delayed action on legislation. In 1988, following the 1986 WHA Resolution, IBFAN lobbying prompted the Department of Health to issue a Health Circular banning samples and free and low-cost supplies in the health care system. This action helped strengthen the UK position in the lobby for a stronger Directive. Building alliances with over 48 agencies, including the British Medical Association, the Food Commission, the Maternity Alliance, the National Dairy Council, and the Women's Environmental Network, the IBFAN group maintained its pressure for better protection for UK infants, including a ban of



**Detail from an SMA  
Staydown advertisement**

If your baby throws up perhaps it needs formula with hard-to-digest corn starch added, this advertisement suggests.



### **Milupa promotion to midwives**

Companies are limited to providing scientific and factual information to health workers. But in the UK a midwife can win a free stereo if she gives her contact details and information on her workplace to Milupa.

## Key facts - United Kingdom\*

Population	59,542,000
Under 5 mortality rate/1000	7
Infant mortality rate/1000	6
GNI per capita (US\$)	24,230
Life expectancy at birth	78
% breastfed at birth**	71
% breastfed at 6 weeks**	43
% breastfed at 6 months**	22
% of population using improved drinking water sources	100
% of population using adequate sanitation facilities	100

*State of the World's Children 2003, UNICEF (most figures 2001) except \*\* (reference 6)*

\* England is part of the United Kingdom, having 85% of its population



### Taking concerns to the top

Baby Milk Action's Policy Director, Patti Rundall, questions Nestlé's board of directors at the company's shareholder meeting in Switzerland. Patti received the prestigious Order of the British Empire from the Queen in 2000 for 'services to infant nutrition'.

advertising. The baby food industry lobbied hard against such a ban, using free sampling companies such as Bounty and baby care magazines to run consumer surveys to support their case that advertising is popular with parents and an important source of information. Before the UK decided whether to adopt the strictest measures permitted by the Directive or the bare minimum, there were several debates in Parliament. Despite this, the Government's overarching preference for minimal regulation carried more weight than the advice of civil servants and the health lobby, and advertising was permitted within the health care system.

In the UK in September 1997, the Baby Feeding Law Group (BFLG) was formed by health worker organisations, consumer groups and the IBFAN group. Its variable membership comprises about 16 organisations – for example, key professional bodies such as the Royal College of Midwives and the Royal College of Nursing, the mother-support groups and the UK's UNICEF Baby Friendly Hospital Initiative. Together this group is a powerful force, and has campaigned on several issues relating to health policy in the UK and the Government's position in international fora (the group persuaded the Government to support the science-based recommendation of exclusive breastfeeding until 6 months of age and of 6 months as the appropriate age to introduce complementary foods for all infants).

Many UK professional bodies, including members of the BFLG, accept sponsorship and advertising revenue from baby food companies, permitting companies to participate in conferences where they go well beyond the permitted distribution of scientific and factual information to health workers. Branded gifts – pens, mug mats, stress relievers and calendars – are given out freely. Health professionals are given incentives such as 'cool bags' to join mailing lists. Through open discussion of these difficult issues, the BFLG encourages its members to bring their policies into line with the Code and Resolutions, slowly improving their positions in relation to sponsorship and conflicts of interest.

Over the years, the IBFAN group and the members of the BFLG have submitted, as part of consultations, comments to various Government departments, such as guidelines issued to the Trading Standards Offices, which are responsible for enforcing the UK law, and to the Food Standards Agency (FSA). The FSA aims to be an independent watchdog to protect the public's health in relation to food and to manage food safety and nutrition. Many of the policies and practices developed by the FSA have been transferred to the equivalent European body, the European Food Standards Agency. The IBFAN group has also submitted comments to the UN Committee on the Rights of the Child (when it was reviewing the UK Government's compliance with the UN Convention on the Rights of the Child) on the Government's failure to implement the Code and Resolutions fully.

In 1999, the Infant and Dietetic Foods Association formed an NGO of its own, INFORM (although this did not have a structure of its own and was thus a quasi-organisation), which claimed that it campaigned for a mother's right to information on infant feeding issues. Not all of its materials mentioned that INFORM was an industry initiative. Its materials included a free phonecard for members of the public to telephone for further information. When they did so, INFORM took name and address details and passed these on to infant feeding companies which then sent information and samples through the post. The industry is also present on some Government committees, commenting on food quality and labelling issues.

In the UK, the Trading Standards Authority, a state-financed and state-run network, is responsible for enforcing the country's *Infant and Follow-on Formula Regulations*, but it does not conduct routine monitoring. In July 2003 the first case to come to court resulted in the conviction of Wyeth/SMA for illegal infant formula advertising (SMA is a breastmilk substitute brand name, which Wyeth gave to a subsidiary company

when restrictions were placed on promoting brand names)<sup>42</sup>. The company was fined £60,000 (US\$96,000) including costs. In contesting the case, the company, on behalf of IDFA, challenged the legitimacy of the ban on advertising to the general public as a ‘fetter to the free movement of goods.’

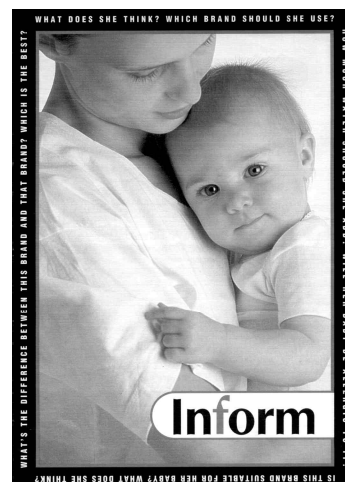
The UK national IBFAN group carries out monitoring on an ad hoc basis and responds to violations reported by members of the public. Complaints are sent to the offending company, the independent, but Government mandated, Advertising Standards Authority, the particular magazine, shop or other channel which carried the violation, or the Minister for Public Health and Trading Standards. As one Case Study respondent commented, however, *‘all monitoring of adverts/sales practices etc. seems to be after the event and then the damage is done even if the advert is withdrawn.’* For each baby born in the UK, the baby feeding industry spends at least £20 (US\$32) per baby promoting its products, while the Government spends £1.60 (US\$2.6) to promote breastfeeding<sup>43</sup>.

Advertising of infant formula within the largely publicly funded health care system is permitted under UK law. Outside the health care system advertisements for infant formula are rare. Companies generally restrict their promotion in the mass media and to the public directly to follow-on formula or to brand names that encompass a range of products including infant formula. In parenting magazines, which are popular, babies portrayed in the adverts for follow-on milks often appear younger than 6 months old. Moreover, the similarity between the packaging for follow-on milks and that for infant formula from the same company means that a reader could easily gain the impression that the product advertised was for a young baby.

Companies are always competing with each other to devise new marketing strategies and products. Sales representatives hold events in pharmacies to give out samples and leaflets to mothers with babies. New packaging, such as small sachets of formula for individual ‘one-time’ use and special ‘feeding systems’ are promoted. Strategic shelf placement of products is important. The Sales Director of Cow and Gate/Milupa, Ian Thomas, is quoted as saying in 1997<sup>44</sup>: *‘We suggest milk is merchandised on the left hand side of the fixture, followed closely by an early weaning block – jars and packet foods from 4 months – to stop mums drifting into home-made foods.’*

One of the most alarming marketing trends in the UK is the manufacture, promotion and sale of so-called special milks, which claim to remedy a baby’s slow weight gain or common feeding occurrences such as possetting, and which are designed to appeal to mothers who are breastfeeding and artificially feeding. Companies claim that they fall under the EU Directive relating to medical foods rather than that covering infant and follow-on formulas, and so the infant formula marketing restrictions do not apply.

Baby Milk Action is currently the secretariat for the International Nestlé Boycott Committee (the boycott first began in the US in 1977 and has now been launched by national groups in 20 countries). It is a co-ordinating centre within IBFAN on trade issues and NGO capacity building. It has achieved noteworthy victories, such as bringing a successful challenge before the UK Advertising Standards Authority in May 1999 against a Nestlé anti-boycott advertisement in which the company claimed to market infant formula ‘ethically and responsibly’. The group was instrumental in bringing about a Public Hearing on Nestlé at the European Parliament in November 2000 at which the IBFAN group from Pakistan presented evidence of violations. Nestlé’s refusal to attend the public hearing turned out to be a public relations disaster for the company. Baby Milk Action owns a token number of shares in Nestlé, enabling a representative to attend annual shareholder meetings to raise issues of concern directly with the board in front of other shareholders.



#### Inform leaflet

Campaign leaflet launched to argue for freedom of information for mothers. It poses the questions: *“What does she think? Which brand should she use? Is this brand suitable for her baby?”* But it doesn’t reveal *Inform* is a front for the baby food industry. People contacting its information line received unsolicited promotional mail from baby food companies.



#### Give Nescafé the boot!

The Nestlé boycott not only puts pressure on the biggest violator of the Code and Resolutions, it keeps the baby milk issue in the public eye. Logos such as this, reproduced on leaflets and t-shirts, show how campaigners have learned the power of marketing. Wherever Nestlé products are sold, there is an opening for boycott supporters to voice their concerns over Nestlé’s baby food marketing malpractice.



## Key facts - Kenya

Population	<b>31,293,000</b>
Under 5 mortality rate/1000	<b>122</b>
Infant mortality rate/1000	<b>78</b>
GNI per capita (US\$)	<b>340</b>
Life expectancy at birth	<b>50</b>
% Exclusively breastfed (<6 months)	<b>5</b>
% Breastfed with complementary foods (6 - 9 months)	<b>67</b>
% Still breastfeeding (20 - 23 months)	<b>24</b>
% of population using improved drinking water sources	<b>88 (urban) 42 (rural)</b>
% of population using adequate sanitation facilities	<b>96 (urban) 82 (rural)</b>

*State of the World's Children 2003, UNICEF (most figures 2001)*

## Kenya – a voluntary code

To develop a Kenyan Standard, all relevant stakeholders, such as industry, consumers and relevant Government departments, have by law to be represented on the committee drawing up the relevant code. Thus the baby milk industry was involved in drafting the 1983 Kenyan Code and may have influenced the Government to opt for a voluntary code through the Bureau of Standards rather than legislation (Kenyan standards are mandatory only if a company applies for a quality certification). This stance has been taken despite the fact that sales of breastmilk substitutes in Kenya are at present relatively small. It appears that the industry does not wish to be constrained from developing the market.

The Kenyan Code was revised in 1999 to include the WHA Resolution on exclusive breastfeeding for an infant's first six months followed by continued breastfeeding for at least two years, and the WHO recommendation that milk substitutes for lactose intolerant infants should be used only under the recommendation of a health professional. The Technical Committee of the Bureau of Standards includes government departments, NGOs and the industry.

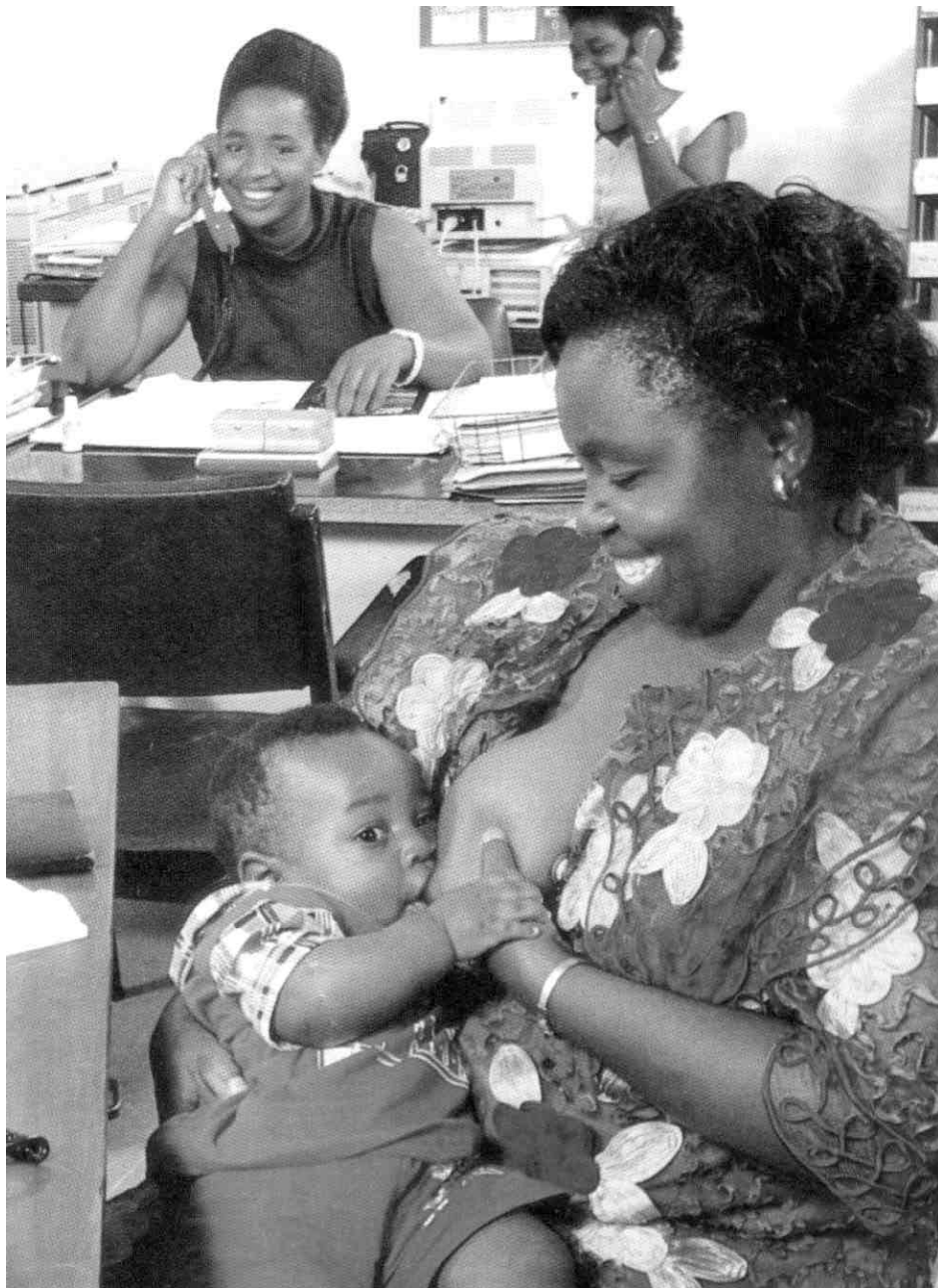
The Kenya Bureau of Standards is responsible for monitoring its code, but the Bureau is under-resourced and relies mostly on the goodwill of companies to comply. IBFAN groups have conducted their own monitoring initiatives and have found that some manufacturers not only continue to violate the provisions of the code but are also taking advantage of problems such as HIV and emergencies to push breastmilk substitutes.

A recent development has been 'healthy baby' competitions, which encourage mothers to feed their infants complementary foods at an early age so as to win fabulous prizes.

The under-resourced Kenyan health care system is an easy target for companies. Nurses interviewed for the Case Study claimed that infant formula donations were a thing of the past, but mothers still receive free supplies in hospitals. Representatives of baby food companies also visit health facilities to talk with mothers attending postnatal and antenatal classes.

IBFAN's three groups in Kenya, the Breast-feeding Information Group (BIG), the Kenya Food and Nutrition Action Network (KEFAN), and the Consumer Information Network (CIN) continue to lobby to strengthen the weak Kenyan regulations. The groups sit on the National Infant Feeding Steering Committee of the Ministry of Health, which aims to reinforce implementation of the Kenyan Code, and have conducted their own monitoring exercises. Industry continues to lobby to get themselves on this Committee, but so far to no avail. One Committee member told the Case Study researchers that the involvement of manufacturers might compromise the Committee's goals.

The Consumer Information Network has attempted to use European Union (EU) export measures to target Code violations within the country made by EU-based manufacturers. An EU Council Resolution requires companies to comply with the *International Code* in 'third countries'. To date, however, the EU has taken no action in response to reports of these violations or reports from NGOs in other countries. The EU Commission was called upon to review operation of these measures at the European Parliament Public Hearing into Nestlé in November 2000, but has still not done so.



## Key facts - Mexico

Population	<b>100,368,000</b>
Under 5 mortality rate/1000	<b>29</b>
Infant mortality rate/1000	<b>24</b>
GNI per capita (US\$)	<b>5,540</b>
Life expectancy at birth	<b>73</b>
% Exclusively breastfed (<6 months)	<b>38</b>
% Breastfed with complementary foods (6 - 9 months)	<b>36</b>
% Still breastfeeding (20 - 23 months)	<b>21</b>
% of population using improved drinking water sources	<b>95 (urban) 69 (rural)</b>
% of population using adequate sanitation facilities	<b>88 (urban) 34 (rural)</b>

*State of the World's Children 2003, UNICEF (most figures 2001)*

## Mexico – also a voluntary code

The Mexican Case Study concluded that:

*The infant formula and infant food industry is inside all the issues related to infant nutrition and mother and child care. Company representatives are present in almost all the activities of teaching, research and sponsoring health professionals.*

Industry involvement in Mexico goes back to the 1950s when the industry promoted a deal with various social insurance bodies and unions to provide free supplies of breastmilk substitutes to mothers 'unable to breastfeed' for the first six months of their babies' lives. Moreover, the industry, primarily Nestlé and US company Mead Johnson, has sponsored much of the research and conferences at the National Institute of Medical Science and Nutrition from which most of the Government research on infant feeding has emanated since 1946.

Putting pressure on governments to counter that of industry has been essential in most countries in getting the Code and Resolutions implemented. National groups have often gained support from international initiatives to enable them to do this. In Mexico, for instance, attempts to include at least some aspects of the Code within national legislation were given an added impetus by two activities: a media campaign highlighting the international boycott of Nestlé; and IBFAN deciding to hold its two-year international meeting, with UNICEF support, in Mexico in 1984. At the meeting an umbrella group for Mexican NGOs working on women and children's health was formed (Red de Grupos para la Salud de la Mujer y del Niño – REGSAMUNI). REGSAMUNI proved to be critical in lobbying the Ministry of Health, which eventually brought in some restrictions on infant food promotion in the *Law of Health Regulation for sanitary control of activities, stores, products and services matters*, published on 18 January 1988.

An IBFAN group in Mexico was officially formed in 1985 by individuals closely connected in different ways with mother and child care. Since 1988, it has been organising the boycott of Nestlé products in the country (the international boycott was suspended in 1984 when Nestlé promised to abide by the Code, but relaunched in 1988 when Nestlé was found to have broken its word).

Mexico has implemented several of the provisions of the Code in national law, but rather than a single piece of legislation, implementation is scattered throughout 6 rules and regulations, such as including labelling provisions in regulations on product quality.

Efforts to implement the Code and Resolutions fully in legislation in Mexico, however, were set back in 1991 when the Government agreed with the industry to establish a voluntary code. The industry was keen to be seen to be doing something following the Nestlé Infant Formula Audit Commission report which found widespread free supplies (see page 14) and before the launch in Mexico of UNICEF's global Baby Friendly Hospital Initiative (see page 44). The Mexican National Board of Manufacturers and Distributors of Breastmilk Substitutes was founded at this time to sign an agreement with the Government, promising to stop distributing breastmilk substitute samples and free and low-cost supplies. The agreement was ratified on 30 May 1995 and again on 24 July 2000. Under this agreement, manufacturers and distributors promise to:

*establish control instruments to guarantee that all promotion and marketing of infant formula is done in conformity with the principles and aims of the*



### Taking directions from Nestlé

A road sign in a Mexican village near Xalapa is adorned with the Nestlé Infant Food name and blue bear logo.

**International Code of Marketing of Breastmilk Substitutes (WHO) and of the official regulations in country.**

As always, however, the devil is in the detail. Taken together, the various rules and regulations do not live up to the agreement's promise to conform to the Code. Specifically, they allow advertising and promotion of infant formula if they include information on the benefits of breastfeeding and if materials:

*expressly indicate infant formula use is only recommended in the following cases: a) baby's human milk intolerance, b) because absence of mother, and c) because incapacity of mother to produce milk or because any other sustained sanitary reason.*

Mexico has no regulations reflecting the Code's provision on requiring the information provided to health workers to be scientific and factual only.

Free supplies remain widespread. Many health workers receive supplies for their own infants from company representatives, donations that influence their own attitude towards breastfeeding - many regard the UNICEF Baby Friendly Hospital Initiative, which aims to change hospital practices to support breastfeeding, as a politically-motivated attempt by the government to save money on infant formula by encouraging 'free' breastfeeding.

Companies attempt to forge close links with health workers. In 1985, the Mexican Foundation of Health was set up, a private philanthropic institution linked to the Nestlé Fund for Nutrition. The Foundation focuses on training health professionals in nutrition, particularly in medical schools, and influencing health policy. One of its main activities is organising and hosting the Nestlé Conference of Nutrition. The Foundation's Technical Board Committee comprises representatives from Nestlé Mexico and the International Board of Companies.

Another Committee member is the Mexican Academy of Paediatrics, which is also sponsored by Nestlé. The company logo appears on the Academy's publications, notices, announcements and website. Another major manufacturer, Gerber, also sponsors the website of the Mexican Association of Paediatrics, while Wyeth has sponsored prizes for the best paediatric thesis. The Mexican Society of Paediatrics endorses advertising of Curity baby bottles, while the National Federation of Paediatrics supports AVENT products.

The international IBFAN network has been at the forefront of helping countries to draft national legislation. The IBFAN Mexico group has taken up this task at national and regional levels. In February 2002, it held a course in Mexico for representatives from the Ministries of Health, Commerce and Industry and related departments, and Members of Parliament from several Latin American countries. A draft model law for Latin America was developed by participants, putting the Code and Resolutions into appropriate legal language.

IBFAN's monitoring reports, which demonstrate widespread violations of this voluntary code as well as the *International Code* and Resolutions, are part of its campaign for tougher action.



**No controls**

The marketing of feeding bottles and teats is not even covered by the Mexican voluntary code.



**Violation**

Free samples such as this are received on a regular basis by Mexican hospitals.

Note the idealizing images.

## Key facts - Bolivia

Population	<b>8,516,000</b>
Under 5 mortality rate/1000	<b>77</b>
Infant mortality rate/1000	<b>60</b>
GNI per capita (US\$)	<b>940</b>
Life expectancy at birth	<b>63</b>
% Exclusively breastfed (<6 months)	<b>29</b>
% Breastfed with complementary foods (6 - 9 months)	<b>76</b>
% Still breastfeeding (20 - 23 months)	<b>36</b>
% of population using improved drinking water sources	<b>95 (urban) 64 (rural)</b>
% of population using adequate sanitation facilities	<b>86 (urban) 42 (rural)</b>

*State of the World's Children 2003, UNICEF (most figures 2001)*

## Bolivia – legislation pending

Bolivia adopted a national regulation in 1984 to protect infant nutrition, based on the recommendations of the *International Code*, but it does not have the force of law.

IBFAN Bolivia was founded in 1987 as a non-profit private voluntary organisation under the legal umbrella of AIS/HAI Bolivia (Health Action International Bolivia) and only later became part of the IBFAN Latin America network and IBFAN worldwide.

In 1992, the infant feeding industry managed to ward off legislation by agreeing to a voluntary code with the Government. IBFAN Bolivia has kept up pressure for legislation, and a draft law went before Parliament in 2000. Since then, however, this draft has languished and has been accompanied by a marked decline in Government support for all initiatives associated with breastfeeding. IBFAN attributes this to the Government's support of free trade policies and its desire to put Bolivia clearly into the global market. The Bolivian Government seems torn between giving into the pressures from free trade adherents, supported by international trade agreements and the baby food industry, and fulfilling the wishes of many in the community to protect infant health.

Confronted with this support for free trade, IBFAN Bolivia is now working to raise awareness at community level and among civil society organisations of infant feeding issues and to encourage them to lobby and put pressure on politicians. IBFAN Bolivia believes that information is the most powerful tool in stirring up political will to act in the interests of infant health and survival.

IBFAN Bolivia is a full member of the country's National Committee for Breastfeeding Promotion and has been delegated by the Committee to monitor the country's voluntary code periodically, although no official protocol is in place. Thus it has carried out monitoring in 1993, 1997 and 2000 with support and technical assistance from the international IBFAN network, IBFAN's International Code Documentation Centre in Malaysia, and UNICEF in Bolivia. Industry has had no involvement with this monitoring.

IBFAN Bolivia publishes its monitoring reports detailing the violations and the companies involved and distributes them widely, both throughout Bolivia and internationally. The violations of greatest concern are that companies continue to promote their products within the health care system, including providing incentives to health workers, and to retailers to display their products prominently. The results of the monitoring within Bolivia have been endorsed by the Bolivian offices of UNICEF and WHO and the authorities of the Bolivian Medical College. IBFAN invited more than 200 representatives of the community, members of parliament and national authorities to the official presentation of its monitoring results in 2001. International support lent weight to the national efforts. Guests from NGOs in Europe (WEMOS), Canada (INFACT) and Spain (CECU) and from Consumers International endorsed the results. The mass media and many independent journalists were invited.

The Bolivian voluntary code does not provide for any sanctions against infringement, and no company has ever been charged with breaking the code's rules. Companies do care about their public image, however, and have become careful not to violate the code in too obvious a manner to avoid the risk of their being targeted in the mass media as unethical with a resulting loss of public support. Nestlé has shown particular interest in IBFAN Bolivia's activities with representatives for Latin America sometimes approaching IBFAN Bolivia to ask if it has found any company violations.

IBFAN regularly produces a wide range of pamphlets, posters, magazines, manuals and leaflets. It also produces a daily radio programme for the extensive network of regional radio stations, which stresses the benefits of breastfeeding and the need for regulation. It has produced videos describing not only the national situation but also the experience of Code implementation in other countries, such as India, Pakistan and Brazil, based on footage provided by partner IBFAN groups. The main constraint for these activities is finance.

In recent years, the number of NGOs involved in advocacy and campaigning on the issue of infant feeding in Bolivia has been diminishing. Without official support from the Ministry of Health, their strength is weakening. These organisations usually have to rely on other sources of financial support as the Government is not forthcoming. Other IBFAN partner groups in Europe and Canada are able to give some financial support. IBFAN Bolivia has a policy of not accepting grants from industry, corporations, political parties or commercially oriented institutions.

Besides IBFAN, four other organisations are involved in advocacy and campaigning on infant feeding in Bolivia: COTALMA, La League Lait, PROCOSI and UNITAS. COTALMA offers training to health professionals and carries out research. La League Lait provides training and information to community, women's and mothers' groups and prepares educational materials. PROCOSI, funded by USAID to work in the health sector, conducts field research into infant nutrition, distributes vitamin A and iodine, and is involved in vaccination, reproductive health and other programmes related to family planning. UNITAS is a network focusing on food security issues, which promotes breastfeeding (to a certain degree) through its community education programmes (mainly publications) and its operational research into food security.

The baby feeding and pharmaceutical industry maintains a strong hold over national authorities in Bolivia. There has been an increase in commercial sponsorship, particularly aimed at health professionals. It regularly provides financial support for events attended by medics, nutritionists and pharmacists. The monthly bulletin of the Bolivian Paediatric Society receives Nestlé's financial support.

IBFAN Bolivia submitted a formal complaint to the Board of Directors of the Bolivian Medical College about a certificate granted by the Bolivian Paediatrics Association to Nestlé in 1998, which claimed that '*Nestlé fulfils the regulations of the International Code and contributes to improve infant nutrition in Bolivia*' (sic), because neither claim was true. In response, the Board simply demanded an explanation from the Paediatrics Association. This example illustrates that the relationships between promoters of breastfeeding and medical associations are not always smooth or free from controversy. IBFAN Bolivia has tried, however, to keep open good channels of communication with the medical associations, which sometimes endorse IBFAN actions.

The Ministry of Health of Bolivia granted a certificate to Nestlé in 1999 claiming that the company operates in Bolivia according to the regulations of the *International Code*, when once again evidence clearly demonstrated that this was not the case. Nestlé published the letter alongside others in a book which it distributed around the world. The book later became a public relations disaster for the company when it became apparent that Nestlé was misrepresenting letters it had published and had to apologise.



### Special displays do not happen by accident

This Wyeth brochure for storekeepers in Bolivia, exposed in the 1998 *Breaking the Rules* report, explains how to present *Isomil* and *Promil* formulas in an attractive and eye-catching way.



### Wyeth's new design

Wyeth produced and distributed these 'shelf-talkers' in Bolivia for displaying alongside products in shops to draw attention to the 'new design'. As well as being eye-catching, they stress the 'excellent quality' of the product.



## International Forum 1989

IBFANers from around the world gathered in Manila to celebrate the 10th anniversary of IBFAN's formation and to discuss progress and plan future strategy.

Local organisers built on media interest to launch boycotts of the major violators of the marketing requirements in the Philippines.

IBFAN groups meet periodically at regional meetings. The global IBFAN Coordinating Council meets about every two years.



### 3. Discussion and conclusions

IBFAN's overarching strategy has been to pursue the virtuous cycle of international standards, national measures and independent monitoring, working with other governmental and non-governmental organisations, to protect breastfeeding. Lessons learned through monitoring company practises on the ground feed back to inform policies at international and national level. Efforts to protect breastfeeding and appropriate infant feeding practises in general, take place alongside efforts to promote and support breastfeeding. Together, protection, promotion and support are achieving increases in breastfeeding rates in many countries (see right).

IBFAN's work focuses on protection. Baby food marketing is increasingly regulated. Threats to these gains are detected early and, to varying degrees, countered.

#### The success of IBFAN's strategy

IBFAN was formed to campaign in the first instance for a strong *International Code of Marketing of Breastmilk Substitutes*. Although not all of its wishes for the Code were taken on board, it is fair to say that the majority did find their way into the final draft. The success of this is perhaps demonstrated by the opposition to the Code from the International Confederation of Infant Formula Industry, who described it as 'irrelevant and unworkable'<sup>45</sup>, though they later promised to abide by it and today claim that they are doing so.

The decision to adopt the Code as a Recommendation rather than as a Regulation, which would have given it a status in international law requiring its adoption by WHA Member States was a serious weakness (see page 17). However, other international agreements such as the *Innocenti Declaration*<sup>46</sup> of 1991 and the Convention on the Rights of the Child have given the Code<sup>47</sup>, and the subsequent, relevant Resolutions clarifying and amplifying it, a legal status beyond the moral authority of the WHA.

One of the strengths of the Code is its requirement for a review every two years. A weakness is that these reviews focus on the call for governments to implement the Code and Resolutions, and that reviewing company compliance is taken by WHO to be outside its mandate. This interpretation does perhaps have political overtones as successive WHO Director Generals have promoted 'partnerships' with industry, particularly with pharmaceutical companies, many of which also produce breastmilk substitutes, to meet its requirements for resources, either in kind or cash. The influence of industry over WHO policy in a whole host of areas is something the NGO sector frequently alleges and denounces.

The reviews have allowed the Code to keep pace with developments in scientific knowledge and marketing practices and to address questions of interpretation. For example, the wording in the Code allowing 'free supplies' of breastmilk substitutes in certain circumstances was exploited by companies to justify widespread distribution of supplies, prompting the Assembly first to try to clarify those circumstances, then finally to adopt a Resolution in 1994<sup>48</sup> stating there should be '*no donations or free or subsidized supplies of breastmilk substitutes and other products covered by the International Code of Marketing of Breastmilk Substitutes in any part of the health care system.*' This gives a very clear instruction to companies (which have taken a decision to dispute the status of the Resolution) and clear criteria to be monitored by governments and NGOs.

As another example, the appropriate age of introduction of complementary foods has been addressed several times. In 1994 this was set at about 6 months, updating

#### Exclusive breastfeeding gains

More infants are gaining the irreplaceable benefits of exclusive breastfeeding during their first four months, according to data from 35 developing countries.

Rates have increased in the 21 countries listed below.

Iran achieved the highest average annual increase in breastfeeding, 6 percentage points, followed by Brazil and Zambia. Breastfeeding rates have declined in Colombia, Jordan, Kenya, Kyrgyzstan, Morocco and Tunisia.

Breastfeeding gains stem from initiatives to publicise the benefits to both mother and child and to prohibit the advertising and promotion of breastmilk substitutes, feeding bottles and teats.

Country	% Exclusively Breastfed at 4 months	% pt. increase per year
Iran	66	6
Brazil	42	4
Zambia	27	4
Burkina Faso	12	3
Egypt	53	3
Madagascar	61	3
Malawi	11	3
Nicaragua	30	3
Peru	63	3
Philippines	47	5
Ghana	19	2
Sri Lanka	24	2
Tanzania	41	2
Yemen	25	2
Cameroon	15	1
Dom. Rep.	25	1
Indonesia	53	1
Mali	13	1
Senegal	16	1
Togo	15	1
Zimbabwe	16	1

Text and table from:  
UNICEF *Progress of Nations 1999*



the 4–6 months used in the Code. The failure of companies to comply with the Resolution forced IBFAN to bring this issue to the WHA repeatedly, prompting WHO to conduct an extensive review of scientific studies and to put forward a Resolution in 2001 clearly stating the recommendation that infants be exclusively breastfed for the first 6 months. This requirement has also been incorporated in WHO's *Global Strategy for Infant and Young Child Feeding*, adopted in 2002<sup>49</sup>, another important tool for the promotion and protection of appropriate feeding practices.

Ten Resolutions clarifying and amplifying the *International Code* had been adopted by 2002. Behind all of these Resolutions lies a great deal of work by IBFAN in researching and developing appropriate policies, communicating these around the network, lobbying at national level to brief delegations to the WHA and lobbying at the Assembly itself.

The same strategy of pursuing global standards is repeated at other relevant international policy-setting bodies such as the International Labour Organisation (on rights for working women), the World Summits for Children and the Codex Alimentarius Commission. The last of these, Codex, was early perceived by IBFAN to pose a threat to all the gains that have been made, as it is Codex standards, rather than WHA Resolutions, that the World Trade Organisation defers to in deciding if a national regulation is justified on health grounds or is an unfair barrier to trade. The dominance of Codex meetings by industry-linked or industry-funded delegates and lobbyists demonstrates that industry has drawn the same conclusion.

The IBFAN network enables groups in both industrialised and developing countries with particular expertise to share this with groups in other countries. Most IBFAN groups are staffed by volunteers and all attempt to raise their own resources for their work. The funding support of IBFAN groups with access to development budget lines in donor countries has been important, particularly in bringing advocates from developing countries to international fora to raise their concerns directly.

## Implementing the *International Code* and Resolutions

Having measures at an international level has been invaluable for bringing in measures at a national level, though it is a regrettable facet of industry intransigence that arguments won at the WHA have to be repeated in every country. Support in terms of training of national groups and policy makers, global exposure of company malpractice and letter writing campaigns to politicians has sometimes been critical in moving forward implementation at a national level.

All the Case Study countries have implemented the *International Code* and Resolutions to some extent: The Case Studies illustrate that struggles over the Code and Resolutions are never over. So, whereas those in Bolivia and Kenya may feel that getting the measures implemented in national law is the priority to protect breastfeeding, the Indian Case Study indicates that getting the law enforced is the next hurdle, while further down the line is the task of tackling marketing practices not covered by the existing implementation of the Code and Resolutions (such as depicting older infants or promoting complementary foods, or advertising different foods of the same name and packaging as infant formula). Constant pressure on governments as well as industry is needed.

Even if a government actively supports the Code and Resolutions, such as in India and Brazil where the governments tried to protect breastfeeding even before the WHA approved the 1981 *International Code*, legislation can still be delayed because of the influence of industry on parliamentarians. Indeed, of all the Case

Study countries, India was one of the last to implement the Code in some form. This experience has convinced NGOs in India that it is critical to focus on parliamentarians, whereas the NGOs in other Case Study countries emphasise medical professionals, government departments and the general public as their major targets. The European experience of lobbying on EU Directives has shown the importance of lobbying parliamentarians, but also critically important has been the networking at national level with health professionals and other public interest stakeholders. Policy makers need to hear the consistent message that it is essential to implement the *International Code* and Resolutions from health and social justice advocates to counterbalance industry pressure and the general perception that increased trade and market growth is always desirable. Otherwise the lobby can fail at the final hurdle.

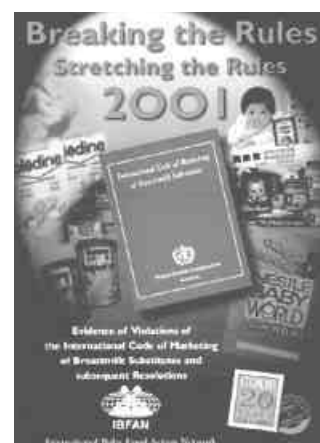
All the Case Study countries have signed the *International Convention on the Rights of the Child*. The UK IBFAN group, Baby Milk Action, has succeeded in using the monitoring mechanism for the Convention to flag up the Government's failure to implement the Code and Resolutions. The UN Committee on the Rights of the Child called on the Government to do so and other IBFAN groups are pursuing the same strategy.

## Enforcing the Code and Resolutions – the need for independent monitoring

Monitoring is the key to IBFAN's success. At a national level monitoring helps to achieve the primary objective of saving infant lives by exposing and stopping some of the malpractice. It also demonstrates the need for legislation or the need to strengthen existing measures. It identifies new marketing strategies. Monitoring feeds back up to the international level and informs the issues to be addressed in the reviews every two years of the Code and Resolutions at the WHA. It provides evidence to the UN Committee on the Rights of the Child when implementation of the Code and Resolutions is considered and to events such as the European Parliament Public Hearing into Nestlé malpractice. Monitoring also identifies the worst culprits, showing Nestlé to be far ahead of its industry competitors in terms of the scale of violations and the degree of contempt for the provisions of the Code and Resolutions, and is used in promoting the international Nestlé boycott.

Even though companies have tried to stall or prevent legislation, they have been largely kept out of monitoring national measures or the *International Code* and Resolutions (a company's obligation, independently of government measures, to ensure that company conduct at every level conforms to the Code's provisions, as set out in Article 11.3, remains). In practice, monitoring is mainly carried out by NGOs and not the government, either by default – because the government is not doing anything – or by delegation – in Bolivia, the relevant government body has appointed IBFAN to monitor. However, because of a lack of resources monitoring is not systematic or constant.

NGOs are also involved in letting the authorities know about the violations they discover as a result of their monitoring. Indeed, in India, two IBFAN groups have been officially delegated to do so (along with two government bodies), although Nestlé is challenging this. Several countries provide for sanctions if a company infringes national laws but the English and Belgian fines are paltry compared with revenue from sales of breastmilk substitutes. Of all the Case Studies, only India mentioned companies actually being prosecuted – and one of those cases (against Nestlé) has become stalled in the courts. In the summer of 2003 Wyeth was successfully prosecuted in England by the Trading Standards Authority.



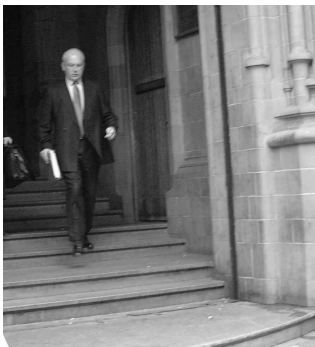
### ***Breaking the Rules***

IBFAN's periodic international monitoring report ensures that aggressive marketing by baby food companies does not go unnoticed.



### Tightening regulations

'Humanized' images have long been banned from labels in Brazil. It has taken clarifications when the regulations have been revised to prompt companies to remove animal figures, such as the *Similac* bear.



### Guilty as charged

The UK's Trading Standards offices are responsible for enforcing the *Infant Formula and Follow-on Formula Regulations* introduced in 1995. Companies were only ever warned about malpractice until 2003, when a criminal prosecution was brought against Wyeth for an advertisement for its SMA brand.

The company was convicted and fined for a 'cynical and deliberate breach of the regulations'. The company director (who was also Chair of the UK industry body - pictured leaving court above), was criticised for being 'extraordinarily evasive throughout his cross-examination'.

In other countries authorities may stop violations through a warning when complaints are made, but seem reluctant to take up expensive court cases. The impact on the time and resources of NGOs is also a consideration. As the Bolivian Case Study commented, *'the legal and judiciary system in Bolivia is slow and cumbersome; it is often under the sway of politicians and influential individuals; corruption is high; and legal actions take time and money.'*

But the lack of prosecutions or the fact that sanctions are weak do not mean that legislation or monitoring is ineffective. In England, Wyeth's fine for illegal advertising amounted to 3 minutes turnover for the company. The adverse publicity and the precedent were far more important. In Brazil, the industry is more compliant with national legislation, particularly since the Government stepped up its monitoring, without legal actions being brought. Generally, the industry would seem to be more aware of damage to its image than before, as publicising the results of monitoring has a negative effect on a company's reputation and credibility, even if there are no legal repercussions. Although violations continue, the Case Studies suggest that certain kinds of baby food promotion can be targeted, even if a country, such as Bolivia, has not implemented the Code and Resolutions in national legislation. National measures and the very existence of the *International Code* and Resolutions have clearly made a difference by acting as a benchmark or standard to which those concerned with people's survival and health can continue to hold corporations to account.

Naming and shaming powerful corporations takes courage as the results are not welcomed. Companies are disparaging of IBFAN's monitoring and either deny violations, accuse monitors of hoarding violations instead of reporting them (as if the violations were unknown to the people who instigated them) and dispute the interpretation of the Code and Resolutions. The strategy is to label the monitoring as somehow biased, extending this complaint to any organisation or grouping which criticises company marketing activities. The effective answer to this is to have the documentary evidence to back up the claims of malpractice, which IBFAN monitoring achieves. However, gaining media attention for monitoring results is another challenge. Baby food companies have a great deal of influence on the media as most have a wide range of products and so large advertising budgets. Companies sometimes threaten legal action against the media, which may be sufficient to persuade an editor to drop a story rather than having the inconvenience and expense of lawyers checking it is not open to challenge.

One sign that industry's attempt to marginalise and discredit IBFAN and other campaigners has failed is that they are now desperate to engage in 'dialogue' so they can say to other organisations and the public that they are in discussions to resolve the differences they have with their critics. Meeting for the sake of meeting, without clear terms of reference (including minuting and reporting procedures) and clear objectives is not seen as constructive by IBFAN. Industry's responsibilities are already clearly defined and the evidence shows that companies will comply if compelled to do so. The bad faith shown by the industry when bound only by voluntary codes, and its misrepresentation of past meetings means that a careful risk/benefit analysis is required before any meeting.

Those considering industry involvement in an initiative should question if anything is to be gained. It is worth recalling events surrounding UNICEF's Baby Friendly Hospital Initiative (BFHI) prior to its launch in Mexico in 1991. BFHI was, in part, prompted by the evidence of widespread free supplies of breastmilk substitutes in the country. Baby food companies pressed to be 'partners' in the initiative. IBFAN, which advocated an initiative free of industry involvement, met with the International Association of Infant Formula Manufacturers (IFM) in New York prior to the launch

to question whether companies would take action to end free supplies, voluntarily complying with WHA Resolutions. The message taken away was that companies would only stop distributing free supplies if compelled to do so. IFM has disputed the validity of WHA Resolutions and cited 'antitrust/competition laws' as prohibiting industry-wide undertakings being given (however, fear of antitrust laws has not prevented IFM from organising coordinated lobbying against WHA Resolutions)<sup>51</sup>. UNICEF finally took the route of keeping the initiative free from industry involvement and sponsorship and making a ban on free and low-cost supplies of breastmilk substitutes one of the requirements for a hospital to be certified 'Baby Friendly'.

The Case Studies indicate that the industry is active in all Case Study countries in the mass media, in professional medical associations and hospitals, and reaching out to the general public. Cause-related marketing activities, where a company links its name to a good cause under government or a charity's auspices, are also being seen.

New communication technologies have had different effects in different countries. In Bolivia, little effect was noticed, whereas in India, advertising on cable television networks reached such a height that the Government passed a law banning the promotion of infant formulas on cable television. Most Case Studies identified some sort of banned promotion through the media, mainly television and radio, but also magazines and newspapers.

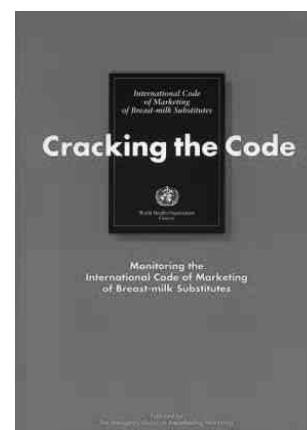
## Promoting health – breastfeeding versus artificial feeding

Promotion of breastmilk substitutes has an effect even if women cannot afford the products. All kinds of complementary foods and other milks, powdered and condensed, are given to infants at too early an age. In Bolivia, some mothers imitate artificial feeding practices they have seen in advertisements, but give teas, juices and water instead. In Kenya, the Case Study noted that *'exclusive breastfeeding is now rare but the use of infant formulas is not widespread either'*. Medical professionals in private hospitals seem almost guaranteed to promote bottle-feeding, whereas in public hospitals and clinics, the advice is mixed. Several Case Studies pointed out that women were often 'worried into' using breastmilk substitutes by promotion suggesting that their breastmilk was not sufficient or nutritious enough.

Lack of information and support includes a general lack of awareness among women and medical professionals of the benefits of breastfeeding, the hazards of artificial feeding, the correct way to prepare formula, and how to tackle breastfeeding problems. Promotion and encouragement of breastfeeding needs to accompany monitoring. In all the countries, there are range of activities such as mother support groups, and newer, imaginative ideas such as training postal workers in Brazil to promote the practice. The Case Studies looked in particular at: the UNICEF Baby Friendly Hospital Initiative; training; World Breastfeeding Week; and national policies on childcare, rooming-in and breastfeeding.

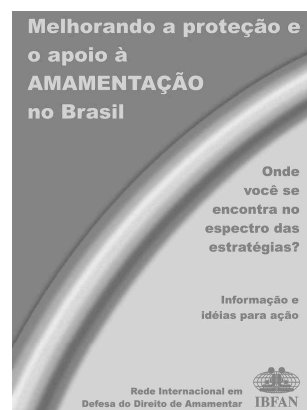
General initiatives stem from government and from NGOs. Indeed, except for Kenya, it seems that the governments of all Case Study countries are involved in some way in promoting breastfeeding (although some involvement is on paper only rather than active engagement). The Brazilian Government and NGOs seem particularly active in a range of initiatives, indicating that the Government practises what it preaches about breastfeeding.

All the countries have adopted and are pursuing the UNICEF Baby Friendly Hospital Initiative to some degree and the inclusion of the Code and Resolutions in the criteria



### 'Systematic' violations found by IGBM

Criticism of IBFAN's monitoring prompted 27 UK academic, church and development organisations to form the Interagency Group on Breastfeeding Monitoring (IGBM), which conducted monitoring in 4 countries and published the report *Cracking the Code* in 1997. IGBM found 'systematic' violations and UNICEF commented<sup>50</sup> that IBFAN's monitoring was 'vindicated'. The industry then attacked IGBM for bias, incorrect interpretation of the marketing requirements and poor methodology.



### Improving the protection and support of breastfeeding in Brazil - where are you in the spectrum of strategies?

The Brazilian IBFAN group launched its Case Study report at the national Milk Bank Conference in 2002 with key stakeholders.

This summary booklet was widely distributed, highlighting the action individual health workers and parents could take to support implementation of the Code and Resolutions and promote breastfeeding.

## The Ten Steps to Successful Breastfeeding

Every facility providing maternity services and care for newborn infants should:

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

Source: *Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services*, a joint WHO/UNICEF statement published by the World Health Organization.

can be very effective in removing promotion. Despite the fact that according to the Case Study authors, in some instances such as Bolivia and India, enthusiasm has declined in recent years, the Initiative does seem to have improved practices within hospitals and with the training of staff. Difficulties were cited with persuading health care staff to comply with all the steps in addition to their other work, especially if they are not paid or are underpaid. Other major drawbacks cited were that only a limited number of hospitals or clinics providing maternity services are certified; private hospitals do not appear to be interested in the initiative; there is little or no monitoring once hospitals have been certified and in some cases certified hospitals use certification to promote themselves but do not continue to follow the standards. In Mexico, some health care staff regard the Initiative as a political measure imposed upon them by the Government; others regard the promotion of breastfeeding as a means for the Government to cut down on its public expenditure, in this case, on the provision of formula.

This would suggest that those supporting breastfeeding need to take account of other government trends which result in cuts in public health expenditure. In general, the Case Studies do not analyse the effects of structural readjustments and free market reforms on health systems but they do show that private hospitals tend to promote bottle-feeding more than public ones, and that it is difficult, if not impossible, for NGOs or governments to have access to private facilities or to regulate them. If governments have to cut their public health budgets still further or are compelled to allow further competition in health 'markets,' the baby food companies may well exploit this.

NGOs and governments undertake various initiatives to train staff in breastfeeding support, although government commitment to these varies – they are given top priority in Brazil, but much lower priority in India.

All countries celebrated World Breastfeeding Week<sup>52</sup>, and the Case Studies give the general impression that it is a worthwhile effort. In most countries, the major impetus comes from NGOs, although governments may endorse the activities, as in Bolivia, or actively engage and even lead them, as in Brazil.

The Case Studies looked at various standards of the International Labour Organisation (ILO) governing maternity leave and breastfeeding at work<sup>53</sup>. Not all the Case Study countries conform to ILO standards governing maternity leave and breastfeeding at work. In Kenya it was mentioned that the Government did not want to sign up to the ILO standards for fear of losing its competitive advantage concerning child labour. For all countries, however, it seems that even if some legislation is in place on work and breastfeeding, it is not necessarily implemented or followed; and workers and employers are not necessarily aware of legislation so do not follow it or ask for it to be implemented. Moreover, the legislation can be selective in terms of its coverage – for example, only insured workers are covered in Mexico, only full-time workers in Bolivia, and only formal sector workers in India.

Political priorities can also shape a government's attitude to infant feeding. To be seen to be helping the disadvantaged, several of the Case Study governments have, at times, distributed free powdered milk or milk tokens, usually with the encouragement of the industry. The UK Government, elected in 1997 with a pledge to reduce social inequalities, is reforming the Welfare Food Scheme, a universal benefit which was set up after the second World War. In the consultations with the Government, IBFAN and other NGOs highlighted the way that the milk tokens (which had greater monetary value when exchanged for formula), and the commercial promotion of artificial feeding permitted in the health care system, were undermining breastfeeding and infant health. In the proposed revised scheme, the

Government has decided to provide advice on 'healthy eating' and to allow the vouchers to be used to purchase family foods, so removing the implied disincentive to breastfeeding. In devising such strategies, IBFAN encourages governments to ensure that breastfeeding does not become promoted as something just for the poor – or for women in developing countries. A consistent message, which highlights the benefits of breastfeeding for all mothers and babies is important. Needless to say, the changes are being fiercely opposed by the baby food and milk industry.

Policy makers can also be prompted to protect breastfeeding because of its relevance to wider health concerns. For example, the growing concerns about high levels of obesity and other food related non-communicable diseases and the burden they place on health care systems, is prompting governments to consider the case against the irresponsible marketing of unhealthy processed foods. IBFAN's efforts have ensured that the benefits of breastfeeding throughout the life cycle are starting to be recognised – bringing the need for Code implementation right to the fore for policy makers who would otherwise not think about infant feeding. Once the economic factors are considered, governments themselves can become effective drivers for health protection.

## Strategies for the future

Each country and NGO has evolved different strategies to address their varying priorities. Bolivian groups felt that working with the (now quiet) Government breastfeeding committee had been the most successful strategy; Brazilian groups also emphasised that working with government departments had to be a priority, even though some were concerned about the dangers of getting sucked into government machinery. All countries highlighted the importance of the training of health professionals through various means.

Experience influences setting of priorities for the future. In Bolivia and Kenya, which currently have voluntary agreements only, the Case Studies suggest the priority is for the Code and Resolutions to be implemented in national law. All Case Studies conclude there is need for independent monitoring of corporate compliance with the Code and Resolutions, both to ensure companies are meeting their responsibilities and to evaluate the effectiveness of any government system in place. Monitoring general compliance with other international agreements and initiatives such as the UNICEF Baby Friendly Hospital Initiative 'Ten Steps' is also recommended. All agree that there needs to be more training and education on infant nutrition at all levels: schools, universities, government workers, medical professionals. The experience on the ground leads most IBFAN groups to conclude that the further WHA Resolutions are important for addressing new marketing techniques.

There seemed to be reasonable to good collaboration between various NGO sectors within the Case Study countries. Brazil in particular highlighted the importance of reaching out to other NGOs that are not so obviously concerned with Code matters or breastfeeding, such as groups working more directly with communities, women's groups and workers' groups. The UK group is a member of networks addressing corporate accountability, food safety and food security issues as well as linking with health worker organisations.

In times of economic hardship, it becomes harder to get people involved with NGO work. The Bolivia Case Study mentioned that because much of the work is unpaid and the economic situation in the country is deteriorating, most people's preoccupation is with earning whatever living they can.

Where breastfeeding rates are increasing, it is due to the efforts to promote

breastfeeding and because of the checks and balances on the baby food industry for which IBFAN and others have worked so hard. The groups and agencies working to protect infant health need continued resources to build on their achievements to date and, perhaps more importantly, to stop them being undermined. The baby food industry never sleeps in its attempts to find new ways to build its market.

### Do companies change when left to their own devices?

The advertisement shown right appeared in *Women's Own* magazine in the UK in 1961, before regulations were introduced.

The advertisement shown beneath is typical of many placed today in the unregulated market in the US. This example appeared in the magazine *Parents* in 1998. Nestlé presents its infant formula with the message 'Bring out the very best in your baby'.

Companies are required to abide by the Code and Resolutions independently of government action (or lack of it). The failure of companies to do so when they are left to their own devices, graphically demonstrated here, should serve as a cautionary tale.

Thanks to the work done in encouraging the implementation of the international tools at national level, aggressive promotion has been effectively outlawed in many countries. Over half of the world's population is protected. Although companies continue with more subtle promotional methods, and enforcement measures are variable, in some countries the decline in breastfeeding is being reversed (see page 39).

Where aggressive marketing is less extreme, we should ask: is it because companies have changed their philosophy as they sometimes claim, or is it because checks and balances have been introduced through decades of campaigning?



Meet Kim. Seven weeks old, and not the fussy type. How does mom do it? With lots of love, cuddles and Carnation Good Start. Good Start is the only routine formula designed to help avoid fussiness, crying and gas—common feeding problems caused by whole proteins. Because only Good Start's protein is specially processed into smaller pieces to be extra gentle on a baby's developing system. And Good Start digests more like breastmilk in a baby's tummy than the leading formula. No wonder Kim's so happy. Not to mention mom & dad! To learn more about Carnation Good Start from Nestlé, call 1-800-789-7766 ext. 007. Or visit our website at [www.carnationbaby.com](http://www.carnationbaby.com). And remember, breastmilk is the ideal food for babies. Talk to your doctor about your feeding choices.

If milk allergy is a concern, use formula only under a doctor's supervision.

## 4. Recommendations to other campaigns

How applicable is IBFAN's strategy of pursuing the virtuous cycle of international standards, national measures and independent monitoring to other campaigns?

### International standards

The corporate sector was greatly concerned when the *International Code of Marketing of Breastmilk Substitutes* was adopted in 1981 and efforts were put into promoting voluntary codes rather than regulations. As Judith Richter comments in her 2002 Cornerhouse briefing paper *TNC Regulation in an Era of Dialogues and Partnerships*:

*In the 1980s the International Pharmaceutical Manufacturers' Association delayed international regulation of its practices for several years by arguing that it needed time to implement its own 1981 voluntary code. At the same time, it lobbied for weaker public measures. What started out as an UNCTAD [UN Conference on Trade and Development] debate to regulate a whole range of pharmaceutical industry practices ended in 1998 with the World Health Assembly adopting the relatively loose and non-committal WHO Ethical Criteria for Medicinal Drug Promotion.*

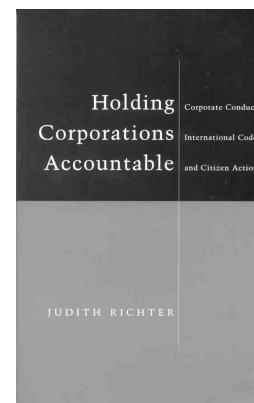
Similarly the 1985 FAO *International Code of Conduct on the Distribution and Use of Pesticides* is a voluntary code, but it is something campaigners are using to monitor company activities against and are having some success in stopping malpractice.

The tide may be turning, however, with the *Framework Convention on Tobacco Control* being adopted by the World Health Assembly in May 2003. The framework sets out acceptable marketing standards for companies wherever they operate in the world and was particularly supported by governments of developing countries, currently the main target of tobacco companies, which are more closely regulated in industrialised countries. The Convention will come into force in international law once ratified by 40 countries.

The global epidemics of obesity, diabetes, heart disease and other food-related non-communicable diseases are fast overtaking infectious diseases as the world's biggest killers, even in developing countries. The spotlight is being turned onto the marketing of high fat, high salt, high sugar processed foods, and NGOs are pushing for binding regulations to be adopted under the auspices of the World Health Assembly. The industry is rolling out the same old strategy of wanting to be included in 'dialogue' and is pressing for 'cooperation' rather than regulation. As CBS reports in an article: *'Junk food reps meet with WHO'* (9 May 2003):

*Francois-Xavier Perroud, spokesman for Nestle - the world's biggest food and beverage company - said that the industry wanted to work together with WHO. He said that success in the battle against obesity and ill health would come "not through opposing opinions and attitudes" but through cooperation based on sound science.*

According to investment bank UBS Warburg<sup>54</sup>, 46% of Nestlé's income comes from 'less healthy foods' and is at risk if regulations are brought in (Nestlé also has significant shares of the global pet food and cosmetics markets). With such massive sums at stake on one hand and the health and well-being of millions on the other, treading the path ahead will require the same courage from campaigners as that shown on the infant feeding issue.



**Holding Corporations Accountable**  
Judith Richter  
(Zed Books)

IBFAN's work on the baby milk issue is taken as a case study on how to achieve corporate accountability.

As this section shows, perseverance is an essential attribute.





### Stop WTO rules undermining breastfeeding

IBFAN groups are forming alliances with campaigners working on trade issues. The UK IBFAN group is a member of the UK Trade Justice Movement, described as *'a fast-growing group of organisations campaigning for trade justice - not free trade - with the rules weighted to benefit poor people and the environment'*.

Above, supporters of the baby milk campaign at a Trade Justice Movement rally in London in 2001.

IBFAN is closely involved in this new campaign, as breastfeeding plays a key role in prevention of these diseases throughout the life cycle, and many baby food companies are also involved in marketing junk foods to older children.

Other campaigns in the areas of trade and environmental protection are seeing the value of working at an international level. The World Trade Organisation agreements under negotiation on the General Agreement on Trade in Services (GATS) and on Technical and Intellectual Property Rights (TRIPS) are both a threat and an opportunity. They could cement and legitimise corporate power, or they could limit and regulate it.

International agreements, when they are binding at all, are binding on governments, not transnationals. There have been some moves to make transnationals liable at an international level for their activities. The European Union export measures for infant formula and follow-on formula provide one example, but as explained in this report, these are not working due to the refusal of authorities to accept denunciations from NGOs.

The European Parliament has called for a wider Monitoring Platform to monitor proposed EU standards in a broad range of areas covering human rights and the environment. Under the white paper *EU Standards for European-based enterprises operating in developing countries*<sup>55</sup>, complaints could be registered with the Monitoring Platform for investigation and levelling of sanctions. These proposals have not been taken forward by the EU Commission, which instead favours the OECD (Organisation for Economic Cooperation and Development) voluntary code of conduct and round table discussions involving industry and NGO sectors. Of the White Paper's provisions, the Parliament has been limited to holding its own Public Hearings, the first being into Nestlé baby food marketing practices.

The United Nations' route for TNC monitoring and regulation struck the rocks when the UN Centre on Transnational Corporations was wound up at the beginning of the 1990s after trying to include recommendations at the Rio Earth Summit in Agenda 21 (the UN's global plan of action) for the environmental regulation of TNCs and attempting to draft a binding Code of Conduct for TNCs.

In the legal field, there is scope for bringing action against a company in its host nation rather than the country where violations of human rights have taken place. A ground-breaking case in the UK saw the company Thor successfully prosecuted in UK courts over the ill health of workers in South Africa after the highest court in the UK (the House of Lords) ruled that a case should be heard in the home country of a company if 'substantial justice' would not be obtained overseas<sup>56</sup>. There is perhaps the opportunity to bring cases before the International Court of Justice at some future date.

On the whole, however, enforcement of standards has to take place at a national level.

## National implementation of international standards

An international standard is an excellent tool for prompting regulations at a national level. In some cases, such as with EU Directives and international Treaties and Conventions, this is a legal requirement, generally respected by governments. Other measures may have only moral force, which, however, is no small thing. This was the case with the *International Code of Marketing of Breastmilk Substitutes* until the time of the Convention on the Rights of the Child.

National measures are best achieved by national campaigning organisations. IBFAN's strength has been to bring together campaigners who were already concerned about their national situation – it does not set up groups. This is surely a model that can be followed by other campaigns, not only because it is effective, but because it is respectful of indigenous knowledge and skills. Where northern groups can help is with training, communication and resources for their partner organisations and by supporting national campaigns by mobilising their own advocates and members. Northern groups should also be open to learn, not only to improve understanding of the situation in developing countries, but also of that in their own.

IBFAN's experience has shown the need to form strong alliances with as many different sectors as possible, particularly at the national level. Networks which bring citizens groups together provide opportunities for sharing experiences and learning how to counter harmful industry pressure – both outside and inside organisations. The importance of this sharing cannot be underestimated: it is essential for building the broad coalitions which governments need if they are to make big policy shifts.

At the same time, in an era where corporations are pushing themselves forward as good 'corporate citizens', there is a need for health campaigners to be wary of false friends. The WHA has adopted a Resolution highlighting the need for governments and health workers to protect against conflicts of interests in the area of infant health. It is argued that accepting financial support and working 'in partnership' with baby food companies inevitably present conflicts of interest and so are prohibited by the Resolution (this is disputed by some). Other Resolutions have stressed the need for independent monitoring and the right of mothers to receive information free from commercial influences.

## Monitoring

Monitoring is essential to ascertain whether companies are abiding by international standards and, perhaps as importantly, to evaluate the effectiveness of government measures. It could be argued that monitoring in some form should take place even when effective, regulatory frameworks have been introduced to provide independent verification that these continue to work.

Monitoring will inevitably be attacked by those it catches out. If it has been conducted well and is evidence based, campaigners will be able to combat such attacks. Seeking peer review and publication of results in a professional journal and/or endorsement by official bodies can help in arguments over credibility.

The results of monitoring should be used imaginatively to bolster national and international measures and to expose companies that argue they should be trusted to self-regulate or be included as 'partners' in government and other systems.

## Perseverance

Key to the success of IBFAN's strategy are:

- its evidence-based approach
- its insistence on pursuing necessary measures as opposed to settling for what is readily acceptable to industry and politicians
- building of alliances with appropriate stakeholders
- persistence
- vigilance

This report opened by tracing back the baby food industry's long-term assault on breastfeeding cultures. Today, companies are using aggressive marketing strategies and attempting to undermine regulation even in those countries where sales are as yet minimal, in the expectation that future markets will justify the effort. If business works to a time-scale of decades, campaigners have to be prepared to do the same.

Too often campaigners and their supporters and funders want quick answers and a clear sign that a problem has been solved. Looking for a quick fix can divert resources into solutions that are readily accepted by industry and politicians, but in fact solve little.

Even when there is a genuine breakthrough, such as the adoption of the ***International Code of Marketing of Breastmilk Substitutes***, this may open up a new set of challenges. It would have been welcome if the Code by itself had stopped company malpractice, but it did not. What it did provide was an invaluable international tool which is being vigorously utilised by dedicated campaigners to stop corporate malpractice, so saving lives and preventing avoidable suffering.

# Glossary

**Breastmilk substitutes** - *'any food being marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not suitable for that purpose'* (from the *International Code*). These are substances which replace that part of a baby's diet best provided by breastmilk. Included are infant formula and follow-on formulas and complementary foods marketed for use in a feeding bottle or for use during the period when exclusive breastfeeding is recommended (i.e. up to the age of 6 months).

**Codex** - The Codex Alimentarius Commission is an international body set up by the United Nations World Health Organisation and Food and Agriculture Organisation to set standards relating to food quality and safety.

**Committee on the Rights of the Child** and the **Convention on the Rights of the Child** - The Convention is an international agreement, binding in international law, which requires governments to take certain action to protect the rights and well-being of children. The Committee is part of the United Nations system. Submissions are made to it every five years by governments and other interested organisations. The Committee issues reports setting out what further action governments must take to fulfil their obligations.

**Complementary foods** - *'any food, whether manufactured or locally prepared, suitable as a complement to breastmilk or to infant formula, when either becomes insufficient to satisfy the nutritional requirements of the infant. Such food is also commonly called "weaning food" or "breastmilk supplement"'* (from the *International Code*).

**Corporate accountability** - the requirement that companies are held to account for their actions by independently monitored measures.

**Corporate responsibility** - industry-promoted measures whereby companies attempt to demonstrate that they are operating in a responsible manner.

**European Commission** - *'The European Commission embodies and upholds the general interest of the Union. The President and Members of the Commission are appointed by the Member States after they have been approved by the European Parliament. The Commission is the driving force in the Union's institutional system'* (EU website). Commissioners are the executive officers of the European Union, responsible for different directorates, such as Trade or Development. Commissioners are appointed by agreement of the governments of member states and can put forward legislation, known as directives.

**European Council of Ministers** - *'The Council is the EU's main decision-making body. It is the embodiment of the Member States, whose representatives it brings together regularly at ministerial level'* (EU website).

**European Parliament** - a directly elected body with responsibility for scrutinising the working of the European Union and approving the appointment of Commissioners. The Parliament approves EU legislation (directives), but does not have the power to initiate legislation.

**European Union** or **EU** - a 'free trade area' made up of 15 European nations, where trading and some other laws are harmonised with the aim of making trade between member states as straightforward as trade within a member state.

**Exclusive breastfeeding** - breastfeeding without the introduction of any other substances, including water, teas or juices. Exclusive breastfeeding is recommended by the World Health Assembly for the first 6 months of life.

**Follow-on** or **follow-up** formulas - modified milks marketed for feeding 'older' infants. These products were described as 'not necessary' by the World Health Assembly in 1986.

**Gastroenteritis** - inflammation of the lining of stomach and intestine. An acute condition of diarrhoea and vomiting particularly dangerous in infants, producing rapid and severe dehydration (from Baillière's Midwives' Dictionary).

**Globalisation** – the formation of businesses, organisations and regulations that transcend national boundaries.

**IBFAN** - International Baby Food Action Network, consisting of more than 200 groups in over 100 countries, working to protect infant health by monitoring and campaigning for implementation of the *International Code*.

**Infant mortality** - the number of deaths of infants before the age of one year, per thousand live births.

**International Code** - The *International Code of Marketing of Breastmilk Substitutes*, adopted by the World Health Assembly in 1981. The full text is available on the website [www.ibfan.org](http://www.ibfan.org).

**Necrotising enterocolitis** - an inflammatory disease of the bowel of a newborn child up to 4 weeks old, which is associated with septicaemia (blood poisoning). It is thought to be due to bacteria proliferating in the bowel and penetrating the bowel wall at points where it has

suffered damage. Ulceration and haemorrhage of the bowel wall are found and may progress to perforation (adapted from Baillière's Midwives' Dictionary).

**NGOs** - Non-Governmental Organisations. Sometimes referred to as 'civil society'. NGOs may be Public Interest NGOs (PINGOs), Business Interest NGOs (BINGOs), Business Oriented NGOs (BONGOs), Government Organised NGOs (GONGOs).

**TNCs** - Transnational Corporations. TNCs are a form of multinational company. TNCs tend to transcend national boundaries and have the same name and similar brand portfolios wherever they operate.

**UN** - United Nations.

**Under 5 mortality** - the number of deaths of children before the age of five years, per thousand live births.

**UNICEF** - United Nations Children's Fund.

**WHA** - World Health Assembly. The United Nations highest health policy setting body. WHA sets the policies to be followed by WHO.

**WHO** - World Health Organisation. The executive body for WHA policies.

**Whole milks** - milks that have not been modified for infant feeding.

**WTO** - World Trade Organisation. A United Nations organisation for setting rules governing international trade rules.

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  46. The *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding* was issued in August 1990 by 30 governments meeting in Florence, Italy. In September 1990, the World Summit for Children endorsed the *Innocenti Declaration* and its operational targets became part of the Summit's goals for the year 2000.
  47. The *Convention on the Rights of the Child* (CRC) was adopted by the United Nations General Assembly on 20th November 1989. As a Convention, the CRC is binding on governments which have a legal, and not just a moral, obligation to fulfil their commitments. article 24 of the CRC spells out the obligations of governments (States Parties) to diminish infant and young child mortality and combat disease and malnutrition by taking measures to ensure that all sectors of society, particularly parents, **"have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding..."** according to UNICEF the CRC means that, **"States Parties are placed under an obligation to ensure that the advantages of breastfeeding are universally understood and to take appropriate measures to achieve this goal. This can only be accomplished if the information reaching the general public, and parents in particular, is factual, objective, and not prepared with a view to persuading mothers to forgo or diminish breastfeeding and use an artificial product in the mistaken belief that it is equivalent to breastfeeding."** Progress Report on the Baby Friendly Hospital Initiative, UNICEF New York, January, 1998.
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wherever they are pursued: in the developing world, WHO estimates that some 1.5 million children die each year because they are not adequately breastfed. These facts are not in dispute.... the findings of the International Baby Food Action Network (IBFAN), in its regular monitoring activities, are clearly vindicated by this report."

51. IFM on its website ([http://www.ifm.net/ifm\\_qais.html](http://www.ifm.net/ifm_qais.html)) has made similar points to those made to IBFAN at the 1991 meeting. For example, in disputing the validity of World Health Assembly Resolutions, including 47.5 which explicitly states that there should be *'no donations of free or subsidized supplies of breast-milk substitutes and other products covered by the International Code of Marketing of Breast-milk Substitutes in any part of the health care system'*, IFM stated: *'Since the WHO Code was published in 1981 there have been nine resolutions but most of these resolutions either do not conform with or they directly contradict the WHO Code or other resolutions.'* The subsequent Resolutions have been adopted by WHA to address questions of interpretation and to respond to changes in scientific knowledge and marketing practices. Resolutions have progressively become more explicit on the ban on free and low-cost supplies in response to evidence of companies exploiting loopholes. Even if it accepted the WHA Resolution, IFM has argued that the industry as a whole could not undertake to comply: *'Because of antitrust constraints, there is little that IFM can do about a member company that violates the WHO Code... Under antitrust/competition laws in many countries, it is not possible for companies to meet and discuss matters relating to marketing practices either among themselves or at a joint meeting with third parties.'* Fear of antitrust laws has not prevented IFM members from taking a common lobbying position against WHA Resolutions. For example, prior to the 2001 WHA, IFM called on member companies to oppose any action being taken on infant and young child nutrition at the meeting (IFM message dated 24 July 2000).
52. World Breastfeeding Week is an initiative of the World Alliance for Breastfeeding Action (WABA), of which IBFAN is a member. A different theme is chosen each year, such as the ecological benefits of breastfeeding) and activities at all levels of society promote this. The week is nominally in August, but because of variations in holiday seasons may be celebrated at other times. For example, in Europe it takes place in October.
53. In 1919, the International Labour Office adopted the first Maternity Protection Convention, 1919 (No 3) which has been (and still can be) ratified by 33 countries; it was followed, in 1952, by Maternity Protection, 1952, (No 103) which 37 countries ratified over the years. The revision of the latter began in 1999, and, after a two-year process, on 15 June 2000, Maternity Protection Convention, 2000 (No 183) and Recommendation 191 were adopted by 304 votes (22 were against; 116 abstained). Convention 183 came into force on 7 February 2002.
54. UBS Warburg report profiled in the *Food Magazine*, Food Commission, January/March 2003.
55. *EU standards for European Enterprises operating in developing countries: towards a European Code of Conduct*, adopted by the Parliament on 15th January 1999.
56. From the website of Leigh, Day and Co. ([www.leighday.co.uk](http://www.leighday.co.uk))

The legal responsibility of multinational companies

Three key factors have enabled multinationals to avoid responsibility for their overseas operations:

- \* The principle that a claim brought in a multinational's home court can be halted on the grounds that the local 'host court' is a more appropriate venue. This principle has been applied in the UK, Australia, Canada and the US.
- \* The 'corporate veil' barrier which generally shields a parent company shareholder from the wrongdoing of its subsidiaries.
- \* The obstacles to access to justice in local courts for people in developing countries.

However over the last 7 years substantial inroads have been made on behalf of overseas claimants. In the UK, this largely stems from the House of Lords' rulings that such claims should proceed in the British courts where 'substantial justice' would not be obtained overseas, enabling the claims of thousands of overseas victims to be litigated and settled here.

In addition, our case against Thor Chemicals was the first of its kind in suing a parent



company for designing and exporting hazardous technology from England to South Africa, where health and safety deficiencies were replicated. Many South African workers died or were injured from mercury poisoning as a result. At trial, Thor admitted legal responsibility for the South African operations.

# Appendix

## IBFAN groups in the Case Study countries

IBFAN was founded in 1979 at the end of a Joint Meeting called by WHO and UNICEF on infant and young child feeding that concluded by calling for an international code of marketing practices (see, 'International pressure for regulation', page 17). Unusually for the time, WHO and UNICEF had decided to invite not only the baby food industry to this meeting but also its most outspoken critics from citizen groups, as well as government and UN officials and various health experts. Six groups attending the Joint Meeting set up the Network; today, it comprises over 200 groups in more than 100 countries. There are IBFAN groups in all the Case Study countries. Their dates of formation (where given in the Case Studies) are as follows:

<b>Belgium</b>	VZW Vereniging Begeleiding en Bevordering van Borstvoeding (VBBB - Association for Supporting and Promoting Breastfeeding) – founded 1993. VZW Borstvodeing (Breastfeeding NGO) – founded 1981. IBFAN member since 2001.
<b>Bolivia</b>	IBFAN Bolivia (legally under Health Action International Bolivia rather than a separate entity) – founded 1987. 300 volunteers.
<b>Brazil</b>	IBFAN Brazil – founded 1983. 100 volunteer representatives.
<b>England</b>	Baby Milk Action – founded 1977. 2,200 members. 4 staff.
<b>India</b>	Breastfeeding Protection Network of India (BPNI - regional focal point) – founded 1991. 1,871 members. Association for Consumers Action on Safety and Health (ACASH).
<b>Kenya</b>	Breast-feeding Information Group (BIG). Kenya Food and Nutrition Action Network (KEFAN). Consumer Information Network (CIN).
<b>Mexico</b>	IBFAN Mexico – founded 1985. 25 volunteer representatives.

## Photo credits

All photos are from IBFAN or are IBFAN collected violations, except:

Page 7:     ***Nestlé in Profile..***

Page 9:     UNICEF, Islamabad Children's Hospital, Pakistan.

Page 33:    From the 1998 calendar of the National Food & Nutrition  
Commission of Zambia.

