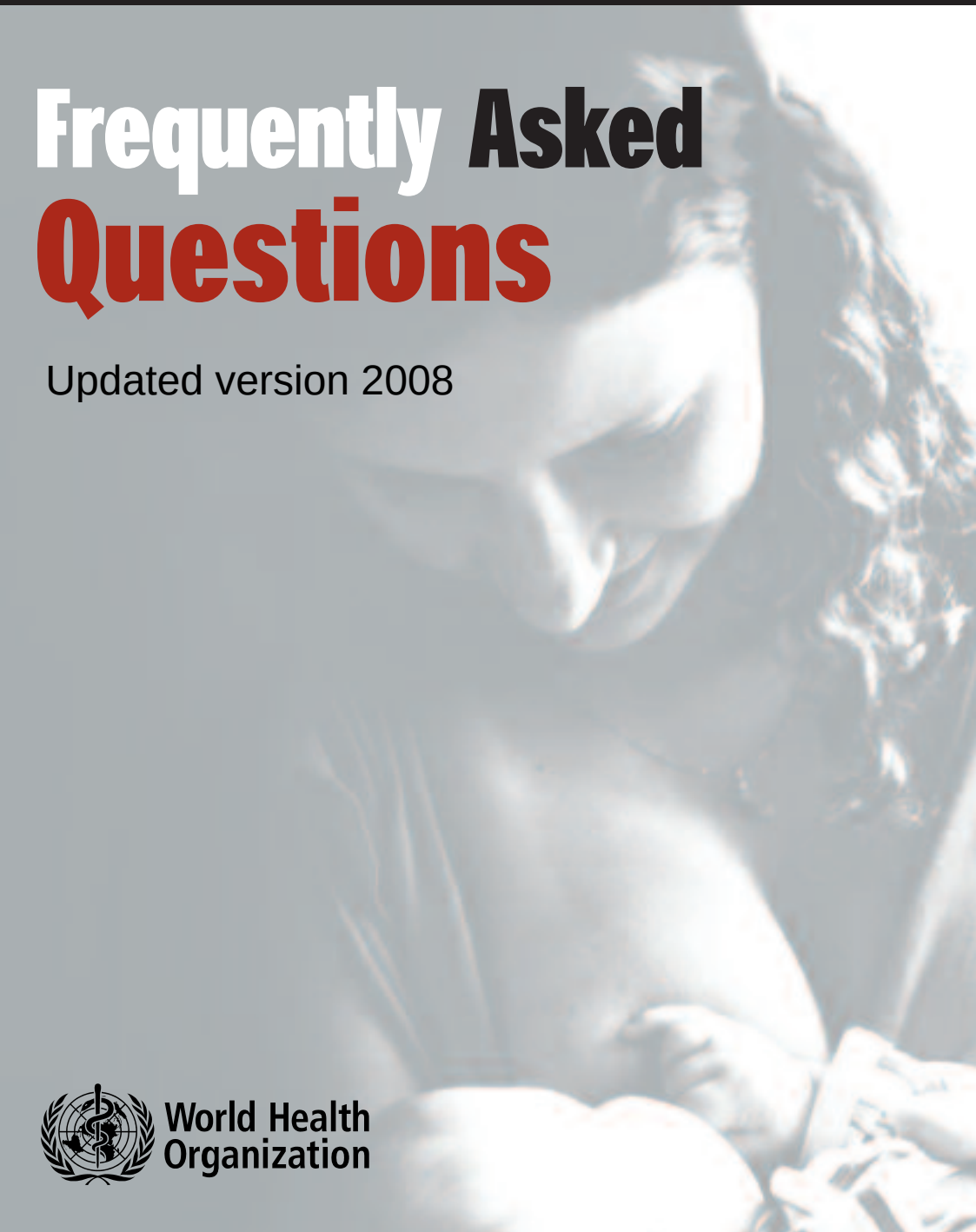
THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES

Frequently Asked Questions

Updated version 2008



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Many people who have heard about the International Code of Marketing of Breast-milk Substitutes have expressed interest in knowing more about it. The purpose of this document is to provide easy-to-read detailed information on specific questions related to the Code. It is intended for policy-makers and others concerned with the Code, as well as the general public.

Q. WHAT IS THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES?

The Code is a set of recommendations to regulate the marketing of breast-milk substitutes, feeding bottles and teats. The Code was formulated in response to the realization that poor infant feeding practices were negatively affecting the growth, health and development of children, and were a major cause of mortality in infants and young children. Poor infant feeding practices therefore were a serious obstacle to social and economic development. The 34th session of the World Health Assembly (WHA) adopted the International Code of Marketing of Breast-milk Substitutes in 1981 as a minimum requirement to protect and promote appropriate infant and young child feeding.

The Code aims to contribute "to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution" (Article 1).

The Code advocates that babies be breastfed. If babies are not breastfed, for whatever reason, the Code also advocates that they be fed safely on the best available nutritional alternative. Breast-milk substitutes should be available when needed, but not be promoted.

The Code was adopted through a WHA resolution and represents an expression of the collective will of governments to ensure the protection and promotion of optimal feeding for infants and young children.

Q. WHAT ARE THE CURRENT WHO RECOMMENDATIONS FOR FEEDING INFANTS AND YOUNG CHILDREN?

To achieve optimal growth, development and health, WHO recommends that infants should be exclusively breastfed for the first six months of life. Thereafter, to meet their nutritional requirements, infants should receive adequate and safe complementary foods while breastfeeding continues up to two years of age and beyond.

Exclusive breastfeeding from birth is possible for most women who choose to do so. It is recommended for all children except for a few medical conditions, such as maternal medication with radioactive substances.[1] Exclusive breastfeeding as often and as long as the baby wants results in ample milk production.

Q. WHY IS BREASTFEEDING IMPORTANT?

Breastfeeding is unparalleled in providing the ideal food for infants. Breast milk is safe, clean and contains antibodies which help protect the infant against many common childhood illnesses.

The protection, promotion and support of breastfeeding rank among the most effective interventions to improve child survival. It is estimated that high coverage of optimal breastfeeding practices could avert 13% of the 10.6 million deaths of children under five years occurring globally every year. Exclusive breastfeeding in the first six months of life is particularly beneficial, and infants who are not breastfed in the first month of life may be as much as 25 times more likely to die than infants who are exclusively breastfed.

Positive effects of breastfeeding on the health of mothers and infants are observed in all settings. Breastfeeding reduces the risk of acute infections such as diarrhoea, pneumonia, ear infection, haemophilus influenza, meningitis and urinary tract infection. It also protects against chronic conditions in the child such as allergies, type I diabetes, ulcerative colitis, and Crohn's disease. Breastfeeding promotes child development and is associated with higher IQ scores in low-birth-weight babies. Breastfeeding during infancy is associated with lower mean blood pressure and total serum cholesterol, and with lower prevalence of type-2 diabetes, overweight and obesity during adolescence and adult life. [2]

[1] WHO/UNICEF. Breastfeeding counseling: A training course. WHO/CDR/93.4, Geneva, World Health Organization 1993, http://www.who.int/child-adolescent-health/publications/NUTRITION/BFC.htm

[2] WHO. Evidence on the long-term effects of breastfeeding: systematic reviews and meta-analyses. Geneva: World Health Organization, 2007, http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/ISBN_92_4_159523_0.pdf

Breastfeeding delays early return of fertility in the mother and reduces her risk of postpartum hemorrhage and breast and ovarian cancer.

Interventions to improve breastfeeding practices are cost-effective and rank among those with the highest cost-benefit ratio. The cost per child is low compared to that for curative interventions.

Q. DOES WHO PROVIDE GUIDELINES FOR MOTHERS WHO ARE UNABLE TO OR CHOOSE NOT TO BREASTFEED?

WHO has developed guidelines for feeding very low-birth-weight babies whose nutritional requirements cannot be met by breast milk alone, as well as for counselling working women on how to sustain breastfeeding with the addition of other feeding options, if needed.

Guidance is also available for HIV-positive women who choose not to breastfeed on adequate and safe alternatives. The guidelines, training materials and job aids on HIV and infant feeding provide detailed instructions on how to prepare, administer and safely store breast-milk substitutes, including commercially prepared infant formula.[3]

Q. WHAT PRODUCTS ARE COVERED BY THE CODE?

The Code applies to the marketing and related practices of the following products: breast-milk substitutes, including infant formula; other milk products, foods and beverages, including bottle-fed complementary foods; feeding bottles, and teats. It also applies to their quality and availability, and to information concerning their use.

Since the Code covers products that are suitable for use as a partial or total replacement of breast milk, it should be read in conjunction with current global recommendations for breastfeeding and complementary feeding, such as the Global Strategy for Infant and Young Child Feeding. For example, as the global recommendation is exclusive breastfeeding for six months, any food or drink promoted to be suitable for feeding a baby during this period is a breast-milk substitute, and thus covered by the Code. This would include baby teas, juices and waters. Formulas for infants with special medical or nutritional needs also fall within the scope of the Code.

[3] WHO, UNICEF, UNFPA, UNAIDS. HIV and infant feeding update. Geneva, 2007.

Q. WHY IS THE CODE IMPORTANT?

The Code is an important part of creating an overall environment that enables mothers to make the best possible feeding choice, based on impartial information and free of commercial influences, and to be fully supported in doing so.

Poor breastfeeding practices are still common, both in developing and developed countries. Only about 39% of children globally are exclusively breastfed for four months and a considerably smaller proportion for the full recommended six months. In addition to the risks posed by not having breast milk's protective qualities, breast-milk substitutes and feeding bottles in particular carry a high risk of contamination that can lead to life-threatening infections in young infants. Infant formula is not a sterile product and it may carry germs that can cause fatal illnesses. Artificial feeding is expensive, requires clean water, the ability of the mother or caregiver to read and comply with mixing instructions and a minimum standard of overall household hygiene - factors not readily met in many households in the world.

Improper marketing and promotion of food products that compete with breastfeeding are important factors that often negatively affect the choice and ability of a mother to breastfeed her infant optimally. Given the special vulnerability of infants and the risks involved in inappropriate feeding practices, usual marketing practices are therefore unsuitable for these products.

Q. WHAT ASPECTS DOES THE CODE COVER?

The Code sets out detailed provisions with regard to, *inter alia*:

1. Information and education on infant feeding.
2. Promotion of breast-milk substitutes and related products to the general public and mothers.
3. Promotion of breast-milk substitutes and related products to health workers and in health care settings.
4. Labelling and quality of breast-milk substitutes and related products.
5. Implementation and monitoring of the Code.

Q. WHAT DOES THE CODE SAY ABOUT INFORMATION AND EDUCATION ON INFANT FEEDING?

The Code and subsequent relevant WHA resolutions call upon governments to ensure that objective and consistent information is provided on infant and young child feeding, both to families and others involved in infant and young child nutrition.

Informational and educational materials should clearly state the benefits and superiority of breastfeeding, the social as well as financial costs of using infant formula, the health hazards associated with artificial feeding and instructions for the proper use of infant formula.

Q. WHAT ARE THE LIMITS SET BY THE CODE ON THE PROMOTION OF BREAST-MILK SUBSTITUTES TO THE GENERAL PUBLIC AND MOTHERS?

The Code explicitly states that "there should be no advertising or other form of promotion to the general public" and that "manufacturers and distributors should not provide … to pregnant women, mothers or members of their families, samples of products…"

Promotion through any type of sales device, including special displays, discount coupons and special sales, is prohibited.

Furthermore, no company personnel should seek direct or indirect contact with, or provide advice to, pregnant women or mothers.

Q. DOES THE CODE RESTRICT PROMOTIONAL ACTIVITIES TO HEALTH WORKERS AND IN HEALTH CARE SETTINGS?

The Code and subsequent relevant WHA resolutions call for a total prohibition of any type of promotion of products that fall within their scope in the health services.

Furthermore, donations of free or subsidized supplies of breast-milk substitutes or other products, as well as gifts or personal samples to health workers, are not allowed in any part of the health care system.

Also, information provided by manufacturers and distributors to health professionals regarding products should be restricted to scientific and factual matters.

Q. WHAT DOES THE CODE SAY ABOUT LABELLING AND QUALITY OF BREAST-MILK SUBSTITUTES?

No pictures of infants or other pictures idealizing the use of breast-milk substitutes are permitted on the labels of the products.

Information on artificial feeding, including that on labels, should explain the benefits of breastfeeding and the costs and dangers associated with the unnecessary or improper use of infant formula and other breast-milk substitutes.

Unsuitable products for feeding infants, such as sweetened condensed milk, should not be promoted.

Q. WHAT ARE THE REQUIREMENTS FOR THE IMPLEMENTATION OF THE CODE?

Governments should act on the Code, taking into consideration subsequent relevant WHA resolutions. They can adopt legislation, regulations or other measures such as national policies or codes.

The Code is a minimum requirement, and therefore governments can adopt additional, possibly more stringent, measures than those set out in the Code and make them legally binding.

Q. HAS THE CODE BEEN UPDATED SINCE 1981?

No, there is only one version of the Code. However, there have been a number of WHA resolutions adopted since 1981 that refer to the marketing and distribution of breast-milk substitutes.[4] The Code and subsequent WHA resolutions must be considered together in the interpretation and translation into national measures.

[4] World Health Assembly Resolutions 33.32, 34.22, 35.26, 37.30, 39.28, 41.11, 43.3, 45.34, 46.7, 47.5, 49.15, 54.2 and 55.25 have further clarified or extended certain provisions of the Code.

Q. WHO SHOULD BE INVOLVED TO MAKE IMPLEMENTATION OF THE CODE A REALITY?

While governments have the primary responsibility to take action on the International Code, they can only achieve this with the full cooperation of all concerned stakeholders, including food manufacturers and distributors, health care professionals, nongovernmental organizations and consumer organizations. The Global Strategy for Infant and Young Child Feeding (see below) specifies roles and obligations of many actors in the implementation of the Code and in protecting, promoting and supporting breastfeeding more generally.

Q. IS THE IMPLEMENTATION OF THE CODE SUFFICIENT FOR THE IMPROVEMENT OF INFANT AND YOUNG CHILD FEEDING?

No, additional measures are required as stipulated in the Global Strategy for Infant and Young Child Feeding endorsed by WHO Member States in 2002. The Global Strategy includes nine operational targets consistent with the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions, the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding and the Baby-friendly Hospital Initiative.

In addition to the implementation of the Code, the Global Strategy also calls for actions to:

- ensure that every facility providing maternity services fully practises the 'Ten steps to successful breastfeeding';
- enact imaginative legislation protecting breastfeeding rights of working women and enforce them;
- develop, implement, monitor and evaluate a comprehensive policy on infant and young child feeding;
- ensure that the health and other relevant sectors protect, promote and support exclusive breastfeeding for six months and continued breastfeeding for up to two years or beyond; and that they also promote timely, adequate, safe and appropriate complementary feeding from six months onwards; and
- provide guidance on feeding infants in exceptionally difficult circumstances.

To ensure full implementation of all its components, the Global Strategy calls upon governments to appoint a national coordinator with appropriate authority and to

constitute an effective broad-based body to lead coordinated multi-sectoral implementation of the strategy by all concerned parties.

Q. IS THE CODE CONSISTENT WITH INTERNATIONAL HUMAN RIGHTS AND OTHER LEGAL INSTRUMENTS AND WHAT DOES THIS MEAN IN TERMS OF LEGAL OBLIGATIONS?

Today, a wide and increasing range of international human rights standards and norms can be called upon to enhance and protect infant and young child feeding practices, including exclusive breastfeeding, from any disruptive influences.

The *United Nations Convention on the Rights of the Child* (CRC) is the most comprehensive international human rights framework in this regard. Numerous articles of the CRC are supportive of the aim of the Code, particularly the right of children to the highest attainable standard of health, by, inter alia, reducing infant mortality, and promoting breastfeeding. The CRC not only reflects the legal obligations of Governments towards all children and mothers under its jurisdiction, but also provides legal and normative guidance on protecting, promoting and supporting infant and young child feeding.

Countries having ratified the CRC are legally bound by its provisions. In other words, governments can be legally held accountable for action or inaction which hinders the enjoyment of the rights and freedoms set forth in it. Therefore, both national and international mechanisms for monitoring CRC implementation should address the implementation of the Code in their activities.

Q. WHAT ARE THE REQUIREMENTS FOR MONITORING OF NATIONAL MEASURES?

Resolutions WHA 49.15 and 54.2 call upon governments to ensure proper and effective monitoring and reporting mechanisms and processes for effective implementation of the Code and subsequent relevant WHA resolutions. These should be **transparent, independent,** and **free from commercial influence** and address labelling, all forms of advertising and commercial promotion across all media. Responsible bodies should be empowered to investigate Code violations, and impose appropriate sanctions according to existing legal systems.

Q. WHO IS RESPONSIBLE FOR MONITORING THE IMPLEMENTATION OF THE INTERNATIONAL CODE?

Primary responsibility for the implementation and monitoring of the Code lies with governments, acting individually and collectively through the World Health Organization. Other concerned parties, nationally and internationally, should collaborate fully with governments in this endeavour.

In this respect, manufacturers and distributors of products that fall within the scope of the Code are responsible for monitoring their marketing practices, and taking steps to ensure that their conduct fully conforms with the Code.

Similarly, health professionals and health managers have a responsibility to monitor marketing practices and ensure that their institutions or practices fully comply with the provisions set forth in the Code.

Nongovernmental organizations, institutions and individuals can draw the attention of manufacturers and distributors to activities which are incompatible with the Code, and inform the government so that action can be taken.

To foster collective action, Member States should report annually to the Director-General of WHO on their action on the recommendations, enabling the Director-General to report in alternate years to the WHA on the status of the implementation of the Code.

Q. WHO IS RESPONSIBLE FOR TAKING ACTION WHEN VIOLATIONS OF THE CODE ARE REPORTED BY CONCERNED INDIVIDUALS OR ORGANIZATIONS?

According to the decision of the WHA, governments of Member States decide on the legislation, regulations and/or other suitable measures to give effect to the Code and the subsequent relevant WHA resolutions in their own countries. This means that it is up to individual Member States to decide what, if any, actions they would take in response to a violation of the Code.

Q. HOW DOES THE CODE APPLY IN THE CONTEXT OF HIV?

Global recommendations on infant feeding for HIV-infected mothers include[5]:

- The most appropriate infant feeding option for an HIV-infected mother depends on her individual circumstances, including her health status and the local situation, but should take consideration of the health services available and the counselling and support she is likely to receive.

- Exclusive breastfeeding is recommended for HIV-infected women for the first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time.

- When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected women is recommended.

- At six months, if replacement feeding is still not acceptable, feasible, affordable, sustainable and safe, continuation of breastfeeding with additional complementary foods is recommended, while the mother and baby continue to be regularly assessed. All breastfeeding should stop once a nutritionally adequate and safe diet without breast milk can be provided.

- When HIV-positive mothers choose not to breastfeed from birth or stop breastfeeding later, they should be provided with specific guidance and support for at least the first two years of the child's life to ensure adequate replacement feeding. Programmes should strive to improve conditions that will make replacement feeding safer for HIV-positive mothers and families.

The fact that HIV can be transmitted through breast milk should not undermine efforts to support breastfeeding for most infants, as their health and survival are greatly improved by breastfeeding. At the same time, the Code seeks to ensure the proper and informed use of breast-milk substitutes when these are necessary.
The Code and the WHA resolutions therefore:

- recommend that governments regulate the distribution of free or subsidized supplies of breast-milk substitutes to prevent spillover to babies who would benefit from breastfeeding and whose mothers are HIV- negative or unaware of their status;
- protect children fed with breast-milk substitutes by ensuring that product labels carry necessary warnings and instructions for safe preparation and use;
- ensure that the product is chosen on the basis of independent medical advice.

[5] WHO on behalf of the Inter-agency Task Team on Prevention of HIV infection in pregnant women, mothers and their infants. Consensus Statement, HIV and infant feeding technical consultation. Geneva, October 25-27 2006. Available at http://www.who.int/child-adolescent-health/publications/NUTRITION/consensus_statement.htm

With the rising prevalence of HIV, governments may consider accepting free or low-cost supplies for distribution to HIV-positive mothers. WHA resolution 47.5, 2.(2), however, urges Member States to ensure that there are no donations of free or subsidized supplies of breast-milk substitutes and other products covered by the Code in any part of the health care system. Instead of accepting donations, national authorities should consider negotiating prices with manufacturers and offer breast-milk substitutes at a subsidized price or free of charge to be used for infants of mothers living with HIV. It is recommended that this be done in a manner that:

- is sustainable;
- does not create dependency on donated or low-cost supplies;
- does not undermine breastfeeding for the majority of infants;
- does not in effect promote breast-milk substitutes to the general public or the health care system;
- assures sufficient quantities for as long as individual infants need them.

Q. HOW DOES THE CODE APPLY IN COMPLEX EMERGENCIES?

For the majority of infants and young children in emergency situations, the emphasis should be on protecting, promoting and supporting breastfeeding and ensuring timely, safe and appropriate complementary feeding. There will always be a small number of infants who will need to be fed breast-milk substitutes for the long or short term. This may be necessary if their mother is dead or absent; or too ill, malnourished or traumatized to breastfeed until she has recovered, and if no wet-nurse is available. Breast-milk substitutes should be procured and distributed as part of the regular inventory of feeds and medicines, in quantities only as needed. There should be clear criteria for their use and education for caregivers about hygienic and appropriate feeding. When breast-milk substitutes are distributed without control in emergency situations, the result is often a dangerous and unnecessary increase in early cessation of breastfeeding.

Q. HOW DOES THE CODE APPLY TO MEDICAL INSTITUTIONS DEALING WITH INFANTS WHO HAVE A MEDICAL INDICATION NOT TO BREASTFEED?

To be accredited as 'baby-friendly', a hospital is required to avoid all promotion of breast-milk substitutes and related products, bottles and teats, not accept free or low-cost supplies or give out samples of those products. Hence, infant formula needed for infants with medical reasons for its use should be obtained through normal procurement channels.

For more information on the International Code of Marketing of Breast-milk Substitutes, please contact:

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