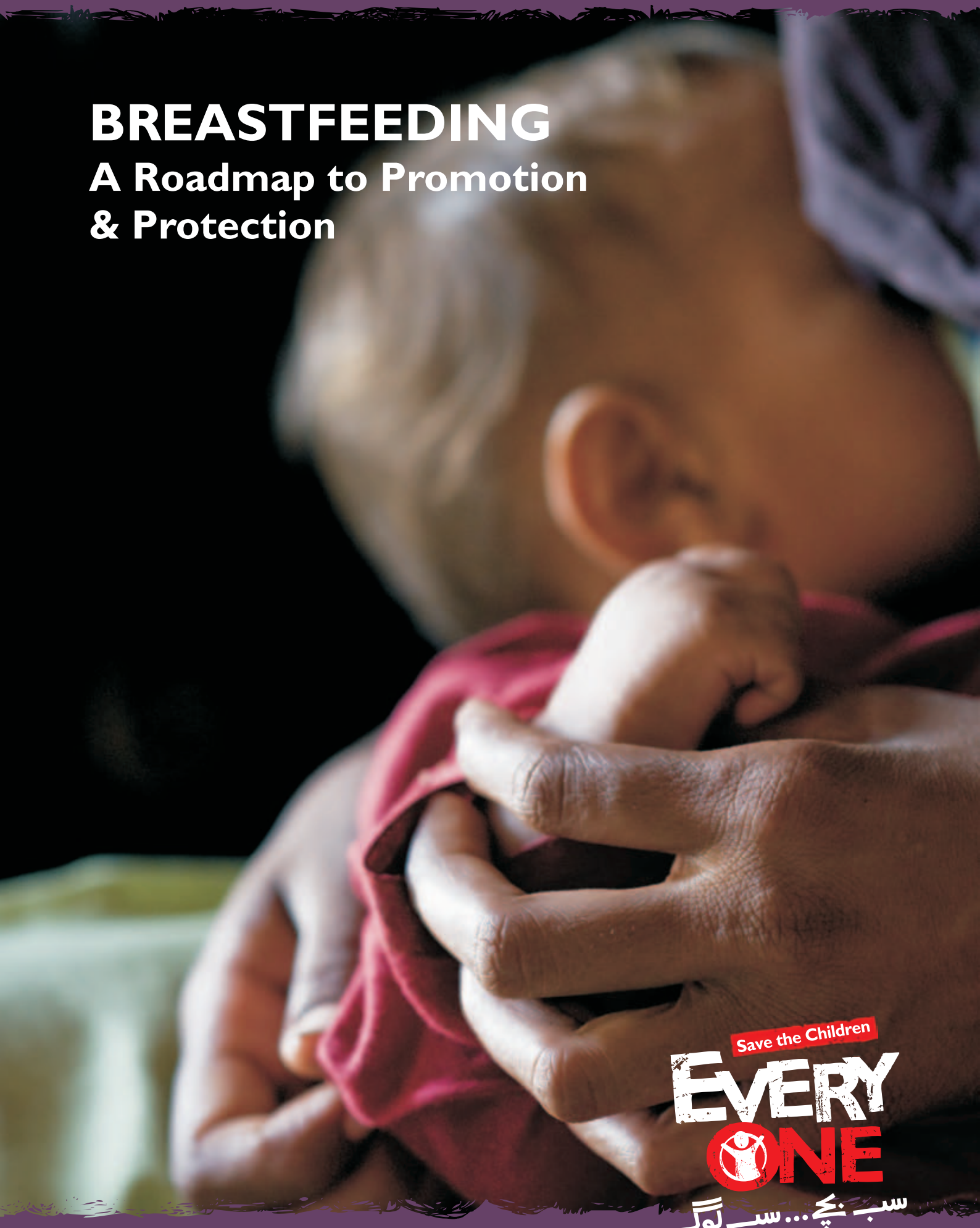
Every Child is Born with the Right to Survive

BREASTFEEDING

A Roadmap to Promotion & Protection



Save the Children

EVERY ONE

سب بچے... سب لوگ

Save the Children works in more than 120 countries.
We save children's lives. We fight for their rights.
We help them fulfill their potential.

Author & Acknowledgments:

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Cover Photo:
Kausar 21, from Muradabad, District Muzaffargarh, breastfeeds her 5 month old baby.

Photography by: Ayesha Vellani
Designed by: Amna Hasan

BREASTFEEDING

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Save the Children

FOREWORD

Save the Children's EVERY ONE campaign was launched in April 2010 in Pakistan. The campaign focuses on Pakistan's achievement of the Millennium Development Goal (MDG) 4 which is to achieve a two third reduction in child mortality by 2015. Progress towards achieving MDGs remains a challenge for Pakistan and there is a need to accelerate the efforts to achieve the desired results by the deadline.

As a party to the United Nations Convention on the Rights of the Child, Pakistan is bound to commit to Article 6 which states that, "States Parties shall ensure to the maximum extent possible the survival and development of the child".

According to the results of the National Nutrition Survey 2011, Pakistan has a high rate of malnutrition. 43% children under five years of age are stunted, 15.1% are wasted and 32% are underweight. 62.5% children were recorded to be anemic, while 37.7% had iron deficiency. Women and children also suffer from some of the world's heights levels of vitamin and mineral deficiencies. Ironically in Pakistan, the exclusive breastfeeding rate for six months stands at a mere 37%.

The report in hand highlights key violations of "The Protection of Breastfeeding and Young Child Nutrition Ordinance 2002", its further explores loopholes in the effective implementation of existing laws, low level of awareness amongst health workers and prevalent unethical practices by breast milk substitute companies.

Who stands responsible? I believe every segment of the society has a role to play. Be it humanitarian organizations, civil society, government bodies or individuals, we need to advocate for the foremost right of a new born towards his mother's milk. While the government is obligated to work at the policy level, we are bound to ensure effective implementation of these laws.

I hope that this research will play a pivotal role in identifying and addressing issues emanating from the violation of breast feeding code. The recommendations put forth by the study will help in formulating a comprehensive strategy to curtail such violations.

We hope the government of Pakistan will take necessary steps for the effective implementation of the Protection of Breastfeeding and Young Child Nutrition Ordinance 2002, including notification of the Infant Feeding Board in the official gazette to monitor implementation of the law. Such steps will go a long way in ensuring better prospects of a healthy life for millions of children in Pakistan. Similarly, the provincial governments should take effective measures to implement their respective provincial laws.

David Skinner
Country Director
Save the Children Pakistan Program

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ABBREVIATIONS & ACRONYMS

ANC	Antenatal care
BFHI	Baby-Friendly Hospital Initiative
BHU	Basic Health Unit
BMS	Breast-milk substitute
CLL	Concurrent Legislative List
Code	International Code of Marketing of Breast-milk Substitutes
CPSP	College of Physicians and Surgeons Pakistan
EBF	Exclusive Breast Feeding
FGD	Focus Group Discussion
FLL	Federal Legislative List
HCP	Health Care Provider
IBFAN	International Baby Food Action Network
IGBM	Interagency Group on Breast-feeding Monitoring
IFE	Infant Feeding in Emergencies
ILO	International Labour Organization
IYCF	Infant and Young Child Feeding
KII	Key Informant Interview
KP	Khyber Pakhtoonkhwa
MNH	Maternal and Newborn Health
NGO	Non-Governmental Organisation
PDHS	Pakistan Demographic Health Survey
PMA	Pakistan Medical Association
PMDC	Pakistan Medical and Dental Council
PPA	Pakistan Pediatric Association
PNC	Post Natal Care
RUTF	Ready-to-use Therapeutic Foods
WHA	World Health Assembly
WHO	World Health Organization

DEFINITIONS OF BREASTFEEDING INDICATORS

Early Initiation Rate
The early initiation rate is the percentage of infants less than 12 months of age who first suckled within one hour of birth.

Ever Breastfed Rate
The ever breastfed rate is the proportion of infants less than 12 months of age who were ever breastfed.

Current Breastfeeding Rate
The current breastfeeding rate is the proportion of infants less than 24 months of age who were breastfed in the last 24 hours

Exclusive Breastfeeding Rate
Exclusive breastfeeding rate is proportion of infants less than 6 months of age who were exclusively breastfed in last 24 hours. Infant had received only breast milk from his/her mother or a wet nurse, or expressed breast milk, and no other liquids or solids with exception of drops or syrups consisting of vitamins, mineral supplements or medicines.

Continued Breastfeeding Rate at 2 years
The continued breastfeeding rate at two years is the proportion of children, 20-23 months of age who were breastfed in the last 24 hours.

Bottle-feeding Rate
The bottle-feeding rate is the proportion of infants less than 12 months of age who were receiving any food or drink from a bottle in the last 24 hours.

Median duration of breastfeeding
The median duration of breastfeeding is the duration above which 50% of the mothers in a given survey have a longer duration of breastfeeding.

EXECUTIVE SUMMARY

Globally there were about 7.6 million children under the age of five who lost their lives in 2010[1]; most of which could have been avoided by taking available preventive measures and scaling-up the known interventions[2]. Most deaths occur in first year of life, and are mainly associated with inappropriate breastfeeding practices. Importance of exclusive breastfeeding for essential growth and development of infants and young children is accepted globally[3]. About 22% of the newborn deaths could be prevented if breastfeeding is initiated within first hour after birth and 16% if breastfeeding is started within first 24 hours[4]. Infants who are not breastfed are 15 times more likely to die from pneumonia and 11 times more likely to die of diarrhoea as compared to those who are breastfed exclusively[5]. Although breast milk is readily available soon after birth, lack of awareness among mothers and families on importance of exclusive breastfeeding, unethical involvements of health staff in prescription of breast milk substitutes as well as engagement of manufacturers and distributors in unlawful promotion of breast milk substitutes influence attitude, practices and decision making process of breastfeeding[6]. In order to address the issue of unethical and misleading promotion of breast milk substitutes, a long advocacy struggle by activists, lobbyists and international child right organizations influenced the United Nations to pass an"International code on Marketing of Breast Milk Substitutes" (the Code) in 1981, which promised to protect, promote and sustain unhindered provision of essentially required breast milk to infants and young children globally[7]. Many countries have worked since then to plan and implement Code but implementation in terms of result-oriented advocacy and procedural changes at both health facilities and household level for improved breastfeeding have been minimally seen[8].

In Pakistan although there is an increase in early initiation of breastfeeding but the exclusive breastfeeding rates and the ever-breastfed rates are stable. The mean duration of breastfeeding months has decreased with an increased prevalence of bottle feeding. In Pakistan various factors contribute to code violations, which include lack of awareness among mothers/care takers, unethical marketing of breast milk substitutes by multinational companies, lack of competency based skills among health providers. Promotional campaigns by formula milk companies is supported by practicing doctors in Pakistan and this increases the chances of bottle feeding in most cases. Various studies have shown that doctors support receiving gifts, promotional material and donations from formula milk/feeding bottle manufacturers[9,10].

A large population based survey was conducted by Save the Children in 2012 across Pakistan. Target group included 1) Mothers of infants up to 6 months age, 2) health professionals and 3) Information Items on Infant Feeding in Government/ Private/ NGO run Health-care facilities. A total sample size of 4800 was used, which included 2400 for target-1; 1202 for target 2, and 1368 for target-3. Data collection was done through multi-cluster random sampling with the help of three different structured tools. Some of the important findings of the survey include:

- Although majority mothers are advised exclusive breastfeeding and weaning by health care providers, a contradiction exists in practice, where many mothers are also advised formula milk; mostly by doctors. Not only the doctors recommend formula milk, they also recommend some specific brands of formula milk. Some of the mothers had seen promotional message of formula milk and a few have had free samples and gifts of formula milk.

- Most mothers are aware of early initiation of breastfeeding, and have knowledge of the duration of exclusive breastfeeding, yet less mothers actually practice it. Few mothers are key decision makers in infant feeding in their households.

- Many doctors have been visited by representatives of formula milk companies for product information and they have received gifts and free samples from companies.

A qualitative assessment was also done to explore the factors responsible for the code violation in Pakistan. Important determinants of this code violation were highlighted, which include:

- Many health care providers are unaware of the Code and its rules.

- Most health care providers consider that this law does not carry forceful penalty in case of violation, and also there is no monitoring system in place for proper enforcement of the Code.

- Aggressive marketing campaigns and unethical promotional strategies by the formula milk industry have increased the community demand for breast milk substitutes.

- There is a huge private health sector in Pakistan which is largely unregulated and operates for profit and is mostly influenced by the formula milk industry.

- There is an prevails lack of capacity at the district level, as the role of committees needs to be strengthened and inspectors intoned to be in place for implementing regulations.

- Although there has been an increase in female labor force participation, little attention is paid to workplace lactation support programmes for working mothers who breastfeed. Working mothers find it difficult to continue their breastfeeding, due to the lack of supportive measures at workplace settings, non-availability of breastfeeding breaks and no privacy to express breast milk, lack of employers support towards breastfeeding and flexibility in duty hours. This leads to discontinuation of breastfeeding among working mothers in Pakistan.

Recommendations:

- Advocacy effort should be made focusing on breastfeeding as a right of every infant and every child under the age of two years.

- Sustained national level advocacy, and BCC campaigns and programmes to spread messages about benefits of breastfeeding must be done.

- Religious leaders in Pakistan can play a vital role in this advocacy as the Holy Quran has advised breastfeeding for two years. This must be used as a motivating agent in all advocacy campaigns and religious leaders must be given detailed trainings on the Code.

- Advocacy efforts should also be initiated by the civil society for the effective implementation of the Code/ Law or any other legislative framework (currently Protection of Breast Feeding Law 2009).

- Ministry of Health Services Regulation and Coordination Division (NHSRC) should assume stewardship role and develop monitoring mechanisms for proper enforcement of Code.

- Notification of Infant Feeding Board at Federal level under 2002 Ordinance and in Punjab and Sindh

Iffat Mai, 19, District Muzzafargarh breastfeeds her youngest child, Ahmad. Iffat Mai was 15 when she got married and now has 3 children. The eldest child, a girl is 4 and the youngest is Ahmad, 5 months.

under their respective provincial laws will be helpful in implementation.

- Provincial laws call for establishing Infant Feeding Boards at the provincial level i.e. the Punjab and Sindh Infant Feeding Board to monitor implementation of the law.

- The Provincial government must delegate powers to district health departments for protection of breastfeeding through facility-based as well as community-based multi-sectoral interventions for prevention of unethical marketing at health facilities including private health facilities and clinics.

- All employers should be bound by law to provide a 6 month maternity leave to mothers after delivery in order to practice exclusive breastfeeding.

- With reference to supporting working mothers for promotion of breastfeeding, the following interventions can be done:

    - Educating and guiding working mothers about breastfeeding[11];
    - Enhancing employers' awareness about importance of breastfeeding[12,13];
    - Arranging physical facilities for the breastfeeding support at workplace
    - Flexibility in the work environment for lactating mothers;
    - Developing a mother and baby friendly policy at work.

1. BACKGROUND

Although global child deaths have declined by 26% since 2000 and 35 % since 1990, few countries are going to achieve international targets for improving the child survival rates before 2015's deadline of child mortality related Millennium Development Goal, MDG-4. Since 1990 the number of children dying a year has come down to 7.6 million in 2010 from 12 million as reported in 1990, at an average rate of 1.8% annual reduction[14]. Although Child mortality is declining in various countries, yet more has to be achieved in terms of better health outcomes[15]. *The Countdown to 2015* report for year 2012 indicated that out of 7.6 million children under 05 years who died in 2010, 18% deaths were attributed to Pneumonia and 11% to diarrhoea. These deaths could have been avoided by available preventive measures and prompt treatment. Approximately 90% of these deaths were in Sub-Saharan Africa and South Asia, and five countries with the highest death toll are India, Pakistan, Nigeria, Democratic Republic of Congo and Ethiopia[16].

Malnutrition has been proven as one of the strongest risk factors in child mortality, and is responsible for more than 50% of under-five deaths in the developing countries[17]. Over two-third of these deaths occur in the first years of life, which are often associated with inappropriate feeding practices[18]. It has been estimated that 830,000 deaths could be avoided if every baby is breast fed within first hour of life. About 22% of newborn deaths can be prevented if breast feeding is initiated with in the first hour after birth, and 16% if breast feeding is started within first 24 hours[19]. Babies who are given breast milk within an hour after birth are up to three times more likely to survive than the ones breastfed a day later[20]. In the first hours and early days, after childbirth, a mother produces colostrum, which is most potent natural immune system booster[21]. Infants not breastfed are 15 times more likely to die from pneumonia and 11 times more likely to die of diarrhoea than those who are exclusively breastfed for first six months of life[22].

At the same age, risk of dying from diarrhoea or pneumonia increases more than two-folds for children who are not exclusively breastfed as compared to the one who are[23]. Infants aging 6–11 months if not breastfed have an increased risk of such deaths[24]. Adequate and nutritionally balanced provision of food during infancy is a critically important determinant of child survival which is largely dependent on awareness level and skill based competency of care givers, mothers, families, communities and health service providers in any society[25]. Although, breast milk is readily available soon after birth, lack of awareness among mothers and families on the importance of exclusive breast feeding, unethical involvements of health staff in prescription of breast milk substitutes as well as engagement of manufacturers and distributors in unlawful promotion of breast milk substitutes have influenced the attitude, practices and decision making process jeopardizing the initiation, continuation and promotion of breast feeding in general and exclusive breast feeding in particular[26,27].

The importance of exclusive breastfeeding in terms of growth and development of infants and young children and the protection from gastrointestinal infections is accepted globally[28]. Credible evidence from more than 200 papers indicates that exclusive breastfeeding has a direct protective effect against gastrointestinal infection[29]. With literacy and gender equity improving day by day, employment opportunities for women are also increasing. In addition to this many women are engaged in unskilled labor owning to inflation. There are many mothers who believe that breastfeeding is associated with distortion of beauty and many others who do not have access to counselling services for initiation of breast feeding and therefore they see comfort and convenience in feeding their infant with formula milk depriving the

infants and young children from essentially required balanced diet i.e. breast milk[30]. The health consequences in the late infancy, childhood, adolescence and even beyond among those who are not breastfed are more drastic in comparison to those who are fed on breast milk. These include elevated risks of obesity, CVD, allergy, type 2 diabetes mellitus and gastrointestinal conditions[31].

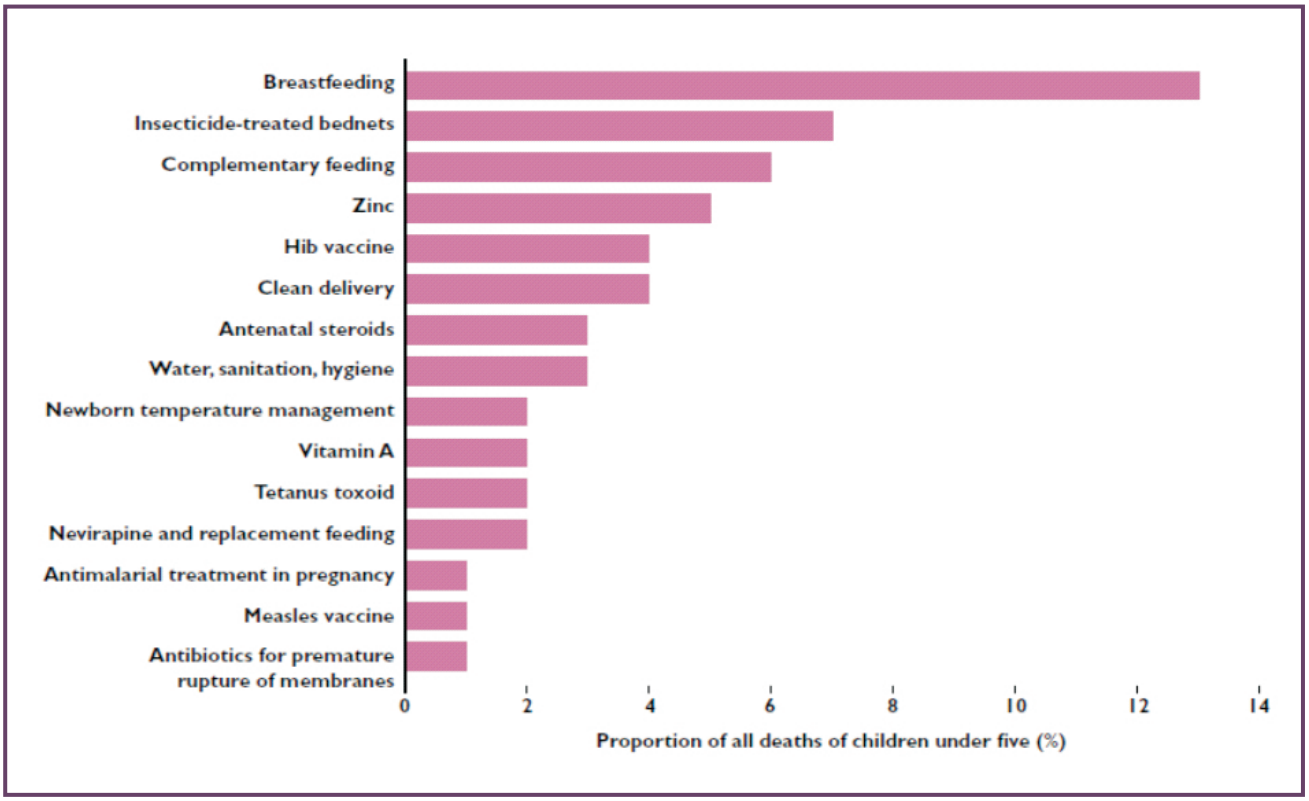

Figure 1: Proportion Of Child deaths Under Five That Could Be Prevented

SOURCE: Jones, G et al., 'How many child deaths can we prevent this year?' Lancet Child Survival Series, 2003, 362:65-71

Pakistan is no different from most of the developing countries of the world in terms of disease burden in children under five years of age. Social, economic, cultural, political and economic factors come into play compounding the already debilitated situation of health service delivery. Though beautifully designed, it requires ample support in terms of supportive monitoring, resource allocation, effective utilization, substantial policy and procedural changes with respect to human resource availability, efficiency and effectiveness .Pakistan is one of those countries where reduction in child mortality has been slow and not on track to achieve the MDG-4.

With an estimated 352,400 under-five deaths in 2011, Pakistan is ranked third among the top five countries including India, Nigeria, Congo, and China, which accounted for half of the deaths in children under five worldwide[32]. These five countries contributed to half the deaths from infections and other half deaths due to neonatal causes[33].

Pakistan's under-five mortality rates witnessed slow decrease from 117 per 1000 live births in 1991 to 94 per 1000 in the year 2007. Similarly infant mortality rate declined from 91 per 1000 to 78 per 1000 live births between the years 1991 to

2007[34,35]. But the neonatal mortality rates in Pakistan are stalling, and little progress has been achieved in this indicator so far. In Pakistan, causes of low rates breast feeding include perception of mothers of having insufficient milk, working mothers, mothers with chronic disease, children with congenital or acquired disease, mothers having another pregnancy, mothers who have twin babies and children whose mothers have died[36]. Similarly, lower rates of EBF are influenced by factors like education, employment status and affordability[37]. Other determinants of primary importance are: deplorable situation of water and sanitation, food insecurity among poor populace especially women and young girls who remain always marginalized. Among other factors, the female literacy is one of the determinant of maternal and child health. Unfortunately in Pakistan, the female literacy rate among mothers in recent survey was found to be only 40.5%[38].

With regards to child health, the National Nutrition Survey 2011 paints a dismal picture. Severe stunting (i.e. very low height for age) was observed to be alarmingly high (23.5%) among children at national level out of 43.7% of total stunted children with mild, moderate and severe stunting status. Proportion of *wasting* (i.e. low weight for height) at national level was 15.1%. About 5.4% of children were found severely anemic and 56% moderately anemic. One third (33.4%) of the index children were found to be iron deficient at national level. 22% of children under five years of age have had an episode of diarrhea in last one month. NNS 2011 also revealed that only 40.5% of mothers had initiated breast feeding within one hour of birth. Survey analysis showed that 65% mothers exclusively breastfed their children up to six months and 78% continued breast feeding up to 12-15 months.

The qualitative aspect of the study indicated that "the traditional practice of pre-lacteal feeding (Ghutti) still continues and cannot be avoided as it is a centuries' old practice. Probing revealed that "Honey" is used as the first pre-lacteal feed across the country. The cultural variation also existed; other forms of pre-lacteal feed included "Gurr" (Jaggery) more commonly given in Northern Punjab, clarified butter in Northern Punjab/KP/ Gilgit-Baltistan, fennel-flavored sherbet also given in KP. It was an astonishing finding that besides water Donkey's milk, which is perceived to prevent epilepsy, is also given, in Gilgit Baltistan.

Promotional campaigns by formula milk companies is supported by practicing doctors in Pakistan and this increased the chances for bottle feeding in most cases. Various studies have shown that doctors support idea of receiving gifts, promotional material and donations from formula milk/feeding bottle manufacturers[39,40].

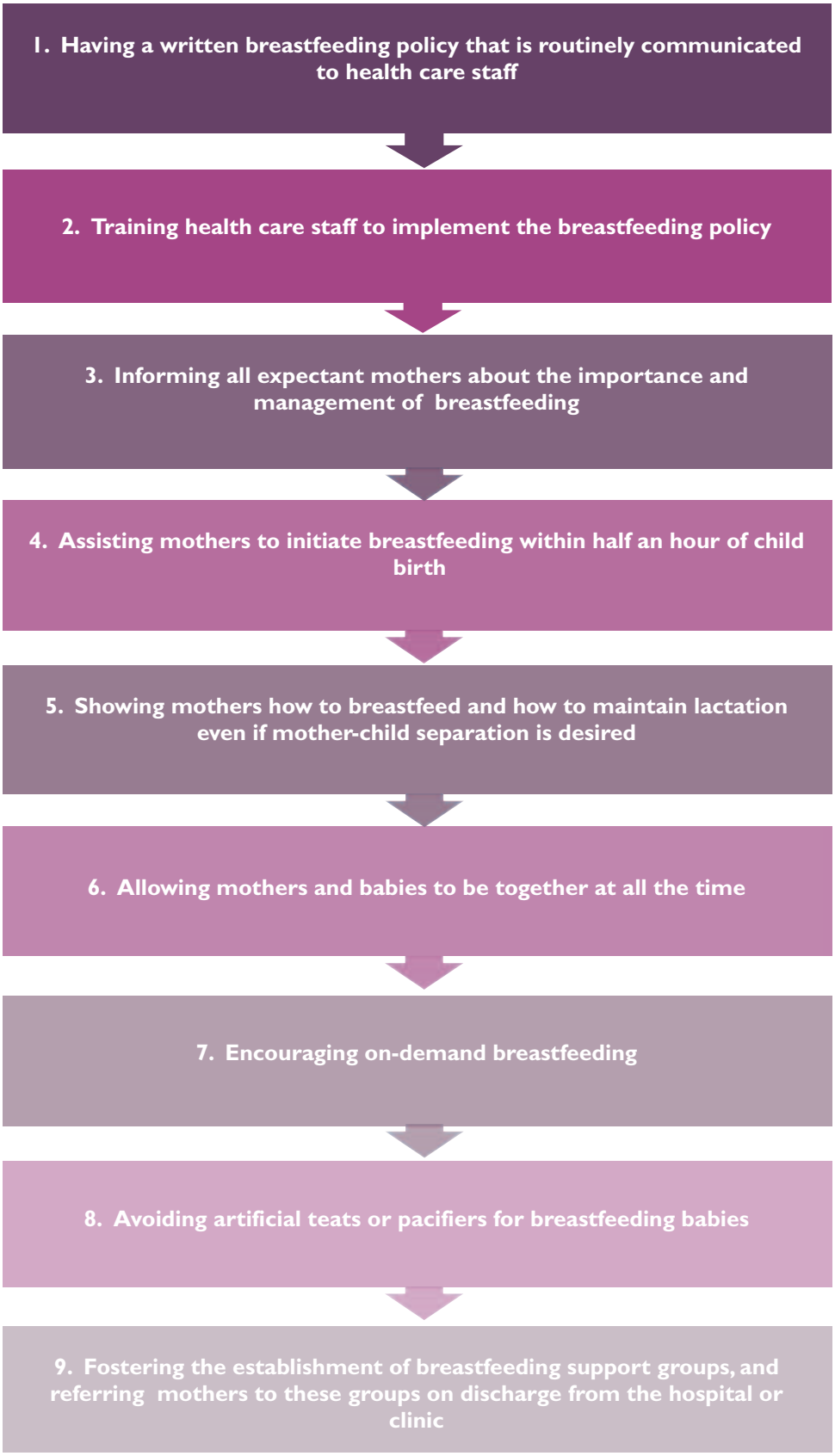

Figure 2: Nine Steps To Successful BreastFeeding

Source: Setty 1996 (based on WHO 1990 and UNICEF 2004)

1.1. GLOBAL MOVEMENTS FOR PROMOTION OF BREASTFEEDING

Global movement against formula milk first started in the 1970s. The New Internationalist published report on Nestlé's marketing practices in 1973. It was titled as "Babies Mean Business," and it described how the company preyed on poor mothers to use formula milk. Another report "The Baby Killer," published by London's non-governmental organization in 1974 really exposed the baby formula industry[41]. Nestle was accused of misguiding third world mothers to use formula milk through inappropriate promotions, which, even at that times, was considered to be less healthy and more expensive than the naturally available breast milk. It was reported that besides handing out pamphlets and samples to new mothers, companies hired sales girls in nurses' uniforms to drop by homes unannounced and sell baby formula milk.

Infant Formula Action Coalition, a group of change catalysts, formally launched a boycott in the U.S. protesting against unethical promotion of the breast milk substitutes by Nestlé in 1977[42]. Soon it spread to France, Finland and Norway and countless other countries. The allegations led to hearings in Senate in USA and in the World Health Organization. In 1978, Senator Edward Kennedy held a series of U.S. Senate Hearings on the industry's unethical marketing practices. International meetings with the World Health Organization, UNICEF and The International Baby Food Action Network followed after establishment of the IBFAN in late 1979[43]. At the platform of World Health Assembly, co-supported by UNICEF, WHO and other agencies of United Nations, long consultations were held among members. A landmark was achieved in the form of "an international code of marketing for infant formula and other products used as breast-milk substitutes" available for member states, achieved in May 1981 when 118 member states favoured in adoption of the Code against only 01 in opposition while 03 did not participate.

In 1981, the 34th World Health Assembly adopted Resolution WHA34.22, which includes the International Code of Marketing Breast-Milk Substitutes[44]. The International code on Marketing of Breast Milk Substitutes (Code) conceptualized in 1981 is premised on the need on part of member states to protect, promote and sustain the unhindered provision of essentially required breast milk to infants and young children. The Code was supposed to be translated into country specific legislative frameworks in order to ensure the promotion and protection of breastfeeding. Since 1981 after its adoption, World Health Assembly (WHA) has re-affirmed the Code on at least 17 occasions for resolutions but keeping the same legal status of the Code. When the word Code is used, it refers to the original version of International Code on Marketing on Breast milk Substitutes, subsequent resolutions of WHA and the country specific adapted versions of the Code in entirety.

Subsequent interventions include many but more important were the Innocenti Declaration[45] in 1990; and Baby-friendly Hospital Initiative[46] in 1991, and celebrating World Breastfeeding Week in 1992. WHO and UNICEF developed a Global Strategy for Infant and Young Child Feeding in 2002[47]. In 2003, WHO developed a community based guideline titled "Community-based Strategies for Breastfeeding Promotion and Support in Developing Countries". As such, the Global Strategy was designed for use by the governments and other stakeholders to take certain actions that could protect promote and support mothers to follow the recommended feeding practices. Many influences affect a mother's choice of feeding her child in early stages of infant's life. These include traditional and cultural practices, violators of International Code of Marketing of Breast milk Substitutes and subsequent relevant resolutions, a mother's level of awareness, family pressures, and working environment.

It is very important to understand linkage of health systems, resources and capacity of health staff in any given country. In developing countries, with meagre resources allocated for health, focus on curative health, lack of health education, and limited

capacity of health staff in counseling, especially nutritional advice; effective implementation of health and nutritional interventions becomes more difficult[48]. Globally, many countries have worked significantly in order to plan and implement International Code but implementation in terms of result-oriented advocacy and procedural changes at both health facilities and household level for improved breastfeeding have been minimally seen[49].

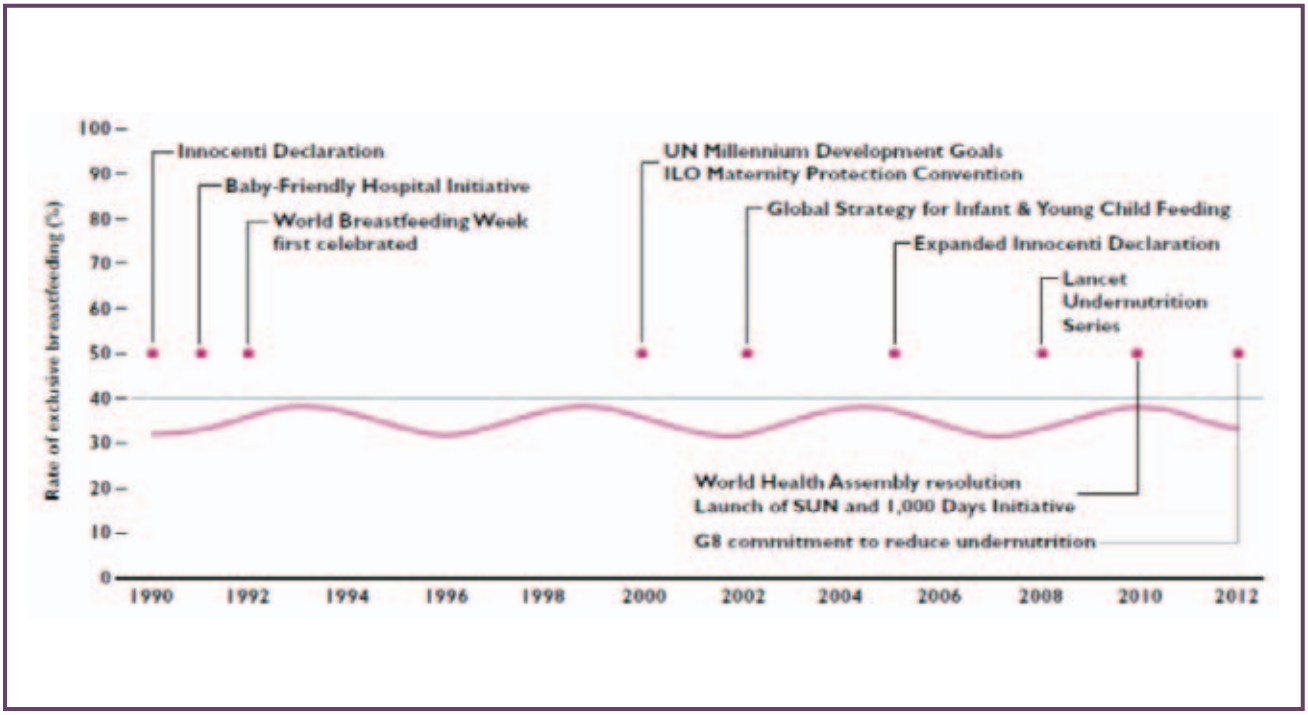

Figure 3: Global Movements And Rates Of EBF
SOURCE: UNICEF. World Breastfeeding Conference, 2012

1.2. FORMULA MILK INDUSTRY IS GROWING FAST

Worldwide, 92 million children under six months of age, meaning two out of three babies are either artificially fed or fed a mixture of breast milk and other foods. The baby milk formula business was worth $25 billion in 2012; Nestle alone was worth of $11.5 billion globally. The baby-food industry as a whole is set to grow by 31% by 2015, with most of the growth concentrated in Asia[50].

According to "Breaking the Rules, Stretching the Rules 2010" report generated by International Baby Food Action Network (IBFAN), the 11 manufacturers of the infant formula milk were found to be committing 500 violations in 46 countries with a wider range of offences in a period of just three years from October 2007 to October 2010. Premiumization by branding the promotion of infant formula with name like Gold, like Nan Gold and Premium Nutrica are also some of the unnoticed violations the manufacturers are making. Similarly violations are also seen in marketing when companies of BMS add false nutritional nomenclature with products like probiotics, DHA, AA, Optipro, LCPUFA, immunofortis, Omega-3 and lactoferrin. These are just some examples used to give the impression that these ingredients in the formula milk are essential items for growth and development, and that the formula milk does contain all those ingredients while in reality the BMS actually do not possess such value[51].

1.3. TRENDS IN BREASTFEEDING IN PAKISTAN

There is enough evidence indicating that early initiation and exclusive breast feeding is associated with potential prevention of two third of the deaths occurring because of disease budren and malnutrition[52].

Although it requires to investigate the factors which are contributing in improving the early initiation and exclusive breastfeeding in Pakistan, yet it is understandable that during the past ten years massive efforts have been made by both civil society and International development partners in Pakistan to help the government in prioritizing issues linked with MDG-4 and MDG-5.Various mother and child health programs and advocacy campaigns in the last decade have been helpful in creating demand for services as well as improving the knowledge, attitudes and practices besides improving the competency based skills of the health service providers.

In Pakistan various factors contribute to code violations, which include lack of awareness among mothers/care takers, unethical marketing of breast milk substitutes by multinational companies and lack of competency based skills among health providers. Promotional campaigns by formula milk companies is supported by practicing doctors in Pakistan and this increases the chances of bottle feeding in most cases. Various studies have shown that doctors support receiving gifts, promotional material and donations from formula milk/feeding bottle manufacturers[53,54].

1.3.1. INCREASE INTHE EARLY INITIATION OF BREASTFEEDING

There has been an improvement in the early initiation of breastfeeding rate in last five years in Pakistan. While there has been an increase in Balochistan, Sindh, KP Provinces, and in rural areas of Pakistan, a slight decrease has been observed in Punjab.

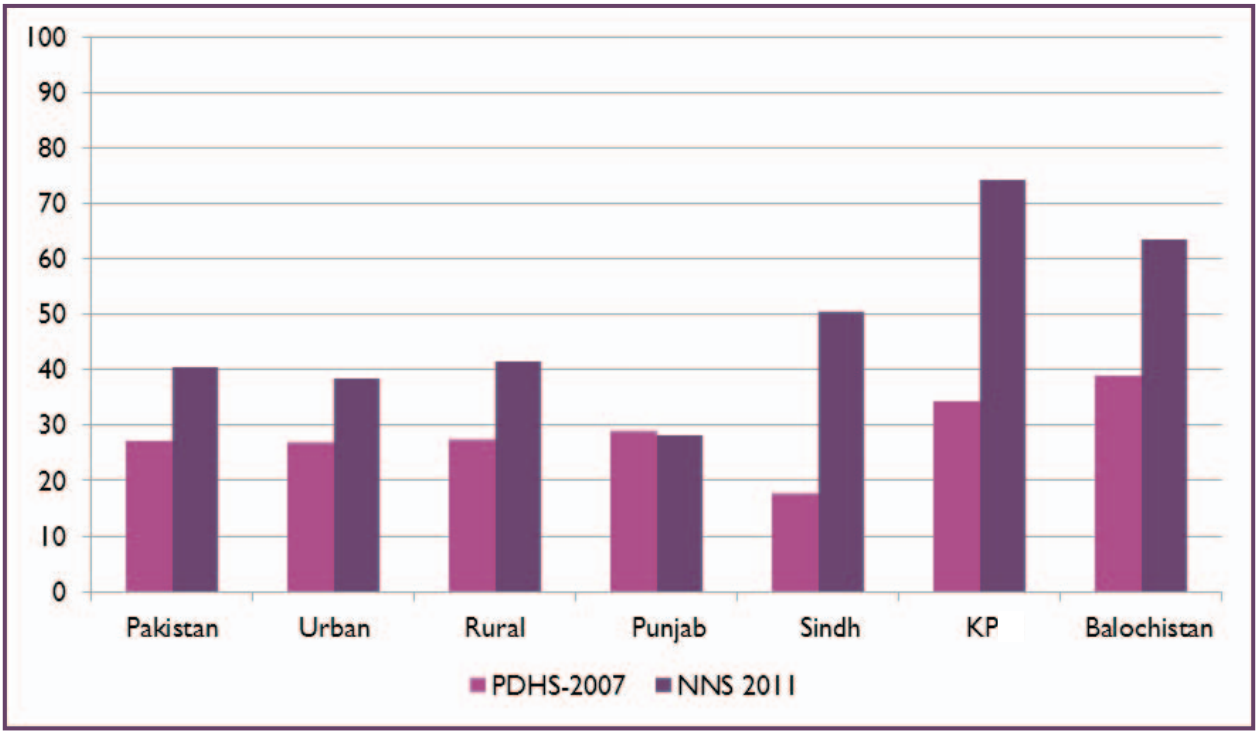

Figure 4: Early Initiation Of BreatsFeeding

1.3.2. INCREASE IN EXCLUSIVE BREASTFEEDING

Exclusive breastfeeding means that the infant is fed only breast milk (with no other liquids (including water) or food on demand) for first 6 months of life. Proportion of EBF is estimated on the basis of feeding practices in past 24hours dietary recall.

There is an increase in the exclusive breastfeeding (up to 6 months) in Pakistan in last five years, in almost all areas of the country. NNS 2011 showed that 65% of mothers exclusively breastfed their children under-6 months. Exclusive breastfeeding was higher in rural (67%) than in urban areas (59%) of Pakistan. Rate of exclusive breastfeeding was highest in KP (83%) and lowest in Punjab (48%).

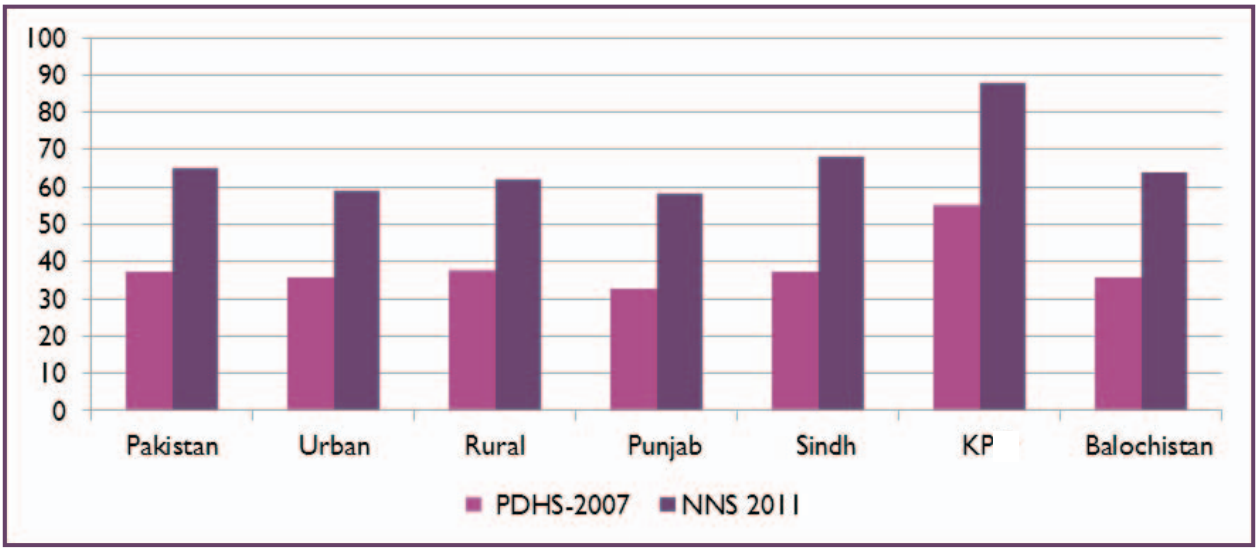

Figure 5: Exclusive Breastfeeding (Children Aged <6 Months)

1.3.3. STABLE EVER-BREASTFED RATES

Ever breastfed rate is the percentage of infants less than 12 months of age who were ever breastfed. The data from last 20 years in Pakistan shows that the rate of ever breast fed children has been stable in Pakistan and ranges between 92% to 96%.

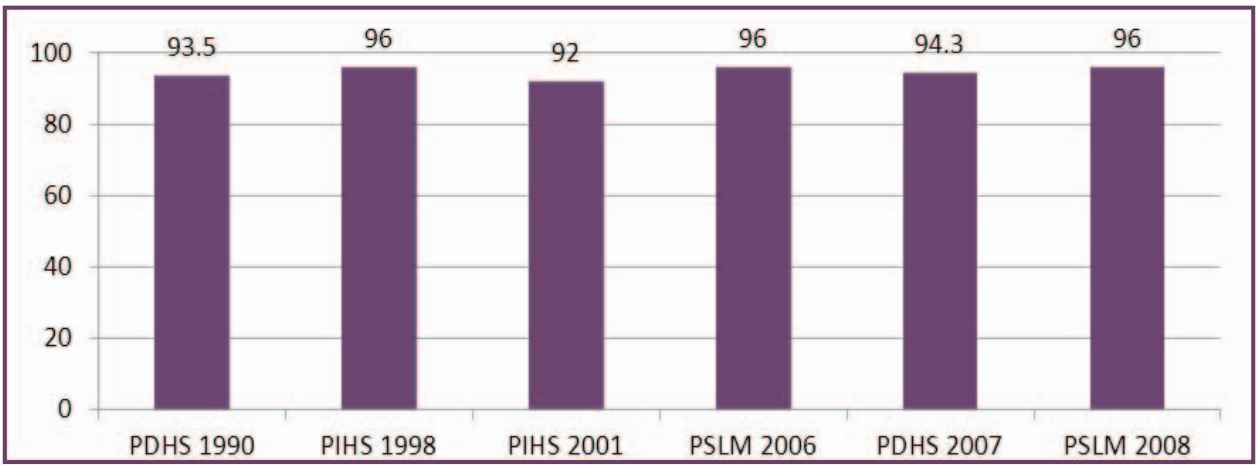

Figure 6: Ever Breast fed

1.3.4. DECREASE IN MEAN DURATION OF BREASTFEEDING

Mean duration of breastfeeding is the average number of months children are breastfed during their childhood. It is estimated in months of breastfeeding. There has been a steady decline in the mean duration of breastfeeding (months) in Pakistan over the last three decades. It has gone down from 22.8 months in 1975 to 18.3 months in 2007[55]. So on an average in Pakistan the children are breastfed for lesser duration as compared to past.

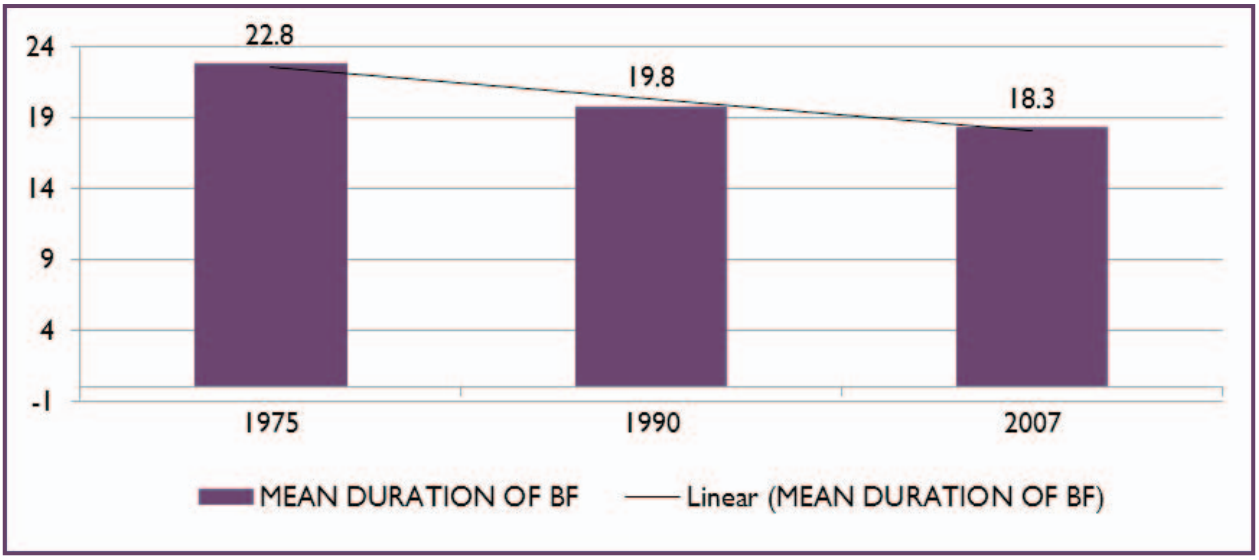

Figure 7: Mean Duration Of Breastfeeding (in Months)

Although there is increase in early initiation of breastfeeding and exclusive breastfeeding rates; and the ever-breastfed rates are stable, this decreased trend in average number of months children are breastfed in Pakistan needs further attention. Many reasons are contributing towards this decrease; like individual level factors such as gender, size and health of infant; working status and age of mother; the family level factors like income, number of children, and interaction with health providers who prescribe formula milk. Other social factors including lack of policies and practices regarding promotion of breastfeeding, weak implementation of the Code, lack of support for working mothers in work environment for on-site breastfeeding, and flexible work environment for feeding mothers may also contribute to this decline. Promotion of breast milk substitutes by formula milk industry is an important influencing factor causing decrease in the mean duration of breastfeeding in Pakistan. This is also evident from the increase in bottle-feeding rates in Pakistan during last three decades, as shown below.

1.3.5. PREVALENCE OF BOTTLE FEEDING

The bottle-feeding rate is the proportion of infants less than 24 months of age who received any food or drink from a bottle in the last 24 hours. This percentage of bottle feeding is increased in Pakistan in last twenty years.

The percentage of children under 24 months of age who were reported to be bottle-fed was 21.8% in 1990, while it increased to 34.1% in 2007[56]. As discussed above many factors contribute to decrease in the mean duration of breastfeeding and these factors are also responsible for the increase uptake of bottle feeding in children.

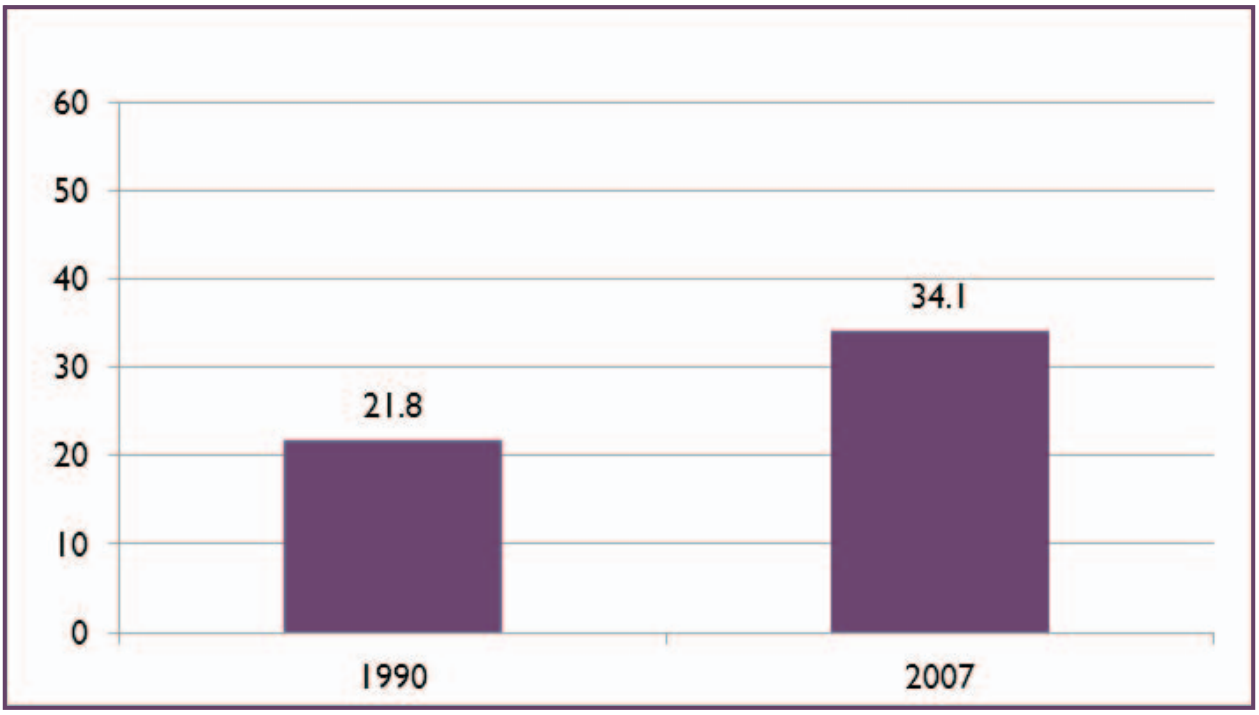

Figure 8: Proportion Of Bottle Feeding (children Aged <24 Months)

1.4. LEGISLATIVE FRAMEWORK FOR IMPLEMENTING BREASTMILK CODE IN PAKISTAN

There are some improvements in the breastfeeding indicators in Pakistan like the increase in the early initiation rate of breastfeeding, the exclusive breastfeeding rate, and ever breastfed rate. In the last two decades, a number of maternal and child health interventions including the National Maternal Newborn and Child Health (NMNCH) were initiated in Pakistan, with infant and child nutrition being an important component of all. Although no impact evaluation of these projects with reference to their role in breastfeeding indicators improvement has been done, they may have contributed directly or indirectly in improving certain indicators of breastfeeding.

Pakistan was among the 118 countries who had voted in favour of adopting International Code of Marketing of Breast-milk Substitutes during the World Health Assembly in May 1981. However the legislation came very late in Pakistan when "The Protection of Breast-Feeding and Child Nutrition Ordinance, 2002" (XCIII Of 2002) was passed on 26th October 2002, and Pakistan became one of the 42 countries with legislation to adopt most of the articles of the Code. But implementation of law in Pakistan remained a dream in the absence of rules and detailed procedures for its implementation. These rules came very late through the Protection of Breast-feeding Rules 2009, notified through the Ministry of Health S.R.O on 2nd November, 2009. Although The Protection of Breast-Feeding and Child Nutrition Ordinance 2002 also stressed on formation of a National Infant Feeding Board (NIFB) to monitor implementation of the said Ordinance, this NIFB came into existence very late on 5th July 2010. On 30th June 2011, 18th Constitutional Amendment abolished many Federal Ministries including health, and health became completely a Provincial subject in Pakistan. After this devolution, Provinces were authorized to make legislations pertaining to all matters in health including provincial level health policies and strategies.

Punjab introduced legislation on breastfeeding and child nutrition in 2012, by adopting Protection of Breast-Feeding and Child Nutrition Ordinance 2002. It is similar to Protection of Breast-Feeding and Child Nutrition Ordinance, 2002.

Recently in 2013, Sindh Assembly also unanimously passed the Sindh Protection of Breastfeeding and Child Nutrition Act-2013 on 13th February 2013. It is also similar to the Federal law and has same implementation modalities.

In Khyber Pakhtunkhwa Province, draft Health Bill is pending which is repealing around nine federal health related laws including the 2002 Ordinance and there are only two vague sections on breastfeeding in the bill, but with new setup in the province, it is expected that proper legislation will be done soon.

1.5. FEDERAL ROLE IN POST DEVOLUTION HEALTH

The Article 270AA(6) in 18th Amendment saves all existing federal health laws and these laws continue to remain in force until altered, repealed or amended by what is referred to as "competent authority." Existing health-related laws will continue to be in force. Although the 18th Amendment "saved" laws, it transferred power to alter, repeal or amend laws in favour of provinces, which are "competent authority" as referred to in the Article 270AA(6).

- Entry 32 in Federal Legislative List (FLL) clearly mentions "International treaties, conventions and agreements and International arbitration" asa Federal role.
- Legal, medical and other professions" has been shifted from the Concurrent Legislative List CLL to Part II of FLL.
- Health workforce regulation is now dealt with federally, and is now exclusively a federal subject. (Entry 43 shifted from CLLto Pt. II of FLL).
- Specialized Research and Development is a federal subject (Entry 16 of Part I of FLL).
- Similarly the "Enquiries and statistics for the purpose of any of the matters" in the Part I (Entry 57) and Part II of FLL (Entry 17).
- There can be a National Health Insurance, where there is a void at provincial level (Entry 29 of Part I of FLL).

So even after the 18th amendment, there is a crucial role of federal government in regulating the profession and ethical practices related to professions as well as regulating the industry related to medical profession. The constitution still gives Federal Government and newly established National Health Services Regulation and Coordination Division (NHSRC) at the Federal level, a clear mandate to enter into and subsequently deal with international agreements, and implement the existing obligations as outlined in the Federal Legislative List, Part I. NHSRC is an institutional mechanism for dealing with international partners and agreements. A brief sketch of various departments under this Division is given below:-

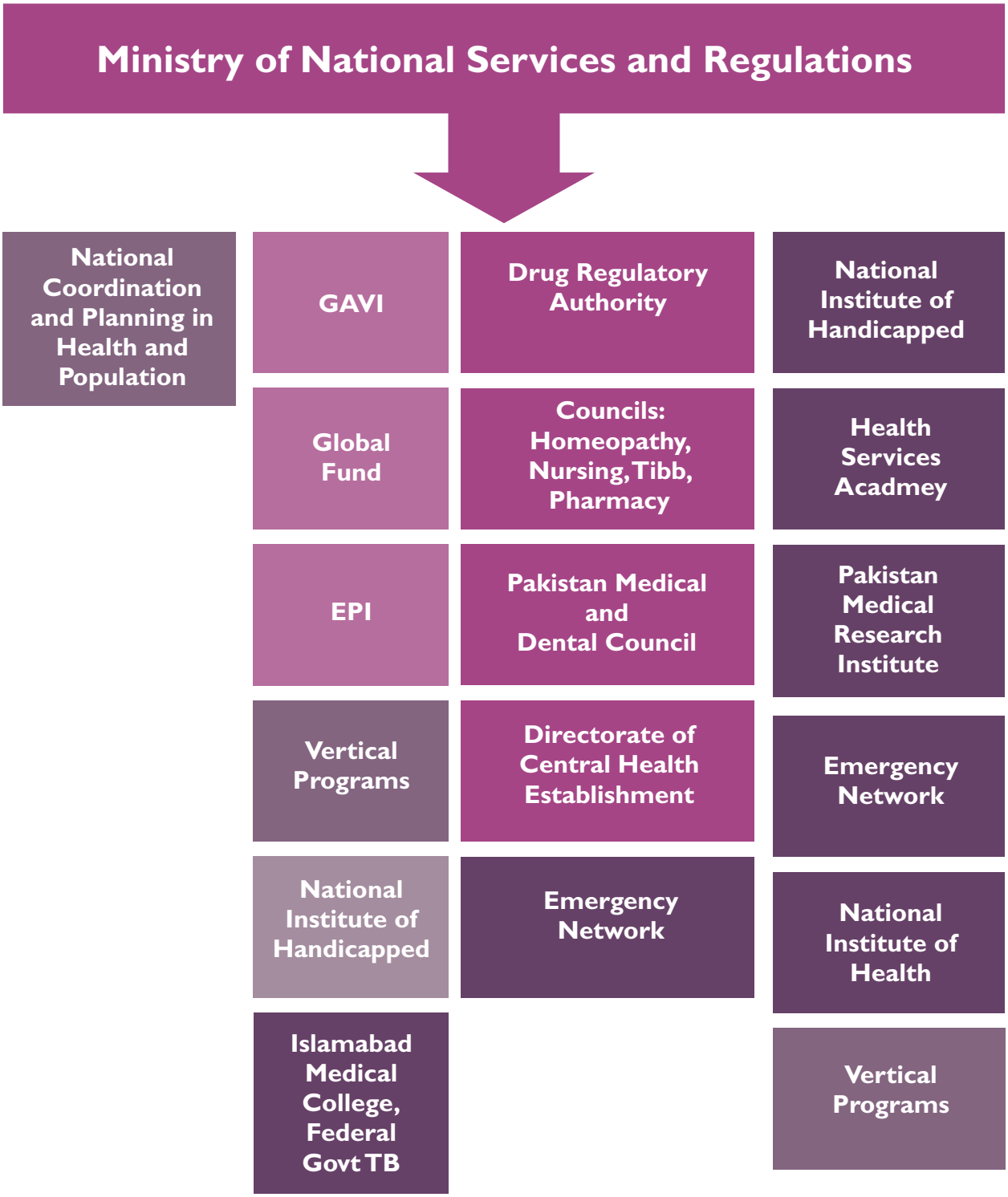

Figure 9: National Health Services Regulation And Coordination Division

SOURCE: Ministry of National Regulation and Services Regulations and Coordination Division. Handover papers by Sania Nishtar. Available at sanianishtar.info

2. CODE VIOLATION SURVEY IN PAKISTAN

A large survey was conducted across Pakistan's four provinces by Gallup Pakistan during December 2012.The study Target Groups included;

1) Mothers of infants up to 6 months of age who are living in Large Cities, towns and villages of Pakistan;
2) Health professionals who have contact with pregnant women or mothers of young infants serving in large cities, towns and villages of Pakistan and
3) Information Items on Infant Feeding in Government/ Private/ NGO run Health-care facilities which see pregnant women or mothers of young infants.

A total sample size of 4970 was used, including2400for target-1; 1202 for target 2 and 1368 for target-3. Data collection was done through multi-cluster random sampling with the help of three different structured tools.

2.1. RESULTS

2.1.1. MAJORITY MOTHERSADVISED FORMULA MILK

Majority (84%) of the mothers interviewed said that they have been advised to use formula milk or other milk or drinks or food for infants under 6 months of age. This proportion varies significantly (p=0.001) among various Provinces; being highest in KP (90%) and lowest in Balochistan (68%). There was no significant difference in urban and rural areas.

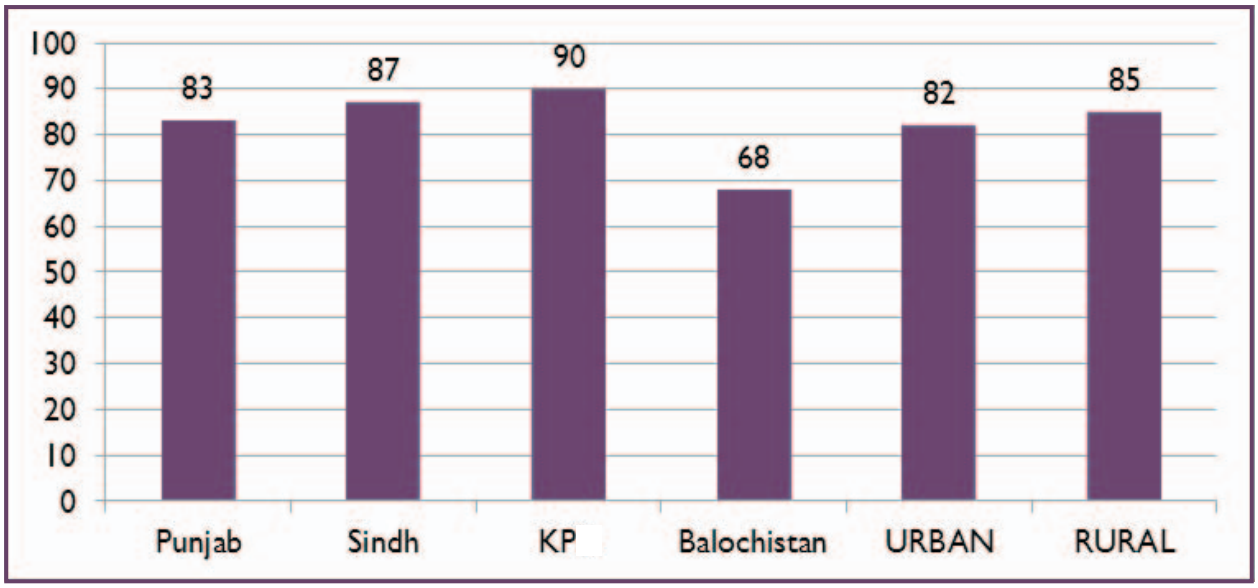

Figure 10: Mothers Advised Formula Milk And Other Drinks In Different Areas Of Pakistan

The situation is tantamount to violation of Article 01 of the International Code which is meant to safeguard the adequacy of nutrition for infants and related to the protection and promotion of breast-feeding. This is also a violation of articles 05 and 06 of international Code which are related to general public, mothers and healthcare system respectively.

Most importantly the findings are indicative of the failure in establishing and pursuing a functional and effective monitoring and evaluation system thus creating this violation of the Article 11 of the Code.

2.1.2. MAJORITY MOTHERS ADVISED BY DOCTORS TO USE FORMULA MILK

Among those mothers who received advice for formula milk, almost half (47%) were advised by doctors to use formula milk. 34% were by husband/relatives/friends. Proportion varies in the provinces; highest in Balochistan (62%) and lowest in Sindh (44%). More were advised by doctors in urban (61%) as compared to rural (40%) areas of Pakistan. Those 34% advised by husband/relative/friend, can also be attributed to health workers; as their advice might have been linked to health providers.

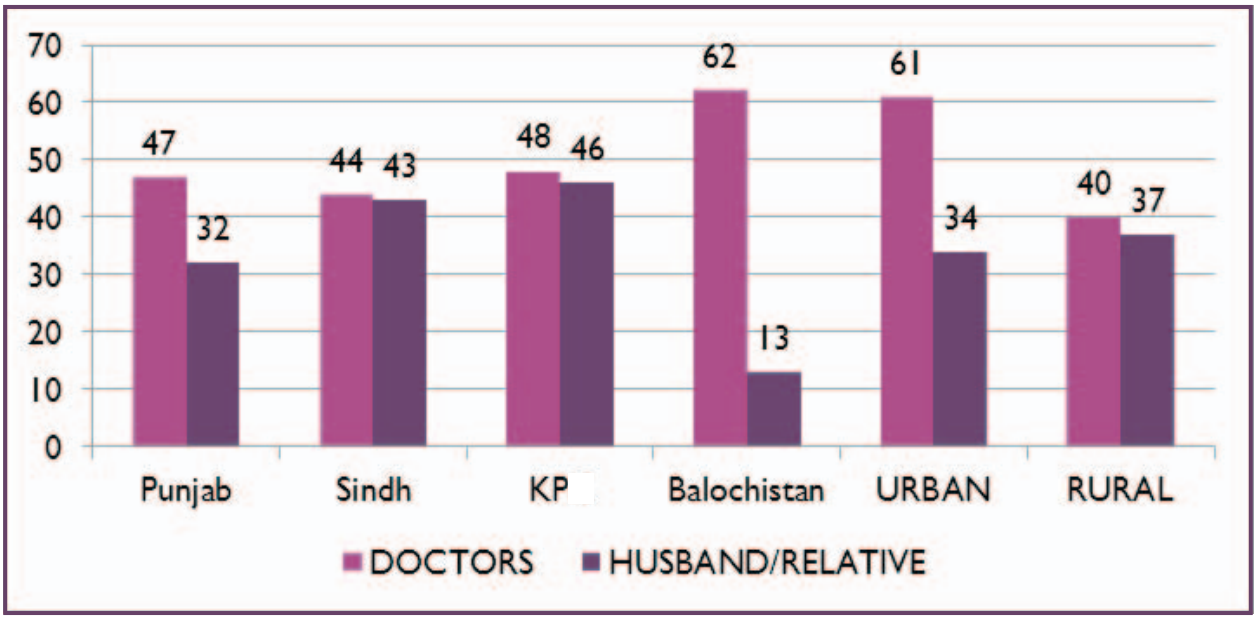

Figure 11: Mothers Advised Formula Milk By Doctors And Relatives

The findings of the survey related to involvement of healthcare staff in promotion of the breast milk substitute (although there is not a single substitute for the natural breast milk) indicate the violation of the article 07 (7.1 in particular) which calls for the avoidance of involvement of the heath care staff in unnecessary promotion of formula milk. Continued efforts and commitments by the healthcare staff to promote breastfeeding need to be endorsed.

2.1.3. SPECIFIC BRAND OF FORMULA MILK RECOMMENDED

27% were recommended to use a particular brand of infant formula. Among those who were recommended a specific company/brand, the top Company recommended was Nestle (88%). The highest proportion of specific brand recommendation was in Balochistan (60%) while lowest in KP (2%). Recommendation was found to be 37% in urban and 22% in rural areas of Pakistan. This is a reflection of the clear violation of the of the articles 01, 04, 05 and 07.

Punjab	35
Sindh	17
KP	2
Balochistan	60
Urban	37
Rural	22

Table 1: Specific Brand Recommended

2.1.4. RECOMMENDATION OF SPECIFIC BRANDS BY DOCTORS:

Among those who reported that a specific brand of formula milk was recommended, almost all were advised by doctors to use a specific brand of milk or complimentary feed. This is a reflection of the clear violation of the of the article 07 specifically the article 7.1, 7.2. 7.4 The proportion is almost similar in all provinces.

Punjab	72
Sindh	71
KP	100
Balochistan	94
Urban	87
Rural	63

Table 2: Specific Brand Recommended By Doctors

2.1.5. MAJORITY MOTHERS ADVISED EXCLUSIVE BREASTFEEDING

About 89% mothers were advised to exclusively breast-feed their infant till 6 months of age, but only 41% had this advice by a doctor or nurse. This implies that among the respondents who reported to be advised exclusive breastfeeding by someone, less than half were advised by a health provider. This result indicates a gap in nutritional counseling of mother by health staff, which needs to be addressed. Ideally, all lactating mothers must be advised exclusive breastfeeding for at least 6 month.

2.1.6. MANY ADVISED FOR WEANING

38% were advised to wean with home-made foods along with breast milk from 3-4 months. 27% were advised commercial baby-foods along with breast milk from 3-4 months.

2.1.7. FEW HAD SEEN PROMOTIONAL MESSAGE OF FORMULA MILK

11% mothers had seen or read about promotional/ advertisement campaign of companies selling or manufacturing infant formula, baby food, bottles and teats. This is a violation of article 04 of the international Code dealing with unethical marketing strategies and especially with Information and Material which promotes the use of formula milk. There was significant provincial variance ($p=0.000$) in promotional messages; it was high in Punjab (16%), nil in KP and 1% in Balochistan. There was not much difference between urban and rural areas.

Punjab	16
Sindh	7
KP	0
Balochistan	1
Urban	13
Rural	10

Table 3: Seen Promotional Message

2.1.8. PROMOTIONAL MESSAGE SEEN AT DOCTOR'S CLINIC

Among those who had seen a promotional advertisement, majority (66%) saw it at a doctor's or nurse's clinic or hospital or dispensary etc.There was significant difference in provinces; same in Punjab (35%) and Sindh (33%); none reported in KP and all reported seeing message in doctor's clinic in Balochistan; little difference in urban rural areas.

Punjab	35
Sindh	33
KP	0
Balochistan	100
Urban	38
Rural	33

Table 4: Seen Promotional Message At Doctor's Clinic

2.1.9. PROMOTIONAL MESSAGE SEEN ONTELEVISION

Out of those 11% who have seen/read the promotional messages of infant formula, most said they have seen it on TV. No significant difference was seen in provinces and in urban/rural.This is indicative of the violation of the article 11 and 08.

Punjab	98
Sindh	100
KP	94
Balochistan	100
Urban	100
Rural	97

Table 5: Seen Promotional Message on Television

2.1.10. FEW HAVE HAD FREE SAMPLES OR GIFTS

Three percent of all mothers interviewed, reported receiving free sample during last 6 months for their infants. These samples were mainly given by doctors (56%) or nurses (13%). 19% received them from other health workers; 8% said that they were given by a representative of company and 4% received from a shop owner or pharmacist.

There was a provincial level difference in free samples given by doctors; where none in KP, half of the respondents in other three provinces had free samples from doctors.

Punjab	57
Sindh	44
KP	0
Balochistan	50

Table 6: Free Samples By Doctors

2.1.11. MOST MOTHERS AWARE OF EARLY INITIATION OF BREASTFEEDING

80% of mothers interviewed said that breast-feeding should commence immediately after birth of the baby. There was however difference in provinces; in KP 100% said immediately after birth.

There was no significant difference between urban and rural residence on the knowledge of initiation of breastfeeding.

	Immediately	Within A Day	After A Day
Punjab	75	18	6
Sindh	79	16	4
KP	100	0	0
Balochistan	82	16	2
Urban	81	14	4
Rural	79	16	5

Table 7: Knowledge Of Initiation Of BreastFeeding

2.1.12. KNOWLEDGE OF DURATION OF BREASTFEEDING

A significant majority, 62% of mothers interviewed said that infants should be exclusively breastfed up to 5-6 months. But the proportion aware of 6 months exclusive breastfeeding was highest in KP (86%) and lowest in Punjab (58%).

There was no significant difference in urban and rural areas regarding knowledge of duration of exclusive breastfeeding.

	Exclusive Breastfeeding (5-6 Months)
Punjab	58
Sindh	63
KP	69
Balochistan	86
Urban	61
Rural	63

Table 8: Knowledge Of Duration Of Exclusive BreastFeeding

2.1.13. BREASTFEEDING PRACTICES

About 73% of mothers interviewed said their infant is being given only breast milk up to the age of 6 months. It was highest in KP (87%) and lowest in Balochistan (60%). There was a gap in knowledge and practices as although 86% mothers in Balochistan knew that exclusive breastfeeding must be sustained for up to the age of six months, only 60% were actually feeding their infants exclusively with breast milk.

There was a significant difference in exclusive breastfeeding rates among lactating mothers in urban versus rural areas. And exclusive breastfeeding was seen to be practiced more in rural areas (77%) as compared to urban areas (66%).

	Only Mothers Milk (%)	With Other Milk (%)
Punjab	69	23
Sindh	79	14
KP	87	13
Balochistan	60	40
Urban	66	25
Rural	77	18

Table 9: BreastFeeding Practices

Reasons quoted for not breast-feeding were insufficient milk production (39%), weak child (21%), sick child (12%) and poor health of mother (19%). About 4% worked outside and could not feed their baby and 4% said that child did not take their feed.

A kilo of infant formula is worth ten times the value of a kilo of milk powder. According to global marketing reports, the baby food market exceeds US$31 billion per annum. A formula-fed baby consumes 13 to 15 kg of formula in the first six months. Families who cannot afford the cost (on average 1,600 Soles = US$ 575) are forced to over-dilute the formula or use other milks, or introduce other foods before six months, thus leading to malnutrition, allergies and even death, because of diarrhoea. Physiologically, no more than 3% of newborns need formula[57].

In addition to this the breast feeding allows preventing diarrhoea, pneumonia and malnutrition directly and contributes in reducing cause-specific mortality and morbidity associated with ARI as well. Costs of travel, service and medication can be saved if exclusive breastfeeding is ensured through proper placement of measures including enforcement of International Code.

2.1.14. FEW MOTHERS ARE KEY DECISION MAKERS IN INFANT FEEDING

Only 44% mothers interviewed reported that they themselves are the decision makers in infant feeding. 22% said that doctors are the key influences, another 12% mentioned other health workers, and about 22% reported the family members and relatives to be the decision makers

	Mother Herself	Doctor	Mother-in-Law	Lady's Mother
Punjab	43	24	6	5
Sindh	35	26	14	10
KP	62	10	16	1
Balochistan	55	15	11	2
Urban	39	32	8	6
Rural	44	17	11	5

Table 10: Decision Making in Infant Feeding (all values are in %)

2.1.15. MAJORITY ADVISED BREASTFEEDING BY HEALTH PROVIDERS

84% mothers interviewed responded that they had been advised by a health care provider (HCP) to give breast milk to infant. There was some difference in provinces, but not much difference in urban and rural areas.

Punjab	82
Sindh	79
KP	100
Balochistan	85
Urban	82
Rural	85

Table 11: Advised BreastFeeding by HCP (%)

2.1.16. MANY DOCTORS REPORTED COMPANY REPVISITS

32% of health professionals reported they were visited by a representative of companies of Infant Formula or baby Foods in last 6 months reflecting the violation of article 08 of International Code which spells out the ethical parameters of the working protocols for the persons engaged in promotion of BMS. Also a violation of the article 06, 07 and 11. But there was significant difference in provinces with highest percentage in Balochistan (47%) and lowest in Sindh (25%). There was significant difference in urban (38%) and rural (20%). The company most frequently reported was Nestle (74%).

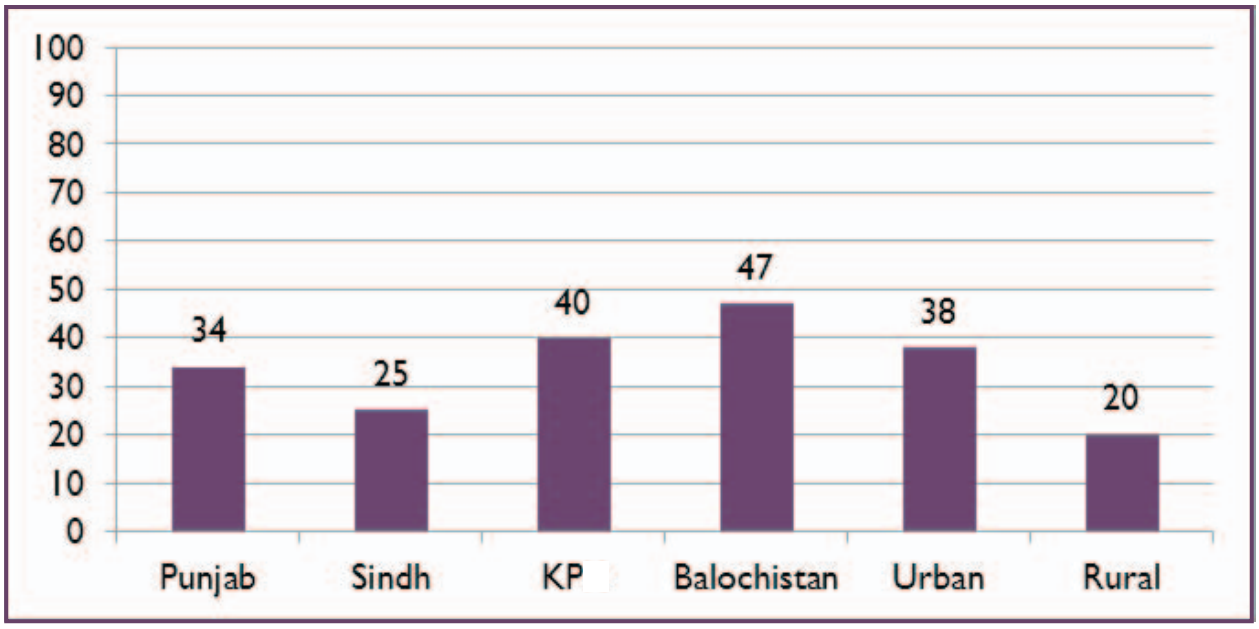

Figure 12: Doctors Having Visits By Company Reps (%)

2.1.17. MANY DOCTORS REPORTED MULTIPLEVISITS BY COMPANY REPS

There was significant difference in the number of visits by the company reps in various provinces. In KP majority (92%) reported just one visit; 47% of doctors in Sindh reported more than five visits; in KP no one reported five or more visits by company reps. This indicates that the marketing strategies of the breastmilk manufacturers are targeting parents and care givers keeping in view their ethnic, geographical, social and literacy aspects. They also target the health service providers who can then easily influence the parents and the care givers.

This indicates how much the companies are investing in promotion of formula milk and are in turn violating articles 04, 08 and 11 of the international Code.

	1 time	2 times	3 times	4 times	5 times	>5 times
Punjab	72	28	10	9	0	19
Sindh	44	33	10	23	11	47
KP	92	8	5	10	0	0
Balochistan	70	13	0	4	0	26
Urban	59	30	11	14	4	28
Rural	95	13	2	7	0	15

Table 12: Number Of Visits By Multiple Company Reps (%)

2.1.18. PURPOSE OFVISITS MOSTLY PRODUCT INFORMATION

Among those who were visited by company reps, 76% said the visit was for product information to health professionals. There was a significant difference in the purpose of visit in province and in urban versus rural areas.

In KP 90% reported that the purpose of the visit was to provide information to pregnant women; in Punjab majority (63%) reported that the purpose of visit was product information to health professionals.

Under article 08 and 11, the persons engaged by the manufacturers and distributors of the formula milk are forbidden to interact with the mothers of the infants and young children.

	To give information to pregnant women or mothers	To give product information to health professionals	To give samples to health professionals
Punjab	37	63	17
Sindh	6	41	5
KP	90	0	13
Balochistan	4	57	26
Urban	29	82	16
Rural	44	56	7

Table 13: Purpose Of Company Reps Visits (%)

2.1.19. HEALTH PROFESSIONALS RECIEVED GIFTS FROM COMPANIES

20% health professionals said that they have received some gifts from companies of infant formula, baby foods or feeding bottles. Most common gifts were note-pads, prescription pads, pens and calendars. Proportion is higher in Balochistan (33%); least in Sindh (15%).
This is a violation of the article 06, 07, 08 and the article 11.

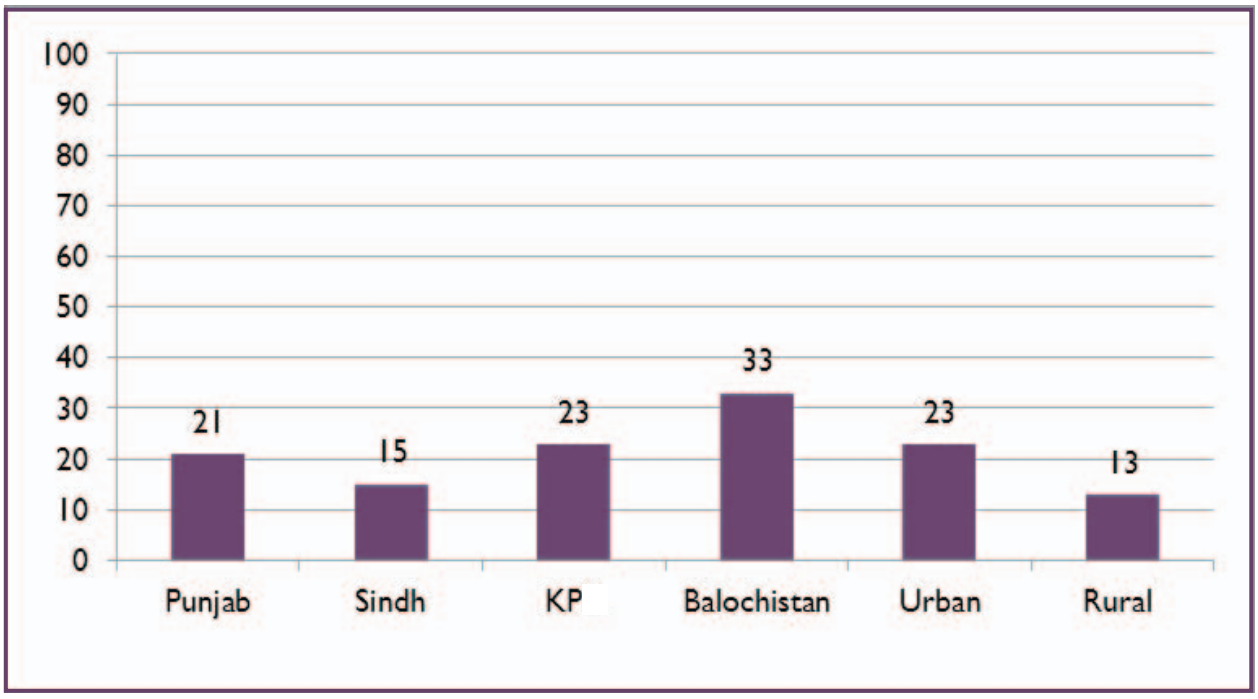

Figure 13: Received Gifts From Companies

2.1.20. FEW HEALTH FACILITIES RECEIVED FREE SAMPLES

10% of all health professionals said that their health facility was given free samples over last 6 months.

Punjab	10
Sindh	1
KP	2
Balochistan	27
Urban	7
Rural	9

Table 14: Facilities Receiving Samples (%)

2.1.21. MAJORITY HCP HAD KNOWLEDGE OF EARLY BREASTFEEDING

About 87% HCP said that breast-feeding should commence immediately after birth of baby. This proportion was highest in KP (99%) with almost similar (87%) in other Provinces.

Punjab	87
Sindh	85
KP	99
Balochistan	86
Urban	87
Rural	88

Table 15: Breastfeed immediately After Birth (%)

2.1.22. KNOWLEDGE OF EXCLUSIVE BREASTFEEDING

Although majority of health professionals (67%) said infants should be exclusively breast-fed up to 5-6 months of age, 32% reported that exclusive breast-feeding up to 3-4 months of age is not a positive finding.

2.1.23. HAVE ADVISED MOTHERS ON BREASTFEEDING

95% of health professionals said they have advised mothers and pregnant women about breast-feeding. 83% said they had advised on exclusive breast-feeding up to 6 months of age. Majority of health professionals visited for the study (51%) said that they advise about mothers' milk and weaning with home-made foods from 4 months of age. 29% recommend breast-feeding and weaning with packaged baby foods from 4 months of age onwards. 11% were recommending bottle feeding in some form as well.

2.1.24. INFORMATION MATERIAL ON BREASTFEEDING IN HEALTH FACILITIES

Majority health facilities visited had some information material about breastfeeding. In most cases the material was targeted towards general public (81%) and in 33% cases, for health providers. But the situation in Balochistan was reported to be different, where 98% of information was targeted towards health providers.

2.1.25. COMPANY NAME ON INFO MATERIAL

In half the cases, information material had the company name on it. This proportion was very high in Balochistan (82%) and Sindh (71%); but lowest in KP (28%). This is a clear violation of the article 04 and 11 of the international Code.

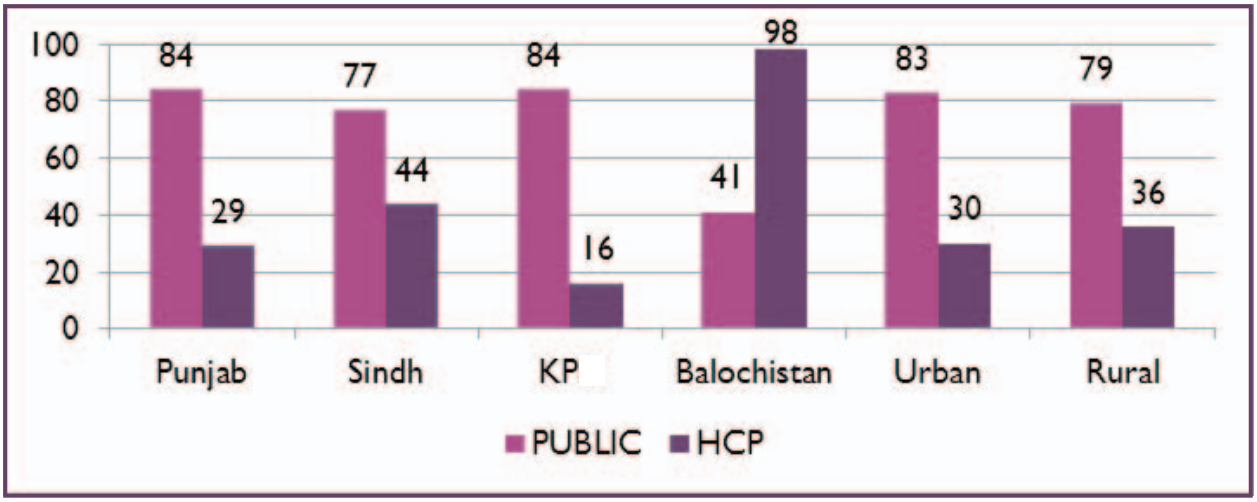

Figure 14: Target Audience Having Information

2.1.26. NAME OF THE PRODUCT

In 22% cases, even name of the product was also written in the information material available at the health facility. It included, name of infant formula (53%), baby food (26%), follow-on-formula (24%) and feeding-bottle (5%). This is violation of the article 09 of the international Code.

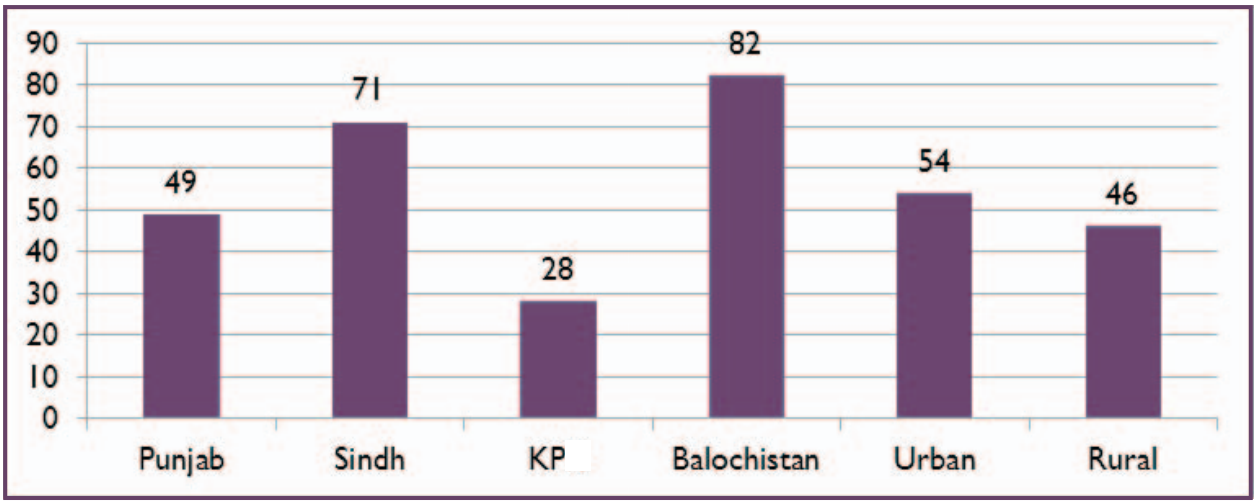

Figure 15: Company Name On Info Material

There was a significant provincial variation; in all the provinces except Balochistan. The product mentioned in most cases was follow-on formula, but in case of Balochistan it was infant formula. There was not much difference in urban and rural areas.

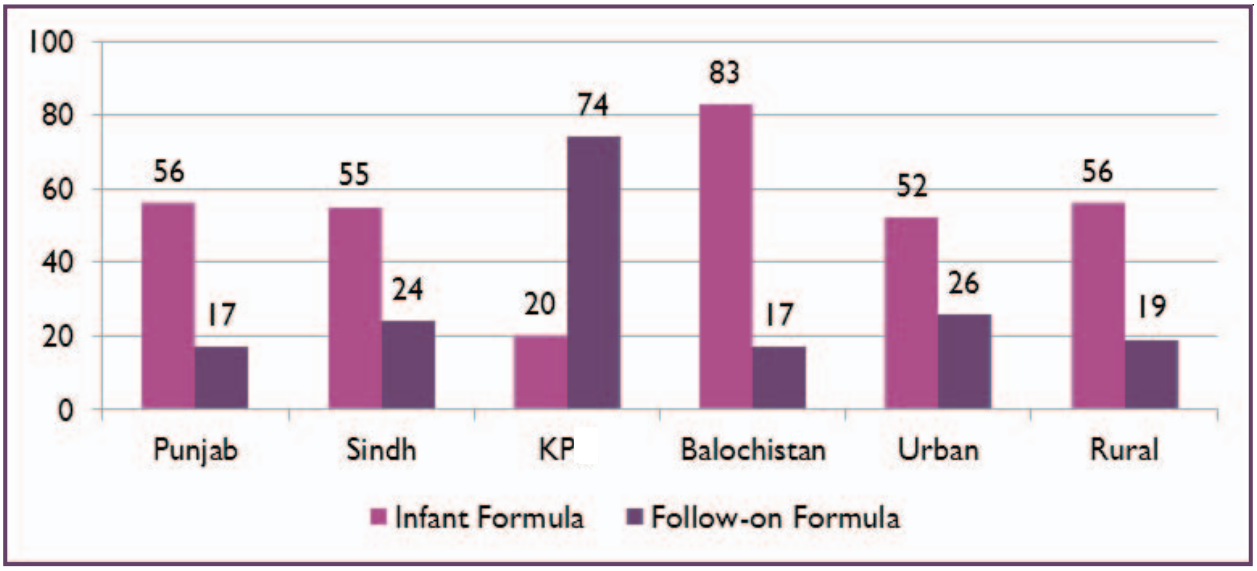

Figure 16: Name Of The Product

2.1.27. INFORMATION ABOUT IMPORTANCE OF BREASTFEEDING

82% items had pointed out the benefits and importance of breast-feeding. This is encouraging yet it can be calculated that the remaining 18 % have failed to comply with the article 09, 10 and 11 of the international Code.

2.1.28. INFORMATION THAT BOTTLE FEEDING IS GOOD

Interestingly, 82% of the information items observed in the study, mentioned that bottle feeding is as good or even superior to breast-feeding. And 57% regarded infant formula the best substitute of mothers' milk or superior to it. The proportion was highest in Balochistan. This is really alarming in terms of violation of the articles 09, 10 and 11 but more so in terms of jeopardising the prospects of breast feeding by changing the attitudes of mothers and family members during the decision making process. There was little difference between rural and urban areas.

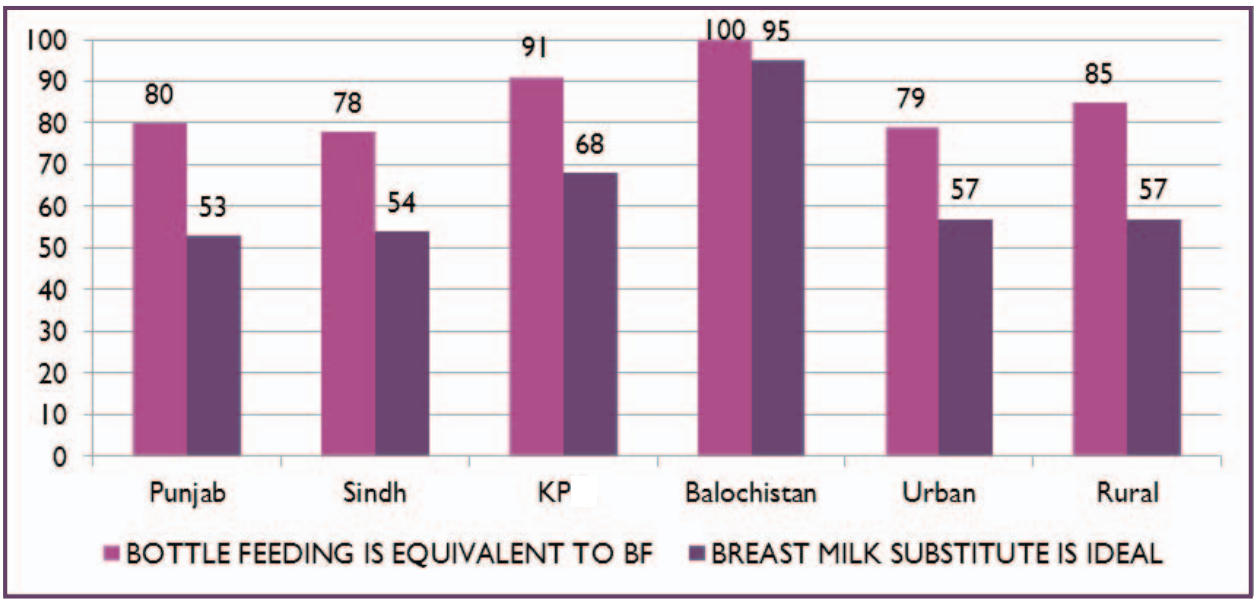

Figure 17: Information That Bottle Feed Is Good

3. OVERALL CONCLUSION OF QUANTITATIVE ASSESSMENT

A very large proportion of mothers (84%) interviewed reported that they were advised to use formula milk /other milk or food for infant under 6 months of age. There was significant difference among provinces, highest in KP (90%) followed by Baluchistan (68%), but there was no difference among rural and urban regions. This highlights the need to discourage the promotion of formula milk in community. Health providers are one of the agents who recommend formula milk. It may be due to the fact that they think formula milk is better and more useful, but importance of breast feeding initiation, exclusive breastfeeding and sustaining breastfeeding for 24 months stands like a universal truth. This can be seen in terms of scientific evidence supporting its importance, its naturally balanced composition and its suitability for optimal feeding, growth and development.

This trend of doctors recommending formula milk was highest in Baluchistan and lowest in Sindh. More doctors were providing the same recommendation in the urban as compared to the rural areas. Not only were these doctors persuading mothers to use formula milk, they were also in the lead to recommend a specific brand to mothers, making it more evident that there is a strong connection between medical practitioners and formula milk companies. This was same in all provinces, and Nestle was in the lead in terms of approaching medical practitioners for promotions.

Among mothers who reported to have received advice for exclusive breast feeding, 27% were also advised to use commercial baby food along with breastfeeding from 3-4 months. This is a clear violation of article 07 specifically the article 7.1, 7.2. 7.4 of the Code. All technical entities and research organizations working for the child health rights as well as advocacy campaigns including the UNICEF, WHO, Lancet and SNL (Saving Newborn Lives) suggest exclusive breastfeeding and give anything else to the infants for 6 months after birth[58].

11% mothers reported to have seen promotional messages of formula milk and other products and most of them have seen these promotional messages at clinics (doctors or nurses), hospitals or dispensary etc. There was little difference in rural and urban areas. Among those who saw promotional messages of infant formula, most had seen them on TV making it the most important source of advertisement by companies. 3% mothers reported receiving free samples in last 6 months for their infants and majority of these samples were given by doctors and nurses. Although majority of the mothers responded that breastfeeding should be initiated immediately after the birth of the baby, there was a gap in knowledge and practices regarding exclusive breastfeeding. Exclusive breastfeeding was more common in rural areas as compared to urban areas. Most common reasons reported for not breast feeding were insufficient milk production, weak child, poor health of mother, outside work by mother. The same proportion responded that child did not take their feed. One important finding was that only 44% mothers reported to be the key decision makers in infant feeding followed by doctors and other health workers.

Only 2% doctors said they were visited by a company representative in the last 6 months. It was significantly different in provinces but this difference was not significant in rural/urban areas. Nestle made the most visits and76% of the respondents reported that the purpose of the visit was product promotion. There was a significant difference in the purpose of visit between provinces and in urban versus rural areas. In KP 90% of the respondents reported that the purpose of the visit was to provide information to pregnant women. In Punjab majority (63%) of the visits were for product information to health professionals. Some health professionals received gifts from companies and few received free samples in last 6 months as well. Although majority of the health

professionals (67%) said infants should be exclusively breast-fed up to 5-6 months of age, 32% said exclusive breast-feeding up to 3-4 months of age which is not a positive finding.

Mostly health professionals said they have advised mothers and pregnant women about breast-feeding, but a majority of health professionals said they advised breast-feeding along with weaning with packaged baby foods from 4 months of age onwards. This again is in contradiction of the exclusive breastfeeding needs for 6 months. What was shocking was that 11%of these health professionals actually recommended bottle feeding. Majority of the health facilities visited had some information material about breastfeeding, but the material had some company's name on it along with the name of a BMS product. This is in violation of the article 09 of the Code. It included, name of infant formula, baby food, follow-on-formula and feeding-bottle.

Interestingly, information available at health facility mentioned that bottle-feeding was as good or even superior to breast-feeding which again is in contradiction to the articles 01, 04, 05, 06, 07, 08, 09, and 11 of the international Code. 57% of the material even regarded infant formula the best substitute of mothers' milk. The proportion was highest in Balochistan.

Kausar, 21, from District Muzaffargarh, breastfeeds her 5 month old baby

4. QUALITATIVE ASSESSMENT

4.1. FINDINGS FROM THE QUALITATIVE ASSESSMENT

4.1.1. UNDERSTANDING OF CODE AMONG HEALTH OFFICIALS

The sharing of information on the Code, Breast Feeding Ordinance (2002) and Rules (2009) among stakeholders were found to be scarce. Majority of the respondents were found to be unaware of Breastfeeding Protection Laws, the National Infant Feeding Board and Provincial Health Committees. Only 20% health professionals who worked either at provincial level technical positions or managerial levels at districts had heard about the Code, the Breastfeeding Protection Ordinance and Breastfeeding Rule.

During the Key Informant Interviews held with the focal persons working in nutrition at district level and paediatricians working at both secondary and tertiary care hospitals, it was realized that their information pertaining to the Code, Ordinance and Rule is very limited, to its use as a tool for precluding the breast milk substitutes during infancy and childhood. They could not articulate on the varying aspects of the Code including its essence with respect to protection of breastfeeding. Similarly their unawareness on the existence of National Board, Provincial Committees and district level committees is enough to conclude that the transmission of information and support for establishment of functional units for the effective implementation of the Law (Breastfeeding Protection) at district level has been inadequately addressed.

The focal persons working at district level in majority of the cases (60%) were found to be unaware of the legal status of the Breast Feeding Rule and Composition, Powers and Authority of the national infant board and provincial boards; characteristics of the international code and terms of reference set for the coordination. However those who remained engaged at some stages of the fruition of the Ordinance and Rules (40% working at national and provincial level only) shared information which was only related to status of the Ordinance and Rule with respect to fulfilment of obligations articulated in the international Code. Their information was limited to existence of a certain law and the national level adoption of the international Code. The findings from the KIIs is indicative that they also had improper and very often incomplete information with respect to functions of the board, roles and responsibilities and their own role in implementing the law at district level. When asked about the technical and financial assistance which may be required for the implementation of the law, the majority was found to say that it was the responsibility of the government to implement the law.

4.1.2. ENFORCEMENT OF THE CODE

Worth mentioning is the revelation that the paediatricians, gynaecologists, mothers and district health department staff were likely of the view that this (breastfeeding law) is a weak law and in their own opinion they exclaimed that like any other law in Pakistan it does not carry any forceful penalty in case of violation. There is no monitoring system in place for proper enforcement of the Code, and without proper monitoring and enforcement of the Code, there cannot be any implementation. One nutrition expert working at district level shared,

"This is an extremely weak law!!!! I know there have been many violations but no one has been arrested or penalized so far."(Nutrition expert)

Another one added,

"First of all I do not think that this law possesses ample power to grapple with the ones who are powerful. Even if it is, it has to be executed in a manner like other laws in this country are executed for dealing with fraud and violations of consumer rights."

This explains partly why the healthcare givers are least concerned with respect to their formal obligation for helping the mothers with early initiation of breastfeeding at all health facilities.

During the KIIs it was also revealed that there are neither district level committees nor any instruction provided by the provincial health department in past for formulation of such committees. Protection of breastfeeding is recognized essential by all stakeholders yet the responsibility of ensuring and monitoring the breastfeeding initiation; exclusive breastfeeding; complementary feeding and avoiding unnecessary indulgence of salesmen and promoters of breast milk substitutes at health facilities especially in NICUs and nursery is not explicitly framed. One of the key informants added,

"The non-availability of district level frameworks, action plans and monitoring mechanisms has led to the conclusion that both ordinance (2002) and rules (2009) of Breast Feeding Protection have been formulated to acquire the national level prestige. More has to be done on provincial and district level ranging from familiarization of district level stakeholders through establishment of committees to the level of active reporting (0n violations) and imposition of penalties to those who violate the law."(District Health Officer)

Both provinces and districts have not developed the strategies to ensure the optimal breastfeeding strategies. None of the hospitals visited (06 in total- 02 private) had the ten steps of breast feeding displayed in their labour rooms, maternity wards, nurseries or NICU. More than 80% of the secondary level hospitals and more than 50 % of the tertiary care hospitals did not have their staff member working in maternity oriented/trained in breastfeeding techniques. The formulations of task forces for regulation of use of formula milk are non-existent even at the provincial levels. The capacity of the staff has not been built up to desired level of competency based knowledge. One medical officer added,

"We as a nation are less sensitized on the preventive aspect. We can spend millions of rupees on projects in health but cannot implement a law to ensure the child survival."(Medical Officer DHQ Hospital)

With regards to availability of material for both promulgation of the Code, Ordinance and Rule, only few health facilities (less than 20%) had material available and displayed at prominent places but for breast feeding promotion, the district health departments did not have any information on development of material at provincial level. They also showed that lack of concern on non-availability of such material at health facilities. One of the district health officials (ADHO) said,

"No serious efforts have been made by senior management to stop the display of material given by the companies in our health facilities. The provincial health authority is responsible to provide us the information material and if they do not, we do not care. We have so many other things to do" (ADHO)

With respect to inspection of BMS for compliance with desired standards both in terms of nutritive values and promotion of breastfeeding with messages on those products, the health facility administrative staff and district health managers were of the view that it is beyond their job requirements. They also asserted that provincial authorities are responsible for ensuring compliance. They currently do not have any such

arrangements at district level. Adding on they said that reporting of violation and subsequent pursuance of legal actions is something that requires specific allocation of funds, recruitment and training of human resource and availability of infrastructure and material. Another doctor added,

"By God, only today I came to know that there is an international law for it and that Pakistan is signatory to"

Other female doctors added,

"I have been working for this nursery for the last 02 years and none of our staff has ever been trained on breastfeeding law."(Female Medical Officer Paeds)

Similarly the district health managers could not share any strategic plan, work plan or any other policy document relevant to protection and promotion of breastfeeding at district level.

4.1.3. PERCEPTION OF GENERAL PUBLIC ABOUT THE CODE

Most of the respondents during FGDs (among mothers, religious leaders and LHWs) were found to be completely unaware of the Code, Ordinance and the Rules with a very few exceptions of LHWs. They shared their concerns that such laws have been formulated and passed by the political leaders for their personal gains. They feared that such laws are not sufficiently substantiated with authority and power and that influentials (pointing towards healthcare givers) are not brought to book even if violations are reported. They showed their lack of understanding in their involvement in effective implementation of this law. They were found to be oblivious of the importance of this law with regards to the protection and promotion of breastfeeding.

Majority of respondents, however were seemingly cognizant of the importance of breastfeeding. However mothers (who recently had delivered at health facility) added that it has been learnt from the health professionals that soon after birth mothers fail to produce milk and that newborn cannot suck adequately to cope with loss of energy from his body. This kind of misguidance and scientifically incorrect information spread by the health professional compels the lactating women to buy the breast milk substitute thinking that the artificial milk products may contain all important ingredients needed by their newborns.

One of the lactating mothers who gave birth to a child of 3.3 kg at a local private hospital in DG Khan informed,

"I have breastfed all my children (03) within an hour. But this time I had to undergo operation (C-Section) and the doctor told my husband to buy milk for the newborn even before he was born. She (doctor) said that it may take a longer before you recover from unconsciousness (anaesthesia) and for that long we cannot keep your baby unfed."(Lactating Mother)

A significant proportion of mothers of newborn were approached by the promoters and salesmen directly who advised them to initiate artificial feeding. When asked about the measures taken by the government for Promulgation (of Code/ordinance and Rule) by province and districts, the district health managers informed that awareness among all pregnant and lactating mothers is being undertaken through ante-natal and post natal clinics and that regular sessions for health professionals are being held to promote and protect breast feeding yet the health managers in majority of the cases could not provide any means of verification including any work plan, report or attendance sheet for any such activity. They also admitted that no appropriate measures have been taken either at provincial or district level for the promulgation of this Law (Ordinance and Rule) among general public. The district health managers and hospital administrators were

also found to be in a state of confusion when asked about coordination with other departments for the effective implementation of this law. One of them said,

"How it is possible for two or three departments to coordinate such a law which is actually no one's responsibility right now because provincial authority has approved it?"

4.1.4. REGULATION OF THE PRIVATE SECTOR

This is yet another important reason for failure on part of district health departments that private sector itself is not regulated. Even if the law is implemented at public sector facilities, a significantly high number of infants born at the private health facilities would still be victimized with denial of their right to have access to only quality food which is breast milk.

4.1.5. LACK OF CAPACITY BUILDING MEASURES

When asked about the capacity building measures for strengthening the roles of committees and placement of inspectors at district level, the KII at district level did not have information to provide to the interviewer. They also do not have any correspondence with the provincial level authorities in this regard. The responses from the provincial level are indicative of the preliminary progress on formulation of terms of references for the inspectors. When asked about the issues and challenges after 18th amendment in implementation of this law, the respondents in KIIs asserted that the main challenge is of ownership and scarcity of human and financial resources. They vehemently said that the human resource was inadequately recruited with huge capacity building needs left unaddressed. Sharing of information by the national and provincial health departments is often delayed as well. They also showed their concerns over the fragmentation of ministries including health and population welfare and suggested to include various other stakeholders especially law and social welfare department in implementation of the law at district level.

In KIIs with district health administrative and managerial staff, it was shared that companies were found to have interaction with mothers of new-borns and children of less than 06 months of age directly.

"The promoters of the breast milk substitutes were also found to provide information on initiation of weaning foods instead of encouraging mothers to exclusively breastfeed their children by 06 months of age."(DMS DHQ Hospital)

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Although the proportion of mothers who were given samples of BMS by the salesmen directly is very small, yet a significantly high proportion has seen and understood the messages aired on TV or displayed at important sites including the clinics of paediatricians critically influencing their concerns pertaining to the health of their child. There appears to be no legislation which could prohibit the un-ethical advertising of breast milk substitutes. The respondents in FGD held with religious leaders and health facility staff separately in two rural settings were of the view that spending of the government on health promotion of breast feeding is seemingly less financed in comparison to what is being spent by BMS companies. One of the senior medical officers at a THQ hospital said,

"Look, it is fairly understood that companies like Nestle have been spending a lot on promotion of their products. They come here, provide us samples, material and even in some cases equipment but we do not know what portion of budget in annual allocation is there for protection and promotion of breastfeeding. We do not have separate staff who could be engaged in counselling the mothers for breast feeding nor do we have incentives for that…."(SMO,THQ Hospital)

4.2. ADDITIONAL BARRIERS FOR BREAST FEEDING PRACTICES

4.2.1. INDIVIDUAL LEVEL FACTORS (MOTHERAND INFANT)

Perception that the baby is weak: Most mothers, if they think that their baby is weak, will revert to formula milk. Many respondents shared the fact that mothers keep coming to GPs and paediatricians asking about best milk substitutes for their child who they think is weak not growing strong.

Perception that Mother is weak: There is strong chance that if mother has some medical problem or if she is considered to be weak, substitute milk will be used. This is common in rural areas. Families don't allow breastfeeding by weak mothers and those having even minor levels of medical problems.

Repeated Pregnancies: Due to problem of repeated pregnancies, most mothers could not complete the 2 years duration of breastfeeding. So chances are that first and second baby will not be breast fed for two years.

Gender of Baby: Most respondents said rates of breastfeeding may be less in case of female baby; especially mean duration of breastfeeding is usually less in girl child.

Hospital Delivery/Caesarean: In case of operation, usually resulting due to a delivery complication, chances are that baby will be given formula milk. This is coupled by another fact that most neonatal wards are targeted by the formula milk industry. So chances of breastfeeding become less in a hospital setting. One more reason being that there is a delay in the mother and infant contact in admitted cases. So most hospital based deliveries end up in formula milk initiation for infant.

Working Mothers: In Pakistan female labour force participation is increasing but little attention is paid to workplace lactation support programmes for working mothers who breastfeed. Working mothers find it difficult to continue their breastfeeding practices. Studies conducted among lactating mothers have indicated that the lack of supportive measures at workplace settings, including availability of breastfeeding breaks, privacy to express breast milk, employers' support towards breastfeeding, and flexibility in duty hours, leads to discontinuation of breastfeeding among working mothers[59,60].

In Pakistan maternity leave is 12 weeks, with only six weeks after birth and mothers need to report back to job within six weeks of delivery, and with no policy practices supporting lactating mother at work for on-site breastfeeding, they have to substitute for breast milk. The fear that it will be difficult to substitute breast feeding later, compels them to start using formula milk even earlier than six weeks. That may be one reason that women with higher level of educations have lower rates of breastfeeding in Pakistan. Another reason for lower breastfeeding among educated and working mothers may be a higher interaction with the formula milk companies through advertisements, thus there is a direct effect of promotion altering their choice.

4.2.2. FAMILY LEVEL FACTORS

Family Income: Affordability to purchase formula milk decreases the chances of breastfeeding, and more so for exclusive or complete breastfeeding. The notion that formula milk is of higher quality, and aggressive marketing campaigns by formula milk companies, link it with higher perceived social class and even the lower income families get attracted. Most respondents said that breastfeeding rates are lower in affluent educated and urban resident mothers, as compared to rural, poor women. So there has to be a link between affordability of bottle feed and breastfeeding.

Child care: children being cared by someone other than mother, have more chances of using milk

Hasina 23, and Ali Hassan, 3 from Muradabad, District Muzaffargarh.

substitutes.

Women Empowerment: This study's findings reported only 44% mothers saying that they have decision making role in household, common finding is that mothers have very less decision space in such matters. Even the decision of feeding breast milk is taken by head of household and other members of family.

Family's contact with health providers: The more the family is in contact with doctors, the more are the chances of using formula milk. There is strong evidence that doctors and practitioners influence decisions of infant feeding. Doctors have been working as accomplices of formula milk industry and the more women have interaction with doctors, the less the chances of breastfeeding. Women having more interaction with health providers are more likely to bottle feed and use formula milk.

Residential Location: most respondents stated that communities of high income localities are more inclined towards formula milk. This is also linked to issue of affordability, baby care being done by house maid, working mothers and busy social life of mothers.

5. RECOMMENDATIONS

5.1. ADVOCACY CAMPAIGN BY CIVIL SOCIETY

Advocacy must be focussed on breastfeeding as a right of every infant and every child under the age of two years. Starting from notables of community especially targeting men (fathers), local leaders, grandmothers and wider communities must be involved for promoting early initiation of breastfeeding, exclusive breastfeeding for six months and continuation of breastfeeding till two years.

5.1.1. Sustained national level advocacy and BCC campaigns and programmes to spread messages about benefits of breastfeeding must be done. These campaigns must include local language in TV, radio, shows, newspapers, magazines and billboards advertising, as well as community-level work such as counseling and village support groups.

5.1.2. Religious leaders in Pakistan can play a vital role in this advocacy as the Holy Quran has advised breastfeeding for two years. This must be used in all advocacy campaigns and religious leaders must be given detailed trainings on the Code.

5.1.3. Advocacy efforts should also be initiated by the civil society for the effective implementation of the Code/ Law or any other legislative framework (currently Protection of Breast Feeding Law 2009) coupled with formal submission of requests to the law enforcement agencies for imposition of fines and award of punishments for the violators as well as capacity building of all stakeholders engaged in implementation of Code.

5.1.4. Specific roles and responsibilities for public sector departments and civil society for advocacy campaigns at district level need to be chalked out and monitored.

5.2. IMPLEMENTATION OF BREASTFEEDING PROTECTION LAWS

5.2.1. Ministry of Health Services Regulation and Coordination Division (NHSRC) should assume stewardship role and develop monitoring mechanisms for proper enforcement of Code. The Federal law is applicable to ICT, FATA, Balochistan and KP as they have not enacted their own laws and the existing Protection of Breastfeeding rules, 2009 and Infant Feeding board also apply there.

5.2.2. Notification of Infant Feeding Board at Federal level under 2002 Ordinance and in Punjab and Sindh under their respective provincial laws will be helpful in implementation. Breastfeeding Rules 2009, provide operational details regarding prohibitions, guidance and compliance procedures.

5.2.3. Provincial laws call for establishing Infant Feeding Boards at the provincial level i.e. the Punjab and Sindh Infant Feeding Board to monitor implementation of the law. But Federal Government through its National Infant Feeding Board can still ensure compliance of BMS companies through establishment of a portal just like the one established at International Code Documentation Centre at IBFAN.

5.2.4. The provincial government must delegate powers to district health departments for protection of breast feeding through facility-based as well as community-based multi-sectoral interventions for prevention of unethical marketing at health facilities including private health facilities and clinics.

5.2.5. Warnings must be prominent and in local language.

5.2.6. All doctors must be reached through the Pakistan Medical Association (PMA), Pakistan Paediatric Association (PPA), Family Physicians Association, CPSP, PMDC and use these forums to discourage prescription and advice of formula milk.

5.3. SUPPORTING WORKING MOTHERS

All employers should be bound by law to provide a 6 month maternity leave to mothers after delivery in order to practice exclusive breastfeeding.

With reference to supporting working mothers for promotion of breastfeeding, many interventions have proven successful in promoting breastfeeding rates among working mothers[61]. Some of these interventions include:

- Educating and guiding working mothers about breastfeeding[62];
- Enhancing employers' awareness about importance of breastfeeding[63,64];
- Arranging physical facilities for the breastfeeding support at workplace[65];
- Flexibility in work environment for lactating mothers[66,67];
- Developing a mother and baby friendly policy at work[68,69].

A child looks on as he is being breastfed by his mother during Save the Children's Nutrition Awareness-raising sessions held in District Muzaffargarh; helping to empower women and improve the health of their children and themselves.

ANNEX-I
INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES[70]

Aim: To protect and promote breastfeeding by ensuring appropriate marketing and distribution of breast-milk substitutes.

Scope: Breast-milk substitutes, when marketed or otherwise represented as a partial or total replacement for breast milk. These can include food and beverages such as: infant formula, other milk products, cereals for infants, vegetable mixes, baby teas and juices, and follow-up milks. The Code also applies to feeding bottles and teats. It also protects and supports those who are not breastfed by ensuring that their care givers are provided with correct information, e.g. through labeling specifications.

Advertising: No advertising of above products to the public.

Samples: No free samples to mothers, their families or health workers.

Healthcare facilities: No promotion of products, i.e, no product displays, posters or distribution of promotional materials. No use of company-paidpersonnel. Health authorities are encouraged to promote breastfeeding, discourage use of infant formula and ensure that only authorised personnel demonstrate to pregnant mothers the correct use of formula and the potential hazards of its use.

Health workers: No gifts or samples to healthworkers. Product information must be factual and scientific. Distributors and manufacturers should disclose to the employers of healthcare workers any contributions made in-kind, and must not take on any type of educational role unless granted government permission.

Supplies: No free or low-cost supplies of breast-milk substitutes to any part of healthcare system.

Information: Information and educational materials must explain the benefits of breastfeeding, health hazards associated with bottle-feeding, the difficulty of reverting back to breastfeeding, the costs of using infant formula and, where applicable, the proper use of infant formula.

Labels: Product labels must clearly state the superiority of breastfeeding, the need for the advice of a health worker and a warning about health hazards, and be written in the local language. No pictures of infants, or other pictures or text idealising the use of infant formula.

Products: Unsuitable products, such as sweetened condensed milk, should not be promoted for infants. All products should be of a high quality, have expiration dates, and take account of the climatic and storage conditions for the country where they are used. A number of subsequent WHA resolutions adopted in the intervening years addressed and continue to address the marketing of breast-milk substitutes as described on the following page.

World Health Assembly Resolutions:

As previously noted, a number of World Health Assembly resolutions have been adopted in the intervening years to supplement the Code and provide greater guidance and clarity as to its interpretation:

(f) 1981: Resolution 34.22 emphasises adherence to the Code as a minimum standard to which states should adhere, and urges signatories to implement the Code in their territories via legislation, regulation or other measures.

(g) 1982: Resolution 35.26 recognises that commercial advocacy of breast-milk substitutes can contribute to increased artificial feeding. The Resolution reinforces previous calls to signatory states to implement and monitor the Code.

(h) 1984: Resolution 37.30 requests that the Director-General of WHO work with Member States to implement and monitor the Code. The Director-General was also asked to examine further the promotion and use of unsuitable foods for children.

(i) 1986: Resolution 39.28 urges Code signatories to ensure that in those cases where breastmilk substitutes are required, they are provided through normal channels and not freely or at a reduced price. Further, the Resolution calls on Member States to refrain from promoting any food or drink before breastfeeding (potentially interfering with breastfeeding), and deems follow-up milks "not necessary".

(j) 1988: Resolution 41.11 requests the WHO Director-General to provide legal and technical assistance to Member States in their transposition of the Code into appropriate national norms.

(k) 1990: Resolution 43.3 highlights the WHO/ UNICEF statement on "protecting, promoting and supporting breastfeeding: the special role of maternity services". The Resolution further urges signatories to ensure that all national legislation and health policy fully expresses the stated aims and principles of the Code.

(l) 1992: Resolution 45.34 reaffirms the Code's role as a minimum standard and, building on the aforementioned statement of Resolution 43.3, welcomes the adoption of the WHO/UNICEF 'baby-friendly' hospital initiative, whose focus is the positive role that health services play in the protection, promotion and support of breastfeeding.

(m) 1994: Resolution 47.5 reiterates previous calls to end "free or low cost supplies", and extends the scope of this provision to the entirety of the healthcare system. This call has the practical effect of superseding Article 6.6 of the Code. The Resolution also provides practical guidelines on the provision of breast-milk substitutes in emergency situations.

(n) 1996: Resolution 49.15 calls on governments to ensure that: complementary foods are not marketed so as to undermine the exclusive use of breastfeeding; healthcare professionals are not put in situations of conflict of interest and, crucially, that the monitoring of the Code and subsequent WHA Resolutions is conducted in an independent and transparent manner free from commercial influence.

(o) 2001: Resolution 54.2 establishes an international recommendation time frame of six months for exclusive breastfeeding, at which stage it calls for the introduction of safe or appropriate foods until a child reaches two years of age.

(p) 2002: Resolution 55.25 endorses the Global Strategy on Infant and Young Child Feeding. This strategy

advocates national policies that aim to create environments that protect, promote and support beneficial child feeding methods. It mandates that baby food producers comply with the Code and appropriate national provisions and ensure a uniform quality of their products. Further, the Resolution recognises the role of correct infant feeding in reducing the risk of obesity.

(q) 2005: Resolution 58.32 requests that signatories ensure that health claims for breast-milk substitutes are not permitted unless specifically allowed by law, and that states should be aware of the potential risks of contamination of formulas (and that this risk is correctly labeled) and ensure that this information is conveyed accordingly through label warnings. The Resolution further reiterates the need to ensure that child healthcare professionals' financial support or backing does not create conflicts of interest.

(r) 2006: Resolution 59.11 requests that Member States take measures to ensure that any response to the HIV pandemic (at the time) does not compromise compliance with the Code.

(s) 2007: Resolution 59.21 in the same year reiterates a request for ongoing WHO technical assistance to states to better enable them to implement and monitor the provisions of the Code.

(t) 2008: Resolution 61.14 endorses the action plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases. The Resolution includes the promotion of breastfeeding and complementary feeding as examples of key interventions to reduce risk factors for non-communicable diseases.

(u) 2009: Resolution 61.20 in the same year again urges signatories to improve efforts to monitor and enforce those national measures taken to implement the Code, and to avoid conflicts of interest in so doing. Importantly, the Resolution calls for an investigation of the safe use of donor milk through human milk banks for those children in need and for whom milk sources are otherwise unavailable.

(v) 2010: Resolution 63.14 calls on Member States to implement recommendations aimed at reducing the impact of marketing of 'junk' foods to children, and to follow guidelines to restrict such marketing where appropriate (for example, schools).

(w) 2011: Resolution 63.23 in the same year compels states to strengthen their degree of implementation into national legislation of the following documents: the Code, the relevant WHA Resolutions, the Global Strategy on Infant and Young Child Feeding, the Baby-Friendly Hospital Initiative and the Operational Guidance for Emergency Relief Staff and Programme Managers on Infant and Young Child Feeding in Emergencies. It also specifies that health and nutrition claims shall not be permitted, except where specifically provided for, in relevant Codex Alimentarius standards or national legislation.

(x) 2012: Resolution 65.6 requests WHO to provide clarification and guidance on the inappropriate promotion of foods for infants and young children cited in Resolution 63.23, taking into consideration the ongoing work of the Codex Alimentarius Commission and to "develop risk assessment, disclosure and management tools to safeguard against possible conflicts of interest in policy development and implementation of nutrition programmes consistent with WHO's overall policy and practice".

ANNEX-2
SALIENT FEATURES OF PROTECTION OF BREASTFEEDING ORDINANCE IN PAKISTAN

1. The Government shall take adequate measures to guarantee adequate and safe nutrition for infants through regulation of marketing of breast-milk substitutes.

2. There are clear instructions on labeling of breast-milk substitutes and complementary foods.

3. Health Workers are required to try their best to implement these rules. They should try to eliminate practices that retard initiation and continuation of breast-feeding.

4. Health Workers should not accept any gifts from Manufacturers or Distributors of Breast-milk Substitutes. They should not accept any samples of these products, nor give them to any person.

5. The Manufacturers and Distributors might give information about products to Health Professionals but it should be based on scientific facts. It should never imply that bottle feeding is superior to breast-feeding.

6. All such information items should have following information:
   - Benefits and superiority of breast-feeding
   - Preparation for and maintenance of breast-feeding including maternal nutrition
   - Adverse effects of introduction of bottle feeding on maintaining breast-feeding
   - Difficulty of reversal of decision to not breast-feed
   - Social and financial implications of bottle feeding
   - Detailed method of preparation of the product
   - Method of how to feed a baby with cup and spoon
   - Adverse effects of bottle feeding

7. Information items regarding complementary feed should state adverse effects of early introduction of complementary foods, how complementary foods can be prepared at home, and that they should be given to infants above 6 months of age and with a spoon not in a feeding bottle.

8. No items should contain name or logo of any particular manufacturer or distributor.

9. Only factual information should be given.

10. There should be no illustration that encourages bottle feeding or discourages breast-feeding.

11. Information should be in Urdu.

ANNEX-3
OBJECTIVES OF THE CODE VIOLATION SURVEY IN PAKISTAN

A national survey of 2400 mothers of infants up to 6 months of age, 1200 health professionals and health facilities spread across rural and urban areas of 4 main provinces of Pakistan was carried out by Save the Children through Gallup Pakistan during October, 2012.

The main objectives of the Code Violation Survey were:

1. What influences a mother to make her choices for feeding her new-born and up to 6 months of age? This includes the impact of the immediate surrounding on the women/family's decision making.

2. The role of government in bad feeding practices because they do not monitor Code violations or neglect to provide an enabling environment for mothers to breast-feed.

3. The role of companies who violate the Code, thus leading to bad feeding practices.

4. The impact of health practitioners who reinforce inappropriate recommendations.

5. Of particular interest is to what extent health workers are targeted by companies producing breast-milk substitutes (BMS), encouraging them to promote their products to mothers.

ANNEX-4
FIELD GUIDE FOR QUALITATIVE RESEARCH METHODS

1. General Information about respondents

2. Administration

1- Existence of National Infant Feeding Board and Provincial Infant Feeding Committees
   - i. Composition
   - ii. Characteristics
   - iii. Terms of Reference
   - iv. Powers and Authority
   - v. Coordination
   - vi. Functions and Roles & responsibilities
   - vii. Quorum of meetings and resolutions passed for the Implementation and Follow up
   - viii. Administrative, Technical and Financial Support available and required
   - ix. Declaration of No Conflict of Interest

2- Functionality
   - i. Reporting on performance
     - a. Coordination with line departments and legislative authorities
     - b. Monitoring mechanisms for violation of Code
     - c. Reporting Mechanisms for violation of Code
     - d. Number/Type of action taken on violation of Code
     - e. Record of formal requests made for donations in cash or in kind including breast milk substitutes
     - f. Record of Consultative meetings held with experts and advocates of nutrition, civil society, manufacturers and distributors of BMS and other ministries, line departments, religious leaders and teachers
   - ii. Development of national, provincial and district level strategies for promotion of breast feeding
   - iii. Development/Adaptation of information and education material for infant and young child feeding
   - iv. Involvement in public awareness programs on breastfeeding and young child feeding at community level

3- Capacity building, Strengthening and Monitoring of the Committee and Inspectors

4- Inspection measures taken by the Inspectors under patronage of Board or Committees
   - i. ToRs for inspection
   - ii. Roles and responsibilities off inspectors, educational qualification, trainings and technical capability
   - iii. Schedule of inspections
   - iv. Availability of Checklists/tools/ Log frames for inspections covering quality assurance, expiry, manufacturing, labeling, packaging and nutritional compatibility at
     - a. Plant
     - b. Markets
     - c. Health facilities

v. Reports generated
vi. Reporting channels
vii. Actions taken

5- Assessment of investigation process and legal support available
i. Initiation
ii. Filing of case
iii. Types of cases registered or in process
iv. Technical capacity of Board for the legal proceedings

6- Issues And Challenges including threats

3. Promulgation, Public Awareness and Prohibitions

1- Promulgation measures (of Code/ordinance and Rule) taken by province and districts
i. Awareness among end users i.e. pregnant and lactating mothers
ii. Awareness among health professionals
iii. Awareness among allied health staff
iv. Awareness among general public
v. Awareness among management staff at provincial and district level

2- Record of health professional orientation completed on Code/Ordinance/Rule

3- Record of mothers/care givers orientation completed on Code/Ordinance/Rule

4- Record of orientation workshops arranged by companies for their distributors and salesman on Code/Ordinance/Rule

5- Involvements of healthcare workers in promotion of designated products

6- Involvements of healthcare workers in distribution of designated products among women and children

7- Assessment of reporting mechanism at healthcare settings in case of violation of Ordinance and Int Code and action taken

8- Trainings/ Orientations conducted for the implementers

9- Availability and functions of Work force/Task force with-
i. Assignments/roles and responsibilities to check violations in desired specification in terms of sale, products, packaging, promotions and labelling
ii. Assignments for Assessment of conformity with desired standards
a. Essential messages related to breast feeding
b. Nutritional facts
c. Preparation Methods
d. Disadvantages and consequences
e. Benefits
f. Labeling

4. Information and Material

1. Submission of Information and material by manufacturers and distributors for approval with

the board and committees and status

2. Assessment of availability protocols, guidelines and tools with manufacturers and distributors for compliance with Int Code of marketing, Ordinance and Rule in I&M produced by the companies

3. Availability of material for promulgation of the ordinance and prohibitions at provincial and district level

4. Assessment of Availability of Code/ Rule/Ordinance at health facilities and information and guidelines and policy frameworks and awareness on such material in settings (private and public) where health service providers are working.

5. Assessment of Availability Breast Feeding Material for health workforce, Breastfeeding corners, IEC for parents at health facilities and information and guidelines and policy frameworks and awareness on such material in settings (private and public) where health service providers are working.

6. Assessment of availability and follow-up mechanisms of breastfeeding policy, breastfeeding rules, breastfeeding techniques and procedures and guidelines and steps of breastfeeding in hospitals

7. Assessment of in house training/orientations held on promotion of breastfeeding and detail of sponsorship

8. Inspection of donated material in maternal and paediatric wards, OPD, nursery and NICUs

9. Inspection for display of material directly or indirectly promoting the BMS and other foods

5. Violations

1- Assessment/ observation of Products for quality assurance and compliance with Rules 2009 and CODEX ALIMENTARIUS COMMISSION AND THE CODEX CODE OF HYGIENIC PRACTICE FOR FOODS FOR INFANTS AND CHILDREN FOR

i. Labeling
   a. Availability of Message(s) for promotion of breast feeding local language
   b. Importance of Mothers Milk
   c. Do not show words like "Humanized" or "Materialized"
   d. Do not show comparison with mothers' milk
   e. Do not show Graphics, Drawing or pictures of child, bottles to promote its use
   f. Correct method of preparation of milk
   g. Nutritional facts, composition and ingredients in Urdu
   h. Batch Number, Expiry date and Storage conditions
   i. Disadvantages and consequences
   j. Benefits

ii. Warning for Infant Formula Milk, Complementary Food and Milk Products, Bottle Feeding (Rule 10-1 a, b, c, d, e, f, 11-1, 11-2)

6. Penalties and Prosecutions

1- Assessment of official correspondence made to the manufacturers and distributors by the

board and committees or otherwise by Federal or provincial governments.

2- Record of Penalties imposed

3- Stay Orders against verdicts/ penalties

4- Gifts, contribution, sponsorship, financial assistance, non-financial incentives given to health workers

5- Assessment of Information and Education Material for in health facilities with and without visible messages on

i. Superiority of breast feeding
ii. The preparation for and maintenance of breast feeding and its importance
iii. The negative effects of both BMS on breastfeeding and introduction of bottle feeding
iv. The difficulty of reversing to breastfeeding once breastfeeding starts
v. Health hazards of bottle feeding
vi. The social and financial implications of feeding with a product
vii. The health hazards of improper feeding/ unnecessary feeding with breast milk substitutes
viii. How to feed with cup and spoon
ix. The health hazards of complementary feed in early stages]
x. Promotion of home-made complementary foods and importance
xi. Age limits (above 06 months)
xii. Presence of graphics, pictures and drawings which may allure the caregivers and mothers for BMS use
xiii. Logos- should not contain
xiv. Language-should be in simple, easy to under Urdu

ENDNOTES

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CODEVIOLATION SURVEY IN PAKISTAN

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OVERALL CONCLUSION OF QUANTITATIVE ASSESSMENT

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BREASTFEEDING

A Roadmap to Promotion & Protection

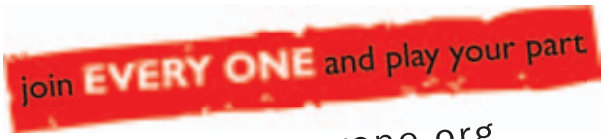
Breastfeeding is an amazing way to protect babies. Quite simply, it saves lives. It's the most effective approach to preventing the diseases and malnutrition that cause child deaths.

But breastfeeding is undervalued. Progress made in the 1980s in increasing breastfeeding rates has almost stalled. And in some countries, it's in reverse.

The four major barriers that prevent mothers from breastfeeding and to support mothers from breastfeeding are examined: community and cultural pressures; the shortage of health workers; lack of maternity legislation; and inappropriate promotion of breast-milk substitues.

We are Asking for:

- An increase in the number of health workers and vaccinators with provision of better training and incentives.
- Scaling up of routine immunization to reach marginalised areas.
- An adoption of policies and scaling up of investments to improve child nutrition.
- An increase in resource allocation towards social protection schemes (like Benazir Income Support Program and Bait-ul-Maal) with a focus on nutrition outcomes.



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