



REVIEW AND EVALUATION OF NATIONAL ACTION TAKEN TO GIVE EFFECT
 TO THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES:
 REPORT OF A TECHNICAL MEETING

The Hague, 30 September - 3 October 1991

This document presents the report of a meeting convened by WHO, with the participation of UNICEF, during which representatives of 14 Member States discussed steps taken to give effect to the International Code of Marketing of Breast-milk Substitutes. It summarizes lessons learned and recommendations for action under five headings: development and implementation of national measures, training and education in the health sector, information to the general public and mothers, monitoring and enforcement, and manufacturers and distributors of products within the scope of the International Code. Both the review and evaluation exercise, which was undertaken by the competent authorities in each country, and the meeting to consider results were made possible thanks to a generous contribution by the Government of the Netherlands. The summary of results, which served as the basis for discussion at the meeting, is found in Annex 1.

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INTRODUCTION

1. The Forty-third World Health Assembly in May 1990 requested the Director-General "to support Member States ... in adopting measures to improve infant and young child nutrition, inter alia by collecting and disseminating information on relevant action of interest to all Member States" (resolution WHA43.3). With funds provided by the Government of the Netherlands, and in collaboration with the Government of Sweden and the Swedish International Development Authority, WHO provided technical support to 14 Member States¹ that had indicated a desire to undertake an in-depth review and evaluation of their own experiences in giving effect to the International Code of Marketing of Breast-milk Substitutes.²

2. The results of the national review and evaluation exercise were summarized in a background document (Annex 1), which served as the basis for discussion by representatives of the countries concerned (Annex 2). The purpose of the meeting was to focus in concrete and practical terms on what Member States can do to give effect to the principles and aim of the International Code, with support from WHO, UNICEF and other interested parties. Also present at the meeting were representatives of five nongovernmental organizations in official relations with WHO that have a particular interest in infant feeding: the International Federation of Gynecology and Obstetrics, the International Pediatric Association, the International Confederation of Midwives, the International Organization of Consumers Unions, and the International Association of Infant Food Manufacturers.

3. Participants emphasized that it was essential to see the International Code in the broad context of which it was a part. Breast-feeding is fundamental to the healthy growth and development of infants and young children, and it contributes to the health and nutritional status of their mothers. The International Code is one of several important actions required in order to protect and promote breast-feeding.

4. Participants considered that, since the adoption of the International Code, considerable progress had been achieved. Consciousness had been raised about the importance of breast-feeding, and promotion of products within the scope of the Code had grown less aggressive. Nevertheless, they concluded that a great deal remained to be done to ensure that the full impact of the Code was felt in all countries.

5. Participants were unanimous in observing that their national review and evaluation exercise had been valuable in terms of increasing awareness and understanding of the importance of the International Code and its place in their countries. They considered that all countries would benefit from such an exercise. On the basis of lessons learned, participants reached a number of conclusions and made a number of recommendations, which they addressed to the Director-General of WHO under the following headings.

DEVELOPMENT AND IMPLEMENTATION OF NATIONAL MEASURES

Lessons learned

6. Success in implementing the International Code depends on a clear intersectoral perspective. The responsibility of health, law, trade and industry, and food quality, among other important sectors, converge in a single instrument.

¹ Brazil, Egypt, Finland, Guatemala, Islamic Republic of Iran, Kenya, the Netherlands, Nigeria, Papua New Guinea, the Philippines, Poland, Sweden, United Kingdom of Great Britain and Northern Ireland, and Yemen.

² Governments used for this purpose a common review and evaluation framework (unpublished document in Arabic, English and Spanish) prepared by WHO.

7. It is essential that all concerned parties be involved in the development and monitoring of national measures adopted to give effect to the International Code. In this context, "concerned parties" include health authorities, health care systems and the health professionals and other workers employed in them, nongovernmental including women's and consumer organizations, professional groups, manufacturers and distributors of products within the scope of the Code, and institutions and individuals.¹

8. Development and implementation of national measures to give effect to the International Code is a continual process, which has proven to be more complex than expected. Difficulties encountered include:

- lack of political commitment. Experience has shown that, while the process of giving effect to the International Code may be started by influential individuals, political bodies or professional organizations, long-term political commitment cannot be achieved without the active interest and involvement of communities and families;
- insufficient attention to intersectorality. Direct responsibility to give effect to the International Code usually lies with the health authorities. However, many other sectors have important roles to play in this regard;
- failure to recognize that the International Code applies to all countries, whatever their stage of socioeconomic development;²
- questions relating to the scope of the Code,³ including (a) products that are sometimes erroneously perceived and used as breast-milk substitutes, e.g. starchy gruels, herbal teas and follow-up formula; (b) the absence of internationally recognized quality and design standards for feeding bottles and teats; and (c) problems related to other infant-feeding utensils, e.g. feeding cups with perforated lids, and dummies;
- the erroneous assumption frequently made that application of the International Code is limited to a particular age group;
- the negative impact in some countries resulting from partial adoption of the International Code;
- a failure to respect the principles and aim of the International Code in newly evolving market situations, e.g. countries moving towards a market economy or population groups beginning to participate in a cash economy.

¹ As noted in paragraph 2 of this report, international representatives of some of these same concerned parties were present at the meeting. See also Annex 2.

² Article 11, paragraph 1, of the International Code calls upon governments to "take action to give effect to the principles and aim" of the Code, "as appropriate to their social and legislative framework, including the adoption of national legislation, regulations and other suitable measures". Referring to the Code as a "minimum measure and only one of several important actions required in order to protect healthy practices in respect of infant and young child feeding", the Thirty-fourth World Health Assembly (May 1981) urged all Member States "to give full and unanimous support to ... the International Code in its entirety as an expression of the collective will of the membership of the World Health Organization" (resolution WHA34.22).

³ For a discussion of the scope of the International Code, see pages 33-34 of Annex 3 to the relevant WHO publication (Geneva, 1981). As noted therein, the "[C]ode's references to products used as partial or total replacements for breast milk are not intended to apply to complementary foods unless these foods are actually marketed -- as breast-milk substitutes, including infant formula, are marketed -- as being suitable for the partial or total replacement of breast milk".

Recommendations

9. Governments should make a political commitment to give effect to the principles and aim of the International Code in its entirety, as a minimum measure. Political commitment implies monitoring of compliance with national measures, imposition of sanctions, and availability of adequate human and other resources to follow up.
10. Governments have full responsibility for formulating and adopting national measures to give effect to the International Code. In so doing, however, governments should consult with all concerned parties as an important means of ensuring their active participation in the implementation of these measures.
11. When adopting measures to give effect to the International Code, national authorities should use clear definitions and exact specifications. The scope of these measures should include all products that are perceived and used as breast-milk substitutes, whether or not suitable for this purpose, and whatever the age of the children concerned.¹ When appropriate, technical support in this regard should be sought from WHO.
12. National measures adopted to give effect to the International Code should be seen as a standard component of every maternal and child health policy and programme. They should apply to health services in both the public and private sector.
13. The competent national authorities, where this has not already been done, should appoint a national breast-feeding coordinator and establish a multisectoral breast-feeding committee composed of concerned parties. The responsibilities of the coordinator and committee should include ensuring observance of national measures taken to give effect to the International Code.
14. International organizations, directly or via country offices where they exist, should provide national authorities with information concerning the International Code. Documentation on measures that have been adopted in various countries, together with information on experiences in their implementation that could be useful to other countries, should be gathered and disseminated by WHO, UNICEF, the Code Documentation Centre,² and other appropriate organizations and bodies.

¹ The report by the Director-General on infant and young child nutrition to the eighty-ninth session of the WHO Executive Board (document EB89/28) notes that "the representative of the International Association of Infant Food Manufacturers (IFM), at the meeting in The Hague ... said that she had taken careful note of the concerns expressed by some governments and other parties about the potentially negative consequences for child health that could result from confusion in the market place between bona fide infant formula and follow-up formula. She indicated that these concerns would be brought to the attention of IFM members, with a view to their taking all necessary steps to ensure that their marketing practices made a very clear distinction between these two products".

² The International Baby Food Action Network (IBFAN), in Penang, Malaysia, is located in the Regional Office for Asia and the Pacific of the International Organization of Consumers Unions, which is a nongovernmental organization admitted into official relations with WHO in 1986. IBFAN periodically holds 10-day training courses on implementing the International Code for participants from around the world who are sponsored by government or private funds. Course content includes the policy, socioeconomic and legal dimensions of the Code, and individual guidance and references are provided. Participants also have access to the extensive range of related materials collected by the Code documentation centre on the premises.

15. Steps currently being taken towards ending the donation or low-price sales of supplies of infant formula to maternity wards and hospitals should be continued and strengthened.¹ Henceforth, infant formula should be made available through the normal procurement channels in all countries and not through free or subsidized supplies.
16. Charitable and other donor agencies should exert great care in initiating, or responding to, requests for free supplies of foods used to feed infants. These agencies should review, and adapt as appropriate, the policies relating to the distribution and use of milk products for infant feeding that have been adopted by such bodies as the Office of the United Nations High Commissioner for Refugees, the World Food Programme, and the International Committee of the Red Cross. To avoid interfering with breast-feeding practice, no more than the minimum amount of infant foods should be provided, for distribution under appropriate supervision and follow-up.
17. Consultations should be held regarding the problems of countries that, due to newly evolving market situations, are particularly vulnerable to marketing practices relating to products within the scope of the International Code. This includes countries that are in the process of moving from centrally planned to market economies and to countries with population groups that are beginning to participate in a cash economy.

TRAINING AND EDUCATION IN THE HEALTH SECTOR

Lessons learned

18. Health professionals and other persons working in the health sector are frequently unaware of the latest developments related to infant-feeding practices and, in particular, about how to advise mothers in this regard. This includes lack of awareness about the principles and aim of the International Code and, where relevant, national measures that have been adopted to give effect to it. This tendency is aggravated by a rapid turnover among health personnel.
19. The relations between health personnel and infant-food manufacturers are not always compatible with the principles and aim of the International Code.

Recommendations

20. National measures which have been adopted to give effect to the International Code should be presented in clear and understandable language, and disseminated widely.

¹ The report (document EB89/28) to the eighty-ninth session (January 1992) of the WHO Executive Board notes that the President of IFM has informed the Director-General of a policy statement adopted by the IFM General Assembly in March 1991, and the related decision of the IFM Executive Committee in June 1991, concerning donations of infant formula to hospitals and other institutions in developing countries. IFM announced that it agreed with WHO and UNICEF on the goal of ending donations or low-price supplies of infant formula to maternity wards and hospitals in developing countries by the end of 1992. IFM agreed to work with WHO and UNICEF in a country-by-country process aimed at the development, by governments, of regulatory or other official measures as appropriate. IFM pledged its full cooperation in these efforts, which it announced would commence immediately in several countries and would be extended to other countries in 1992. To this end, IFM requested the good offices of the Director-General of WHO and the Executive Director of UNICEF in facilitating the process. IFM, whose membership includes more than 30 national and international infant-food manufacturers, said that it regarded it to be essential that the measures taken by governments be clear and unambiguous, and that they engage the responsibility not only of all manufacturers, but also of all concerned in the health care system.

21. All initial and in-service health worker training in breast-feeding should include (a) information and advice regarding the responsibilities of health workers under the national measures adopted to give effect to the International Code; (b) a discussion of the principles summarized, and operational targets contained, in the Innocenti Declaration¹ and the joint WHO/UNICEF statement on breast-feeding and the role of maternity services;² and (c) lactation management and how to foster the establishment of breast-feeding support groups in the community.

22. WHO should encourage and support the revision, and where necessary preparation, of the infant-feeding content of health workers' training curricula, textbooks³ and other learning materials, in association with relevant international professional and voluntary organizations. These materials should include the principles and aim of the International Code and information in regard to health workers' responsibilities under it.

23. On behalf of their membership in countries, international professional associations should develop, or where appropriate strengthen, guidelines for establishing ethical standards of conduct between health workers and manufacturers and distributors of products within the scope of the International Code.

INFORMATION TO THE GENERAL PUBLIC AND MOTHERS

Lessons learned

24. In some countries, manufacturers and distributors of products within the scope of the International Code, with prior approval of the competent authorities, are permitted to use the mass media and the formal and informal educational sectors to disseminate information about their products. This discrepancy between the International Code and measures adopted to give effect to it causes confusion and creates additional work for national authorities.⁴

25. While national authorities are in a position to regulate information services and the content of promotional messages within their territories, they are unable to deal unilaterally with the rapidly expanding international telecommunications revolution, for example satellite and cable television transmission. This is resulting in some countries in promotional practices that are incompatible with national measures that have been adopted to give effect to the International Code.

¹ The Innocenti Declaration was produced and adopted by participants at the WHO/UNICEF policy-makers' meeting on "Breast-feeding in the 1990s: a global initiative", which was held at the Spedale degli Innocenti (Florence, Italy, 30 July-1 August 1990).

² Protecting, promoting and supporting breast-feeding: the special role of maternity services. A joint WHO/UNICEF statement. World Health Organizations, Geneva, 1989. Arabic, English, French and Spanish; a list of some 25 other language versions is available on request.

³ WHO, with the collaboration of IBFAN, is undertaking a desk review of the breast-feeding content of the main medical textbooks in use around the world. As a first step, questionnaires in Arabic, English, French and Spanish were sent to more than 500 medical schools in 1990. The next step will be taken in cooperation with the Institute for Reproductive Health at Georgetown University, a WHO collaborating centre in Washington, D.C. In the light of the latest scientific information and clinical experience, specific recommendations to publishers will be prepared on such topics as physiology, lactation management, prenatal counselling of mothers, and related fertility questions. To help ensure the best product and widest impact, WHO will enlist the aid of the International Federation of Gynecology and Obstetrics and the International Pediatric Association.

⁴ See in this connection paragraph 43 in Annex 1, including the example of the Philippines.

26. The feeding bottle as a child-care symbol, typically found in public facilities (e.g. airports), is not supportive of breast-feeding. The same is true of feeding bottles and teats used in connection with the promotion of other products.

Recommendations

27. National authorities should provide information and education on infant and young child nutrition and feeding that is adapted to local language, culture and literacy needs.

28. Governments should explore, on a bilateral or multilateral basis, means of regulating the promotion via international satellite and cable television transmission of products within the scope of the International Code, in keeping with the Code's provisions.

29. WHO should continue to provide appropriate learning materials, including video films, on infant and young child nutrition and feeding, for adaptation and use in countries.

30. The feeding bottle and teat should not be used as a child-care symbol,¹ nor should it be used in connection with promoting any other product, e.g. mineral water and baby-care items.

MONITORING AND ENFORCEMENT

Lessons learned

31. The monitoring of measures adopted to give effect to the International Code, often with the support of national and international nongovernmental organizations, has been successful in some countries. In many other countries, however, monitoring has proved to be absent, poorly planned, or ineffective for lack of the proper designation of responsibilities among those concerned. Other factors contributing to incomplete monitoring are an absence of baseline data, trained staff, appropriate indicators, and adequate funding.

32. Difficulties encountered in enforcing national measures include absence of sanctions, inadequate sanctions or inability to apply them in practice, and provisions that require subjective interpretations on the part of national authorities.²

Recommendations

33. To the extent possible, the monitoring of national measures adopted to give effect to the International Code should be undertaken through existing mechanisms, e.g. those relating to food inspection, health service practices and trade regulation. Appropriate training should be provided for those persons concerned.

34. The monitoring of national measures should include periodic surveys of knowledge, attitudes and practices among health workers.

¹ Following the meeting, the representative of the International Organization of Consumers Unions and the President of the International Association of Infant Food Manufacturers wrote, respectively, to the International Organization for Standardization (ISO) and to the International Air Transport Association (IATA) to recommend that a suitable child-care symbol be found to replace the feeding bottle frequently used in public transport facilities and to offer their cooperation to this end. Both ISO and IATA are nongovernmental organizations in official relations with WHO.

² See in this connection paragraph 43 in Annex 1, including the example of the Philippines.

35. WHO, in collaboration with other agencies and organizations, should develop indicators for monitoring national measures based on agreed definitions. These indicators, together with guidelines for their adaptation and use, should be disseminated to countries.¹

MANUFACTURERS AND DISTRIBUTORS OF PRODUCTS WITHIN THE SCOPE OF THE INTERNATIONAL CODE

Lessons learned

36. In many countries measures adopted to give effect to the International Code, sometimes developed in collaboration with the infant-food industry, are weaker than the provisions of the Code itself. In other countries they are non-existent.

37. In situations where national measures are weaker than the International Code, manufacturers and distributors of products within its scope have generally adopted marketing policies and promotional practices that do not conform to the provisions of the International Code in its entirety.² Among other things, this approach has complicated efforts to define violations of national measures.

38. Generally speaking, manufacturers and distributors have made a distinction between developing and industrialized countries where their marketing practices in relation to the International Code are concerned.³ However, neither the Code itself nor the World Health Assembly has made such a distinction.

¹ For example, WHO, in collaboration with UNICEF and other interested organizations and agencies, has developed a limited number of breast-feeding indicators that are relatively easy to measure and interpret, and at the same time operationally useful in terms of the application of results (document WHO/CDD/SER/91.14). They should facilitate intra-country comparisons over time, while increasing confidence among programme managers and decision-makers about how to influence attitudes towards breast-feeding, how to increase awareness of the importance of this practice, and how to provide the types of support that will both motivate and enable mothers to breast-feed their children. The definitions of breast-feeding categories used cover exclusive breast-feeding, predominant breast-feeding, full breast-feeding, breast-feeding, complementary feeding, and bottle-feeding.

² IFM has affirmed that, "to further the association's goal of maintaining 'high ethical standards for the marketing of infant foods', [it] has voluntarily established procedures for investigating allegations of non-compliance by member companies with IFM commitments. In 1987, IFM initiated a complaints procedure, and in 1991, it named an Ombudsman to independently arbitrate and investigate any allegations which cannot be resolved directly". Source: IFM: A commitment to infant and young child health, Paris, 1991, p. 29.

³ In October 1989, IFM "reaffirmed to the WHO Director General the commitment of its member companies to support the principles and aim of the WHO Code. In practice, this individual, voluntary commitment by member companies is carried out by conforming to the WHO Code in its entirety in developing countries, except where specific national codes or other measures have been implemented by governments. In developed countries, IFM member companies comply with the national codes and regulations, and/or with voluntary industry codes established in consultation with the relevant authorities. Such voluntary codes are designed to give practical effect to the WHO Code as appropriate to the social and legislative framework of the countries concerned. In their absence, each company remains responsible for the marketing practices best suited to consumer needs, in line with the aim of the WHO Code, and in accordance with the circumstances and applicable legal requirements in any specific country". Source: Ibid., pp. 15-16.

39. Too little attention has been paid to regulating the marketing and promotion of feeding bottles and teats, and other devices including dummies (also known as pacifiers or soothers) and feeding cups with perforated lids. In addition, there are no internationally recognized standards for the quality and design of feeding bottles and teats.¹

40. At the retail level, infant formula is frequently displayed for sale together with a variety of other products commonly used for infant feeding, e.g. herbal teas, starchy gruels, sweetened condensed milk, and follow-up formula. This practice contributes to these other products being incorrectly perceived as appropriate breast-milk substitutes, thus greatly increasing the risk of their being used inappropriately in feeding infants.

Recommendations

41. Manufacturers and distributors of all products within the scope of the International Code should comply with the Code in its entirety in all countries, unless specifically prohibited from doing so by national legislation.

42. Governments and concerned organizations should seek to define and adopt internationally recognized standards relating to the design and quality of feeding bottles and teats.

43. At the retail level, infant formula displayed for sale should be separated from other products commonly used for infant feeding.

¹ The report (document EB89/28) to the eighty-ninth session (January 1992) of the WHO Executive Board notes that "a group of major producers of feeding bottles and teats (nipples) announced in 1991 the creation of the World Association of Bottles and Teats Manufacturers (WBT). The objectives of WBT are to oversee the quality and design of products and ensure 'that parents are provided with the fullest information regarding the products manufactured under the [organization's] Code of Practice'."

ANNEX 1

BACKGROUND DISCUSSION DOCUMENT

[NUT/MCH/91.1]

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INTRODUCTION

1. In their reports, Member States indicated that the measures they have taken to give effect to the International Code are at one of the following stages:

- development of national measures (adaptation of the International Code to local circumstances);
- adoption of national measures via legislation, promulgation of directives, voluntary agreements with the infant-food industry or other means;
- implementation of national measures by spreading awareness of their existence and the implications for the various interested parties, as well as establishment of necessary administrative systems;
- monitoring of compliance with national measures by those assigned responsibilities under them, particularly the infant-food industry and the health sector;
- ensuring compliance with national measures when violations are identified, according to the means set forth in the measures themselves and relevant administrative systems;
- evaluation and revision of national measures, if this is found necessary.

2. The present document focuses on those factors which were mentioned in national reports as having facilitated, delayed or prevented smooth progress from one step to the next in giving effect to the International Code; those adaptations of the International Code that governments found useful; and any pitfalls that, based on experience, other countries might be advised to avoid.

MAIN FEATURES OF THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES AND ITS
IMPACT IN COUNTRIES

3. Broadly speaking, the International Code concerns marketing practices in respect of breast-milk substitutes, feeding bottles and teats; composition and labelling in respect of the food products within its scope; promotion of breast-feeding; and provision of objective and consistent information and education on infant feeding.

4. Countries have usually treated each of these components differently. Product composition and labelling, for example, tend already to be regulated by laws, which in turn are often modified to reflect the principles and aim of the International Code. Labelling aspects can sometimes usefully be discussed together with regulation of marketing practices. In contrast, nutritional composition is usually treated as part of the relevant standards of the Codex Alimentarius and rarely together with marketing. In some countries breast-feeding promotion, which is mainly a responsibility of the health sector, is dealt with in a framework independent of the Code, while in others the International Code has clearly served an advocacy function in this regard. Country reports have been particularly frank about problems encountered. For example, Sweden stated that it is "regrettable that, so far, the Code has not been used as a lever to promote breast-feeding and ultimately to adopt a national breast-feeding strategy".

5. The present document focuses mainly on the marketing aspects of the International Code, sometimes mentioning labelling issues as well as breast-feeding promotion. It progresses through the steps of the Code implementation process, summarizing some of the major issues highlighted in the country reports that have been found to help or hinder progress at that stage. It also summarizes issues relating to the content of national measures.

6. The Government of Brazil expressed this way its perception of the need for national measures to give effect to the International Code: "Government interventions aimed at stimulating breast-feeding were not able to overcome the aggressive force of the marketing strategies adopted ..." The International Code itself, the use made of it by governments, health professionals and nongovernmental organizations, and the response of much of the infant-food industry have improved many aspects of the marketing of breast-milk substitutes. This is the result of a combination of factors including direct action by governments, support provided by WHO and UNICEF, advocacy by international nongovernmental organizations, and changes made by the infant-food industry. Broadly speaking, levels of advertising in marketing and distribution practices have been reduced, especially in broadcast media, marketing tactics like the use of "milk nurses" have nearly disappeared, and other strategies like product sampling are less common than before. Recommended labels with required notices and warnings are commonly in use, and most brands of sweetened condensed milk no longer state on their labels that they can be used for infant feeding.

7. There is also little doubt that in many countries the advent of the International Code and the continuing request from WHO to national authorities for information on national action taken to give effect to its principles and aim have raised awareness about infant feeding issues on the part of governments and health officials alike. In many cases progress has been made on the national level in giving effect to some articles of the International Code even if action on the entire Code appears to have stalled.

8. The potential impact of the International Code, combined with substantial, continuing local breast-feeding promotional efforts, is illustrated by Brazil, where national production figures for infant formula by a monopoly company increased from 6500 to 26 000 tonnes during the period 1970-1977. In 1980 production was still at nearly 25 000 tonnes but fell to about 17 000 tonnes in 1981 when the passage of the International Code led to the immediate cessation of free donations to maternity wards and to health professionals for their own children. (Production levels remained more or less constant throughout the 1980s and were at 14 000 tonnes in 1990 despite a 63% increase during the decade in the population of infants

under six months of age. This may have been the combined result of national efforts to promote breast-feeding throughout much of the 1980s, the effect of the national code, which became law in 1988, or even the result of an increased use of inappropriate breast-milk substitutes.)

The need for national measures

9. Countries having local manufacturers of breast-milk substitutes may have to adopt national measures to obtain many of the benefits associated with the International Code. Although the International Code applies equally to local and international companies, the former may feel less need to abide by it than international companies unless government agencies, health professionals or local nongovernmental groups actively monitor the situation. Nevertheless, many countries reported that local agents and distributors of international companies do not always adequately comply with the International Code. Modifications of national measures adopted to give effect to the International Code are thus considered necessary in some cases.

STAGES IN IMPLEMENTING NATIONAL MEASURES GIVING EFFECT TO THE PRINCIPLES AND AIM OF THE INTERNATIONAL CODE

Development of national measures

Facilitating factors

10. In some countries work on national measures to give effect to the International Code was able to proceed rapidly because of steps that had already been taken to regulate marketing practices. This was true in the case of Sweden, which already had a national code in 1964. Revised in 1975, it now resembles the International Code. In Finland a voluntary agreement between the Association of Finnish Paediatricians and the infant-food industry, which was drawn up in 1979, covered provisions that are now contained in articles 4 and 6 of the International Code.

11. It is reported that some factors, which initially facilitated rapid progress in the early stages of work on national measures, in the end served to weaken them. These include development of national measures that fail to involve either nongovernmental organizations, including consumer groups, or the infant-food industry;¹ adoption of an industry-produced code of marketing; use in developing national measures of health experts who are identified with the infant-food industry; and adopting low age cut-off points that permit continued direct advertising of products, if only in respect of products intended for slightly older infants.

12. These kinds of "short-cuts" appear to have led in some cases to dissatisfaction with national measures, and eventually required that additional time and effort be spent on their revision. In countries like the Philippines and the United Kingdom, where national measures have left out important components of the International Code, confusion and irritation were reported to have resulted among consumer groups and others that insisted that the International Code was intended as a "minimum measure".

¹ In Sweden, although the national breast-feeding mothers' support group was formally represented in the national code development process, it felt that its views had often been ignored. In the United Kingdom consumer groups claimed that they had been "insufficiently represented in code drafting and monitoring bodies". In both countries consumer groups consider national codes to be weaker than the International Code. Interested parties may also be inadvertently left out. Adoption of the Swedish code was delayed for nearly a year when an organization called the Business Delegation on Marketing Law questioned the legal implications of the Swedish code.

Technical constraints

13. Most countries began discussing the essence of the principles and aim of the International Code in 1979-1981 in preparation for the discussion and adoption of the International Code at the Thirty-fourth World Health Assembly in 1981. Afterwards, many countries established national working groups or committees to examine the International Code and to determine the most appropriate way of adopting it in the light of national circumstances. For most countries this was a difficult and time-consuming process. For example, it required cooperation among sectors that normally do not work together: health policy, hospital administration and infant nutrition; corporate, constitutional and other types of law; business, advertising and marketing; and communication and related fields. Relevant officials simply may not have had enough time available to participate, especially where the importance of the issues was not fully appreciated. In Kenya development of a national marketing code required the greatest number of technical meetings ever held for any standard or code of practice. In Poland political, social and economic constraints have thus far prevented the working party responsible for developing local legislation from being convened. Although technical support from WHO is available to Member States in developing national measures, relatively few countries have requested it.

The role of the infant-food industry

14. Direct efforts by the infant-food industry or their local agents and distributors to weaken national measures or delay their adoption have been mentioned in a number of country reports. Another industry approach described has been the preparation of guidelines for, or provision of assistance in, developing national measures, which were weaker than the International Code. In Kenya, for example, a three-year review of the national code concluded in 1986 that many loopholes were present "as a result of the involvement of the manufacturers during the developmental stage".

The role of health professionals

15. Some country reports have indicated that the health professionals assigned to work on committees responsible for implementing the International Code were unaware of the relevant issues, lacked interest, or connected with the infant-food industry. The report from Sweden observed that the only nongovernmental representative appointed to a national working group was a paediatrician who had been a consultant to one of the two local infant-formula companies for fifteen years.

16. Sometimes these constraints are combined and it is difficult to decide which is more significant. For example, several drafts of a national marketing code have been produced in Yemen since 1983, but no further progress has been made due to "pressure of commercial companies to delay the adoption of the code" and "lack of awareness of the scope of the code and issues related to infant nutrition among policy-makers and senior health staff".

Other constraints and problems

17. In countries such as Poland, which are changing from a planned to a market economy, there is little awareness of the International Code or other ways of dealing with marketing practices, since these are reported to have been weak or officially ignored in the past.

18. The development of the European Commission Directive on Infant Formulae and Follow-on Formulae¹ and the implications of "European integration" were cited as factors likely to affect in unknown ways marketing of products within the scope of the International Code in some European countries. This may also be true with respect to product exports by European

¹ Adopted in 1991. See Official Journal of the European Communities, No. L 175, 4 July 1991, pp. 35-49.

manufacturers. Finland noted that "there is a need for debate ... on the observance of the Code in the exporting of baby foods". In the United Kingdom the advent of a European Directive halted work on development of national measures to deal with feeding bottles and teats.

19. In some countries problems have arisen concerning the precise meaning of certain provisions of the International Code, whether linked to a failure to understand one of the official languages¹ in which it was adopted, or for lack of a local translation. In Poland a translation was first made available only in 1988. In Finland the Finnish Food Industries Federation agreed to endorse the International Code as a voluntary agreement on condition that an official Finnish translation be made available and that certain notes and specifications be added corresponding to conditions in the country. However, no such Finnish translation has yet to appear. An unofficial translation was sent to health centres and maternity hospitals in June 1991. Countries have not always availed themselves of the opportunity they have, as Member States of WHO, to refer to the Director-General for technical comment and clarification difficulties they may have in interpreting provisions of the International Code.

Adoption of national measures

20. Country reports show that it can be difficult to decide which portions of national measures can and should be adopted into law. In some countries restrictions on advertising (Article 5 of the International Code) have implications for constitutional provisions relating to free speech. In such cases countries have tended to opt for developing voluntary agreements with the infant-food industry. In Sweden, where relevant changes in the constitution were estimated to require at least six years, part of the national measures adopted were issued as guidelines; part as regulations for the health sector; part as a voluntary agreement with the infant-food industry; part as an agreement with the Consumer Board and the Business Delegation on Marketing Law that any future entrants would conform to the voluntary agreement; and part as a unilateral pledge by industry regarding non-commercial informational and educational materials to the public. Swedish companies agreed to abide by these agreements in both domestic and foreign markets.

21. In several countries measures have been taken gradually, some existing before the adoption of the International Code, others being developed soon thereafter, and still others that are in the process of being developed today. In the case of the United Kingdom, for example, the Code of Practice for the Marketing of Infant Formulae was adopted in 1983. Additional steps were taken via a revised health service circular in 1989 incorporating new aspects, including cessation of the distribution to hospitals of free or subsidized supplies of infant formula.

22. The process of adopting measures to give effect to the International Code as law has been perceived as problematic in some countries, partly because of the time required, but also because of the difficulties associated with raising awareness among legislators about relevant issues. Simpler approaches have been tried in some countries such as gazetting measures as a supplement to existing acts under the authority of relevant ministers.

Implementation of national measures

23. Some country reports observed that the adoption of national measures has little effect if those persons who need to implement them are not aware of the measures or the implications for their work. In many countries information about the International Code, or national measures giving effect to it, is rarely adequately conveyed to decision-makers, the mass media and consumers, although sometimes nongovernmental groups attempt this task. More important, perhaps, may be whether the infant-food industry and the health sector are adequately informed to enable them to carry out their responsibilities.

¹ Arabic, Chinese, English, French, Russian and Spanish.

Infant-food industry

24. The task of informing all relevant producers, importers, wholesalers and retailers about their responsibilities under the International Code does not appear to have been thoroughly developed in many countries. Usually the responsibility has been left to the infant-food industry, even though it does not have contact, let alone influence, with all the parties concerned. The situation is presumably more complex in a market having many competitors, for example Nigeria where 32 brands of infant formula are available, than in a country like Sweden, which has only two.

25. Once national measures have been adopted, local industry, or local agents for international companies, react differently in response to specific cultural and business factors. While in some countries, for example Finland and Sweden, the behaviour of the infant-food industry has been described by government as exemplary, other governments have alluded to difficulties in securing the industry's full cooperation.

Health sector

26. Both the International Code and many of the national measures adopted to give effect to it can be difficult to understand for persons not used to legal language. At the same time, national measures have to be disseminated, discussed and understood by responsible institutions and individuals before commitment and adherence to them can be expected. To facilitate this process, the Philippines has developed a primer on the International Code, which is to be distributed to all concerned parties. However, many other countries have limited themselves to printing the International Code, for example 30 000 copies in Polish that were distributed widely among health workers and other groups in 1988.

27. Most ministries of health have issued one or more directives to their personnel to call attention to the International Code and to the national measures that have been adopted to give effect to it. Nevertheless, this approach has not always been found to lead to widespread awareness of national measures and the corresponding responsibilities of health workers. Country reports provided little information as to how much, if any, information about national measures giving effect to the International Code is incorporated into training curricula for health workers.¹ Several country reviews reported disappointment regarding awareness of national measures among health workers. Thus, for example, in Nigeria personnel in only 6% of health facilities polled knew about the International Code or national action taken to give effect to it, including the national code of marketing of breast-milk substitutes.

28. It may be difficult to create awareness of national measures in countries where health sector responsibilities are decentralized. For example, in Sweden only two of the country's 25 county councils produced informational material for their health staff on the subject.

29. Even where information about national measures has been disseminated to health professionals, sometimes little attention is paid to these measures. Brazil noted that neonatologists were particularly oriented towards artificial feeding, while the Philippines stated that "to witness neonatologists sincerely convinced by manufacturers is appalling".

30. Implementing national measures is frequently hindered by inadequate numbers of health personnel. In the Philippines the Bureau of Food and Drugs has been unable to implement the labelling aspects of the national marketing code because of the demands placed on it by a new generic drugs act. Guatemala, with assistance from UNICEF, has only recently been able to establish a full-time professional position in the Ministry of Health to educate personnel from both industry and the health care system concerning their respective responsibilities under the national code, to promote compliance with it, and to identify violations.

¹ The report from Nigeria recommends that this information should be provided.

31. In some countries implementation of national measures in the health sector is hampered by physicians' expectations, and even demands, regarding gifts and other benefits from infant-formula manufacturers. The Ministry of Health in the Philippines, for example, noted that it is now often doctors who solicit gifts and donations from companies. In Egypt some doctors themselves give mothers gifts and product samples as an incentive for them to return to their clinics.

Monitoring of compliance with national measures

32. Depending on local circumstances, various authorities have been assigned responsibility for monitoring compliance with national measures. In Nigeria monitoring is the responsibility of the Food and Drugs Administration whose Control Department is in charge of enforcement. In Sweden the Consumer Board formally reviews all complaints concerning marketing violations; 38 essentially minor, but clear, violations have been filed since 1984, nearly all by nongovernmental organizations. Only two complaints have been made with respect to composition and labelling issues, which are handled by the National Food Administration. In contrast, the National Board of Health and Welfare "does not appear to have been very active in monitoring or keeping themselves informed about how the code is being implemented or how the aim of the code is fulfilled".¹

33. Monitoring appears to be inadequate in some countries. In a 1986 review of the national code in Kenya "it was observed that the code was being openly violated. Concern was also expressed that no one was monitoring adherence to the code ..." In Finland "no official system has been created ... for monitoring the implementation of [International] Code objectives ... Since the marketing of products covered by the Code has not been any problem in Finland, we have no practical experience of the application of the [consumer protection] law in this respect". The present country review and evaluation exercise is reported to have detected several violations of this voluntary agreement, which responsible officials said would be taken up with manufacturers and central retailers. In Egypt compliance is considered mainly a moral commitment, and there is no official system either for monitoring adherence to the International Code or for recording violations.

34. Several countries have noted that, without effective monitoring and follow-up, previous achievements in restraining inappropriate marketing practices can be eroded. It was also noted that constant effort is required, if only to ensure that new employees, both in the health professions and industry, are aware of their responsibilities under national measures.

35. Guatemala has recommended that a "practical and tailored survey instrument should be developed by WHO that would more easily permit the collection of standardized information for subsequent reviews and evaluations of the International Code".

Difficulties and constraints

36. Several countries have encountered difficulties in establishing mechanisms for monitoring the implementation of national measures. Self-monitoring by the infant-food industry has in some cases been found to be inadequate or unsatisfactory. In others national codes have failed to designate a responsible monitoring authority. Elsewhere the authorized institution lacks the personnel or resources to engage in effective monitoring. Governments often depend on nongovernmental organizations, such as breast-feeding women's support groups, to perform this function. However, governments rarely provide resources for this purpose and the resultant antagonistic relationship that has sometimes occurred between the two parties has been reported to inhibit cooperation.

¹ Reports from both Finland and Sweden indicated that the International Code was considered important more out of solidarity with Third World countries than because of a perceived need to protect, promote or support breast-feeding domestically.

37. Certain alleged breaches of the International Code are particularly difficult to detect because they take place on a small scale or for only a short time. Examples are temporary low-price sales or, in the case of Papua New Guinea, the discounting of out-of-date stock of infant formula.

Ensuring compliance with national measures

38. Some countries have reported that large companies have been willing to correct infringements of national measures when these have been brought to their attention. Occasionally, companies find that this takes a long time to accomplish because of the independence of some of their product distributors.

39. In many countries national measures have not included specific sanctions or penalties that are strong enough to force uncooperative companies to comply. In Kenya a report prepared in 1986 expressed concern that "there was no provision for the prosecution of violators" despite the national code's being "violated openly". In Nigeria infringements of the local marketing code can lead to fines and even prison terms, although thus far no sanctions have been imposed on any company.

40. The Philippines has considerable experience with this aspect of the implementation process. The Ministry of Health is empowered to enforce the national code and can suspend or revoke licences for violations. There is also a provision in the law for fines following court convictions. However, in most cases the Ministry-appointed interagency code monitoring committee has simply held discussions with the companies and written "cease and desist" letters. There is one pending trial case, but the physician involved in a gift-giving episode is said to be reluctant to swear an affidavit. The Filipino system is reported to result in continuous efforts by the infant-food industry to circumvent the rules, which in turn takes a great deal of the Ministry's staff time.

EVALUATION AND REVISION OF NATIONAL MEASURES

41. Some years after adopting and implementing national measures, many countries have concluded that a review and evaluation can be useful to determine how well they have worked in practice and whether there is any need to strengthen or otherwise revise them. In some ways the delay between the development of national measures and their promulgation into a formal law or regulations has served a similar end. This is illustrated by Nigeria where a national marketing code was first developed in 1982, revised in 1986, and finally promulgated as a decree in 1990. This delay may in fact prove to be advantageous to the extent that it facilitates the preparation of necessary revisions.

42. At the same time, revision of national measures can prove difficult since it implies going yet again through the entire development process. Some countries have taken short-cuts to adopting more formal measures such as laws, which later rendered revision difficult. In Kenya the code revision process experienced difficulties when consumer groups were no longer willing to meet with industry representatives to discuss implementation of the national marketing code.

43. National measures frequently do not cover all the features of the International Code, which was adopted as a "minimum requirement". Some countries have identified these differences as weaknesses or loopholes in their national measures and, in some cases, this has led to a consideration of their revision. The following are some of the elements of the International Code occasionally not covered by national measures adopted to give effect to it.

- Some forms of advertising direct to consumers are permitted. The European Commission Directive (paragraph 18) states that "advertising of infant formulae shall be restricted to publications specializing in baby care and scientific publications". At the same time, however, "Member States may further restrict or prohibit such advertising". In the United

Kingdom advertising direct to mothers in special literature for them, for example on infant feeding, is allowed "under the supervision or care of the health care system". The Code Monitoring Committee "is giving further consideration to this question" in view of the complaints being received.

- In the Philippines advertisements and industry sponsorship of health professionals are screened by Government for acceptability. This is described as causing the biggest "headache" to the Ministry of Health in view of the burden placed on available personnel. It has also put the Government in an adversary position as much with the infant-food industry, which has not understood the basis for its decision, as with nongovernmental groups, which have not accepted that advertising and sponsorship are necessary at all. (On the other hand, the system is said to ensure that industry stipends are provided only on behalf of doctors working in hospitals where rooming-in is practised.) In Sweden advertising of foods intended for use by infants above six months of age is permitted if it is "factual and moderate", although this provision is said to be difficult to interpret in practice. (A Consumer Board official remarked that "what you cannot say is clearer than what you can".)
- Some countries permit educational or promotional literature on infant feeding, for the public and/or for health professionals, often including advertisements for foods for infants. Such materials tend to be more attractive and produced in larger quantity than those that governments can afford.
- Feeding bottles and teats are frequently not covered under national measures. A voluntary code of marketing for these products is under discussion in the United Kingdom.
- Little attention has been given to warnings on labels for products, for example glucose, teas, cereals and milk products, that are perceived and used as breast-milk substitutes in some countries, whether or not they are represented by manufacturers to be suitable for this purpose.
- Papua New Guinea had already established strong infant-feeding policies and laws before the advent of the International Code, "but the legislation, unfavourably, does not cover the marketing of breast-milk substitutes".

Impact of national measures on infant-feeding practices

44. Many country reports expressed governments' interest in receiving support in maintaining better statistics on the prevalence and duration of breast-feeding and on the use of breast-milk substitutes, in part to measure the impact of marketing control measures and breast-feeding promotion activities. Reports indicated increased awareness in countries that it is not enough to look at statistics on initiation and duration of breast-feeding, but that the length of exclusive breast-feeding and the extent of bottle-feeding, though neglected in most previous surveys, must also be considered.¹

45. Data on the production or importation of infant formula would in most cases be an even more sensitive impact indicator. Unfortunately, such data are usually difficult to obtain, in part because international import/export statistics combine infant formula with other "dietetic" products, but also because of the confidential nature of such information among competitors. Data on importation and production of feeding bottles and teats are even more difficult to come by.

¹ See Indicators for assessing breast-feeding practices (document WHO/CDD/SER/91.14), op. cit.

46. Data from Brazil on the impact of monitoring were presented above (paragraph 10). Guatemala believes that its national marketing code, which was adopted into law in 1983, was responsible for a sharp decline in the importation of infant formula during the period 1983-1987. The Government has no comparable figures since then, but is concerned that "because there has not been a formal system in place to monitor, evaluate and promote compliance with the [code, this situation] may have been reversed over the last two or three years". The Government's view is based on an apparent increase in the sale of feeding bottles and teats in the country, which has a population of 8.5 million. One industry representative estimated that over 500 000 bottles and 1.5 million teats were sold in 1990 alone.

47. There are other useful ways of measuring the impact of national measures. For example, in the United Kingdom the cessation of free supplies of infant formula to hospitals after 1989 was said to have "alerted health professionals to the need to update their knowledge of breast-feeding management. There is now more demand for information and greater sensitivity to the needs of the breast-feeding mother. Ready-to-feed bottles are more likely to be locked away and given only when necessary".¹

Limitations to what national measures have been able to achieve

48. National measures rarely have an impact on industry promotional efforts directed towards paediatricians and other members of the health community. In Brazil such efforts have included assistance to "hospital schools, scientific meetings, refresher courses and congresses, contributions to the support of scientific journals through systematic publication of announcements, and individual contacts on the part of corporate representatives with doctors". The report from Brazil observes that this practice has affected doctors' professional judgement: "Premature introduction of other foods, including milk as a supplement, prescribed by the doctor, was to represent an interference in the production of mother's milk and reinforce the interventionist role of the doctor as promoter of weaning, covering up the actions of advertising as a mechanism conditioning this behaviour".

49. The report from the Philippines notes that the infant-food industry is able to adapt its marketing systems rapidly, and specifically mentions follow-up formulas, which "Filipino paediatricians are now convinced that babies need". The report points out that not only is it difficult for marketing codes to be modified to meet this challenge, but that "the reliable scientific community on infant and young child nutrition does not seem to be so well organized to meet this role".

50. The national marketing code in Guatemala has succeeded in stopping nearly all consumer advertising. "Of concern, however, is the influx of advertisements for infant formulas, infant cereals, prepared baby foods, bottles, nipples and other products covered by the code, through cable television and international magazines and professional journals that cannot, under current legislation, be regulated or otherwise controlled ... This 'leakage' obstructs national efforts." Papua New Guinea has expressed similar concerns.

51. Many foods perceived and used as breast-milk substitutes are sold alongside infant formula in shops and pharmacies, reinforcing public confusion about their potential usefulness for infant feeding. Shopkeepers can add to the problem by advising mothers on which products to buy. Guatemala suggests that measures be developed to ensure that breast-milk substitutes are displayed separately from other foods at the retail level.

¹ Comments provided by the Baby Milk Action Committee (Cambridge) at the request of the Government of the United Kingdom.

Other relevant national measures

52. Some countries have attempted to limit the spread of bottle-feeding by removing relevant products from free trade. One of the most successful approaches appears to be that adopted in 1977 in Papua New Guinea, which focused on feeding and related utensils (bottles, teats, dummies and cups with perforated lids) rather than on infant foods as such. The result was a rapid drop in bottle-feeding by 1979, although the country report suggests that a lack of follow-up since then may have led to its gradual return. In Iran a uniform label has been adopted, allowing the brand name to appear only in small print in one corner. The result has been an apparent reduction in much of the commercial incentive for promotion.

53. In Kenya the Ministry of Industry refused a licence for the importation of ingredients for the manufacture of infant formula which, in the words of the country report, "clearly shows the commitment of the Government". Infant formula is produced entirely within the country as a result. Yemen has placed certain restrictions on the issuance of licences for the production of artificial infant foods.

54. A few countries have used public funds to subsidize or provide infant formula free of cost, with the intention of restricting use to those infants who have to be fed on it. The dangers associated with this approach are illustrated in Iran where the survey undertaken for the present review found that health workers had great difficulty restricting the distribution of infant formula to those infants who needed it. (In urban areas, whereas coupons allow infant formula to be purchased at a low price, it is provided free of charge in rural areas.) Few of the health workers interviewed were aware of the government directives which identified those newborns who need infant formula. Mothers are said to pressure health workers in the belief that it is their right to obtain infant formula. In addition, a significant black market is said to have developed for these products. There appears to be a trend towards increased mixed feeding (combined breast- and bottle-feeding), despite educational efforts to increase breast-feeding and decrease artificial feeding, possibly suggesting that the present distribution system may be having the opposite of its intended effect.

55. Guatemala recommends that countries still in the process of developing or adopting national measures to give effect to the International Code combine them with protocols for hospital and maternity ward practices that will protect, promote and support breast-feeding.

ISSUES RAISED IN COUNTRY REVIEWS CONCERNING THE CONTENT OF NATIONAL MEASURES ADOPTED TO GIVE EFFECT TO THE INTERNATIONAL CODEScope (Article 2)

56. Some countries have incorporated definitions into national measures that expand the scope of the International Code, while in others they apply only below a certain age. Such decisions can have important effects, depending on the infant-feeding pattern desired. The lowest cut-off point is six months, apparently chosen to allow for continued direct advertising of the commercial gruels commonly given by bottle in Sweden. Finland, Nigeria and the Philippines have marketing codes that apply to products marketed for feeding up to 12 months of age. The twelve-month limit in the Philippines required one manufacturer to change the recommended lower age for its follow-up formula from 6 to 12 months. A two-year limit has been established in Guatemala. Even higher age limits are specified in other countries in order to include other types of commercial infant foods. Five years is currently being proposed in Kenya, where national authorities have considered as a weakness the exclusion of industrial "weaning foods" from their national marketing code. Other countries have included these types of foods in various ways. The scope of the Filipino marketing code, for example, was defined to include "all the products given through feeding bottles".

Definitions (Article 3)

57. In reply to the request of some governments for clarification, WHO has advised that it would not be incompatible with the principles and aim of the International Code if governments were to decide that the definition of "breast-milk substitute" included all products that are "perceived and used" as such, even if these products were not marketed or otherwise represented to be suitable as breast-milk substitutes.

Information and education (Article 4)

58. Some countries have found this article difficult to implement, and have stated that, since they cannot afford to provide the needed information to mothers, they have accepted the role of the infant-food industry. In some cases, companies are not only allowed to include their corporate logo, but also to advertise brand-name products in literature intended for the general public. In some places the need for written requests for donations of informational or educational materials is not required or not enforced. Guatemala has recommended that "the International Code should be strengthened to discourage the production and distribution by industry of 'educational'/promotional materials related to infant feeding aimed at mothers".

The general public and mothers (Article 5)

59. Generally speaking, national measures adopted to give effect to the International Code appear to have been successful in stopping most direct advertising to the public via the mass media. In Nigeria some infant-formula advertisements still appear in the press, although reportedly less often than previously. Distribution of free samples and direct contact with mothers by manufacturers were reported to be no longer occurring.

60. In nearly all countries commenting on this provision, occasional problems are said to occur with retail-level advertising, special displays, temporary price reductions and the like. The problem appears to be the result of decentralized (local agent) decision-making rather than due to decisions taken centrally by a given manufacturer.

Health care systems (Article 6)

61. Some countries report that it is difficult, or entirely impossible, to ensure that private-sector health facilities comply with the provisions of the International Code, or even to respect the national measures that have been adopted to give effect to it.

62. It is reported that, in some instances, the infant-food industry continues to distribute free or subsidized supplies of infant formula to health care institutions, particularly maternity wards, whether or not in response to written requests. A practice called "booking" is described in the report from the Philippines as "leaving products in a health facility or with a health worker on a consignment basis but to be later written off as a bad debt which is tantamount to giving samples of the product".¹

63. Recent alleged violations of the International Code reported by the Philippines include the display in health facilities of posters and other materials from manufacturers or distributors of breast-milk substitutes, "various sampling ploys", and company sponsorship for professional groups without first passing through the regional government health office.

¹ Resolution WHA39.28, which was adopted by the Thirty-ninth World Health Assembly in 1986, has apparently assisted some countries in solving this problem. The resolution urged Member States inter alia "to ensure that the small amounts of breast-milk substitutes needed for the minority of infants who require them in maternity wards and hospitals are made available through the normal procurement channels and not through free or subsidized supplies". See also the footnote to paragraph 15 of the meeting report.

Health workers (Article 7)

64. Information provided by manufacturers and distributors to health professionals has in many countries been found not to be restricted to scientific and factual matters, but rather to be promotional in nature.

65. While the International Code and most national measures giving effect to it mandate the disclosure of any contribution made for fellowships, study tours, research grants, attendance at professional conferences and the like, little progress appears to have been made in most countries in making systematic use of this information to avoid what are described as possible conflicts of interest by using only advisers who have not received such benefits.

Persons employed by manufacturers/distributors (Article 8)

66. Some country reports mention that it is difficult for governments to regulate and/or monitor how company sales personnel are remunerated. Reports did not mention any evidence that company personnel continue to perform educational functions in relation to pregnant women or mothers.

Labelling (Article 9)

67. Labels often do not conform to all requirements, commonly failing to warn consumers of the expense and potential dangers of bottle-feeding, sometimes continuing to use the words "humanized" or "maternalized", often containing pictures or texts idealizing bottle-feeding, and using print that is too small when stating the superiority of breast-feeding. The country review in Poland found that, of the 16 brands of infant formula available, labels on only two mentioned the superiority of breast milk; only three warned of the hazards of inappropriate preparation of the product; six had pictures of infants; and eight used terms like "humanized".

Quality (Article 10)

68. Most country reviews state that national authorities rely on Codex Alimentarius standards where the quality of infant formula is concerned. To combat problems of product adulteration, the Philippines has added a clause that prohibits re-packaging.

Implementation and monitoring (Article 11)

69. This subject is discussed above under stages in implementing national measures giving effect to the International Code (paragraphs 12-43).

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