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**Cross-Sectoral Implementation Guidance  
ADS 212:**

**“Breastfeeding Promotion Policy”**

**October 2001**

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**SEE ALSO COMPANION DOCUMENT, “BREASTFEEDING: USAID BACKGROUND PAPER”**

## INTRODUCTION

### **Implementing ADS 212: Breastfeeding Promotion Policy**

This cross-sectoral field guidance is designed to assist in the implementation of the new ADS 212, a cross-sectoral approach to protection and promotion, and support of breastfeeding. Each page addresses one area of USAID programming, briefly reviews the importance of breastfeeding to the sector and suggests modifications for data gathering as well as breastfeeding promotion policy implementation.

### **Why Do We Need New Strategy and Field Guidance Now?**

Breastfeeding is a unique behavior and life-saving intervention that is cost-effective and do-able. Breastfeeding provides low cost, high quality **food** for infants and young children, improves their **health** and increases infant **survival** six-fold, lowers family **expenditures** for food and health care, improves **nutrient** status thus increasing **productivity**, contributes to **fertility reduction**, and is the safest form of young child feeding in **emergency and disaster** situations. Breastfeeding is also **environmentally friendly**, reducing need for firewood, and reducing pharmaceutical, plastics, and dairy industry waste. Both **workplace efficiency and productivity** benefit in that there is less absence due to family illness when children are breastfed, and breastfed children demonstrate more rapid cognitive development in the early months and years.

Breastfeeding protection, promotion and support are now approved written policy for the entire Agency. Due to improvements in data collection, we can now say that these interventions have a proven track record and are within the Agency's interest. Today with increasing attention to emerging infectious diseases, food security, and economic growth, the need to maintain breastfeeding support is increasingly important. Nonetheless, many USAID technical staff remain poorly informed on the potential benefits of breastfeeding, and still fewer have the skills necessary to implement breastfeeding-supportive policy and programs.

The advances of the 1990s are at risk. Breastfeeding has not as yet been fully integrated into food and disaster relief programming, nutrition efforts, workplace approaches, nor child survival programming. Its impact on micronutrient levels, on fertility, on family health and productivity, and in reducing infectious diseases has not been mainstreamed into the relevant strategic approaches and activities. In addition, misunderstandings concerning the impact of breastfeeding on the spread of HIV/AIDS has created an unwitting backlash, threatening to undo the progress of the last decade.

### **Advances and Trends: Breastfeeding protection, promotion and support achieve results**

Over the last 10 to 15 years, following a Congressional mandate for action, USAID-initiated programming has turned around the decline in breastfeeding worldwide noted in the 1960s and 70s. The last Agency strategy development in this area was completed in 1990, and, in less than a decade, countries with USAID programming saw a nearly 20 percentage point increase in infants exclusively breastfed and experienced a median duration of breastfeeding of nearly 2 months. While there remains much to be done to achieve optimal breastfeeding with appropriate complementary feeding for all, these achievements are real measurable, and significant, and provide a good base for implementation of ADS 212: Breastfeeding Promotion Policy.

## **CHILD HEALTH AND INFECTIOUS DISEASES**

### **Importance to sector**

#### Increased Child Survival

- ◆ Infant mortality remains a major reason for lowered life expectancy and human suffering worldwide; breastfeeding currently prevents about 5-6 million deaths per year, and could prevent an additional 1-2 million. Hence, breastfeeding may be considered the mortality preventive intervention with the greatest impact.
- ◆ Immediate breastfeeding at birth helps avoid hypothermia, a major threat to neonatal survival.

#### Decreased Morbidity

- ◆ Breastfeeding reduces the incidence of pneumonia, diarrhea, reported illness in general, ear infections, juvenile diabetes, colitis, and childhood cancers.
- ◆ Breastfeeding continues to confer antibodies from the mother's immune system to the child as long as breastfeeding continues, for 2 years or longer.
- ◆ Recently, breastfeeding has been found to cause improved cognitive development.
- ◆ Breastfeeding is associated with reduced incidence of later infectious disease and chronic diseases such as diabetes and cancers.

#### Program Issues

- ◆ Cost-effective: Breastfeeding is rated one of the most cost-effective child survival interventions according to a World Bank report on child survival interventions.
- ◆ Nearly universally do-able: Even maternal infectious illness is not a contraindication; the risk of passage generally is more than balanced by the protective effects of breastfeeding.
- ◆ HIV/AIDS is a special issue (See HIV sector )
- ◆ Implement program and demographic data collection for monitoring, evaluation and planning purposes

### **Implementing ADS 212: Breastfeeding Promotion Policy**

#### Promote optimal breastfeeding in all programs

- ◆ Program breastfeeding skills support for optimal breastfeeding (exclusive for 6 months followed by slow weaning for 2 years or more) in all child survival programs.
- ◆ Include breastfeeding in the recovery protocol for all infant and young child illness.
- ◆ Support the Baby Friendly Hospital Initiative (BFHI), which includes early initiation and exclusive breastfeeding and linkage to community support for optimal breastfeeding.
- ◆ Support optimal breastfeeding for its contribution to child spacing.

#### Ensure compliance with the Code of Marketing of Breastmilk Substitutes (see appendix A)

Do not purchase or distribute breastmilk substitutes unless it has been determined that they are necessary to increase child survival, or for research, complying with the USAID policy on human subjects research (See Sample Format for Recording Exceptions, in ADS 212). Substitutes may only be used in a context of optimal breastfeeding support, when steps are taken to ensure that they are used safely, and when use is in compliance with the Code of Marketing of Breastmilk Substitutes.

## MATERNAL AND NEONATAL HEALTH

### Importance to sector

#### Increased Maternal Survival

- ◆ Breastfeeding is associated with improved postpartum uterine involution (contraction) and less blood loss.

#### Decreased risk of cancer and osteoporosis

- ◆ Women who breastfeed have lower risk of breast, ovarian, and endometrial cancer in later years. There is some evidence that breastfeeding may also help prevent osteoporosis.

#### Delayed menses

- ◆ Breastfeeding delays the return of menses, which increases child spacing, allowing more time for the mother to recover between pregnancies. Amenorrhea also reduces the risk of anemia.

#### Increased Neonatal Survival

- ◆ Immediate postpartum skin to skin and breast attachment combats hypothermia (loss of body heat), and hypoglycemia (low blood sugar) which can result from the stress.
- ◆ Immediate breastfeeding can help avoid the use of dangerous traditional prelacteal feeds when full information is shared with the family and community.

### Implementing ADS 212: Breastfeeding Promotion Policy

Promote optimal breastfeeding in programs that “address health and nutrition,” “target infants and young children and/or women of reproductive age” or “influence maternal and child behaviors”.

- ◆ Train birth attendants in the skills of immediate postpartum breastfeeding to avoid potentially deadly hypoglycemia and hypothermia.
- ◆ Support breastfeeding skills for optimal breastfeeding (exclusive for 6 months followed by slow weaning for 2 years or more) for all mothers.
- ◆ Include nutrition counseling in all pregnancy outcome efforts to help the mother maintain adequate stores for breastfeeding and ensure her own health.
- ◆ Implement program and demographic data collection for monitoring, evaluation and planning purposes

Ensure compliance with the Code of Marketing of Breastmilk Substitutes (see appendix A)

Do not purchase or distribute breastmilk substitutes unless it has been determined that they are necessary to increase child survival, or is for research and complies with the USAID policy on human subjects research. (See Sample Format for Recording Exceptions, in ADS 212). Substitutes may only be used in a context of optimal breastfeeding support, when steps are taken to ensure that they are used safely, and when use is in compliance with the Code of Marketing of Breastmilk Substitutes.

## HIV/AIDS

### Importance to sector

#### Mixed or Partial Breastfeeding Carries Increased Risk of Transmission

- ◆ With existing practices in endemic areas, 10-20% of infants will contract HIV through breastfeeding.
- ◆ Factors associated with the higher risks of transmission include non-exclusive breastfeeding, poor breast health (mastitis, cracked nipples, other), high maternal viral load or AIDS, duration of breastfeeding, and poor nutritional status.

#### Exclusive and Healthy Breastfeeding Can Reduce Transmission

- ◆ Exclusive breastfeeding and breast health lower Mother to Child Transmission (MTCT) risk, perhaps to a level comparable to replacement feeding.
- ◆ Rapid weaning is probably associated with increased transmission and should be discouraged.

#### Breastfeeding Lowers Child Mortality in General

- ◆ Breastfeeding is associated with a lower overall mortality risk than non-breastfeeding in most HIV endemic areas, due to the high prevalence of infectious diseases.
- ◆ The immunity conferred through breastmilk, especially in the first six months, protects against opportunistic infections in HIV positive infants.

### Implementing ADS 212: Breastfeeding Promotion Policy

#### Promote optimal breastfeeding in all programs

- ◆ Include breastfeeding skills for optimal breastfeeding (exclusive for 6 months followed by slow weaning for 2 years or more) for all mothers who come for VCT counseling.
- ◆ If diagnosed HIV-positive, counsel on the risks and benefits of all feeding approaches.
- ◆ Recognize that decisions on infant feeding must be based on local circumstances, including HIV prevalence and mortality from other disease, and within the framework of informed choice and confidentiality.
- ◆ Discourage rapid or abrupt weaning.
- ◆ Encourage integration of VCT and other HIV/AIDS programs into antenatal, maternity (“Baby-Friendly Hospital Initiative”), and reproductive health services for consistent messages and comprehensive breastfeeding support.
- ◆ Implement program and demographic data collection for monitoring, evaluation and planning purposes

#### Ensure compliance with the Code of Marketing of Breastmilk Substitutes (see appendix A)

Do not purchase or distribute breastmilk substitutes unless it has been determined that they are necessary to increase child survival, or is for research and complies with the USAID policy on human subjects research. (See Sample Format for Recording Exceptions, in ADS 212). Substitutes may only be used in a context of optimal breastfeeding support, when steps are taken to ensure that they are used safely, and when use is in compliance with the Code of Marketing of Breastmilk Substitutes.

## POPULATION AND FAMILY PLANNING

### Importance to sector

#### Slowed Population Growth

- ◆ Breastfeeding is a major determinant of fertility
- ◆ Delayed fertility return allows the woman and/or couple the time needed to consider all methods and save resources if necessary to use the method.

#### Increased Birth Intervals

- ◆ In many developing countries, breastfeeding has more impact on birth intervals than contraceptive use.
- ◆ If breastfeeding were to deteriorate, contraceptive use would have to double and triple in some countries just to keep fertility stable at the current high levels.

#### Natural Birth Control

- ◆ There is a method of child spacing that promotes optimal breastfeeding, appropriate and timely introduction of family planning during breastfeeding, and adequate child spacing: the Lactational Amenorrhea Method, or LAM

### Implementing ADS 212: Breastfeeding Promotion Policy

Promote optimal breastfeeding in programs that “address health and nutrition,” “target infants and young children and/or women of reproductive age” or “influence maternal and child behaviors”. Since the target population for family planning and breastfeeding support are nearly identical:

- ◆ Program breastfeeding skills support for optimal breastfeeding (exclusive for 6 months followed by slow weaning for 2 years or more)
- ◆ Include counseling on breastfeeding maintenance while using family planning in all family planning programs.
- ◆ Include LAM in counseling on family planning options in every FP and MCH/FP program.
- ◆ Support Baby Friendly Hospital Initiatives (BFHI) which include support and early initiation of breastfeeding.
- ◆ Implement program and demographic data collection for monitoring, evaluation and planning purposes

Ensure compliance with the Code of Marketing of Breastmilk Substitutes (see appendix A).

## NUTRITION, AGRICULTURE, AND FOOD SECURITY

### Importance to Sector

#### Micronutrients

- ◆ Breastfeeding is the major source of micronutrients in early life, and is an essential part of any micronutrient or Vitamin A intervention effort.

#### Other Nutrition and Food Security

- ◆ Breastmilk provides total food security for infants up to six months of age and continues to be a critical source of essential nutrients for two years and beyond.
- ◆ Lactational infertility caused by breastfeeding can help ensure household and community food security by increasing child spacing, slowing population growth and reducing pressures on the food supply.

#### Cost effective

- ◆ Breastmilk is cheaper, safer, more nutritious, and less expensive to produce in terms of household food resources, and safer to store in its original container than other infant food.
- ◆ Breastfeeding reduces the burden on household family food budget by ensuring that family resources and time are not used to purchase formula, bottles, extra firewood, and extra clean water.

### Implementing ADS 212: Breastfeeding Promotion Policy

Promote optimal breastfeeding in programs that “address health and nutrition,” “target infants and young children and/or women of reproductive age” or “influence maternal and child behaviors”.

- ◆ Support programs to provide breastfeeding skills for optimal breastfeeding (exclusive for 6 months followed by slow weaning for 2 years or more) for all mothers.
- ◆ Include promotion of breastfeeding in food security plans. Review strategies and programs to create and strengthen linkages between agriculture, health, and nutrition programs.
- ◆ Promote improved infant feeding practices and maternal dietary practices as part of agricultural and agro-forestry extension services as well as at other group meetings (e.g. marketing associations, dairy processing cooperatives, microfinance clubs, etc.)
- ◆ Develop labor-saving technology to allow women time to care for children (e.g. lower maintenance crops, faster preparation foods etc.)
- ◆ Target mothers and children from birth up to 3 years of age in Title II Food programs for correct and locally appropriate breastfeeding messages.
- ◆ Implement program and demographic data collection for monitoring, evaluation and planning purposes

Ensure compliance with the Code of Marketing of Breastmilk Substitutes (see appendix A).

Do not purchase or distribute breastmilk substitutes unless it has been determined that they are necessary to increase child survival, or is for research and complies with the USAID policy on human subjects research. (See Sample Format for Recording Exceptions, in ADS 212). Substitutes may only be used in a context of optimal breastfeeding support, when steps are taken to ensure that they are used safely, and when use is in compliance with the Code of Marketing of Breastmilk Substitutes.

## **GENDER AND WOMEN’S RIGHTS**

### **Importance to Sector**

#### Empowerment

- ◆ Breastfeeding empowers a woman by enabling her to feel confident in her ability to provide the best in infant nutrition and to exercise preventive health care for herself and her child.
- ◆ Breastfeeding helps women control their fertility and support the survival of their children.

#### Cost effective

- ◆ The cost of making maternal milk (i.e., food for the mother, time off from work, etc.) is much less than the cost of formula in most developing country settings.

#### Work productivity

- ◆ Breastfed infants are less often ill, demanding less maternal absence from work.
- ◆ Exclusive breastfeeding provides all necessary nutrition for brain growth and development in the early months

#### Attention to conducive environments

- ◆ Breastfeeding focuses attention on the need for mother-friendly workplaces, childcare, and gender equality in distribution of food and other resources within the household and community.

### **Implementing ADS 212: Breastfeeding Promotion Policy**

Promote optimal breastfeeding in programs that “address health and nutrition,” “target infants and young children and/or women of reproductive age” or “influence maternal and child behaviors”.

- ◆ Support breastfeeding in all national and international workplace discussions
- ◆ Support the recommendations from the recent International Labor Organization convention encouraging policies that allow women to work and breastfeed.
- ◆ Incorporate family health and breastfeeding into agricultural and job programs.
- ◆ Advocate for women’s access to correct information on feeding choices, family planning, and breastfeeding support.
- ◆ Support Mother-to-Mother support groups and prenatal discussions, which help women establish good breastfeeding skills and support each other in an atmosphere of trust and respect.
- ◆ Enable women to make and act upon their own infant feeding decisions by providing them with correct information and counseling.
- ◆ Implement program and demographic data collection for monitoring, evaluation and planning purposes

Ensure compliance with the Code of Marketing of Breastmilk Substitutes (see appendix A).

Do not purchase or provide breastmilk substitutes unless it has been determined that they are necessary to increase child survival or if for research and complies with the USAID policy on human subjects research. (See Sample Format for Recording Exceptions, in ADS 212).

## **EDUCATION AND HUMAN CAPACITY DEVELOPMENT**

### **Importance to Sector**

#### Early Childhood Development

- ◆ Mother-infant interaction encourages child development.
- ◆ Breastfeeding and weaning behaviors are an essential part of building educational capacity and development.
- ◆ Breastfeeding provides frequent interaction between mother and infant, fostering bonding, a sense of security, and age-appropriate stimuli.

#### Cognitive development

- ◆ Scientific evidence shows that breastfeeding enhances brain development and learning readiness. Breastfeeding protects babies from illnesses that can cause malnutrition, hearing problems, and learning difficulties. Breastmilk is a rich source of vitamin A, which reduces the risk of eye problems, growth failure, and illness.

### **Implementing ADS 212: Breastfeeding Promotion Policy**

Promote optimal breastfeeding in programs that “address health and nutrition,” “target infants and young children and/or women of reproductive age” or “influence maternal and child behaviors”.

- ◆ Incorporate breastfeeding and care into formal and non-formal education curricula including higher education training.
- ◆ Incorporate breastfeeding into children’s programs, educational materials, toys and books.
- ◆ Ensure access to correct information on nutrition, family planning, reproductive health, and breastfeeding for women, men, youth, and school-aged children.
- ◆ Implement program and demographic data collection for monitoring, evaluation and planning purposes

Ensure compliance with the Code of Marketing of Breastmilk Substitutes (see appendix A).

## **ECONOMIC DEVELOPMENT, ENVIRONMENT, AND THE PRIVATE SECTOR**

### **Importance to Sector**

#### Reduced household costs

- ◆ In many countries, the cost of purchasing formula may be equal to the average wage. Breastfeeding is the cheapest and most efficient food.

#### National savings with breastfeeding

- ◆ Breastmilk production is a major contributor to the nation's economy, not just by preventing costly illnesses and reducing the economic burden caused by large populations, but also in the saving of precious import dollars on formula and related products.

#### Slower population growth

- ◆ Breastfeeding increases birth spacing, slowing population growth, thus reducing less economic burden the social sector and other societal resources.

#### Decreased health care and labor costs

- ◆ Breastmilk prevents many illnesses in infants, young children, and mothers, decreasing the burden of disease and related health care costs.
- ◆ With healthier children, parents are less often absent from work due to care of a sick child.

#### Less environmental burden

- ◆ Breastfeeding reduces environmental pollution from plastics and dairy herds (methane).
- ◆ Preparation of breastmilk substitutes involves use of firewood, contributing to deforestation and indoor air pollution.
- ◆ Breastfeeding does not waste scarce natural resources and is the world's most energy-efficient food production system.

### **Implementing ADS 212: Breastfeeding Promotion Policy**

Promote optimal breastfeeding in programs that “address health and nutrition,” “target infants and young children and/or women of reproductive age” or “influence maternal and child behaviors”.

- ◆ Calculate the economic value of breastfeeding and use in strategic planning and policy and advocacy discussions
- ◆ Support and create incentive for work arrangements that allow women to be gainfully employed and to breastfeed, in both public and private sectors.
- ◆ Incorporate promotion of improved infant feeding and maternal dietary practices in microenterprise activities
- ◆ Ensure access to accurate information on breastfeeding and breastfeeding choices (including accurate information on environmental toxins).
- ◆ Implement program and demographic data collection for monitoring, evaluation and planning purposes

Ensure compliance with the Code of Marketing of Breastmilk Substitutes (see appendix A).

## DISASTERS AND EMERGENCIES

### Importance to Sector

#### Ensures infant survival

- ◆ During a disaster, whether natural or man-made, the breastfed child is the most likely child to survive.
- ◆ Breastmilk offers increased protection against many infectious diseases, and is a reliable therapy against diarrhea and other common illnesses.

#### Food security

- ◆ Breastmilk is a safe, sure food, and the only reliable food for infant food security even where reliable water, fuel, and sanitary facilities are scarce.
- ◆ Breastmilk is less susceptible to seasonality than other foods.

#### Cost effective

- ◆ Breastfeeding saves millions of dollars in disaster relief annually.

### Implementing ADS 212: Breastfeeding Promotion Policy

Promote optimal breastfeeding in programs that “address health and nutrition,” “target infants and young children and/or women of reproductive age” or “influence maternal and child behaviors”.

- ◆ Develop and implement appropriate interagency policies and guidelines on infant feeding in emergencies.
- ◆ Prepare humanitarian staff to support mothers and caregivers to appropriately feed their infants in an emergency situation.
- ◆ Monitor infant feeding practices in emergencies.
- ◆ Incorporate breastfeeding education in Title II programs.
- ◆ Target pre-pregnant, pregnant, and lactating women with nutritious foods.
- ◆ Ensure that health care services in emergency or refugee situations are “baby-friendly”, encourage early initiation, and optimal breastfeeding (exclusive for 6 months, continued for 2 years).
- ◆ Implement program and demographic data collection for monitoring, evaluation and planning purposes

Ensure compliance with the Code of Marketing of Breastmilk Substitutes (see appendix A)

Do not purchase or distribute breastmilk substitutes unless it has been determined that they are necessary to increase child survival or for research, complying with the USAID policy on human subjects research (See Sample Format for Recording Exceptions, in ADS 212). Substitutes may only be used in a context of optimal breastfeeding support, when steps are taken to ensure that they are used safely, and when use is in compliance with the Code of Marketing of Breastmilk Substitutes.

**APPENDIX A**  
**International Code of Marketing of Breastmilk Substitutes**

- Art. 1. Aim of the Code
- Art. 2. Scope of the Code
- Art. 3. Definitions
- Art. 4. Information and education
- Art. 5. The general public and mothers
- Art. 6. Health care systems
- Art. 7. Health workers
- Art. 8. Persons employed by manufacturers and distributors
- Art. 9. Labeling
- Art. 10. Quality
- Art. 11. Implementation and monitoring

The Member States of the World Health Organisation:

**Affirming** the right of every child and every pregnant and lactating woman to be adequately nourished as a means of attaining and maintaining health;

**Recognising** that infant malnutrition is part of the wider problems of lack of education, poverty, and social injustice;

**Recognising** that the health of infants and young children cannot be isolated from the health and nutrition of women, their socio-economic status and their roles as mothers;

**Conscious** that breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants; that it forms a unique biological and emotional basis for the health of both mother and child; that the anti-infective properties of breast milk help to protect infants against disease; and that there is an important relationship between breastfeeding and child spacing;

**Recognising** that the encouragement and protection of breastfeeding is an important part of the health, nutrition and other social measures required to promote healthy growth and development of infants and young children; and that breastfeeding is an important aspect of primary health care;

**Considering** that when mothers do not breastfeed, or only do so partially, there is a legitimate market for infant formula and for suitable ingredients from which to prepare it; that all these products should accordingly be made accessible to those who need them through commercial or noncommercial distribution systems; and that they should not be marketed or distributed in ways that may interfere with the protection and promotion of breastfeeding;

**Recognising** further that inappropriate feeding practices lead to infant malnutrition, morbidity and mortality in all countries, and that improper practices in the marketing of breastmilk substitutes and related products can contribute to these major public health problems;

**Convinced** that it is important for infants to receive appropriate complementary foods, usually when the infant reaches four to six months of age, and that every effort should be made to use locally available foods; and convinced, nevertheless, that such complementary foods should not be used as breastmilk substitutes;

**Appreciating** that there are a number of social and economic factors affecting breastfeeding, and that, accordingly, governments should develop social support systems to protect, facilitate and encourage it, and that they should create an environment that fosters breastfeeding, provides appropriate family and community support, and protects mothers from factors that inhibit breastfeeding;

**Affirming** that health care systems, and the health professionals and other health workers serving in them, have an essential role to play in guiding infant feeding practices, encouraging and facilitating breastfeeding, and providing objective and consistent advice to mothers and families about the superior value of breastfeeding, or, where needed, on the proper use of infant formula, whether manufactured industrially or home prepared;

**Affirming** further that educational systems and other social services should be involved in the protection and promotion of breastfeeding, and in the appropriate use of complementary foods;

**Aware** that families, communities, women's organisations and other nongovernmental organisations have a special role to play in the protection and promotion of breastfeeding and in ensuring the support needed by pregnant women and mothers of infants and young children, whether breastfeeding or not;

**Affirming** the need for governments, organisations of the United Nations system, nongovernmental organisations, experts in various related disciplines, consumer groups and industry to cooperate in activities aimed at the improvement of maternal, infant and young child health and nutrition;

**Recognising** that governments should undertake a variety of health, nutrition and other social measures to promote healthy growth and development of infants and young children, and that this Code concerns only one aspect of these measures;

**Considering** that manufacturers and distributors of breastmilk substitutes have an important and constructive role to play in relation to infant feeding,

and in the promotion of the aim of this Code and its proper implementation;

**Affirming** that governments are called upon to take action appropriate to their social and legislative framework and their overall development objectives to give effect to the principles and aim of this Code, including the enactment of legislation, regulations or other suitable measures;

**Believing** that, in the light of the foregoing considerations, and in view of the vulnerability of infants in the early months of life and the risks involved in inappropriate feeding practices, including the unnecessary and improper use of breastmilk substitutes, the marketing of breastmilk substitutes requires special treatment, which makes usual marketing practices unsuitable for these products;

### **THEREFORE:**

The Member States hereby agree the following articles which are recommended as a basis for action.

#### **Article 1. Aim of the Code**

The aim of this Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.

#### **Article 2. Scope of the Code**

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

#### **Article 3. Definitions**

For the purposes of this Code:

"Breastmilk substitute" means any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose.

"Complementary food" means any food, whether manufactured or locally prepared, suitable as a complement to breast milk 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".

"Container" means any form of packaging of products for sale as a normal retail unit, including wrappers.

"Distributor" means a person, corporation or any other entity in the public or private sector engaged in the business (whether directly or indirectly) of marketing at the wholesale or retail level a product within the scope of this Code. A "primary distributor" is a manufacturer's sales agent, representative, national distributor or broker.

"Health care system" means governmental, nongovernmental or private institutions or organisations engaged, directly or indirectly, in health care for mothers, infants and pregnant women; and nurseries or childcare institutions. It also includes health workers in private practice. For the purposes of this Code, the health care system does not include pharmacies or other established sales outlets.

"Health worker" means a person working in a component of such a health care system, whether professional or nonprofessional, including voluntary, unpaid workers.

"Infant formula" means a breastmilk substitute formulated industrially in accordance with applicable Codex Alimentarius standards, to satisfy the normal nutritional requirements of infants up to between four and six months of age, and adapted to their physiological characteristics. Infant formula may also be prepared at home, in which case it is described as "home prepared".

"Label" means any tag, brand, mark, pictorial or other descriptive matter, written, printed, stencilled, marked, embossed or impressed on, or attached to, a container (see above) of any products within the scope of this Code.

"Manufacturer" means a corporation or other entity in the public or private sector engaged in the business or function (whether directly or through an agent or through an entity controlled by or under contract with it) of manufacturing a product within the scope of this Code.

"Marketing" means product promotion, distribution, selling, advertising, product public relations, and information services.

"Marketing personnel" means any persons whose functions involve the marketing of a product or products coming within the scope of this Code.

"Samples" means single or small quantities of a product provided without cost.

"Supplies" means quantities of a product provided for use over an extended period, free or at a low price, for social purposes, including those provided to families in need.

#### **Article 4. Information and education**

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 and those involved in the field of infant and young child nutrition. This responsibility should cover either the planning, provision, design and dissemination of information, or their control.

4.2 Informational and educational materials, whether written, audio, or visual, dealing with the feeding of infants and intended to reach pregnant women and mothers of infants and young children, should include clear information on all the following points:

1. the benefits and superiority of breastfeeding;
2. maternal nutrition, and the preparation for and maintenance of breastfeeding;
3. the negative effect on breastfeeding of introducing partial bottle feeding;
4. the difficulty of reversing the decision not to breastfeed; and
5. where needed, the proper use of infant formula, whether manufactured industrially or home prepared.

When such materials contain information about the use of infant formula, they should include the social and financial implications of its use; the health hazards of inappropriate foods or feeding methods; and, in particular, the health hazards of unnecessary or improper use of infant formula and other breastmilk substitutes. Such materials should not use any pictures or text which may idealise the use of breastmilk substitutes.

4.3 Donations of informational or educational equipment or materials by manufacturers or distributors should be made only at the request and with the written approval of the appropriate government authority or within guidelines given by governments for this purpose. Such equipment or

materials may bear the donating company's name or logo, but should not refer to a proprietary product that is within the scope of this Code, and should be distributed only through the health care system.

## **Article 5. The general public and mothers**

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

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

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.

5.4 Manufacturers and distributors should not distribute to pregnant women or mothers of infants and young children any gifts of articles or utensils which may promote the use of breastmilk substitutes or bottle feeding.

5.5 Marketing personnel, in their business capacity, should not seek direct or indirect contact of any kind with pregnant women or with mothers of infants and young children.

## **Article 6. Health care systems**

6.1 The health authorities in Member States should take appropriate measures to encourage and protect breastfeeding and promote the principles of this Code, and should give appropriate information and advice to health workers in regard to their responsibilities, including the information specified in Article 4.2.

6.2 No facility of a health care system should be used for the purpose of promoting infant formula or other products within the scope of this Code. This Code does not, however, preclude the dissemination of information to health professionals as provided in Article 7.2.

6.3 Facilities of health care systems should not be used for the display of products within the scope of this Code, for placards or posters concerning such products, or for the distribution of material provided by a manufacturer or distributor other than that specified in Article 4.

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

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

6.6 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.

6.7 Where donated supplies of infant formula or other products within the scope of this Code are distributed outside an institution, the institution or organisation should take steps to ensure that supplies can be continued as long as the infants concerned need them. Donors, as well as institutions or organisations concerned, should bear in mind this responsibility.

6.8 Equipment and materials, in addition to those referred to in Article 4.3, donated to a health care system may bear a company's name or logo, but should not refer to any proprietary product within the scope of this Code.

## **Article 7. Health workers**

7.1 Health workers should encourage and protect breastfeeding; and those who are concerned in particular with maternal and infant nutrition should make themselves familiar with their responsibilities under this Code, including the information specified in Article 4.2.

7.2 Information provided by manufacturers and distributors to health professionals regarding products within the scope of this Code should be restricted to scientific and factual matters, and such information should not imply or create a belief that bottle feeding is equivalent or superior to breastfeeding. It should also include the information specified in Article 4.2.

7.3 No financial or material inducements to promote products within the scope of this Code should be offered by manufacturers or distributors to health workers or members of their families, nor should these be accepted

by health workers or members of their families.

7.4 Samples of infant formula or other products within the scope of this Code., or of equipment or utensils for their preparation or use, should not be provided to health workers except when necessary for the purpose of professional evaluation or research at the institutional level. Health workers should not give samples of infant formula to pregnant women, mothers of infants and young children, or members of their families.

7.5 Manufacturers and distributors of products within the scope of this Code should disclose to the institution to which a recipient health worker is affiliated any contribution made to him or on his behalf for fellowships, study tours, research grants, attendance at professional conferences, or the like. Similar disclosures should be made by the recipient.

### **Article 8. Persons employed by manufacturers and distributors**

8.1 In systems of sales incentives for marketing personnel, the volume of sales of products within the scope of this Code should not be included in the calculation of bonuses, nor should quotas be set specifically for sales of these products. This should not be understood to prevent the payment of bonuses based on the overall sales by a company of other products marketed by it.

8.2 Personnel employed in marketing products within the scope of this Code should not, as part of their job responsibilities, perform educational functions in relation to pregnant women or mothers of infants and young children. This should not be understood as preventing such personnel from being used for other functions by the health care system at the request and with the written approval of the appropriate authority of the government concerned.

### **Article 9. Labelling**

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

9.2 Manufacturers and distributors of infant formula should ensure that each container has a clear, conspicuous, and easily readable and understandable message printed on it, or on a label which cannot readily become separated from it, in an appropriate language, which includes all the following points:

1. the words "Important Notice" or their equivalent;

2. a statement of the superiority of breastfeeding;
3. a statement that the product should be used only on the advice of a health worker as to the need for its use and the proper method of use;
4. instructions for appropriate preparation, and a warning against the health hazards of inappropriate preparation.

Neither the container nor the label should have pictures of infants, nor should they have other pictures or text which may idealise the use of infant formula. They may, however, have graphics for easy identification of the product as a breastmilk substitute and for illustrating methods of preparation. The terms "humanised", "maternalised" or similar terms should not be used. Inserts giving additional information about the product and its proper use, subject to the above conditions, may be included in the package or retail unit. When labels give instructions for modifying a product into infant formula, the above should apply.

9.3 Food products within the scope of this Code, marketed for infant feeding, which do not meet all the requirements of an infant formula, but which can be modified to do so, Should carry on the label a warning that the unmodified product should not be the sole source of nourishment of an infant. Since sweetened condensed milk is not Suitable for infant feeding, nor for use as a main ingredient of infant formula, its label should not contain purported instructions on how to modify it for that purpose.

9.4 The label of food products within the scope of this Code should also state all the following points:

1. the ingredients used;
2. the composition/analysis of the product;
2. the storage conditions required; and
3. the batch number and the date before which the product is to be consumed, taking into account the climatic and storage conditions of the country concerned.

## **Article 10. Quality**

10.1 The quality of products is an essential element for the protection of the health of infants and therefore should be of a high recognised standard.

10.2 Food products within the scope of this Code should, when sold or otherwise distributed, meet applicable standards recommended by the

Codex Alimentarius Commission and also the Codex Code of Hygienic Practice for Foods for Infants and Children.

## **Article 11. Implementation and monitoring**

11.1 Governments should take action to give effect to the principles and aim of this Code, as appropriate to their social and legislative framework, including the adoption of national legislation, regulations or other suitable measures. For this purpose, governments should seek, when necessary, the cooperation of WHO, UNICEF and other agencies of the United Nations system. National policies and measures, including laws and regulations, which are adopted to give effect to the principles and aim of this Code should be publicly stated, and should apply on the same basis to all those involved in the manufacture and marketing of products within the scope of this Code.

11.2 Monitoring the application of this Code lies with governments acting individually, and collectively through the World Health Organisation as provided in paragraphs 6 and 7 of this Article. The manufacturers and distributors of products within the scope of this Code, and appropriate nongovernmental organisations, professional groups, and consumer organisations should collaborate with governments to this end.

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

11.4 Nongovernmental organisations, professional groups, institutions, and individuals concerned should have the responsibility of drawing the attention of manufacturers or distributors to activities which are incompatible with the principles and aim of this Code, so that appropriate action can be taken. The appropriate governmental authority should also be informed.

11.5 Manufacturers and primary distributors of products within the scope of this Code should apprise each member of their marketing personnel of the Code and of their responsibilities under it.

11.6 In accordance with Article 62 of the Constitution of the World Health Organisation, Member States shall communicate annually to the Director General information on action taken to give effect to the principles and aim of this Code.

11.7 The Director General shall report in even years to the World Health Assembly on the status of implementation of the Code; and shall, on

request, provide technical support to Member States preparing national legislation or regulations, or taking other appropriate measures in implementation and furtherance of the principles and aim of this Code.

## **APPENDIX B**

### **Suggested Breastfeeding Indicators and Related Definitions**

Modified from Bertrand, J. Indicators for Monitoring and Evaluation of Reproductive Health and Child Survival Programs, Measure Project, 2001, and from USAID ADS 212.

#### DEFINITIONS:

**Optimal Breastfeeding:** Exclusive breastfeeding for the first six months of life, with continued breastfeeding and appropriate complementary feeding for two years or more. Breastfeeding should be initiated immediately postpartum. (Support of adequate maternal nutrition is an important part of breastfeeding support.)

**Exclusive breastfeeding:** the infant has received only breastmilk from his/her mother, and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines.

**Exclusive breastmilk feeding:** May receive expressed breastmilk, in addition to breastfeeding

**Complementary Feeding:** The appropriate addition of other foods while continuing breastfeeding, starting at about six months (N.B. Other foods given during breastfeeding prior to this time are considered “supplementary.”)

**Breastmilk Substitutes:** Foods or liquids used as substitutes for breastfeeding, including use of powdered or liquid milks or formula, wet-nurses, etc. This does not include therapeutic formulas used under medical supervision.

**Replacement Feeding (RF):** Breastmilk substitutes that provide all the nutrients the child needs. This would not include breastmilk substitutes such as powdered milks or animal milks.

## **INDICATORS:**

### **TIMELY INITIATION OF BREASTFEEDING: PERCENT OF INFANTS 0 - < 12 MONTHS WHO WERE PUT TO THE BREAST WITHIN ONE HOUR OF DELIVERY**

#### **Definition**

This indicator measures the timely initiation of breastfeeding. It is calculated as:

$$\frac{\text{\# of infants 0<12 months put to breast w/in 1 hour} \times 100}{\text{Total \# of infants 0<12 months}}$$

#### **Data Requirements**

Recall data from mothers with infants less than twelve months old.

#### **Data Source(s)**

Population-based surveys employing representative samples. The DHS reports the initiation of breastfeeding within one hour for those countries in which the breastfeeding/infant-feeding module is included in the DHS.

Program records may be used to track trends in breastfeeding initiation among clients, but not to measure the impact of program interventions on women with infants in the population of the catchment area.

#### **Purpose and Issues**

Mothers are more likely to successfully initiate lactation, encounter fewer problems breastfeeding, and maintain optimal breastfeeding behaviors if they initiate breastfeeding shortly after birth.

Breastfeeding should begin no later than one hour after the delivery of the infant. Colostrum, the thick yellowish milk produced in the first few days after birth, is nutritious and helps to protect the infant against common infections. Thus, breastmilk is the infant's first "immunization" against common illnesses.

A mother may have difficulty remembering for as long as 12 months when she initiated breastfeeding for her youngest infant, and thus this indicator is subject to potential recall bias. This bias is likely to be even greater in populations that are not accustomed to remembering and conceptualizing time. However, because this particular type of bias (toward a longer or shorter period than actually occurred) is assumed to be randomly distributed across a population, the potential bias should not skew the data to misrepresent the population's general behavior related to breastfeeding initiation.

## **EXCLUSIVE BREASTFEEDING RATE (EBR): PERCENT OF INFANTS 0 <6 MONTHS OF AGE WHO ARE EXCLUSIVELY BREASTFED**

### **Definition**

Exclusive breastfeeding is defined as those infants who receive only breastmilk directly from the breast, and no other liquids or solids including water. Infants, are, however, allowed to have drops of vitamins/minerals/medicines. This definition is often modified to include exclusive breast-milk feeding, which includes feeding of expressed milk.

EBR can be calculated using the following equation:

$$\frac{\text{\# of infants 0-<6 months exclusively breastfed}}{\text{Total \# of infants 0-<6 months}} \times 100$$

### **Data Requirements**

A 24-hour recall of food consumption of infants less than 6 months of age.

### **Data Source(s)**

Population-based surveys employing representative samples (e.g., the DHS). Program records of EBR (to track trends but not impact). The DHS country reports and Nutrition Reports both present the EBR for infants 0-<4 months of age. However, EBR for infants 0-<6 months can be calculated using DHS data.

### **Purpose and Issues**

It is important to note that even in hot, dry climates, breastmilk contains sufficient water for an infant's needs. Additional water or sugary drinks are not needed to quench the infant's thirst, and they can also be harmful. If the infant is also given water, or drinks made with water, then the risk of diarrhea and other illnesses increases.

Indicators of **current** breastfeeding practices can be relatively easily measured and are sensitive to changes resulting from program activities. Using a 24-hour recall period to measure current status may cause the proportion of exclusively breast-fed infants to be overestimated, since some infants who are given other feeding irregularly may not have received them in the 24 hours before the survey.

The best estimates of exclusive breastfeeding are obtained from current status data in cross-section surveys. The advantage of this approach is that it is not subject to recall error. The measure should be interpreted as the percent of infants who “are currently being exclusively breastfed,” rather than the percent that have been exclusively breastfed since birth.

## **MEDIAN DURATION OF BRASTFEEDING (MDB): DURATION OF BREASTFEEDING**

### **Definition**

Breastfeeding is defined as those infants who receive any breastmilk directly from the breast. This definition is often modified to include breast-milk feeding, which includes feeding of expressed milk.

MDB can be calculated using the following calculation:

50%-ile duration of breastfeeding among durations reported by mothers whose infants are 3-4 years of age.

### **Data Requirements**

Recall data on breastfeeding duration from mothers who have weaned.

### **Data Source(s)**

Population-based surveys employing representative samples (e.g., the DHS). Program records of breastfeeding duration (rare).

### **Purpose and Issues**

Breastfeeding continues to be an important nutrition staple and continues to provide immunological disease fighting factors as long as breastfeeding continues. It also contains factors that help the immune system mature.

Indicators of **current** breastfeeding practices can be relatively easily measured and are sensitive to changes resulting from program activities. Using a recall period may cause the duration of breastfeeding to be over- or under-estimated.

The best estimates are obtained from current status data in cross-section surveys. However, there could be considerable truncation of data if all currently breastfed children were included. A possible advantage of using recall among only one age group would be decreased variance in recall. This approach is subject to recall error.

## **LACTATIONAL AMENORRHEA METHOD (LAM) USER RATE (LUR): PERCENT OF ELIGIBLE WOMEN WHO USE LAM**

### **Definition**

Percent of eligible women using the lactational amenorrhea method (LAM) as their contraceptive method, at a given point in time (e.g., at the time of the survey), or from reproductive calendar data. This indicator can be calculated as:

$$\frac{\# \text{ women with infants } < 6 \text{ months of age using LAM as an FP method}}{\# \text{ women with infants } < 6 \text{ months of age}} \times 100$$

### **Data Requirements**

The total number of married women within 6 months postpartum, and of these, the number who are using LAM as their method of family planning.

### **Data Source(s)**

Population-based surveys employing representative samples (e.g., the DHS); or family planning service statistics.

### **Purpose and Issues**

This indicator measures the percent of eligible women of reproductive age in a given population using the LAM method. Ideally, the LUR is measured in the context of a population-based representative survey, by current status. However, recall data may also be used if available. It can be also measured using service statistics, but this is less than ideal, since the findings will not be generalizable to the larger population.

The LUR does not measure the use of LAM in relation to other contraceptive methods.