

THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES

Countering Industry Arguments against Code Implementation: Evidence and Rights-Based Responses



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Introduction

In 1981, the World Health Assembly (WHA) adopted the International Code of Marketing of Breast-milk Substitutes (the original Code¹) to curtail the inappropriate marketing of breastmilk substitutes (BMS), infant feeding bottles and teats.² The original Code provides governments with recommendations on stopping the aggressive and inappropriate marketing of products that come under its scope, with the aim of protecting and supporting breastfeeding.^{3,4}

Since the original Code was adopted, the WHA has continued to keep it up to date, addressing loopholes and new challenges by:

- Adopting subsequent WHA resolutions on a range of relevant topics;⁵
- Calling for transparency and safeguards against conflicts of interest;⁶ and
- Calling on governments to implement relevant World Health Organization (WHO) guidelines, such as the WHO Guidance on ending the inappropriate promotion of foods for infants and young children in 2016 (the 2016 Guidance), which provides recommendations for supporting breastfeeding, preventing obesity and noncommunicable diseases, and promoting healthy diets for infants and young children.⁷

‘The Code’ is an umbrella term that includes the original Code and subsequent WHA resolutions (including the 2016 Guidance). The baby food industry often refers only to the original document, omitting the more recent clarifications contained in the subsequent WHA resolutions. This is an industry tactic used to cause confusion and divert attention away from the important Code developments since 1981.

Additional background on the Code can be found in ***What I Should Know About ‘the Code’: A guide to implementation, compliance and identifying violations.***

Implementing the Code in national laws⁸ is a legal obligation for all countries that have ratified the Convention on the Rights of the Child, which currently includes all countries except one.^{9,10} National laws that give effect to the Code are designed to stop harmful promotional practices and create a regulatory environment that can stand up against the profit-making motives of the baby food industry.

The baby food industry deploys the same interference strategies or corporate playbook every time a country begins the process of developing or amending Code-implementation laws.

1 The term ‘original Code’ refers to the instrument adopted by Resolution WHA 34.22, International Code of Marketing of Breast-milk Substitutes, Thirty-fourth World Health Assembly, 1981, <<https://iris.who.int/handle/10665/156596>> accessed 14 June 2024. Where the context requires, this term distinguishes it from subsequent WHA resolutions and the 2016 Guidance on ending the inappropriate promotion of foods for infants and young children, which, for brevity, are collectively referred to as ‘the Code’ in this document.

2 International Code of Marketing of Breast-milk Substitutes. Geneva: World Health Organization; 1981, <www.who.int/publications/item/9241541601> accessed 10 June 2024.

3 United Nations Children’s Fund (UNICEF), What I Should Know About ‘the Code’: A Guide to Implementation, Compliance and Identifying Violations, 2023, p. 4, <www.globalbreastfeedingcollective.org/what-i-should-know-about-code> accessed 10 June 2024.

4 The Code covers any milks that are specifically marketed for feeding infants and young children up to the age of 3 years; any other product marketed or otherwise represented as suitable for feeding infants up to the age of 6 months; feeding bottles and teats; and per the 2016 Guidance, commercially produced foods that are marketed as being suitable for infants and young children from the age of 6 months to 36 months. A more detailed discussion can be found in the section on scope.

5 World Health Organization, Code and subsequent resolutions, <www.who.int/teams/nutrition-and-food-safety/food-and-nutrition-actions-in-health-systems/code-and-subsequent-resolutions> accessed 10 June 2024.

6 Many WHA resolutions specifically address conflicts of interest. Resolution WHA 49.15, Infant and young child nutrition, Forty-ninth World Health Assembly, 1996, <<https://iris.who.int/handle/10665/179437>> accessed 14 June 2024; Resolution WHA 58.32, Infant and young child nutrition, Fifty-eighth World Health Assembly, 2005, <<https://iris.who.int/handle/10665/20382>> accessed 14 June 2024; Resolution WHA 61.20, Infant and young child nutrition, Sixty-first World Health Assembly, 2008, <<https://iris.who.int/handle/10665/23549>> accessed 14 June 2024; Resolution WHA 65.60, Maternal, infant and young child nutrition, Sixty-fifth World Health Assembly, 2012, <<https://iris.who.int/handle/10665/80480>> accessed 14 June 2024; Resolution WHA 69.9, Ending inappropriate promotion of foods for infants and young children, Sixty-ninth World Health Assembly, 2016, <<https://iris.who.int/handle/10665/252789>> accessed 14 June 2024.

7 Maternal, infant and young child nutrition: Guidance on ending the inappropriate promotion of foods for infants and young children, report by the Secretariat, World Health Organization, 2016, <https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_7Add1-en.pdf?ua=1> accessed 10 June 2024; welcomed in Resolution WHA 69.9.

8 Countries have varied terms and definition for legal instruments. In this document, the terms ‘laws’, ‘legislation’, ‘regulations’, ‘measures’ and ‘policies’ are used interchangeably to mean binding legal measures.

9 United Nations, Convention on the Rights of the Child, New York, 20 November 1989, art. 24.

10 United Nations Committee on the Rights of the Child. General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), CRC/C/GC/15, art. 24, para. 44, <www.ohchr.org/en/documents/general-comments-and-recommendations/crcgc15-general-comment-no-15-right-child-highest> accessed 10 June 2024.

Evidence shows that breastfeeding rates are considerably higher in countries that have enacted legislation that is substantially aligned with the Code compared to countries that have not implemented the Code or have only adopted a few of its provisions.¹¹

Using similar tactics as those applied by the tobacco industry,¹² the baby food industry has consistently worked to thwart, distort and weaken Code implementation laws around the world. This includes lobbying political leaders, threatening litigation against governments and promoting voluntary measures or self-regulation as an alternative to legislation. These actions are coordinated on a global scale and executed by companies in the baby food industry, along with the trade associations and front groups that work on their behalf.¹³

More details about the baby food industry's tactics are available here: ***Protecting Infant and Young Child Nutrition from Industry Interference and Conflicts of Interest***.

Industry actors often raise arguments against Code implementation that lack legal merit, yet present them as valid and serious concerns. This can lead to stalled and weakened laws, as policymakers devote time and resources to understanding and finding solutions to these arguments. The industry views these delayed and compromised measures as successes because they provide an opportunity to profit – regardless of the resulting harm to infant, young child and maternal health.

Common arguments made by the baby food industry and its global political influence network against the Code implementation are set out below, along with suggested responses and their rationales. This resource is grounded in evidence and international human rights law. It is designed to equip policymakers with the information they need to deal with false or misleading industry arguments that are framed to seem valid. It is intended to facilitate national Code implementation by helping policymakers withstand and counter industry opposition.

11 UNICEF and WHO, Global Breastfeeding Scorecard 2023, figures 5 and 6 <<https://www.unicef.org/documents/global-breastfeeding-scorecard-2023>> accessed 24 July 2024.

12 Granheim, Sabrina I., et al., 'Interference in public health policy: examples of how the baby food industry uses tobacco industry tactics', World Nutrition, vol. 8, no. 2, 2017, pp. 288-310, <<https://doi.org/10.26596/wn.201782288-310>> accessed 10 June 2024.

13 UNICEF, Protecting Infant and Young Child Nutrition from Industry Interference and Conflicts of Interest, 2023, p.5, <www.globalbreastfeedingcollective.org/media/2126/file> accessed 10 June 2024.

Common industry arguments opposing the Code and national implementation

Click each argument to find responses that are grounded in evidence and human rights

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Argument 7: Follow-up formula (or growing-up milk) is intended to compete with other commercial products (e.g., plain milk, soda), not with breastfeeding; most children are not breastfed after one year.	10	Argument 18: The baby food industry supports the Code and already has its own policies to comply with it. These so-called voluntary codes or industry self-regulation are more effective, less costly and easier to implement.	18
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V. 'Code implementation violates intellectual property rights.'	14		
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XI. 'Code implementation constrains women's choices, their participation in the workforce and gender equality.' 22

Argument 23: The Code hinders women's participation in the workforce and impedes gender equity. 22

Argument 24: The Code prevents fathers and non-birth parents from contributing to infant feeding and infringes on gender equity. 23

Argument 25: The Code is discriminatory towards the LGBTQIA+ community and a barrier to accessing the formula feeding information that they need. 23

XII. 'Companies must be able to communicate information with consumers and health professionals.' 24

Argument 26: The Code interferes with companies' abilities to communicate with consumers and health professionals. 24

Argument 27: Health care providers need information about which formulas to use and about formula innovations. Therefore, corporate access to health workers, including through sponsored meetings, is needed. 25

Argument 28: To create healthier products, industry needs to have regular interaction with health workers who can identify and articulate needs. 25

Argument 29: Prohibiting advertising deprives consumers of information and undermines parents' right to choose. 26

XIII. 'The Code does not/should not apply in emergencies.' 26

Argument 30: Even though breastfeeding is critical in emergencies, BMS will still be needed in some circumstances. Having governments purchase BMS and related products through normal channels during emergencies is an unnecessary financial burden that can be addressed through company donations. 26

XIV. 'Multi-stakeholder approaches and corporate social responsibility are important.' 27

Argument 31: Complex problems can only be solved with everyone, including industry, around the table. 27

Argument 32: Tying corporations up in regulatory straightjackets is unnecessary when companies already have sound principles and core values. 28

Argument 33: Companies can reorient themselves and shift towards rebalancing purpose and profits. 28

XV. 'BMS and commercial complementary foods are healthier choices.' 28

Argument 34: Breastfeeding may not always be best for an infant and is unimportant after 12 months of age. 28

Argument 35: Commercially-produced complementary foods may be nutritionally superior to home-prepared foods. 29

Argument 36: Follow-up formula and commercial complementary foods are healthier than other alternatives, such as soda, chips or ice cream. Marketing of the 'healthier' products reduces the consumption of these less healthy products. 30

I. 'The Code is not binding.'

Argument 1: The Code is merely a recommendation from the WHA to governments and is thus not binding.

Response: Although the original Code was adopted as a recommendation from the WHA, governments that have ratified the **Convention on the Rights of the Child** – which includes all countries in the world except the United States – are legally obliged to implement the Code to fulfil their obligations under the Convention.¹⁴

- The Convention on the Rights of the Child places a duty on governments to provide their citizens with education and knowledge on “child health and nutrition” and “the advantages of breastfeeding.”¹⁵
- Pursuant to this duty, governments must take appropriate measures to protect the public, particularly parents and caregivers, from the biased and often false information in the marketing of products within the scope of the Code.
- In the case of the child’s right to health, this includes Code implementation.¹⁶

A joint statement in support of increased efforts to protect, promote and support breastfeeding issued by the United Nations Special Rapporteurs on the Right to Food and the Right to Health, the Working Group on Discrimination Against Women in Law and in Practice and the Committee on the Rights of the Child stresses that:

“Adopting such measures must be recognized as part of States’ core obligations under the Convention on the Rights of the Child and other relevant United Nations human rights instruments to respect, protect and fulfil children’s right to life, survival and development; their right to safe and nutritious foods, and their right to the enjoyment of the highest attainable standard of health; and to ensure that women’s rights are protected from harmful interference by non-State actors, in particular the business sector.”¹⁷

Other human rights documents that highlight the need for Code implementation include General Comments No.15 (2013)¹⁸ and No.16 (2013),¹⁹ which specifically urge governments to implement the Code and for industry to comply with it.

II. 'The Code is not universal.'

Argument 2: The Code applies only to low-income or high-risk countries where there is high infant mortality and morbidity.

Response: The language of the original Code does not justify attempts by Code opponents to divide the world according to income levels, health risks or development status. WHA Resolution 34.22, which adopted the original Code in 1981, stressed that breastfeeding must be actively promoted in **all** countries and that adoption of and adherence to the Code are **minimum requirements**.

Many countries, regardless of their income or risk level, have implemented the Code to protect and promote breastfeeding, regulate the marketing of breastmilk substitutes and comply with their international human rights obligations.²⁰ The Code protects all infants, regardless of how they are fed. It also protects caregivers who use BMS from being exposed to misinformation and predatory marketing practices that may encourage the use of more expensive and unnecessary products. All mothers and infants benefit from breastfeeding, regardless of where they live or their socio-economic status.

¹⁴ What I Should Know About ‘the Code’, p.17.

¹⁵ Convention on the Rights of the Child, art. 24.

¹⁶ Protecting Infant and Young Child Nutrition from Industry Interference and Conflicts of Interest, p.14.

¹⁷ Office of the High Commissioner for Human Rights, Joint statement by the UN Special Rapporteurs on the Right to Food, Right to Health, the Working Group on Discrimination against Women in Law and in Practice, and the Committee on the Rights of the Child, in support of increased efforts to promote, support and protect breast-feeding, 17 November 2016, <www.ohchr.org/en/statements/2016/11/joint-statement-un-special-rapporteurs-right-food-right-health-working-group> accessed 10 June 2024.

¹⁸ Committee on the Rights of the Child, General comment No. 15, paras. 44, 81.

¹⁹ United Nations Committee on the Rights of the Child, General comment No. 16 (2013) on State obligations regarding the impact of the business sector on children’s rights, CRC/C/GC/16, paras. 9, 57 <www2.ohchr.org/english/bodies/crc/docs/crc.c.gc.16.pdf> accessed 10 June 2024.

²⁰ World Health Organization, United Nations Children’s Fund (UNICEF), Marketing of breast-milk substitutes: national implementation of the International Code, status report 2024, <www.who.int/publications/i/item/9789240094482> accessed 11 June 2024.

The United Nations position

“Neither WHO nor UNICEF draw any distinction between developed and developing countries with respect to breastfeeding in general or the International Code in particular...it is the position of WHO and UNICEF that the adoption of and adherence to the International Code of Marketing of Breast-milk Substitutes in its entirety in all countries is a minimum requirement...”

Letter to the President of the International Association of Infant Food Manufacturers from Dr Hiroshi Nakajima, former Director General of WHO and Mr. James Grant, former Executive Director of UNICEF, 9 July 1991 (emphasis added)

The human rights perspective

The 2012 Children’s Rights and Business Principles guide companies on the full range of actions they can take in the workplace, marketplace and community to respect and support children’s rights. Regarding marketing and advertising, companies should “comply with the standards of business conduct in World Health Assembly instruments related to marketing and health in all countries. Where national law prescribes a higher standard, business must follow that standard.”²¹

Argument 3: Code implementation is not appropriate for low-income countries because monitoring and enforcement are too complicated and expensive.

Response: National Code implementation is important and essential for all countries. While implementing, monitoring and enforcing regulations can seem challenging, especially in low-income countries, it is possible to find practical and cost-effective strategies.

Processes that can bring positive economic impacts include:

- **Imposing a system of fines:** Penalties deter violations and if adequately levied, can generate substantial revenue for reinvestment in regulatory enforcement efforts or public health projects.
- **Digitization:** Digital solutions can streamline the implementation and monitoring of regulations at a fraction of the cost needed using conventional methods. Digital systems are cost-saving measures that can reduce paperwork, minimize human errors and provide real-time data for monitoring and enforcement.

- **Risk-based monitoring and enforcement:** Prioritizing monitoring and enforcement efforts based on risk assessments and directing resources only to areas with the highest potential for harm or non-compliance, such as promotion in hospitals and labelling, can help efficiently mobilize resources.
- **Capacity building:** Training local officials and regulators in law enforcement, data analysis and compliance procedures will ensure successful implementation, monitoring and enforcement of public health measures.
- **Public awareness:** Raising public awareness about the importance of Code regulations and their role in protecting maternal and child health can facilitate community involvement in Code monitoring and enforcement. An informed public can be motivated to act as watchdogs and report violations, reducing the burden on monitoring and enforcement agencies.
- **International aid:** Many international organizations, NGOs and donor countries are willing to assist low-income countries in strengthening their regulatory frameworks by building regulatory capacity and providing technical expertise.

By adopting strategic and adaptive approaches to Code implementation, monitoring and enforcement, low- and middle-income countries can make progress in this area over time, even with limited resources.²²

Argument 4: The Code only applies where it has been implemented in national legislation; companies follow the laws of each country.

Response: Regardless of national measures, the baby food industry is responsible for ensuring that its conduct **at every level** conforms to the Code.²³ This means that companies are obliged to implement the minimum standards prescribed by the Code wherever they have business activities, **independent of national measures**.²⁴

When countries have laws that are more protective than the Code’s minimum requirements, companies must comply with those stronger national laws, as the Code was adopted as a ‘minimum requirement’ or a floor for rather than a ceiling.²⁵

21 United Nations Children’s Fund (UNICEF), Save the Children and United Nations Global Compact, Children’s Rights and Business Principles, 2012, principle 6, <www.unicef.org/csr/195.htm> accessed 11 June 2024 (emphasis added).

22 Hou, Kroeun, et al., Pilot implementation of a monitoring and enforcement system for the International Code of Marketing of Breast-milk Substitutes in Cambodia, Maternal & Child Nutrition, 2019 <<https://onlinelibrary.wiley.com/doi/10.1111/mcn.12795>> accessed 22 July 2024; and Backholer, Kathryn, et al., Violations of Vietnamese laws related to the online marketing of breastmilk substitutes: Detections using a virtual violations detector, Maternal & Child Nutrition, 2024. (forthcoming)

23 International Code of Marketing of Breast-milk Substitutes, art. 11.3.

24 World Health Organization, The International Code of Marketing of Breast-milk Substitutes: Frequently Asked Questions, 2017 Update, p.13, <<https://iris.who.int/bitstream/handle/10665/254911/WHO-NMH-NHD-17.1-eng.pdf?sequence=1>> accessed 11 June 2024.

25 Resolution WHA 34.22, Thirty-fourth World Health Assembly, 1981, <<https://iris.who.int/handle/10665/156596>> accessed 14 June 2024.

III. 'The Code's scope is narrow.'

Argument 5: The Code protects breastfed infants and young children at the expense of non-breastfed infants and young children.

Response: The Code protects all infants and young children, regardless of how they are fed.

- It recognizes that when mothers do not breastfeed, there is a **legitimate market**²⁶ for formula and baby feeding products and that these products *should* be made accessible to those who need them.
- While the Code ensures that BMS are not marketed or distributed in ways that may discourage breastfeeding, it also ensures that decisions on the use of BMS should be based on accurate information and counselling.²⁷
- The Code further ensures that product labels carry necessary warnings and directions for safe preparation.²⁸

Taking advantage of the term 'legitimate market'

During the Code's drafting process, industry lobbied for text referring to the "legitimate market for infant formula" and often uses this phrase to advance arguments against strong regulation. For example, when breastmilk was found to be one transmission route for HIV, industry argued that mothers living with HIV were a 'legitimate market for infant formula', leveraging this language to call for weaker national Code implementation measures. In doing so, industry ignored the fact that the Code was never intended to ban the sale of BMS, but rather to regulate marketing activities that discourage breastfeeding. The Code is now acknowledged to be of particular relevance in the context of HIV, as it regulates the distribution of BMS to prevent spill-over to infants and young children who would benefit from breastfeeding.

International Baby Food Action Network, International Code Documentation Centre, Code Essentials 1: Annotated International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions, second edition, 2018, p.8, <www.babymilkaction.org/wp-content/uploads/2023/05/201801-CE1-2nd-Edition-Final.pdf> accessed 12 June 2024.

Argument 6: The Code applies only to infant formula products for children up to the age of 6, 12 or 24 months.

Response: The Guidance on ending the inappropriate promotion of foods for infants and young children²⁹ has made the scope of the Code clear: it confirms that BMS should be understood to include any milks (or products that could be used to replace milk, such as non-dairy milk) that are specifically marketed for the feeding of infants and young children **up to the age of 3 years**. This includes follow-up formula (usually marketed as suitable for infants from 6 months of age) and growing-up milks marketed for older infants and young children.³⁰ Countries are therefore required to include these products in the scope of their national laws.

Before the 2016 Guidance, public health advocates and the baby food industry argued for years over which products were being 'marketed' as partial or total replacements for breastmilk. This is largely due to the original Code's use of the ambiguous term 'breastmilk substitute'.³¹

Some Code opponents maintain, without justification, that the Code covers only infant and follow-up formula products for healthy infants up to 12 or 24 months. Others even claim that the scope of the Code excludes milk products marketed for infants from 6 months of age, misconstruing the WHO recommendation to breastfeed exclusively for six months and ignoring recommendations to continue breastfeeding alongside family foods for up to two years and beyond.

The baby food industry's incorrect interpretation of the scope of the Code led it to develop and promote a new range of commercial milk formulas – first follow-up formulas and then growing-up milks – which did not exist when the Code was adopted, and which they claim are exempt from the Code.

26 International Code of Marketing of Breast-milk Substitutes, preamble.

27 International Code of Marketing of Breast-milk Substitutes, arts. 4.2, 6.5, 7.1, 7.2.

28 International Code of Marketing of Breast-milk Substitutes, art. 9; Resolution WHA 58.32; Resolution WHA 61.20; Resolution WHA 63.23, Infant and young child nutrition, Sixty-third World Health Assembly, 2010, <<https://iris.who.int/handle/10665/3097>> accessed 14 June 2024.

29 World Health Organization, Guidance on ending the inappropriate promotion of foods for infants and young children: implementation manual, 2017, p.9, <<https://iris.who.int/bitstream/handle/10665/260137/9789241513470-eng.pdf>> accessed 11 June 2024.

30 Guidance on ending the inappropriate promotion of foods for infants and young children, recommendation 2.

31 Under Article 3 of the original Code, "breastmilk substitute" means any food being marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not it is suitable for that purpose.

Article 2 of the original Code clearly does not support this narrow interpretation of its scope, as nothing in it sets an age limit for its application.³² The baby food industry continues to ignore the clear scope stated in the 2016 Guidance, and growing-up milks are “the main growth-driving category in milk formula globally.”³³

Argument 7: Follow-up formula (or growing-up milk) is intended to compete with other commercial products (e.g., plain milk, soda), not with breastfeeding; most children are not breastfed after one year.

Companies often lobby governments not to include follow-up formula within the scope of their national measures.

- They base their argument on the wording of the original Code, which covers products “marketed or otherwise represented” as replacements for breastmilk.³⁴
- Companies claim that follow-up milks do not replace breastmilk because they are promoted only for older infants and young children who are no longer breastfeeding and that it is better to promote follow-up formula than other unsuitable commercial drinks.³⁵

Response: The 2016 Guidance confirms that BMS include any milks that are specifically marketed for the feeding of infants and young children **up to the age of 3 years**, including follow-up formula and so-called growing-up milk (drinks for young children).³⁶ It is important for countries to include these products in the scope of their national laws because:

- Internationally agreed recommendations for optimal feeding of infants and young children advocate for exclusive breastfeeding for the first six months of life, followed by complementary feeding and continued breastfeeding for up to two years **or beyond**.³⁷ As such, protection of continued breastfeeding up to two years and beyond is essential.
- The baby food industry engages in **cross-promotion**, which is the use of similar brand names, packaging designs, labels, text, images, colour schemes, symbols, slogans or other means for the purpose of promoting another product. Specifically, it promotes toddler milks as part of a strategy to cross-promote infant formula and circumvent national Code legislation.³⁸ Companies use this tactic to extend their marketing to an entire product range and build brand loyalty.
- The WHA considers follow-up milks to be unnecessary.³⁹ Allowing the promotion of follow-up formula can defeat public health efforts to encourage women to continue breastfeeding for up to two years and beyond.

Breastfeeding should remain the first choice for meeting a child’s milk requirements during the period of 6 to 24 months of age and beyond. It offers health advantages for the mother and child and provides immuno-protective factors that help to reduce both the rates and severity of infections during those months.

32 Article 2 of the original Code reads:

“The Code applies to the marketing, and practices related thereto, of the following products: breastmilk substitutes; other milk products, foods, and beverages, including bottle-fed complementary foods, when marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breastmilk; feeding bottles and teats. It also applies to their quality and availability, and to information concerning their use.”

33 Euromonitor International, Milk Formula: Innovation and Segmentation Strategies Amid Entrenched Challenges, December 2020, <www.euromonitor.com/milk-formula-innovation-and-segmentation-strategies-amid-entrenched-challenges/report> accessed 12 June 2024.

34 International Code of Marketing of Breast-milk Substitutes, art. 2.

35 Sokol, Ellen J., The Code Handbook: A Guide to Implementing the International Code of Marketing of Breastmilk Substitutes, Second Edition, International Code documentation Centre, International Baby Food Action Network, 2005, p. 51, <www.babymilkaction.org/wp-content/uploads/2023/06/The-Code-Handbook-2005-with-appendices.pdf> accessed 11 June 2024.

36 Guidance on ending the inappropriate promotion of foods for infants and young children, recommendation 2.

37 World Health Organization, United Nations Children’s Fund (UNICEF), Global Strategy for Infant and Young Child Feeding, <www.who.int/publications/i/item/9241562218>, para. 10.

38 World Health Organization, United Nations Children’s Fund (UNICEF), Information note: Cross-promotion of infant formula and toddler milks, <www.who.int/docs/default-source/nutritionlibrary/breastfeeding/information-note-cross-promotion-infant-formula.pdf?sfvrsn=81a5b79c_1#:~:text=The%20International%20Code%20of%20Marketing%20of%20Breast-milk%20Substitutes,creates%20confusion%20about%20the%20use%20of%20infant%20formula> accessed 11 June 2024.

39 Resolution WHA 39.28, Infant and Young Child Feeding, Thirty-ninth World Health Assembly, 1986, <<https://iris.who.int/handle/10665/163189>> accessed 14 June 2024.

BMS (including follow-up formula) and complementary foods do not have these advantages.⁴⁰ As of 2023, WHO recommends that young children 12–23 months of age who are not breastfeeding should be fed animal milk. Follow-up milks are not recommended.⁴¹

Some countries have broadened the scope of their Code laws to address these concerns. For example, the national measures adopted in Bangladesh, Fiji, the United Republic of Tanzania and Zimbabwe cover BMS products up to the age of 60 months.⁴²

Argument 8: The Code does not apply to complementary foods.

Response: When implementing the Code in relation to complementary foods,⁴³ the focus must be on the **function of the food**:

- Any product (by whatever name or description) that is marketed to **replace** all or some of the breastmilk part of the diet of an infant or young child is a breastmilk substitute and within the scope of the Code. The promotion of these products should be **absolutely prohibited**.
- Any food that is marketed as suitable for infants and young children **below 6 months** of age fits within this category, since international health authorities recommend that all infants be fed only breastmilk for the first six months of life. This includes foods and drinks other than formula milks. Any food introduced before 6 months of age necessarily replaces breastmilk and therefore functions as a breastmilk substitute. Introducing breastmilk substitutes is known to increase the chances that the infant stops breastfeeding earlier than recommended, which deprives infants and their mothers of the consequent benefits of breastfeeding.

- **The inappropriate promotion** of complementary foods that are not marketed to replace the breastmilk part of an infant and young child's diet should be prohibited according to the 2016 Guidance.⁴⁴ Developing or strengthening legal measures to implement the Code provides a useful entry point for building in these protections.

The 2016 Guidance also includes important protections against any promotion of foods for infants and young children that will **cross-promote** breastmilk substitutes (e.g., using similar colours, mascots and wording on labels), or encourage or promote bottle feeding.⁴⁵

Argument 9: Pacifiers (also known as soothers or dummies) are not included in the Code.

Response: Pacifiers are not specifically addressed in the Code itself. In some languages and cultures, the term 'teat' – a product covered by the Code – includes a pacifier. Many countries have included pacifiers in the scope of their Code legislation.

Recalling that the Code is a minimum standard,⁴⁶ and since the use of pacifiers can have implications for breastfeeding, the inclusion of pacifiers in national laws that implement the Code is a matter of policy and public health consideration. Inclusion of pacifiers may be considered if there are concerns about misleading marketing practices or inappropriate promotion that undermines breastfeeding.

Summary of the scope of the Code

The Code⁴⁷ covers the following products,⁴⁸ which national Code laws must include, at a minimum:

- Any milks that are specifically marketed for feeding infants and young children up to the age of 3 years, including infant and follow-up formulas and drinks for young children (often referred to as growing-up or toddler milks);⁴⁹

40 World Alliance for Breastfeeding Action, Protecting, Promoting and Supporting Continued Breastfeeding from 6–24 + Months: Issues, Politics, Policies & Action, 2008, <www.waba.org.my/pdf/gbpm_statement_June09.pdf> accessed 11 June 2024.

41 World Health Organization, WHO Guideline for complementary feeding of infants and young children 6–23 months of age, 2023, <<https://iris.who.int/handle/10665/373358>> accessed 14 June 2024.

42 National implementation of the International Code, status report 2024.

43 Article 3 of the original Code defines the term 'complementary food' to mean 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'. The Guidance on ending inappropriate promotion of foods for infants and young children defines foods for infants and young children in paragraph 6 "as commercially produced food or beverage products that are specifically marketed as suitable for feeding children up to 36 months of age".

44 A concise table explaining what is to be considered 'appropriate' promotion of foods for infants and young children is provided in What I Should Know About 'the Code', p.11.

45 Guidance on ending the inappropriate promotion of foods for infants and young children: implementation manual, p.9.

46 Resolution WHA 34.22.

47 International Code of Marketing of Breast-milk Substitutes, art. 2.

48 What I Should Know About 'the Code', p.7.

49 Guidance on ending the inappropriate promotion of foods for infants and young children: implementation manual, p. 8.

- Any other product marketed or otherwise represented as suitable for feeding infants up to the age of 6 months, since anything fed to a baby before the age of 6 months will replace breastmilk, including water;
- Commercially-produced foods that are marketed as being suitable for infants and young children from the age of 6 months to 36 months⁵⁰ (which are subject to a prohibition on inappropriate promotion per the 2016 Guidance, as opposed to the absolute prohibition that applies to BMS, feeding bottles and teats); and
- Feeding bottles and teats.⁵¹

Argument 10: The Code does not apply to digital environments.

Related arguments include:

- Digital environments are too complex to regulate, particularly for low- and middle-income countries.
- Regulating cross-border marketing is not possible.

Response: In 2023, at the request of the WHA, the WHO published the Guidance on Regulatory Measures Aimed at Restricting Digital Marketing of BMS (the 2023 Guidance).⁵² The 2023 Guidance notes that “digital environments are fast becoming the predominant source of exposure to promotion of breast-milk substitutes globally” and provides recommendations to assist Member States in applying the Code in digital environments.

All countries can regulate digital environments, including cross-border marketing. The 2023 Guidance recognizes that approaches to regulating digital environments need to be tailored to national contexts. For example, actors in the digital space (such as manufacturers, distributors, social media platforms, online advertisers, internet service providers, etc.) will have a registered presence in some countries, but not others. In countries where the entity (such as Google, Facebook or a BMS manufacturer) has a legal presence or is registered, it may be easier for the government to assign it legal duties under the law and be able to enforce these through penalties, as well as through

their licence and registration. In other countries where these entities do not have a legal presence, additional mechanisms may be more effective, such as placing legal obligations on internet service providers to monitor and remove any non-compliant digital content.

UNICEF is available upon request to provide support on including digital environments in Code implementation laws. The Model Law for Protection of Breastfeeding in South Asia includes digital environments throughout. Although it was developed in South Asia, the content of the Model Law is relevant for all regions.⁵³

IV. ‘Code implementation violates international trade agreements.’

Argument 11: Implementation of the Code restricts trade and contravenes international trade agreements.

Response: Not a single formal legal challenge has been brought on the basis of international trade law to Code implementation measures across 146 countries. This includes countries that have enacted measures that go beyond the minimum standards set out in the Code.

However, industry-driven trade threats and arguments persist. These include allegations that certain aspects of proposed Code-based legislation – especially those pertaining to food safety and labelling measures that govern product characteristics – impose unnecessary obstacles to trade under international trade agreements. Often, these arguments are baseless and are used as scare tactics. Nevertheless, it is important for governments to be aware of key international trade law agreements and principles so that they can resist threats and challenges and develop strong, legally sound Code laws.

The World Trade Organization (WTO) Agreement⁵⁴ is the central multilateral treaty governing international trade,⁵⁵ which encompasses several WTO agreements.⁵⁶ There are four main WTO agreements that have some bearing on Code provisions:

50 Ibid., p.5.

51 Many countries have also included pacifiers in the scope of their national measures. Franco-Lares, B., et al., Legislation on marketing of breast-milk substitutes in digital and social media: a scoping review, *BMJ Global Health*, 2023, <www.ncbi.nlm.nih.gov/pmc/articles/PMC10016289/> accessed 12 June 2024.

52 World Health Organization, Guidance on regulatory measures aimed at restricting digital marketing of breast-milk substitutes, 2023, <www.who.int/publications/i/item/9789240084490> accessed 12 June 2024.

53 United Nations Children’s Fund (UNICEF), The Model Law for Protection of Breastfeeding in South Asia: A tool to help strengthen national regulatory frameworks for ending inappropriate marketing of breast-milk substitutes and foods for infants and young children, UNICEF Regional Office for South Asia, 2024 <<https://www.unicef.org/rosa/reports/model-law-protection-breastfeeding-south-asia>> accessed 14 August 2024.

54 Marrakesh Agreement Establishing the World Trade Organization, 1867 U.N.T.S. 154, 15 April 1994, <www.wto.org/english/docs_e/legal_e/04-wto_e.htm> accessed 12 June 2024.

55 World Health Organization, United Nations Children’s Fund, International trade agreements and implementation of the International Code of Marketing of Breast-milk Substitutes: Frequently Asked Questions, 2020, <<https://iris.who.int/bitstream/handle/10665/331897/9789240002722-eng.pdf?sequence=1>> accessed 12 June 2024.

56 Marrakesh Agreement Establishing the World Trade Organization (providing a full list of the covered agreements in the List of Annexes).

- i. The **General Agreement on Tariffs and Trade (GATT)**⁵⁷ governs trade in goods and has the widest application of the WTO covered agreements. Among other things, the GATT prohibits discriminatory measures – which are measures that treat imported products less favourably than domestically produced goods, or treat ‘like’ products from different trading partners unequally.
- ii. The **Agreement on Sanitary and Phytosanitary Measures**⁵⁸ requires that countries do not set unnecessary, arbitrary, scientifically unjustifiable or disguised restrictions on international trade when they adopt national measures to ensure food safety and protection of human life from plant or animal-carried diseases.
- iii. The **Agreement on Technical Barriers to Trade (TBT)**⁵⁹ requires that technical regulations and standards governing product characteristics, production methods and their related processes do not unnecessarily restrict trade.
- iv. The **Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS)**⁶⁰ obliges WTO Members to provide minimum protection to a range of intellectual property rights, including trademarks, and is relevant to labelling measures that restrict use of images or words on product packaging.

*These agreements and their principles are explained in more detail in the WHO/UNICEF policy brief, international trade agreements and implementation of the International Code of Marketing of Breast-milk Substitutes: frequently asked questions.*⁶¹

When implementing the Code and facing threats regarding international trade law, consider the following principles:⁶²

- States have **obligations to protect, respect and fulfil the right to health under international human rights law**, including an obligation to protect and support breastfeeding under Article 24 of the Convention on the Rights of the Child.

- International trade agreements, including WTO agreements, recognize the right of States to regulate, including to protect health. Under WTO law, each WTO Member has the right to determine its own appropriate level of protection with respect to a health risk.⁶³
- When implementing the Code, WTO Members should ensure that regulations are no more trade restrictive than necessary to achieve their objectives.
- WTO Members should also ensure that regulations do not discriminate. For example, they should not treat imported products less favourably than domestic products.

Governments should not be intimidated by threats of potential violations of international trade agreements and should request any such challenges in writing so that a response can be prepared with the assistance of a lawyer. WHO and UNICEF can provide advice on dealing with trade-related threats or challenges.

TBT notification requirements

Regulations implementing the Code may be subject to the TBT Agreement, which includes a requirement under Article 2.9 for governments to notify the TBT Committee of a draft law that may impact trade.

This system of notification to a central registry enables WTO Members to be informed about prospective laws in other countries that may affect trade and raise comments or concerns.^{64,65} WTO Members may express objections to notifications in the TBT Committee, separate from the dispute settlement process. The fact that a WTO Member objects to a notified law does not necessarily mean that the measure violates WTO law or needs to be changed.

Note that the legal measure must still be in draft form and capable of amendment. The WTO TBT procedure requires a 60-day period during which amendments can still be made to the law, so that written comments from other WTO members can be sent on the draft measure. This time should be factored into the legislative timeframe.

57 General Agreement on Tariffs & Trade 1994, 1867 U.N.T.S. 190, <www.wto.org/english/docs_e/legal_e/06-gatt_e.htm> accessed 12 June 2024.

58 Agreement on the Application of Sanitary and Phytosanitary Measures, 1867 U.N.T.S. 493, <www.wto.org/english/docs_e/legal_e/15sps_01_e.htm> accessed 12 June 2024.

59 Agreement on Technical Barriers to Trade, 1868 U.N.T.S. 120, <www.wto.org/english/docs_e/legal_e/17-tbt_e.htm> accessed 12 June 2024.

60 Agreement on Trade-Related Aspects of Intellectual Property, 1869 U.N.T.S. 299, <www.wto.org/english/docs_e/legal_e/31bis_trips_01_e.htm> accessed 12 June 2024.

61 International trade agreements and implementation of the International Code of Marketing of Breast-milk Substitutes.

62 Ibid.

63 Agreement on Technical Barriers to Trade, art. 2.

64 Decision on Notification Procedures, World Trade Organization, <www.wto.org/english/docs_e/legal_e/33-dnotf_e.htm> accessed 12 June 2024.

65 The WTO Secretariat runs technical assistance activities to assist countries in meeting their notification obligations. World Trade Organization, Trade Related Technical Assistance: Technical Assistance in meeting Member's notification obligations, <www.wto.org/english/tratop_e/devel_e/teccop_e/tctdnot_e.htm> accessed 12 June 2024.

The TBT Agreement also contains a further recommendation under Article 2.12 that there is a six-month period between the publication of the final legal measure and the date the new measures come into force. This is to allow exporters from other WTO Member countries sufficient time to change their manufacturing processes to comply with the new regulations.

V. 'Code implementation violates intellectual property rights.'

Argument 12: The Code cannot prevent a company from using a registered name or logo (a trademark) that is part of the company's intellectual property on product labels.

Response: A **trademark** identifies and distinguishes one company's products from that of another. It can take many forms, such as words, slogans, logos, shapes, colours and sounds.

- By registering a trademark, a company has the right to exclude other parties from using that trademark in relation to the same product type for which the trademark has been registered.
- Registration does not guarantee the absolute right to use that trademark. Companies are not exempt from any conditions or restrictions that may be imposed to limit the use of their trademarks by a country's competent authority.

If a government agency adopts a national law that imposes conditions on the marketing of baby food products that result in a limitation on the use of a registered trademark, that law will prevail, notwithstanding the fact that the trademark has been registered in the country.

The July 2016 ruling issued by the World Bank's International Centre for Settlement of Investment Disputes against tobacco giant Philip Morris International is a useful precedent.⁶⁶

- Philip Morris International attempted – but failed – to use a bilateral investment treaty to defeat Uruguayan laws restricting the use of trademarks on tobacco packaging.
- The tribunal found that a trademark holder does not enjoy an absolute right of use, free of regulation. A trademark holder only has an exclusive right to

exclude third parties from the market so that only the trademark holder has the possibility to use the trademark in commerce, subject to the State's regulatory power.

- The defeat of Philip Morris International in this high-profile case should, by analogy, deter the baby food industry from making similar types of attempts to challenge and delay public health protection measures that implement the Code.

As far as multilateral trade agreements are concerned, the WTO Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) also does not require Member States to grant trademark owners the right to use a trademark in the course of trade.⁶⁷ One WTO Panel has stated that TRIPS “does not generally provide for the grant of positive rights to exploit or use certain subject matter, but rather provides for the grant of negative rights to prevent certain acts. This fundamental feature of intellectual property protection inherently grants Members freedom to pursue legitimate public policy objectives.”⁶⁸

TRIPS and public health

“We agree that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members’ right to protect public health In this connection, we reaffirm the right of WTO Members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose.”

World Trade Organization, Declaration on the TRIPS agreement and public health, adopted 14 November 2001, para. 4, <www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm> accessed 12 June 2024 (emphasis added).

⁶⁶ Philip Morris Brands SARL v. Oriental Republic of Uruguay, ICSID, Case No. ARB/10/7, Award 7/8/16, <www.italaw.com/cases/460> accessed 12 June 2024.

⁶⁷ Agreement on Trade-Related Aspects of Intellectual Property, art. 16.1 (describing a negative right to exclude).

⁶⁸ European Communities, Protection of Trademarks and Geographical Indications for Agricultural Products and Foodstuffs, WT/DS290/R, 15 March 2005, para. 7.246, <<https://docs.wto.org/dol2fe/Pages/SS/directdoc.aspx?filename=Q:/WT/DS/290R.pdf&Open=True>> accessed 12 June 2024.

VI. 'A ban on promotion restricts access to and affordability of products.'

Argument 13: Restrictions on marketing make it difficult for companies to survive and sustain formula manufacturing for those who need the products. Restrictions also push up prices, making the products less affordable.

Response: The baby food business is extremely lucrative. The loss of avenues for promotion is unlikely to make the business unprofitable, even if there are fewer product sales.

Companies that market baby foods use unsubstantiated claims of health and other benefits⁶⁹ to persuade consumers to pay higher prices for their products. The nutritional composition of infant formula is tightly regulated in almost every market and there is no scientific evidence that any of the 'optional ingredients' confer any benefits. Marketing that claims otherwise is used to inflate prices by exploiting families' desire to offer their children the best available milk.

The Code does not restrict the manufacture of products or determine their price. Manufacturing is propelled by demand and there will always be a legitimate market for formula products among caregivers of infants who do not breastfeed.⁷⁰ Formula prices depend on factors such as market competition, government pricing policies and production costs – not on Code implementation.

Argument 14: The Code's ban on special sales and price reductions forces parents who cannot afford formula to resort to unsafe infant feeding practices.

Response: The Code does not interfere with the **establishment of pricing policies** and practices intended to provide products at lower prices on a long-term basis.⁷¹ However, random short-term special sales and price reductions are prohibited because of the risks entailed. For example:

- Parents may be enticed into purchasing products because of reduced pricing.
- Once the special sale period is over, some parents may no longer be able to afford to purchase the products at normal prices.

- If breastfeeding has been compromised or discontinued, families may seek cheaper alternatives to formula that are unsuitable for feeding infants.

To address issues of affordability for caregivers who cannot afford formula, governments should implement long-term, sustainable price controls or social protection measures.

VII. 'Code implementation will lead to national economic loss.'

Argument 15: Code implementation will lead to economic loss for the country.

Another way industry makes this argument is by claiming that the Code hinders potential economic prosperity for a country, since restricted marketing negatively affects relevant job creation and investment prospects.

Response: While national Code implementation may require short-term economic adjustments for baby food companies and the national economy, the **long-term benefits** to local communities of protecting, promoting and supporting breastfeeding will outweigh those concerns. The economic impact of implementing the Code should therefore be considered within the broader context of public health and societal well-being.

Companies often threaten to withdraw their investments from countries – particularly those where they manufacture their products or conduct other economic activities – if those countries adopt Code legislation. The industry argument for this withdrawal is that Code-related marketing restrictions lead to reduced sales and profits.

This threat is especially powerful in low-income countries that are just opening their markets. Companies play on the fear of repercussions to the national economy through lost foreign investments and work opportunities, job displacements and reduced tax revenue.

These industry arguments have led to the derailment of Code implementation in countries where policymakers did not realize that profits generated from foreign investments are mostly repatriated to shareholders abroad and are seldom channelled to local communities.

69 Cheung, Ka Y., et al., Health and nutrition claims for infant formula: international cross sectional survey, BMJ, 2023, <www.bmj.com/content/380/bmj-2022-071075> accessed 18 June 2024.

70 International Code of Marketing of Breast-milk Substitutes, preamble.

71 International Code of Marketing of Breast-milk Substitutes, art. 5.3 ("In conformity with paragraphs 1 and 2 of this Article, there should be no point-of-sale advertising, giving of samples, or any other promotion device to induce sales directly to the consumer at the retail level, such as special displays, discount coupons, premiums, special sales, loss-leaders and tie-in sales, for products within the scope of this Code. This provision should not restrict the establishment of pricing policies and practices intended to provide products at lower prices on a long-term basis.").

Some key points to consider regarding the potential economic impact of Code implementation are:

- **Health care savings:** Breastfeeding has proven health benefits across high-income and low-income settings alike. In the long run, a higher rate of breastfeeding can lead to reduced health care costs; the significant health care savings will offset potential short-term costs associated with Code implementation.
- **Improved productivity:** Breastfeeding leads to healthier children, which reduces the risk of sick days taken by working parents, resulting in increased workforce productivity for employers.
- **Economic equity:** Breastfeeding can help reduce health disparities within a country. The optimal nutrition that children receive through breastfeeding improves their overall health, potentially reducing the burden on social and health care services.

Health parity

“Breastfeeding is a natural ‘safety net’ against the worst effects of poverty ... Exclusive breastfeeding goes a long way toward cancelling out the health difference between being born into poverty and being born into affluence ... It is almost as if breastfeeding takes the infant out of poverty for those first few months in order to give the child a fairer start in life and compensate for the injustice of the world into which it was born.”

James Grant, former Executive Director, UNICEF

Policymakers may make use of the **Cost of Not Breastfeeding Tool**,⁷² which quantifies the impacts of not breastfeeding on human lives and the economies in 130 countries.

The Cost of Not Breastfeeding Tool calculates the following types of human and economic costs for mothers and children not breastfed according to WHO recommendations:⁷³

- **Child morbidity and mortality:** The number of cases and mortality due to childhood diarrhoea, pneumonia and attributable cases of childhood obesity.
- **Maternal morbidity and mortality:** The number of cases and mortality related to breast and ovarian

cancer and type II diabetes attributable to not breastfeeding according to recommendations.

- **Health system and household formula costs:** The direct medical costs for treatment of cases of childhood diarrhoea, pneumonia and type II diabetes in women attributable to not breastfeeding, as well as the cost of households using formula as a breastmilk substitute.
- **The future economic cost of mortality and cognitive losses:** The potential loss of contribution to a country’s economy through lost future earnings over a person’s productive years resulting from either premature mortality or cognitive losses in childhood due to not achieving gains in intelligence provided by being breastfed.

The figures generated below clearly defeat industry arguments about economic loss and make a compelling case for governments to invest in measures to scale up breastfeeding and nutrition interventions to strengthen human capital development and economic outcomes. One important action point is to regulate the baby food industry through Code-based legislation.⁷⁴

Astounding numbers

The results of the analysis using the **Cost of Not Breastfeeding Tool** show that not breastfeeding results in approximately:

- **424,249 child deaths (6 to 59 months)** from diarrhoea and pneumonia each year.
- **4.6 million cases of childhood obesity** each year.
- **93,863 maternal deaths** from breast and ovarian cancers as well as type II diabetes each year.
- **195 million IQ points lost** each year.
- **US\$23.94 billion in health system costs** each year.

Aggregating these costs, the total global economic losses are estimated to be **US\$507 billion**, or 0.6 per cent of global gross national income.

Nutrition International, Alive & Thrive, The Cost of Not Breastfeeding Tool, <www.aliveandthrive.org/en/the-new-cost-of-not-breastfeeding-tool> accessed 12 June 2024 (noting that figures continue to be updated; these calculations are based on data updated 14 January 2022).

72 Alive & Thrive, The new Cost of Not Breastfeeding tool, <www.aliveandthrive.org/en/the-new-cost-of-not-breastfeeding-tool> accessed 12 June 2024; Nutrition International, The Cost of Not Breastfeeding Tool, <www.nutritionintl.org/learning-resource/the-cost-of-not-breastfeeding-tool/> accessed 12 June 2024.

73 Alive & Thrive, Frequently Asked Questions About... The Cost of Not Breastfeeding Tool, <www.aliveandthrive.org/sites/default/files/1360-the-cost-of-not-breastfeeding-faq-v4-.pdf> accessed 12 June 2024; Nutrition International, Survive & Thrive, The Global Cost of Not Breastfeeding, August 2022, <[www.aliveandthrive.org/sites/default/files/2022-07/CONBF Global Brief-v6 %281%29.pdf](http://www.aliveandthrive.org/sites/default/files/2022-07/CONBF%20Global%20Brief-v6%20281%29.pdf)> accessed 12 June 2024.

74 Rollins, Nigel C., et al., Why invest, and what it will take to improve breastfeeding practices?, Lancet, 2016 breastfeeding series, vol. 387, issue 10017, pp. 491-504, <[www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)01044-2/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)01044-2/fulltext)> accessed 12 June 2024.

VIII. 'Resource-challenged health facilities need donations of BMS.'

Argument 16: Free and low-cost supplies help hospitals. Hospitals are struggling with inadequate budgets and having to purchase formula only makes this harder.

Response: The argument that hospitals will face financial hardships if free supplies are stopped is more imagined than real. Monitoring has shown that free supplies are mostly given to wealthy hospitals where patients have purchasing power and very seldom given to hospitals in deprived areas.⁷⁵

For any health care system that prioritizes breastfeeding, the small amount of formula products needed for children who have to be fed on formula can be procured through normal channels, the way food for adult patients and other hospital supplies are procured.

WHA resolutions subsequent to the original Code have repeatedly addressed the issue of product donations and, in 1994, resolution WHA 47.5 urged Member States "to ensure that there are no donations of free or subsidized supplies of breastmilk substitutes and other products covered by the International Code of Marketing of Breast-milk Substitutes in any part of the health care system". This is the prevailing recommendation, which supersedes previous approaches taken by the WHA:

- Article 6.6⁷⁶ in the original Code allowed for the donation of free and low-cost supplies (free supplies) of products under the scope of the Code to "organizations and institutions", but only for infants who **"have to be fed on breastmilk substitutes."**⁷⁷ The drafters intended the term "organizations and

institutions" to mean social welfare institutions, such as orphanages. But this allowed unsolicited free supplies to be delivered to hospitals at such regular intervals that many became dependent on them.

- Donations of free supplies became a time-tested technique to encourage formula feeding and create an implied medical endorsement for it.⁷⁸ Mothers who received free formula in hospitals tended to continue with the brand they were given.⁷⁹
- When the adverse effect of free supplies on breastfeeding initiation became clear, the WHA, through resolution WHA 39.28 (1986) called for the "small amount of breastmilk substitutes needed for the minority of infants who require them in maternity wards and hospitals" to be made available through "normal procurement channels and not through free or subsidized supplies."
- This did not stop free supplies, which led to the adoption of Resolution WHA 47.5 in 1994.

UNICEF and WHO launched the Baby-Friendly Hospital Initiative in 1991 to encourage health facilities worldwide to better support breastfeeding.⁸⁰ The initiative developed the Ten Steps to Successful Breastfeeding, which include updating health facility policies to prohibit free or subsidizes supplies and to procure necessary BMS, bottles and teats through regular procurement channels. There is substantial evidence that implementing the Ten Steps significantly improves breastfeeding rates.⁸¹

75 Based on ad hoc monitoring during field visits conducted by International Baby Food Action Network and International Code Documentation Centre from 1999–2019, as part of a Code training agenda.

76 International Code of Marketing of Breast-milk Substitutes ("Donations or low-price sales to institutions or organisations of supplies of infant formula or other products within the scope of this Code, whether for use in the institutions or for distribution outside them, may be made. Such supplies should only be used or distributed for infants who have to be fed on breastmilk substitutes. If these supplies are distributed for use outside the institutions, this should be done only by the institutions or organisations concerned. Such donations or low price sales should not be used by manufacturers or distributors as a sales inducement.").

77 The number of infants who "have to be fed on breastmilk substitutes" includes situations where the mother has died or is critically ill and where there is child abandonment, separation of mother and child due to natural or man-made disasters, inborn errors of metabolism and a select few maternal illnesses. World Health Organization, Report of the Joint WHO/UNICEF Consultation Concerning "Infants who have to be fed on breastmilk substitutes", Geneva, 17-18 December 1985, WHO/MCH/NUT/86.1, <https://iris.who.int/bitstream/handle/10665/61126/WHO_MCH_NUT_86.1.pdf?sequence=1&isAllowed=y> accessed 14 June 2024.

78 International Baby Food Action Network, The Issue: How breastfeeding is undermined, <www.ibfan.org/the-issue/> accessed 12 June 2024; Rosenberg, Kenneth D., et al., Marketing Infant Formula Through Hospitals: the Impact of Commercial Hospital Discharge Packs on Breastfeeding, American Journal of Public Health, vol. 98, no.2, February 2008, pp. 290-95, <www.ncbi.nlm.nih.gov/pmc/articles/PMC2376885/pdf/0980290.pdf> accessed 12 June 2024.

79 Public Citizen, Fact Sheet: Infant Formula Marketing in Doctors' Offices and Health Clinics, <www.citizen.org/article/fact-sheet-infant-formula-marketing-in-doctors-offices-and-health-clinics/> _ednref14> accessed 12 June 2024.

80 UNICEF and WHO, Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative, 2018, <<https://iris.who.int/bitstream/handle/10665/272943/9789241513807-eng.pdf?sequence=19>> accessed 22 July 2024.

81 Global Breastfeeding Collective, Implementing The Baby-friendly Hospital Initiative in Maternity and Newborn Facilities, 2019, <<https://www.globalbreastfeedingcollective.org/media/666/file/%20-%20Advocacy%20guidance%20brief.pdf>> accessed 22 July 2024.

IX. 'Industry has a role in public health policy development and implementation.'

Argument 17: Industry is a key stakeholder in infant and young child feeding and should be part of the policy development process.

Response: The involvement of industry in the policy development process, particularly when governments are taking steps to implement the Code, represents a conflict of interest and undermines Code implementation.

The Code makes clear that governments are responsible for giving effect to its provisions through national legislation, adding that they may seek the cooperation of WHO, UNICEF and other agencies of the United Nations system in doing so.⁸² There is no mandate or suggestion for governments to seek assistance from the industry that they are aiming to regulate.

The 2016 Guidance confirms that the involvement of the baby food industry during the drafting process is inappropriate. Thus, companies' involvement should be confined to interventions at public hearings, and all comments should be taken in writing and be on public record.

Countries can take inspiration from Article 5.3 of the WHO Framework Convention on Tobacco Control (WHO FCTC), which aims to protect strong tobacco control policies from the harmful influence of the tobacco industry. It requires parties to the treaty "to protect their public health policies related to tobacco control from commercial and other vested interests of the tobacco industry". The history of Code implementation suggests that legal measures prohibiting the inappropriate marketing of commercial formula milk products and foods for infants and young children require the same level of protection.⁸³

More information about conflicts of interest and mechanisms to protect against them is available in the UNICEF brief, *Protecting Infant and Young Child Nutrition from Industry Interference and Conflicts of Interest*.

Argument 18: The baby food industry supports the Code and already has its own policies to comply with it. These so-called voluntary codes or industry self-regulation are more effective, less costly and easier to implement.

Response: In resolution WHA 63.23 [2010], the WHA called on Member States to develop and improve controls over the marketing of breastmilk substitutes through **legislative, regulatory and or other effective measures**. It expressed concern over reports of the ineffectiveness of voluntary measures.

Previously, in resolution WHA 34.22 [1981], the WHA had urged Member States to translate the Code into "national legislation, regulations and other suitable measures." The term "other suitable measures" is undefined, and the baby food industry sought to exploit this ambiguity. It convinced quite a few countries to implement the Code as voluntary codes. These are **non-binding arrangements** between industry and one or more other parties, usually the government, to adhere to a set of standards in their marketing practices.

Voluntary codes are favoured by the baby food industry for many self-serving reasons:

- Industry can influence the wording or establish their own rules of conduct and deflect any push for regulation or severe sanctions.
- Voluntary codes tend to reduce standards and rules to their lowest common denominator and usually have few mechanisms to compel compliance.
- They are often used to position companies as rule-abiding or are used to deflect from harmful marketing practices that violate the Code.
- Complaints regarding unethical marketing practices tend to be resolved in favour of companies because of the participation of the baby food industry in adjudicating bodies.
- There is no legal sanction attached to breaches of voluntary codes and their success depends on the will of industry. At worst, companies found to be in breach of a rule of conduct will receive a light reprimand without any serious repercussions.
- Unlike laws, which apply to all actors in the market and are mandatory by nature, companies are free to opt in or out of voluntary codes depending on whether these instruments are to their liking.
- There is evidence that voluntary agreements are not only ineffective, but serve to undermine evidence-

⁸² International Code of Marketing of Breast-milk Substitutes, art. 11.1.

⁸³ Protecting Infant and Young Child Nutrition from Industry Interference and Conflicts of Interest, pp.12- 13.

based regulatory responses and negatively influence public health and policy.⁸⁴

Although the Code requires companies to comply with its provisions,⁸⁵ self-regulation in the absence of mandatory legal measures does not result in effective Code implementation.

Voluntary codes – a minimalist and fragmented approach

“Left to their own devices, transnational corporations are likely to fulfil their responsibility in a minimalist and fragmented fashion. Their strategies may be conducive to economic growth and the stability of their operating environments, but not necessarily to sustainable human development. They still need strong and effective regulation and a coherent response from civil society.”

United Nations Research Institute for Social Development, Visible Hands: Taking Responsibility for Social Development: UNRISD Report for Geneva 2000.

Argument 19: Collaboration with industry is the way forward, in light of diminishing public funds for research, education and training.

Response: Collaboration with the baby food industry gives rise to **conflicts of interest** (COI) within the health system. Professional judgement concerning a primary interest (i.e., unequivocal support for breastfeeding) is unduly influenced by a secondary interest (i.e., sponsorship by or partnership with industry).⁸⁶

When the original Code was drafted, it did not adequately address the issue of COI. Companies were allowed to make contributions to health workers for fellowships, study tours, research grants, attendance at professional conferences and the like, subject only to disclosure to institutions for which the health workers were affiliated.^{87, 88} The WHA has addressed

this issue through subsequent resolutions,⁸⁹ calling on governments to avoid COI in various infant and young child feeding programmes.⁹⁰

The 2016 Guidance also provides some useful recommendations on protecting against COI.

- A WHO information note⁹¹ on the 2016 Guidance observed that health professionals and facilities are often targeted and influenced by the infant and young child food industry through promotion, relationships, and incentives, and that these incentives create COI and can result in the loss of independence, integrity and public credibility. It explains that sponsorship establishes a visible, reciprocal relationship between a company and the organization it sponsors; this reciprocal obligation creates a COI for providers that may compromise patient care and damage credibility, regardless of the size of the contribution or whether it involves in-kind or financial contributions.
- The information note further states that health professionals exposed to targeted commercial activity have more positive attitudes to the products being marketed, are more likely to recommend that their patients use these products and are less likely to be able to identify false or misleading claims made in marketing materials. These effects occur even when health professionals cannot recall sponsors' names and when they believe they are not influenced by exposure to this sort of advertising.

Responses to calls to avoid COI have been uneven due to a **culture of dependence** perpetuated through the health care system, which causes health professionals, scientists and academics to accept conflicts as normal. There are some encouraging signs of moves toward **disentanglement** from the baby food industry. Some national paediatric associations and health professionals are distancing themselves from the baby food industry, whereas others continue to rely on their

84 Erzse, Agnes, et al., A realist review of voluntary actions by the food and beverage industry and implications for public health and policy in low- and middle-income countries, *Nat Food* 3, 2022, pp. 650–663, <<https://doi.org/10.1038/s43016-022-00552-5>> accessed 12 June 2024.

85 International Code of Marketing of Breast-milk Substitutes, art. 11.3.

86 Becker, Genevieve E., et al., Babies before business: protecting the integrity of health professionals from institutional conflict of interest, *BMJ Global Health*, 2022, <<https://gh.bmj.com/content/bmjgh/7/8/e009640.full.pdf>> accessed 12 June 2024.

87 International Baby Food Action Network, International Code Documentation Centre, Code Essentials 3: Responsibilities of Health Workers under the International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly resolutions, second edition, p.31, <www.babymilkaction.org/wp-content/uploads/2023/05/201804-CE3-2nd-Edition-Final.pdf> accessed 12 June 2024.

88 International Code of Marketing of Breast-milk Substitutes, art. 7.5.

89 For example, WHA 49.15 in 1996 urged governments “to ensure that the financial support for professionals working in infant and young child health does not create conflicts of interest, especially with regard to the WHO/UNICEF Baby Friendly Hospital Initiative”. In 2005, WHA 58.32 called on Member States “to ensure that financial support and other incentives for programmes and health professionals working in infant and young-child health do not create conflicts of interest”. Then in 2008, WHA 61.20 called on governments “to strengthen implementation of the International Code ... by scaling up efforts to monitor and enforce national measures in order to protect breastfeeding while keeping in mind the Health Assembly resolutions to avoid conflicts of interest”.

90 Clark, David L., Avoiding Conflict of Interest in the field of Infant and Young Child Feeding: better late than never, *World Nutrition*, vol. 8, no. 2, 2017, <<https://worldnutritionjournal.org/index.php/wn/article/view/146>> accessed 12 June 2024.

91 World Health Organization, Clarification on Sponsorship of Health Professional and Scientific Meetings by Companies that Market Foods for Infants and Young Children: Information note, 19 June 2023, <www.who.int/publications/i/item/9789240074422> accessed 12 June 2024.

financial support. This means that more awareness of the dangers of COI is needed.

At the governmental level, public funding for research, education and training is essential for infant and young child feeding programmes. Rather than treating expenditures for these activities as costs, policymakers should look at them as investments in social and economic development, which allow their populations to reap the health, social and economic benefits that breastfeeding delivers and the health care cost savings resulting from improved breastfeeding practices.⁹²

While refusing private sector sponsorship from the baby food industry may reduce the budgets of professional associations, there are alternatives that could lessen the financial impact. These include raising membership subscriptions, increasing membership recruitment and downsizing expensive activities.⁹³

The most effective solution would be to change the practices of the institutions that give rise to the COI, rather than to place the onus on health professionals to change their conduct. More and more calls are being made for the establishment of clearer boundaries for medical associations, academic institutions and regulatory authorities, with the baby food industry. Clarifying COI rules and strengthening their application within these institutions is an important part in reclaiming science in the public interest.⁹⁴

More information about COI and mechanisms to protect against them is available in the UNICEF fact sheet, Protecting Infant and Young Child Nutrition from Industry Interference and Conflicts of Interest.

Capturing science and the health profession

“Funding for scholarships and grants has the potential to impact what topics are researched, thus influencing the field for years to come. Recommendations on clinical practice may be unduly influenced by close relationships between professional expert bodies and the BMS industry. For example, van Tulleken⁹⁵ has noted that prescriptions of specialist formula milks for cow’s milk protein allergy have increased dramatically over the past decade based on the guidelines of several expert groups. Ten of the 12 authors of the 2012 European Society for Paediatric Gastroenterology, Hepatology, and Nutrition guidelines on diagnosis and management of cow’s milk protein allergy and all authors of the international Milk Allergy in Primary Care (iMAP) guideline on cow’s milk allergy declared financial interests with infant formula manufacturers.”

Grummer-Strawn, Laurence M., et al., Sponsorship of national and regional professional paediatrics associations by companies that make breast-milk substitutes: evidence from a review of official websites, BMJ Open, 2019, <<https://bmjopen.bmj.com/content/bmjopen/9/8/e029035.full.pdf>> accessed 12 June 2024 (internal citations omitted).

X. ‘Code implementation causes the violation of human rights.’

Argument 20: The Code violates human rights, including the rights to freedom, security of the person, and to access and receive information.

Related to these arguments is the claim that the Code penalizes mothers who do not breastfeed.

Response: International human rights law is clear that full Code implementation is part of countries’ human rights obligations, which include the duty to protect, promote and support breastfeeding.^{96,97}

As such, Code implementation must be viewed as furthering the **best interests of the child**, remembering that “[i]n all actions concerning children, whether undertaken by public or private social welfare

92 Baker, Phillip, et al., The political economy of infant and young child feeding: confronting corporate power, overcoming structural barriers, and accelerating progress, Lancet, 2023 breastfeeding series, vol. 401, issue 10375, pp. 503-24, <[www.thelancet.com/journals/lancet/article/PIIS0140-6736\(22\)01933-X/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)01933-X/fulltext)> accessed 12 June 2023.

93 Grummer-Strawn, Laurence M., et al., Sponsorship of national and regional professional paediatrics associations by companies that make breast-milk substitutes: evidence from a review of official websites, BMJ Open, 2019, pp. 1-6, <<https://bmjopen.bmj.com/content/bmjopen/9/8/e029035.full.pdf>> accessed 12 June 2024.

94 Richter, Judith, Conflicts of Interest and Policy Implementation: Reflections from the fields of health and infant feeding, International Baby Food Action Network, Geneva Infant Feeding Association, June 2005, p.8, <www.aaci-india.org/Resources/Conflicts-of-Interest-and-Policy-Implementation-judith-ritcher.pdf> accessed 12 June 2024.

95 van Tulleken, Chris, Overdiagnosis and industry influence: how cow’s milk protein allergy is extending the reach of infant formula manufacturers, BMJ, 2018 <www.bmj.com/content/363/bmj.k5056> accessed 12 June 2024.

96 Committee on the Rights of the Child, General comment No. 15, art. 24, para. 44.

97 Committee on the Rights of the Child, General comment No. 16, para. 57.

institutions, courts of law, administrative authorities or legislative bodies, **the best interests of the child shall be a primary consideration.**⁹⁸

The baby food industry uses narratives that portray government action in implementing the Code as unduly influencing parents' rights to choose. It does this through promoting rhetoric related to personal liberties and **freedom of choice**.⁹⁹

By implementing the Code, countries are helping ensure that caregivers are able to exercise their freedom of choice without being unduly influenced by distorted, incomplete, or inaccurate information and harmful marketing practices. The decision of whether to breastfeed or use BMS is a personal one. Parents and caregivers are free to choose the feeding method that they believe is best for their infants based on their individual circumstances and preferences. The Code does not interfere with this choice, nor does it compel individuals to breastfeed.

The Code certainly does not penalize women who cannot or choose not to breastfeed. Instead, it seeks to ensure that information on infant and young child feeding is accurate, unbiased and not misleading, thus enabling women to **make informed decisions**.

Respecting women's decisions

"Some women choose not to breastfeed, or are unable to. Perceived pressure, or inability, to breastfeed—especially if it is at odds with a mother's wishes—can have a detrimental effect on mental health, and systems should be in place to fully support all mothers in their choices. Women and families make decisions about infant feeding based on the information they receive, and a criticism of the [commercial milk formula's] industry's predatory marketing practices should not be interpreted as a criticism of women. All information that families receive on infant feeding must be accurate and independent of industry influence to ensure informed decision making."

Unveiling the predatory tactics of the formula milk industry, Lancet Editorial, 2023, vol. 401, issue 10375, p. 409, <[www.thelancet.com/journals/lancet/article/PIIS0140-6736\(23\)001186/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)001186/fulltext)> accessed 12 June 2024.

Argument 21: The Code undermines the right to privacy because it forces a person to disclose their reason for needing an alternative feeding method to be demonstrated.

This argument claims that if health workers are only permitted to demonstrate formula milk feeding methods when a child "needs to be fed" a breastmilk substitute, it requires caregivers to disclose the reason why the alternative is being requested. It is of particular concern that a person may need to disclose her HIV status.

Response: The Code does not restrict health workers from providing information or assistance regarding any feeding method, including the use of BMS, when that information is necessary for an infant's health and well-being. Such information is necessary for the health of any infant whose mother or caregiver decides to use a breastmilk substitute, regardless of the reason for doing so.

The Code also does not undermine an individual's **right to privacy** by requiring individuals to disclose sensitive health information. These are concerns normally addressed through a country's legal and ethical frameworks governing health care and patient confidentiality.

Argument 22: The Code violates the right to freedom of expression, including for mothers, industry, the press and other media.

Industry makes various versions of this argument; for example, that the Code infringes on:

- a mother's right to information that would enable her to exercise the choice of whether or not to breastfeed;
- industry's right to furnish information and advertise its products;
- the right to freedom of commercial expression; and
- the guaranteed right to freedom of the press and other media.

Response: Arguments regarding how the Code infringes on the above liberties can be addressed in the following manner:

- i. The Code does not infringe on a caregiver's **right to information**. Rather, it seeks to ensure that information provided by the baby food industry is accurate and not misleading. The Code promotes breastfeeding as the optimal feeding method for infants but allows parents and caregivers to make

98 Convention on the Rights of the Child, art. 3.1.

99 Protecting Infant and Young Child Nutrition from Industry Interference and Conflicts of Interest, p.8.

informed decisions. Since public health goals are not aligned with industry interests, the Code aims to prevent aggressive promotion that might unduly influence those parenting decisions. Marketing and advertising claims are not credible information and are not appropriate sources of information that families can rely upon to inform decisions about feeding their children.

- ii. There is **no unfettered right** to advertise in any jurisdiction. Governments have a duty to protect public health and minimize the negative health effects of products like tobacco, alcohol and unhealthy foods. The Code prohibits promotional practices that target the general public. It does not prevent companies from providing accurate information about their products to health professionals via scientific and factual materials and to the public via appropriate labelling.¹⁰⁰
- iii. Freedom of expression is not an absolute right and can be **subject to limitations**, especially when it conflicts with other rights or public health objectives. In this respect, the much-debated notion of corporate personhood that is advanced to argue that Code implementation will restrict companies' enjoyment of so-called rights, does not change the basic premise that those rights – if legitimate in the first place – must be balanced against the broader interests of society. Governments are thus permitted to impose restrictions on commercial expression in the interest of public health, consumer protection and other compelling concerns. The regulation of marketing and promotion of BMS under the Code is justified on public health grounds, as it aims to protect child health and encourage breastfeeding, the optimal source of nutrition for infants.
- iv. The Code does not curtail the **freedom of the press** and other media. Instead, it places restrictions on the marketing practices of the baby food industry to shield vulnerable infants and young children from potentially harmful promotional practices and to protect breastfeeding. These restrictions safeguard public health, especially in the context of infant and young child nutrition. Journalists and media outlets are free to report on issues related to infant nutrition and to freely discuss and analyse the Code's impact, as well as its implications for public health and individual choices.

XI. 'Code implementation constrains women's choices, their participation in the workforce and gender equality.'

Argument 23: The Code hinders women's participation in the workforce and impedes gender equity.

Some additional ways industry frames this argument include:

- Many more women have joined the workforce, and thus need infant formula to combine their professional and maternal roles; and
- Formula feeding makes it easier for women to get back to work after giving birth and the Code makes it difficult for women to access information on formula feeding.

Response: The argument that the Code hinders gender equity¹⁰¹ is a **manipulation of feminist and women's rights perspectives on gender equity**. It is a strategy that suggests women should be freed from the biological constraints and sole responsibility of breastfeeding, which are holding them back in the workforce. The authors of the 2023 Lancet Breastfeeding Series¹⁰² also observe that the marketing of formula milk has historically associated the product with upward mobility, modernity, and with women's liberation.

The reality is that breastfeeding is not incompatible with employment when the right policies and supports are in place to support mothers and facilitate their rights to both work and feed their children in the way they choose. Making breastfeeding work takes time, resources, policies and investments – and these are not the sole responsibility of women: they are the collective responsibilities of governments, workplaces, communities and families.

The Lancet series describes evidence showing that paid family leave and breastfeeding-friendly employment and childcare environments facilitate both women's participation in the workforce and breastfeeding. These important maternity protection policies are enshrined in International Labour Organization standards. With necessary support, working women can successfully combine workforce participation with breastfeeding. Practical tips are

¹⁰⁰ International Code of Marketing of Breast-milk Substitutes, arts. 7.2, 9.

¹⁰¹ Ibid., pp. 4, 11.

¹⁰² Rollins, Nigel, et al., Marketing of commercial milk formula: a system to capture parents, communities, science, and policy, Lancet, 2023 breastfeeding series, vol. 401, issue 10375, pp. 486-502, <www.thelancet.com/series/breastfeeding-2023> accessed 12 June 2024.

available on what employers can do to support mothers to combine breastfeeding and employment.¹⁰³

Support for breastfeeding also requires societal efforts to tackle both the enduring gender inequities that undervalue the work of breastfeeding and caregiving, and the gender norms that place an unequal burden of domestic labour on women alongside their increasing participation in the formal labour market. The Mothers' Milk Tool is a useful resource that brings increased visibility to the economic value contributed to society by women's unpaid care work through breastfeeding.¹⁰⁴ It can be used to measure the economic value of women's milk production on a country and an individual level, as well as how much is currently "lost" due to cultural barriers and structural impediments to breastfeeding.

Rejecting the framing of breastfeeding as a free or costless activity, or as a lifestyle choice

To breastfeed or commercial formula feed is not a genuine choice if breastfeeding means that women and families must forego employment and secure livelihoods. Breastfeeding is time consuming for women, which takes away from time that could be spent on income-earning activities. Work is one of the top reasons cited for not breastfeeding, highlighting the importance of reducing and redistributing the unfair and heavy unpaid work burdens of women. Time pressures hinder or prevent optimal breastfeeding, with many women juggling multiple care and income-earning responsibilities. Long-standing evidence from low-income and middle-income countries shows the importance of considering mothers' time in developing and implementing infant and young child health and nutrition policies.

Baker, Phillip, et al., The political economy of infant and young child feeding: confronting corporate power, overcoming structural barriers, and accelerating progress, Lancet, 2023 breastfeeding series, vol. 401, issue 10375, pp. 503-24, <<https://www.thelancet.com/series/breastfeeding-2023>> accessed 12 June 2023

Argument 24: The Code prevents fathers and non-birth parents from contributing to infant feeding and infringes on gender equity.

Industry also frames this argument in the following ways:

- Formula feeding allows fathers to play a role in infant feeding; and
- The Code makes it more difficult to access information on formula feeding, and therefore prevents fathers from contributing to infant feeding.

Response: This argument implies that fathers are excluded from participating in the feeding and care of infants and children who are breastfed and that their role is that of a passive or neutral observer who has little influence on the process. In fact, it is known that the support of a baby's father increases the likelihood that the mother will initiate and sustain breastfeeding during the postnatal period.¹⁰⁵

Specific and suitable assistance given by fathers plays a central role in breastfeeding. Fathers, in general, play an important role in infant and young child feeding, regardless of the feeding choice the family makes.

The Code does not make it more difficult to access information about formula feeding. Rather, it protects all families from misleading marketing claims and it protects formula-fed infants from unsafe feeding practices by ensuring the appropriate labelling and use of these products.¹⁰⁶

Argument 25: The Code is discriminatory towards the LGBTQIA+ community and a barrier to accessing the formula feeding information that they need.

Industry claims that the Code causes discrimination because some parents who are non-heterosexual and/or transgender, such as same-sex male parents or mothers who are trans women, cannot breastfeed and rely on formula to feed their infants and young children.

Response: The Code does not prevent anyone from accessing credible information about formula feeding.¹⁰⁷ Marketing claims and promotional materials are not credible sources of information to inform decisions about how to feed infants and young children. Instead, the Code calls on governments

103 For example, United Nations Children's Fund (UNICEF), Breastfeeding when you return to work: Practical tips to help you plan ahead, <www.unicef.org/parenting/food-nutrition/breastfeeding-workplace> accessed 12 June 2024.

104 Smith, Julie P., et al., The volume and monetary value of human milk produced by the world's breastfeeding mothers: Results from a new tool, Front. Public Health, vol. 11, 2023, <www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2023.1152659/full> accessed 12 June 2024.

105 Agrawal, Jayesh, Swarupa Chakole and Chetna Sachdev, The Role of Fathers in Promoting Exclusive Breastfeeding, Cureus, 2022, <www.ncbi.nlm.nih.gov/pmc/articles/PMC9665906/pdf/cureus-0014-00000030363.pdf> accessed 12 June 2024.

106 Resolution WHA 58.32; Resolution WHA 61.20; International Code of Marketing of Breast-milk Substitutes, art.9.

107 It is recognized here that not all people who breastfeed identify as women.

to ensure that objective and consistent information on infant and young child feeding is provided to all families,¹⁰⁸ regardless of their LGBTQIA+ identification. This may include providing information about alternative infant feeding options line with WHO global guidance, such as donor human milk and animal milk when the infant is over six months of age.¹⁰⁹

XII. ‘Companies must be able to communicate information with consumers and health professionals.’

Argument 26: The Code interferes with companies’ abilities to communicate with consumers and health professionals.

This argument is framed in various ways:

- The baby food industry is comprised of respected experts in infant and young child feeding and should be able to help with providing information and education to parents, caregivers and health workers;
- It is part of corporate responsibility for industry to contribute to better nutrition by providing education and training on infant and young child feeding; and
- Governments are not providing enough information about how to feed infants, so industry is filling a gap.

Response: Information provided by the baby food industry cannot be considered **unbiased or free from commercial influence**. While the public health goal is to safeguard health by increasing or sustaining breastfeeding rates, the BMS industry’s goal is to increase sales and use of BMS.¹¹⁰

The Code originally permitted companies to donate informational or educational equipment or materials in certain circumstances.¹¹¹ This loophole has been closed by WHA resolutions calling for COI safeguards and by the specific prohibitions outlined in the 2016 Guidance.¹¹² These make clear that the baby food industry should remain at arm’s length from the health care system. It should only provide health professionals and health workers with scientific and factual information that does not imply or create a belief that bottle feeding is equivalent or superior to breastfeeding.¹¹³

While under-resourced governments may not be fulfilling their responsibility in providing information on infant and young child feeding, allowing the baby food industry to fill this gap is harmful. Company materials often contain content that is discouraging or even damaging to breastfeeding. They use language and illustrations that may at first appear innocuous, even breastfeeding-friendly, but there are often subtexts and subtle messages within the tips and recommendations that **undermine breastfeeding** by implying it is complicated, demanding, difficult or unreliable.^{114, 115}

Rarely do company materials meet all the criteria required by Article 4.2 of the Code, which is aimed at ensuring that the information provided to health workers, pregnant women and mothers is objective and consistent. In particular, such materials seldom fulfil the clause in Article 4.2 that prohibits the use of pictures or text that idealize the use of BMS.¹¹⁶

WHO, UNICEF and many international organizations provide up-to-date, objective and consistent information on infant and young child feeding. These materials are freely available online for policymakers and health workers to adapt and modify for use at the country level, if needed.

108 International Code of Marketing of Breast-milk Substitutes, art. 4.1 (“Governments should have the responsibility to ensure that objective and consistent information is provided on infant and young child feeding for use by families”).

109 WHO Guideline for complementary feeding of infants and young children 6–23 months of age..

110 What I Should Know About ‘the Code’, p.9.

111 International Code of Marketing of Breast-milk Substitutes, art. 4.3.

112 Guidance on ending the inappropriate promotion of foods for infants and young children, recommendation 6.

113 International Code of Marketing of Breast-milk Substitutes, art. 7.2.

114 Auerbach, Kathleen G., Beyond the issue of accuracy: Evaluating patient education materials for breastfeeding mothers, *Journal of Human Lactation*, commentaries, vol. 4, issue 3, pp. 108-110, 1988, <https://journals.sagepub.com/doi/10.1177/089033448800400311?url_ver=Z39.88-2003&rft_id=ori:rid:crossref.org&rft_dat=cr_pub%20%20pubmed> accessed 12 June 2024.

115 Foss, Katherine A. and Brian G. Southwell, Infant feeding and the media: the relationship between Parents’ Magazine content and breastfeeding, 1972–2000, *International Breastfeeding Journal*, 2006, <<https://internationalbreastfeedingjournal.biomedcentral.com/articles/10.1186/1746-4358-1-10>> accessed 12 June 2024.

116 Code Essentials 3, pp. 15-16.

Competing with breastfeeding

“Companies use strategies and messages that are subtle (e.g., positioning commercial milk formula as an acceptable, harmless complement to breastfeeding), overt (e.g., developing and cross-promoting follow-on milks), gendered (e.g., enabling women to be free of biological constraints that infer sole responsibility for infant feeding and partners to have a role in infant care). Some messaging is even confrontational, depicting public health messages as antifeminist Mention of the downsides of commercial milk formula—risks of infant mortality, maternal health, cost to family, environmental harm, and plastic waste—are avoided or misdirected.”

Rollins, Nigel, et al., Marketing of commercial milk formula: a system to capture parents, communities, science, and policy, *Lancet*, 2023 breastfeeding series, vol. 401, issue 10375, pp. 486-502, <www.thelancet.com/series/breastfeeding-2023> accessed 12 June 2024.

Argument 27: Health care providers need information about which formulas to use and about formula innovations. Therefore, corporate access to health workers, including through sponsored meetings, is needed.

Response: The Code allows companies to provide product information that is **scientific and factual** to health professionals.¹¹⁷ However, the argument that companies should have access to health workers is problematic because the Code makes health workers responsible for the encouragement and protection of breastfeeding.¹¹⁸ This responsibility prevents health workers from engaging with companies in any manner that may give rise to **conflicts of interest**, where the private interests of health workers conflict with their official responsibilities.

In 2005, the WHA urged countries to “ensure that financial support and other incentives for programmes and health professionals working in infant and young child health do not create conflicts of interest”.¹¹⁹

This was followed by another resolution on the 2016 Guidance, which specifies, among other things, that health professional associations should not allow such companies to sponsor meetings of health professionals and scientific meetings.¹²⁰

More information about COI and mechanisms to protect against them is available in the UNICEF fact sheet, Protecting Infant and Young Child Nutrition from Industry Interference and Conflicts of Interest.

He who pays the piper calls the tune

“Perhaps of greatest concern is the widespread sponsorship of conferences and other events at which paediatricians meet and disseminate research. The impact of the BMS industry at these events—either as direct sponsors, sponsors of symposia or presenters of information—is not to be underestimated. For example, as Fabbri et al noted,¹²¹ funding of conferences and satellite symposia may bias the scientific content presented at such events.

Furthermore, accepting any kind of support from the industry ‘creates a sense of obligation and loyalty to the company in question’. Even receiving foods and beverages sponsored by industry at these events or receiving conference materials bearing company logos may cause physicians to feel a subconscious onus to reciprocate. These factors have the potential to influence what physicians prescribe to their patients.”

Grummer-Strawn, Laurence M., et al., Sponsorship of national and regional professional paediatrics associations by companies that make breast-milk substitutes: evidence from a review of official websites, BMJ Open, 2019, p.4, <<https://bmjopen.bmj.com/content/bmjopen/9/8/e029035.full.pdf>> accessed 12 June 2024.

Argument 28: To create healthier products, industry needs to have regular interaction with health workers who can identify and articulate needs.

Response: This argument is an attempt by companies to establish relationships with health workers through financial and material inducements, which are prohibited by the Code.¹²² Companies have well-resourced product development departments to conduct the necessary research. Inducements, regardless of form or value, create corporate goodwill that can lead health workers to recommend the company’s products.¹²³

117 International Code of Marketing of Breast-milk Substitutes, art. 7.2.

118 International Code of Marketing of Breast-milk Substitutes, art. 7.1.

119 Resolution WHA 58.32.

120 Resolution WHA 69.9, para. 17.

121 Fabbri, Alice, et al., Conflict of interest between professional medical societies and industry: a cross-sectional study of Italian medical societies’ websites, *BMJ Open*, 2016, <<https://bmjopen.bmj.com/content/bmjopen/6/6/e011124.full.pdf>> accessed 12 June 2024.

122 International Code of Marketing of Breast-milk Substitutes, art. 7.3.

123 Code Essentials 3, p. 29.

Argument 29: Prohibiting advertising deprives consumers of information and undermines parents' right to choose.

Additional ways this argument is framed include:

- The Code prevents companies from providing information that ensures safe and proper use of the product; and
- Consumers need companies to provide information about their products.

Response: Prohibiting the advertising of BMS is necessary due to the vulnerability of infants in the early months of life. The risks involved in inappropriate feeding practices, including the unnecessary and improper use of BMS, mean that the marketing of BMS requires **special treatment**. Usual marketing practices like advertising are unsuitable for these products.¹²⁴

Other than scientific and factual information for health professionals, which the Code allows,¹²⁵ product information relating to use is best conveyed to consumers through labels – which are strictly regulated and governed by food laws and standards, as well as the Code.¹²⁶

XIII. 'The Code does not/should not apply in emergencies.'

Argument 30: Even though breastfeeding is critical in emergencies, BMS will still be needed in some circumstances. Having governments purchase BMS and related products through normal channels during emergencies is an unnecessary financial burden that can be addressed through company donations.

Response: In times of emergencies, company donations can do more harm than good. Disruptions to basic infrastructure, hygiene and sanitation make it difficult to prevent contamination during the preparation of infant formula and other BMS.

Even outside of humanitarian settings, studies have shown that exclusively formula-fed infants were more likely to be hospitalized for any infection, pneumonia and diarrhoea, compared to exclusively breastfed infants.¹²⁷

Accepting company donations may lead to bulk and indiscriminate distribution of products. Receiving free or donated BMS from a trusted health care worker or aid organization increases the likelihood that a family will feed them to a baby or child, regardless of whether they are needed. Emergencies are also often seen as an opportunity for dumping products that are not suitable for sale in normal circumstances, such as expired products and products that are not labelled in local languages.¹²⁸

Company donations of BMS should therefore be **avoided**. Any savings to be made from not having to buy infant formula and other BMS for the relatively small number of infants who require them will be far outweighed by the health care cost of having to treat diarrhoea and other diseases in infants.

Instead, suitable BMS must be procured, distributed and fed only to the limited number of infants who have to be fed them after a proper needs assessment, as part of the regular procurement inventory of foods and medicines. This helps prevent indiscriminate distribution of BMS, which often results in mothers abandoning breastfeeding at a time when it is a lifesaving intervention. In emergencies, more than ever, early initiation, exclusive breastfeeding until 6 months of age and continued breastfeeding until 2 years of age or beyond – as recommended by WHO – are critical child health and survival activities that must be promoted, protected and supported as part of every emergency response and recovery operation.¹²⁹

The WHA has urged Member States to ensure that national and international preparedness plans and emergency responses follow the evidence-based Operational Guidance for Emergency Relief Staff and Programme Managers on Infant and Young Child Feeding in Emergencies (OG-IFE).¹³⁰ One of the key points stressed in the OG-IFE is that donations of BMS,

¹²⁴ International Code of Marketing of Breast-milk Substitutes, preamble.

¹²⁵ International Code of Marketing of Breast-milk Substitutes, art. 7.2.

¹²⁶ International Code of Marketing of Breast-milk Substitutes, art. 9; Resolution WHA 58.32; Resolution WHA 61.20; Resolution WHA 63.23.

¹²⁷ Hengstermann, Susanne et al. Formula feeding is associated with increased hospital admissions due to infections among infants younger than 6 months in Manila, Philippines. *Journal of human lactation : official journal of International Lactation Consultant Association* vol. 26,1 (2010): 19-25. doi:10.1177/0890334409344078. < <https://pubmed.ncbi.nlm.nih.gov/19759351/> > accessed 13 June 2024.

¹²⁸ Hipgrave, David B., et al., Donated breast milk substitutes and incidence of diarrhoea among infants and young children after the May 2006 earthquake in Yogyakarta and Central Java, *Public Health Nutrition*, 2011, pp. 307-15, <www.cambridge.org/core/services/aop-cambridge-core/content/view/7BC8079D2591050A0C25258EF2FAAF01/S1368980010003423a.pdf/donated-breast-milk-substitutes-and-incidence-of-diarrhoea-among-infants-and-young-children-after-the-may-2006-earthquake-in-yogyakarta-and-central-java.pdf> accessed 12 June 2024.

¹²⁹ International Baby Food Action Network, International Code Documentation Centre, Code Essentials 2: Guidelines for Policy Makers on Implementing the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions, second edition, 2018, pp. 50-51, <www.babymilkaction.org/wp-content/uploads/2020/12/201802-CE2-2nd-Edition-Final.pdf> accessed 12 June 2024.

¹³⁰ Resolution WHA 63.23.

complementary foods and feeding equipment should not be sought or accepted in emergencies; supplies should be purchased based on assessed need.¹³¹ The OG-IFE also discusses the subject of procurement and distribution of relevant products in ways that are Code compliant.¹³²

In 2021, UNICEF updated its guideline on the procurement and use of BMS, which confirms that UNICEF can act as the provider of first resort and procure BMS where this is warranted as part of an overall humanitarian response that supports optimal infant and young child feeding.¹³³

The danger of formula milk in humanitarian aid

There are many problems with infant formula donations: These include: product contamination leading to illness and death; labelling in the wrong language or lack of labelling; inappropriate quantities of formula (usually too much); lack of consistent supply of formula; disruption to breastmilk supply through use; lack of targeting to those who need them; and lack of instructions, supplies and support needed to minimize risk (e.g., safe water, a heat source etc.).

A study on infant formula distribution during the 2014–2016 refugee crisis in Europe showed that the presence of infant formula donations and absence of properly managed formula feeding programmes contributed to poor breastfeeding practices.¹³⁴

A UNICEF study¹³⁵ also found that rates of diarrhoea in Yogyakarta, Indonesia in the aftermath of the 2006 earthquake increased six-fold as the consumption of formula doubled.

“Donations of powdered milk in an emergency situation can literally increase the rate of death of young babies, while the people mean to do good.”

- Anne H. Vincent, Head, Health & Nutrition Department UNICEF Indonesia (quoted in *Jakarta Post*, Formula milk ‘dangerous’ as humanitarian aid, 7 July 2008, <www.thejakartapost.com/news/2008/07/07/formula-milk-039dangerous039-humanitarian-aid.html> accessed 17 June 2024).

XIV. ‘Multi-stakeholder approaches and corporate social responsibility are important.’

Argument 31: Complex problems can only be solved with everyone, including industry, around the table.

Response: Although there is currently a policy shift towards closer cooperation between governments and the private sector, this model must be approached with caution in the context of infant and young child feeding, as it has the potential to undermine the Code’s aim to protect the health and lives of infants and young children and the informed decision-making of parents.

Very often, there is insufficient scrutiny of the actual conduct of corporate entities that seek or are offered such partnerships. Historically, the baby food industry has been quick to use partnerships and corporate social responsibility initiatives to gain influence in public policymaking arenas that intersect with their market goals.¹³⁶ They use such initiatives to **white-wash** their tarnished images through association with public interest causes. Effective and comprehensive ethical and policy frameworks for managing individual and institutional COI are rarely established and appropriate roles for the baby food industry are rarely articulated prior to engagement with corporate actors.¹³⁷

The Global Strategy on Infant and Young Child Feeding, which encourages and endorses Code implementation, addresses the risks posed by COI by limiting the role of corporate actors in infant and young child nutrition to conforming with the Code at every level, and meeting the specific quality, safety and labelling standards set by the Codex Alimentarius.¹³⁸

131 Emergency Nutrition Network, Operational Guidance on Infant Feeding in Emergencies (OG-IFE) version 3.0, <www.enonline.net/operationalguidance-v3-2017> accessed 13 June 2024.

132 Ibid., sec. 6.

133 UNICEF. Procurement and use of breastmilk substitutes in humanitarian settings. 2021. <<https://www.unicef.org/documents/procurement-and-use-breastmilk-substitutes-humanitarian-settings>> accessed 13 June 2024.

134 Gribble KD, Palmquist AEL. ‘We make a mistake with shoes [that’s no problem] but... not with baby milk’: Facilitators of good and poor practice in distribution of infant formula in the 2014-2016 refugee crisis in Europe. *Maternal & child nutrition* vol. 18,1 (2022): e13282. doi:10.1111/mcn.13282. <<https://pubmed.ncbi.nlm.nih.gov/34766454/>> accessed 13 June 2024.

135 Hipgrave, David B., et al., Donated breastmilk substitutes and incidence of diarrhoea among infants and young children after the May 2006 earthquake in Yogyakarta and Central Java, *Public Health Nutrition*, vol. 15, issue 2, 2011, pp. 307-315, <<https://pubmed.ncbi.nlm.nih.gov/21426621/>> accessed 13 June 2024.

136 Baker, Phillip et al. Globalization, first-foods systems transformations and corporate power: a synthesis of literature and data on the market and political practices of the transnational baby food industry. *Global Health* 17, 58 (2021). <<https://doi.org/10.1186/s12992-021-00708-1>> accessed 13 June 2024.

137 Lhotska, Lida, Anne C. Bellows and Veronika Scherbaum, Conflicts of Interest and human rights-based policy making: the case of maternal, infant and young children’s health and nutrition, *Right to Food and Nutrition Watch*, 2012, pp. 31-36, <www.righttofoodandnutrition.org/files/R_t_F_a_N_Watch_2012_eng.pdf> accessed 13 June 2024.

138 Global Strategy for Infant and Young Child Feeding, para. 44.

Argument 32: Tying corporations up in regulatory straightjackets is unnecessary when companies already have sound principles and core values.

Response: Scrutiny of corporate policies for compliance with the Code¹³⁹ reveals a concerted effort to avoid, rather than comply with, many of the core provisions of the Code. Corporate interpretations of Code provisions typically fall short of the Code in many areas.

Argument 33: Companies can reorient themselves and shift towards rebalancing purpose and profits.

Response: The stated aims of certain baby food companies to transition from a purely profit-driven model to a more socially responsible model is driven by regulatory pressures, investor demands, consumer preferences and a growing awareness of social trends.

In this regard, many baby food companies claim to support the Code and national measures. Yet they continue trying to weaken Code-based legislation as much as possible when such laws are being developed and amended. Weak laws make for easy compliance and corporate profit. This is why full Code implementation, monitoring and enforcement are important.

As of March 2024, a total of 146 of the 194 WHO Members States have adopted legal measures to implement at least some of the Code's provisions. Of these, only 33 countries have measures in place that are substantially aligned with the Code, and many of them have reported industry interference in their Code implementation process.¹⁴⁰

XV. 'BMS and commercial complementary foods are healthier choices.'

Argument 34: Breastfeeding may not always be best for an infant and is unimportant after 12 months of age.

Response: WHO recommends exclusive breastfeeding for a baby's first six months and then continued breastfeeding for up to two years and beyond. While breastmilk does not represent sole-source nutrition after the first 12 months, it remains a good source of nutrients and immune components, and there is solid evidence that breastfeeding continues to protect children from illness and disease after the first year.¹⁴¹

The 2016 Lancet series on breastfeeding presents an in-depth analysis on the health and economic benefits of breastfeeding.¹⁴² A review of the evidence of the short- and long-term health outcomes of breastfeeding for infants and mothers found that breastfeeding:

- Could prevent an estimated 823,000 child deaths.
- Is associated with lower mortality in both high- and low-income countries.
- Protects against diarrhoea, respiratory infections, otitis media and dental malocclusions.
- Has a beneficial impact on non-communicable diseases; it may protect against obesity and diabetes later in life.
- Is associated with higher intelligence in children and adolescents.
- Is not just an ideal nutritional supply, but is also potentially a personalized medicine. Crucial health imprinting events that have a lifelong effect might be brought about during breastfeeding, mediated directly or indirectly through effects on the infant microbiome.
- Prevents breast cancer (the scale-up of breastfeeding could prevent 20,000 breast cancer deaths annually), improves birth spacing, and might reduce a woman's risk of diabetes and ovarian cancer.

139 Breaking the Rules, Stretching the Rules 2017, pp. 26-28, 130-133.

140 National implementation of the International Code, status report 2024.

141 Lackey, Kimberly A., et al., Breastfeeding Beyond 12 Months: Is There Evidence for Health Impacts?, Annual Reviews, 2021, pp. 283-308, <www.annualreviews.org/doi/pdf/10.1146/annurev-nutr-043020-011242> accessed 13 June 2024.

142 Victora, Cesar G., et al., Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect, Lancet, 2016 breastfeeding series, vol. 387, issue 10017, 2016, pp. 475-90, <[www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)01024-7/abstract](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)01024-7/abstract)> accessed 14 June 2024; Rollins, Nigel C., et al., Why invest, and what it will take to improve breastfeeding practices?, Lancet, 2016 breastfeeding series, vol. 387, issue 10017, 2016, pp. 491-504, <[www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)01044-2/abstract](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)01044-2/abstract)> accessed 14 June 2024.

The 2023 Lancet Breastfeeding Series summarizes research that has strengthened the evidence base regarding the importance of interactions between mother and baby during breastfeeding.¹⁴³ For example, the body of available research now confirms that:

- Suckling at the breast releases oxytocin, prolactin, and other metabolites that foster mother–child bonding and reduce physiological stress for both.
- Hormones in breastmilk stimulate appropriate infant appetite and sleep development, and hormonal, physiological, and metabolic changes during breastfeeding support the mother’s lifelong health in various ways.
- The immune systems of mothers and infants communicate with each other beyond passive immunity during breastfeeding.
- Mothers transmit elements of their microbiota to their children through breastmilk. These good bacteria live in the gut and help fight disease, digest food and regulate the child’s evolving immune system.
- Breastfeeding is much more than the transfer of breastmilk from mother to baby. Suckling from the mother’s breast is a crucial part of the nurturing of infants. Direct breastfeeding versus feeding breastmilk with a bottle, cup, or spoon has important implications for infant health and development, in addition to influencing infant craniofacial structure and reducing risk of malocclusion.
- There are compositional differences in free amino acids and total protein in breastmilk that are delivered at the end of a breastfeed compared to that delivered at the beginning of the feed, and it is probable that retrograde flow of infants’ oral microbiota into mother’s milk takes place during breastfeeding and informs delivery of immunological factors in the milk.
- The skin-to-skin contact occurring through direct breastfeeding supports maturation of critical physiological mechanisms, including temperature control, metabolism, and diurnal adaptation (how infants adjust to the 24-hour day-night cycle).

Argument 35: Commercially-produced complementary foods may be nutritionally superior to home-prepared foods.

Response: The quality of home-prepared complementary foods may vary depending on caregiver skills, knowledge and economic status, but they are nutritious and cost-effective when prepared correctly.

Commercial complementary foods may offer families consistency and convenience, but many are high in sugar, salt and unhealthy fats. Young children and their caregivers are increasingly exposed to inappropriate marketing of foods that are high in added sugar, salt and saturated and trans fats. Ultra-processed commercial complementary foods lack nutrients and fibre and include additives, which can negatively impact long-term health outcomes.¹⁴⁴

Home-prepared complementary foods offer infants and young children opportunities to experience and learn to enjoy a wide variety of flavours and textures, in contrast to commercial complementary foods, which tend to be more limited in their texture and flavour profiles. Learning to share the enjoyment of family foods is a critical developmental task for infants and young children.¹⁴⁵

Resolution WHA 54.2 [2001] urges Member States to improve complementary foods and feeding practices by “ensuring sound and culture-specific nutrition counselling to mothers of young children” and “recommending the widest possible use of indigenous nutrient-rich foodstuffs”.

The Global Strategy for Infant and Young Child Feeding emphasizes that complementary foods must be introduced at the right time, be adequate to meet a growing child’s nutritional needs, be safe, and that meal frequency and feeding method should be suitable for the child’s age.¹⁴⁶ The Global Strategy also encourages the “widest possible use of indigenous foodstuffs” to “help ensure that local foods are prepared and fed safely in the home.”¹⁴⁷

The implementation of nutrition education, approaches and strategies that focus on the availability, accessibility, affordability and consumption of

143 Perez-Escamilla, Rafael, et al., Breastfeeding: crucially important, but increasingly challenged in a market-driven world, *Lancet*, 2023 breastfeeding series, vol. 401, issue 10375, pp. 472-85, <[www.thelancet.com/journals/lancet/article/PIIS0140-6736\(22\)01932-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)01932-8/fulltext)> accessed 14 June 2024.

144 Moreira, Paula R., et al., Complementary feeding methods and introduction of ultra-processed foods: A randomized clinical trial, *Frontiers in Nutrition*, 2022, <www.ncbi.nlm.nih.gov/pmc/articles/PMC9767977/pdf/fnut-09-1043400.pdf> accessed 14 June 2024.

145 For more information, see World Health Organization, United Nations Children’s Fund (UNICEF) and World Bank Group, Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential, 2018, <<https://apps.who.int/iris/bitstream/handle/10665/272603/9789241514064-eng.pdf>> accessed 13 June 2024.

146 Global Strategy for Infant and Young Child Feeding, pp. 8-9.

147 Ibid., p. 9.

nutritious and safe complementary foods is crucial to improve the quality of complementary foods and feeding practices. Breastfeeding and access to a diverse range of nutritious foods will provide children with the essential nutrients, vitamins and minerals they need to develop to their full physical and cognitive potential, with benefits that endure well into adulthood.¹⁴⁸

Argument 36: Follow-up formula and commercial complementary foods are healthier than other alternatives, such as soda, chips or ice cream. Marketing of the ‘healthier’ products reduces the consumption of these less healthy products.

Response: The WHA considers follow-up formulas and growing-up milks to be unnecessary.¹⁴⁹ WHO recommends that infants 6–11 months of age who are fed milks other than breastmilk may be fed either milk formula or animal milk and that young children 12–23 months of age who are not breastfeeding should be fed animal milk. Formula milk is not recommended.¹⁵⁰

There is no evidence to suggest that the promotion of BMS or foods for infants and young children reduces consumption of other processed foods that may be less healthy choices. Advertising and labelling of the so-called ‘healthier’ complementary foods are inappropriate, may discourage breastfeeding and encourage the use of commercial complementary foods before 6 months of age.¹⁵¹

Inappropriate promotion of commercial complementary foods undermines the public health goal of encouraging the use of indigenous foods in complementary feeding, particularly where commercially-produced ultra-processed foods are compared with traditional foods in terms of nutritional value, preparation and taste. Moreover, baby food companies promote complementary foods in hospitals and clinics, leading to the impression that the products are endorsed by the health care system.¹⁵² The 2016 Guidance considers products “marketed as suitable” for feeding children aged 6–36 months and provides guidelines on how this range of products can be appropriately promoted.¹⁵³

148 United Nations Children’s Fund (UNICEF), UNICEF Programming Guidance: Improving Young Children’s Diets During the Complementary Feeding Period, 2020, <www.unicef.org/media/93981/file/Complementary-Feeding-Guidance-2020.pdf> accessed 14 June 2024.

149 Resolution WHA 39.28.

150 WHO Guideline for complementary feeding of infants and young children 6–23 months of age.

151 World Health Organization, Guidance on ending the inappropriate promotion of foods for infants and young children: implementation manual, 2017, p.9, <<https://iris.who.int/bitstream/handle/10665/260137/9789241513470-eng.pdf>> accessed 11 June 2024.

152 The Code Handbook, pp. 55-56.

153 A concise table explaining what is to be considered ‘appropriate’ promotion of foods for infants and young children is provided in What I Should Know About ‘the Code’, p.11.

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