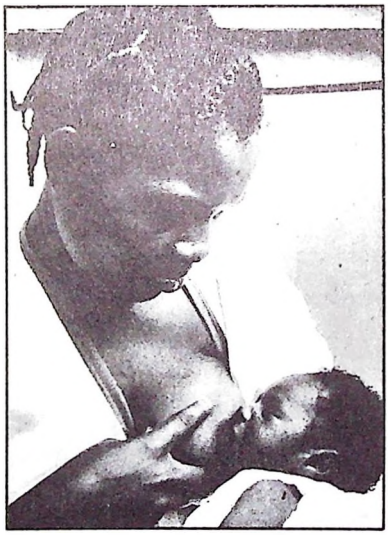
When the answer is not a bottle

In many parts of the developing world the incidence of infant malnutrition and diarrhoea can be directly linked with a decline in breastfeeding, and its replacement by wrongly and unhygienically constituted bottle-fed formulas. PATRICE JELLIFFE describes the factors behind this trend, the efforts to evolve a code of conduct for the marketing of infant formula, and some of the campaigns underway to re-establish breast as best.

The problem of malnutrition among infants and young children has been emphasized by concerned health workers and nutritionists for many decades. However, the problem of marasmus linked with the use of improperly administered infant formulas has only begun to attract world-wide interest in recent years. Careful scrutiny of the mechanisms leading to mounting morbidity and an increasing death toll among young children has underlined the need for action programmes both at international and national levels to counteract faltering trends in breastfeeding in many areas of the world.

Around 10 million cases of infant malnutrition, often accompanied by diarrhoea, occur yearly in the developing countries as a direct or indirect result of a mother ceasing to breastfeed her child. A number of social and economic trends have contributed to the problem. These include rapid urbanization and its accompanying disruption of family life-styles, unemployment, and the low purchasing power among the poorest strata in society which prevents families from being able to obtain enough of the right food to provide a suitable diet for mothers and infants. But three main influences have accelerated the decline in breastfeeding and the parallel, and unprecedented, increase in infant malnutrition.



Human milk is adapted to fit the needs of each individual baby. The absorption of minerals is superior, and breastmilk has anti-infective effects. ICEF 8749/Anand

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The health profession

Health professionals' lack of training in nutrition has now been recognized worldwide, and breastfeeding especially has been neglected. The physiology of lactation and emphasis on the important prolactin and sensitive letdown reflexes are not stressed. Nor are the dangers of separating the mother and child at birth, and of introducing pre-lacteal feeds such as glucose water or formula, which satiate the newborn's appetite and thereby discourage the vigorous suckling needed to assure successful breastfeeding.

Training programmes have equally omitted to point out the wide differences between the composition of bovine and human milk, and that the latter is adapted to fit the needs of each individual baby; that the absorption of minerals such as iron, zinc and calcium is superior from human milk; and that breastfeeding has child spacing and anti-infective effects. In the light of this lack of training and of the lack of resources available for health care, the health services have failed to assume their responsibilities in the context of breastfeeding and its relationship to sound infant feeding practice. Thus they have left open the field — a field into which the infant food industry has energetically stepped.

The food industry

For many years the manufacturers of infant food products have been vigorously promoting milk formulas as well as juices, cereal products and puréed food for use in the early months of life throughout the developing world. Marketing practices have included using company employees to distribute free samples of milk to mothers in hospital and on home visits, as well as booklets, leaflets, and free feeding bottles. These items are also distributed to members of the health ▷

profession, although the literature varies for each audience in terms of the sophistication of the messages and the type of advice given. Many infant products are advertised in medical and paediatric journals, and milk firms have a high visibility at paediatric congresses. In certain quarters, the overall impression reinforces the idea that bottle feeding may be a simpler, more modern and convenient method of child feeding, and nutritionally equivalent to biological feeding.

It is recognized by the health profession that under certain conditions, bottle feeding may be necessary. If the infant is an orphan and no surrogate lactating relative exists, if a mother is severely ill or does not wish to breastfeed, there may be no alternative. But among the poorest and least knowledgeable strata within many societies, bottle feeding is hazardous for the very young. Environmental sanitation standards may be very low, and the importance of cleanliness and sterilization ill-appreciated. It may also prove impossible for a low-income family to afford to buy sufficient formula to bottle feed a three-month old infant with the mix at an adequate nutritional concentration. This can cost between 25 and 93 per cent of the father's daily working wage. Even in situations where the family may be able to afford adequate supplies of formula, it may be unhygienically administered. A recent study by Autret and Miladi in wealthy Arab countries has shown that the frequent incidence of marasmus is related to the increased availability of foreign milk products on local markets, and that cases of infant diarrhoea are now prevalent as infants do not benefit from breastmilk's protective effect.

Working women and legislation

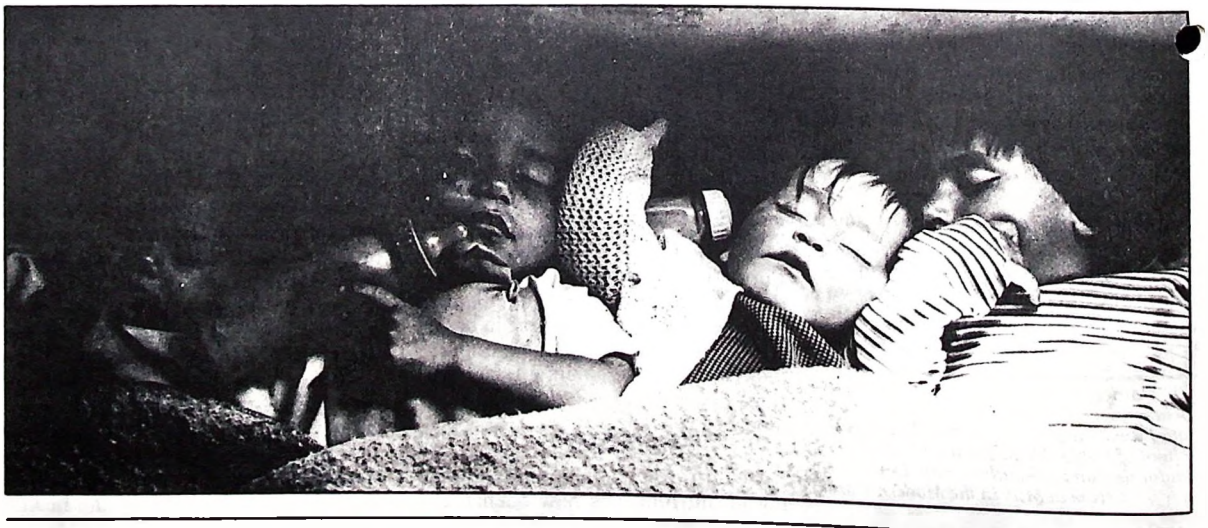
In some developing countries, increasing numbers of women are entering the work force, professional women with skills as well as others employed in factories, in paid agricultural jobs, in the construction industry or as domestic servants. Some countries have adhered to the International Labour Organization Conventions related to working women. These allow 12 weeks maternity leave, intended as six weeks prepartum and six postpartum, but which in many cases can be taken at the woman's discretion, after delivery if preferred, to ensure the establishment of lactation. The conventions also establish lactation benefits, which entitle a working woman to take two half hour remunerated nursing breaks during the day in breastfeeding facilities (crèches) on the premises or nearby.

Many of these requirements although legislatively enacted are not adhered to by employers. Crèches may not be provided, or may be far away from the workplace, or preferential hiring of male employees may become the rule. When crèches are provided, mothers may be hesitant to leave their children in the unhygienic surroundings of an understaffed facility. Alternatively they may not want to travel for several miles in an overcrowded bus in which the risk of infection for the child is high.

The clamour about breastfeeding begins to grow

The difficulties encountered by pregnant and nursing women have been much emphasized in the last decade. Health professionals and nutritionists have drawn attention through numerous publications to the perilous condition of the bottlefed infant in poor communities within developing countries. For 20 years (1950-1970) their work did not receive wide support, but by 1973/74 the World Health Organisation (WHO) had begun to give a much needed impetus to the continuing battle to promote the age-old method of biological infant feeding.

During the 1970s mounting concern began to be expressed both by members of the health profession and by consumer groups and voluntary activists about the marketing practices used in developing countries to promote infant formula and other foods. The inducements to use infant feeding products offered to members of the health profession, such as the distribution of free samples for use by disadvantaged mothers, were among the targets of the criticism. Some of the



Doctors recognize that in some cases bottle feeding may be necessary. But it is not nutritionally equivalent to breastfeeding. ICEF 8748/Wolff

The Code

A draft International Code of Marketing of Breastmilk Substitutes has now been forwarded by the Executive Board of WHO to the 34th World Health Assembly, which in May 1981 will consider its adoption as a set of recommendations. The following are some of the key provisions:

Information and education

● Governments should have the responsibility to ensure that objective and consistent information is provided on infant and young child feeding for use by families and those involved in the field of infant and young child nutrition. This responsibility should cover either the planning, provision, design and dissemination of information, or their control.

The general public and mothers

● There should be no advertising or other form of promotion to the general public of products within the scope of this Code.

● Manufacturers and distributors should not provide, directly or indirectly, to pregnant women, mothers or members of their families, samples of products within the scope of this Code.

Health care systems

● The health authorities in Member States should take appropriate measures to encourage and protect breastfeeding and promote the principles of this Code, and should give appropriate information and advice to health workers in regard to their obligations.

● No facility of a health care system should be used for the purpose of promoting infant formula or other products within the scope of this Code. This Code should not, however, preclude the dissemination of information to health professionals.

● The use by the health care system of "professional service representatives", "mothercraft nurses" or similar personnel, provided or paid for by manufacturers or distributors, should not be permitted.

● Feeding with infant formula, whether manufactured or home-prepared, should be demonstrated only by health workers, or other community workers if necessary; and only to the mothers or family members who need to use it; and the information given should include a clear explanation of the hazards of improper use.

Health workers

● Health workers should encourage and protect breastfeeding; and those who are concerned in particular with maternal and infant nutrition should make themselves familiar with their obligations under this Code.

Labelling

● Labels should be designed to provide the necessary information about the appropriate use of the product, and so as not to discourage breastfeeding.

critics confronted the companies in court, notably the Swiss activist group *Arbeitsgruppe Dritte Welt* v. Nestlé (1974) and the Sisters of the Precious Blood v. Bristol Myers (1976). These cases attracted widescale publicity. Clearly the time had come to try and reach a concensus on the marketing of infant formulas which could be agreed to both by the health professionals and by the food industry.

The first joint meeting to discuss the issue had been convened in 1970 under the auspices of UNICEF and the Pan-American Health Organisation of the UN system, and was held in Bogota. It was followed by similar encounters sponsored by the UN Protein Advisory Group, in Paris, New York, Singapore and India. At the 27th World Health Assembly (1974) a resolution was passed which urged: "all member nations to review the promotional activities of baby food companies, to introduce appropriate remedial measures including a new look at promotion by advertising and the need to devise a code of ethics for the firms." Ross Laboratories had already devised its own code; ten other companies now formed an International Council of Infant Food Industries (ICIFI) and formulated another. Both these codes of ethics are general in nature, and permit wide interpretation in their application.

By the end of the decade the promotion of breastfeeding as one strategy to combat increasing infant malnutrition had become a subject, therefore, of international concern. This led WHO and UNICEF to co-sponsor an international "Meeting on Infant and Young Child Feeding", which was held in Geneva in October 1979 and attended by over 150 participants. These included representatives from UN agencies, from governments, the scientific community, non-governmental agencies, and the organizations and companies of the food industry. The recommendations made at this meeting have been carefully reviewed in further consultations with the groups concerned, and as a result, the fourth version of a WHO/UNICEF Code of Conduct on the marketing of infant formulas has been forwarded by WHO's Executive Board with its endorsement to the 34th World Health Assembly to be held in May 1981. It will be the prerogative of the governments at the Assembly to accept the document as a set of recommendations.

The promotion of breastfeeding

In many countries programmes to promote breastfeeding are being instituted with varying degrees of effectiveness. Much depends on factors such as the existing legislative measures in force, the opportunities available for training, the resources and personnel a country has available for the programme, and the existence of voluntary organizations such as mothers' support groups and consumer advocates.

Before a breastfeeding campaign can be effectively mounted, a community diagnosis is needed as to prevailing infant feeding practices. The necessary information can be obtained in conjunction with other on-going surveys, into fertility or the prevalence of diarrhoea, for example. A number of prevalence studies on breastfeeding have been undertaken in industrialized countries and in developing countries, as part of WHO's collaborative study on breastfeeding, or as part of national or community studies. ▷

Many variables have been examined, including pre-natal care, type of delivery, time of the first breastfeed, the use of pre-lacteal feeds, rooming-in, and the management of breastfeeding. Negative factors, which may inhibit successful lactation, have also been studied: unnecessary sedation of the mother, drugs given routinely to stop lactation, the attitude of health professionals, the role of food aid which interferes with breastfeeding, and family planning advice particularly where lactation-inhibiting oral contraceptives are involved.

In programmes dating from 1946-76, workers concentrated their efforts on testing the effectiveness of changing certain hospital procedures. The care of breasts (nipple retraction, prevention of engorgement) was encouraged, as was rooming-in, the education of parents and midwives, and early skin-to-skin contact. All of these proved beneficial in helping mothers achieve a more successful, and a longer, lactation period.

Towards a co-ordinated infant nutrition policy

In order to promote breastfeeding effectively, a co-ordinated infant nutrition policy is required at government level. This should include four main components: a public education and information campaign for professionals and the general public, using both mass media and material locally developed for distribution to mothers' groups; advisory services for mothers in all relevant health facilities such as pre- and post-natal clinics and maternity and paediatric wards; legislation in favour of pregnancy and lactation benefits; and monitoring of the food companies' activities by government agencies and consumer groups.

In some countries, efforts are already underway to introduce some or all of these components. A wide variety of information and educational literature has been developed in various countries. As part of Thailand's national programme, for example, competitions have been held to select posters, songs, and poems which have been widely disseminated throughout the country. The Paediatric Associations of certain countries (USA, Philippines) have strongly endorsed breastfeeding, and new textbooks have been developed for health cadres.

Adequate nutrition should be ensured for both pregnant and nursing mothers, through advice and extra vitamins, minerals, and food. ICEF 7897/Satyan

Mothers' support groups have played an important role in mobilizing women who wish to breastfeed but need information, encouragement and support. Many such groups exist—La Leche League International (USA), The Nursing Mothers of Australia, Ammenhjelpen (Norway), PPI (Malaysia), Susu Mama (Papua-New Guinea)—working closely with physicians, and are well informed on clinical problems which may arise in the management of breastfeeding.

Some governments have banned the advertising of infant formulas and no longer allow milk company personnel to visit hospital premises. In Papua New Guinea, the sale of feeding bottles, formula, nipples (teats), pacifiers (comforters) is prohibited, and these items can only be obtained on prescription by a suitably qualified practitioner. Only breast milk is advertised.

The code of behaviour of both personnel from the food industry as well as that of health professionals must be scrutinized. Careful decisions must be made at the highest political level regarding the importation and marketing of milk foods, fully realizing the important losses that a country incurs when women of reproductive age, not appreciating the benefits of breastfeeding, elect to bottle feed. There is no question that a considerable economic loss is sustained by their decision, not to mention the costs of rehabilitation of untold numbers of unnecessarily malnourished children. A multiple strategy must be put into effect to reverse the declining incidence of breastfeeding, not least important in which is the adherence of the food industry to the WHO/UNICEF Code of Conduct. All these measures will play a significant part in whether "Health for All by the Year 2000" becomes a reality for the youngest among us, or remains only a dream. □

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