

The International Code in relation to agreements of the World Trade Organisation: health versus trade interests

Trade has an impact on health in various ways. In its preamble, the World Trade Organisation (WTO) states that free trade should contribute to an improvement in the standard of living. This suggests that liberalisation of trade should not be regarded as a goal in itself. Unfortunately, the WTO's first real objective is to facilitate international trade, especially for the richer, industrialised world. Because of its enforcement mechanism (i.e. its authority to impose trade sanctions), the WTO is regarded as having more power than other multilateral organisations such as the World Health Organisation (WHO). The WTO is therefore not only a growing influence in world trade, but is also "set to become one of the most important influences on international health today"¹.

"The International Code of Marketing of Breast-milk Substitutes and relevant subsequent World Health Assembly (WHA) resolutions should be totally and explicitly exempted from WTO trade agreements. In that way they cannot be challenged as being 'barriers to trade' on the basis of these agreements". This was the main conclusion of the participants of the expert meeting that took place in Amsterdam on 20 September 2001, organised by Wemos (Netherlands). Among the participants were international experts in the fields of 'WTO and consumer & health issues' and 'globalisation' and representatives of a number of IBFAN groups. The position of the Code² under the unfolding WTO regime and the options to strengthen the position and reaffirm the authority of the Code were discussed in this meeting. The following paragraphs reflect this discussion.

The Ministry of Trade can hamper Code implementation and enforcement, which is usually the responsibility of the Ministry of Health. There have been numerous cases where foreign infant food companies (or even the government of the country where the company is based; see Guatemala vs. Gerber case) and institutions like the International Monetary Fund and the World Bank have put such Ministries under pressure, with the threat of trade sanctions and other adverse economic consequences. There is as yet no sign that the WTO agreements form a direct threat to the Code. Threats to the Code are not so much to be expected at the level of formal WTO disputes, but rather at the level of bilateral 'behind-the-scenes' pressures using economic power. However, the WTO or WTO agreements have been used as arguments in such pressures, which is already bad enough news for further and effective Code implementation.

The so-called SPS and TBT agreements³ of the WTO acknowledge that governments have the right to take measures 'necessary' for the protection of human health. In these agreements Member States of the WTO are encouraged to base their measures on "international standards, guidelines or recommendations". The SPS agreement also explicitly refers to the Codex Alimentarius (food safety) standards. One of the key questions for the participants of the Amsterdam meeting was: would it be helpful if the Code were officially recognised in relevant WTO agreements?

At first sight one would say 'yes', because the WTO agreements are likely to outweigh decisions taken in the WHA, such as the Code, because of WTO's authority to impose sanctions. The industry might then have more respect for the Code. However, we see a number of dangers here. WTO is less transparent than UN organisations and heavily influenced by industry. Since the Codex Alimentarius is officially recognised under WTO there is an apparent shift from addressing public interests to facilitating trade (i.e. lowering trade barriers). Attempts to get the Code included in WTO agreements or standards may turn out to be counterproductive. In other words, the Code may then be transformed from a 'minimum requirement' (for governments to implement into a measure for the protection of health) to a 'maximum requirement' (that protects public health while posing minimal barriers to international trade).

The Code should be defended from a human rights perspective: that is that life and health are of an intrinsic value which should not be compromised by trade or commercial interests. Referring to the main conclusion of the Amsterdam meeting mentioned above (2nd paragraph), a possible strategy is to urge governments to amend to, or seek a clarification of, the relevant WTO agreements to ensure that provisions of the Code, and its subsequent WHA resolutions, are not subject to be challenged as trade barriers.

¹ "World Trade Organisation: Implications for Health Policy". Medact, Physicians for Social Responsibility, EPHA and Wemos (2000).

² Whenever 'the Code' is mentioned, it is in fact referring to The International Code of Marketing of Breast milk Substitutes and its relevant, subsequent WHA resolutions

³ SPS: *Agreement on the Application of Sanitary and Phyto-sanitary measures*
TBT: *Agreement on Technical Barriers to Trade*

Breastfeeding, why...

Betran AP, de Onis M, Lauer JA, Villar J. Ecological study of effect of breastfeeding on infant mortality in Latin America. *BMJ* 2001;323:303

To estimate the effect of exclusive breastfeeding and partial breastfeeding on infant mortality from diarrhoeal disease and acute respiratory infections in Latin America, national data on infant mortality and breastfeeding were analysed. About 55% of these deaths are preventable by exclusive breastfeeding among infants aged 0-3 months and partial breastfeeding throughout the remainder of infancy. Among infants aged 0-3 months, 66% of deaths from these causes are preventable by exclusive breastfeeding; among infants aged 4-11 months, 32% of such deaths are preventable by partial breastfeeding. Overall, 13.9% of infant deaths from all causes are preventable by these breastfeeding patterns. The annual number of preventable deaths is about 52,000 for the region. Interventions to promote exclusive breastfeeding should target younger infants.

Forste R, Weiss J, Lippincott E. The decision to breastfeed in the United States: does race matter? *Pediatrics* 2001;108:291-6

Black women in the USA are less likely to breastfeed than non-black women, and the primary reason for not breastfeeding is that they "prefer to bottle-feed." This is the result of a study carried out to estimate the effect of maternal and birth characteristics on the decision to breastfeed and to look at breastfeeding practices and their association to racial differences in infant mortality. After controlling for socio-economic background and birth characteristics, race remained a strong predictor of breastfeeding. Analyses of infant mortality indicated that breastfeeding and low birth weight account for the race difference in infant mortality. Efforts to increase breastfeeding in black communities should help narrowing the racial gap in infant mortality.

Arifeen SE, Black RE, Caulfield LE, Antelman G, Baqui AH. Determinants of infant growth in the slums of Dhaka: size and maturity at birth, breastfeeding and morbidity. *Eur J Clin Nutr* 2001;55:167-78

To investigate the influence of size at birth, breastfeeding and morbidity on growth during infancy in poor areas of urban Bangladesh, a cohort of 1654 newborn infants was followed until 12 months of age in slum areas of Dhaka; 1207 infants completed the follow-up. A positive impact of exclusive breastfeeding in the first 3-5 months on infant growth was detectable at 12 months of age. Although the bigger babies in the sample tended to grow relatively even bigger, exclusive breastfeeding appeared to counteract this pattern. Reported diarrhoea was associated with lower body weights and lengths even after adjusting for feeding patterns. The sustained effect on growth and the even more beneficial effect in lighter infants are compelling reasons for promotion of exclusive

breastfeeding in early infancy.

Villamor E, Mbise R, Spiegelman D, Ndossi G, Fawzi WW. Vitamin A supplementation and other predictors of anemia among children from Dar Es Salaam, Tanzania. *Am J Trop Med Hyg* 2000;62:590-7

The association of anemia with socio-economic factors, malaria, HIV infection, and nutritional status was examined among 687 children admitted to hospital with pneumonia. At baseline, haemoglobin concentration was positively associated with the number of possessions in the household, maternal level of education and quality of water supply, and inversely related to malaria infection after controlling for potential confounding variables. Children infected with HIV experienced a significant fall in mean haemoglobin levels over time. The risk of developing severe anemia (< 7 g/dL) during follow-up was lower for children who were breastfed for longer than 18 months as compared to those with less than 6 months of breastfeeding. Children with repeated diagnoses of malaria had 4.1 times the risk of developing severe anemia than did children without the diagnosis. Vitamin A supplements were associated with an overall non-significant reduction of 14% in the risk of developing severe anemia. The authors conclude that malaria, HIV infection, low socio-economic status, and short duration of breastfeeding are strong and independent determinants of anemia in this population.

Gdalevich M, Mimouni D, Mimouni M. Breastfeeding and the risk of bronchial asthma in childhood: a systematic review with meta-analysis of prospective studies. *J Pediatr* 2001;139:261-6

The authors carried out a systematic review of prospective studies that evaluated the association between exclusive breastfeeding during the first 3 months and asthma. Twelve studies that met pre-stated inclusion criteria were identified with a Medline search from 1966 to 1999. Overall, the risk of asthma was reduced by 30% (95% CI: 19% to 40%) with exclusive breastfeeding. The effect was greater (48%) in studies of children with a family history of atopy (rhinitis, eczema, asthma and other allergic reactions) than in studies of a combined population (27%). This review confirms that exclusive breastfeeding during the first months is associated with lower asthma rates during childhood. The effect, achieved through modulation of the immune system by breast milk, avoidance of allergens, or a combination of these and other factors, strengthens the advantage of exclusive breastfeeding, especially if a family history of atopy is present.

Karunasekera KA, Jayasinghe JA, Alwis LW. Risk factors of childhood asthma: a Sri Lankan study. *J Trop Pediatr* 2001;47:142-5

A case-control study was carried out to evaluate the genetic and environmental risk factors of childhood

asthma in a group of Sri Lankan children. Three hundred cases (admitted with symptoms of asthma) and 300 age-matched controls were compared. Parental asthma, asthma in a sibling and in a relative, parental allergic rhinitis, discontinuation of breastfeeding after 6 months in infancy, bronchiolitis in infancy, living in a dusty environment, and a father with primary education compared to secondary education were independently associated with an increased risk of asthma. This study reinforces the view that asthma has many causes. As a preventive measure, continuation of breastfeeding beyond 6 months is important.

Breastfeeding, how...

Kramer MS, Barr RG, Dagenais S, Yang H, Jones P, Ciofani L, Jané F. Pacifier use, early weaning, and cry/fuss behavior: a randomized controlled trial. *JAMA* 2001;286:322-6

Step 9 of the Baby Friendly Hospital Initiative strongly discourages the use of pacifiers because of its reported association, in several observational studies, with early weaning. But such studies are unable to determine whether the association is causal. To test whether regular pacifier use is causally related to weaning by 3 months postpartum, a double-blind randomised trial was conducted in the postpartum unit of a university hospital in Montreal, Quebec, Canada, on 281 healthy, breastfeeding women and their healthy, term singleton infants allocated to 1 of 2 groups. A nurse trained in lactation counselling recommended to avoid pacifier use and suggested alternative ways to comfort a crying or fussing infant to the women of the intervention group (IG; n = 140) but not to those of the control group (CG; n = 141). A total of 258 mother-infant pairs (92%) completed the follow-up. Compared to CG, women in the IG significantly increased total avoidance of pacifier use (38.6% vs 16.0%), reduced daily use (40.8% vs 55.7%), and decreased the mean number of pacifier insertions per day (0.8 vs 2.4 at 4 weeks; 0.8 vs 3.0 at 6 weeks; and 1.3 vs 3.0 at 9 weeks). In the analysis based on random allocation, the intervention had no discernible effect on weaning at 3 months (18.9% vs 18.3%), and no effect was observed on cry/fuss behavior. When random allocation was ignored, however, a strong association between exposure to daily pacifier use and weaning by 3 months was observed (25.0% in the exposed vs 12.9% in the non exposed infants). These results strongly suggest that pacifier use is a marker of breastfeeding difficulties or reduced motivation to breastfeed, rather than a true cause of early weaning.

Hornell A, Hofvander Y, Kylberg E. Introduction of solids and formula to breastfed infants: a longitudinal prospective study in Uppsala, Sweden. *Acta Paediatr* 2001;90:477-82

The introduction of solids and formula was studied among 506 breastfed infants in Uppsala, Sweden, based on daily recordings during the first year. The mothers had previously breastfed at least one infant for at least 4 months. Thirty-four per cent of the infants were introduced to solids before the age of 4 months (4-6

months is recommended in Sweden). Accustoming the infants to solids was a lengthy process: it took a median of 28 days from the first introduction of solids to consumption of more than 10 ml daily, and 46 days before the infants ate 100 ml or more of solids in one day for the first time. These durations were longer the younger the infant was at the introduction of solids. Thirty-two per cent of infants given formula consumed 100 ml or more the first time it was given, and 49% did so within one week, regardless of infant age. Parents and healthcare personnel need to be aware that accustoming breastfed infants to solid food is a lengthy process, and that there is a strong age effect on this duration. It is also important to consider what consequences the (usually) more abrupt introduction of formula might have on breastfeeding.

Black MM, Siegel EH, Abel Y, Bentley ME. Home and videotape intervention delays early complementary feeding among adolescent mothers. *Pediatrics* 2001;107:E67

Is it possible to change feeding habits in the presence of contradictory cultural norms? To evaluate the effect of an intervention to delay the early introduction of complementary feeding, 181 first-time, low-income, black mothers less than 18 years old, were recruited from 3 urban hospitals in Baltimore, Maryland, USA. Infants were born at term, with birth weight appropriate for gestational age and no congenital problems. Shortly after delivery, mothers and grandmothers completed a baseline assessment, and mothers were randomized into an intervention (IG) or control group (CG). IG mothers received home visits every other week for 1 year, plus a videotape made by an advisory group of black adolescent mothers. The intervention focused on: 1) recognition of infants' cues; 2) non-food strategies for managing infant behaviour; and 3) mother-grandmother negotiation strategies. At 3 months, a subset of 121 mothers reported on their infant's intake through a food frequency questionnaire. Mothers who fed their infant only breast milk, formula, or water were classified as optimal feeders (39%); those who added complementary foods were classified as less optimal feeders (61%). After controlling for infant age and family income, mothers of infants in the optimal feeders group were more likely to report accurate messages regarding the timing of complementary food and nearly four times more likely to be in the intervention group. The success of this intervention shows the importance of using ethnographic research to design programmes for behavioural change in the face of contradictory cultural norms.

DiGirolamo AM, Grummer-Strawn LM, Fein S. Maternity care practices: implications for breastfeeding. *Birth* 2001;28:94-100

To assess the impact of five Baby Friendly practices (early breastfeeding initiation, no supplements, rooming-in, breastfeeding on demand, no pacifiers) on breastfeeding in the USA, a longitudinal mail survey was administered to a national sample of women prenatally through 12 months postpartum. The study

focused on 1085 women with prenatal intention to breastfeed for more than 2 months who initiated breastfeeding. Only 7% of mothers experienced all five Baby Friendly practices. The strongest risk factors for early breastfeeding termination were late breastfeeding initiation and supplementing the infant. Compared with mothers experiencing all five Baby Friendly practices, mothers experiencing none were approximately eight times more likely to stop breastfeeding early. The need to work with hospitals to increase adoption of the Baby Friendly practices is illustrated by the small proportion of mothers who experienced all five practices measured in this study.

Scott J, Landers M, Hughes R, Binns C. Factors associated with breastfeeding at discharge and duration of breastfeeding. *J Paediatr Child Health* 2001;37:254-61

To identify determinants of the initiation and duration of breastfeeding amongst Australian women, a prospective cohort study was carried out in 556 women in Perth and 503 women from the Darling Downs area, Australia. Breastfeeding at discharge was most strongly associated with perceived paternal support of breastfeeding. Duration of breastfeeding was most strongly associated with the length of time a mother intended to breastfeed. Interventions that aim to increase the length of time a woman intends to breastfeed, and that highlight the role of the father in successful breastfeeding, are recommended to help achieve recommended targets for breastfeeding initiation and duration.

Sikorski J, Boyd F, Dezateux C, Wade A, Rowe J. Prevalence of breastfeeding at four months in general practices in south London. *Br J Gen Pract* 2001;51:445-50

To determine the prevalence of breastfeeding at birth and at four months in a sample of women from urban general practices, its variation between practices, and relation to practice population deprivation scores, a cross-sectional questionnaire survey based on a random cluster sample of women with infants aged four months in 25 general practices in South London was carried out. Responses were received from 1053 out of 1532 mothers (69%). Of these, 87% (897) had breastfed at birth, while 59% (609) were still breastfeeding their babies at four months. Mothers in rented accommodation were less likely to breastfeed than owner-occupiers, as were women of white, compared with those of black, ethnic origin. Those who completed up to two years and more than two years education after the age of 16 were almost three times more likely to

breastfeed at four months than mothers whose formal education was completed at or before 16 years. Practice-specific rates of breastfeeding ranged from 71% to 100% at birth and 22% to 83% at four months. Median age of starting solids was 16 weeks. It is concluded that housing tenure, maternal education, and ethnic group are significantly associated with breastfeeding prevalence at four months.

Tappin DM, Mackenzie JM, Brown AJ, Girdwood RW, Britten J, Broadfoot M. Comparison of breastfeeding rates in Scotland in 1990-1 and 1997-8. *BMJ* 2001;322:1335-6

In Scotland, breastfeeding at 7 days of age increased by 6.4%, from 35.6% in 1990-1 to 42.0% in 1997-8. The largest increase (11.5%) was seen in Edinburgh and the largest decrease (5.5%) in Aberdeen. About 2.6% of the observed 6.4% increase can be explained by increase in maternal age. The target of 50% breastfeeding at 6 weeks of age by 2005 will not be met unless further health promotion measures are implemented quickly.

Cochrane reviews

Snowden HM, Renfrew MJ, Woolridge MW. Treatments for breast engorgement during lactation (Cochrane Review). *Cochrane Database Syst Rev* 2001;2:CD000046

National surveys have shown that painful breasts are the second most common reason for giving up breastfeeding in the first two weeks after birth in the UK. One factor contributing to such pain can be breast engorgement. Views differ as to how engorgement arises, although restrictive feeding patterns in hospital are likely to have contributed in the past. These differing views are reflected in the range of solutions offered to treat engorgement in breastfeeding mothers, and these treatments are assessed in this review. Eight trials, involving 424 women, were included. Three different studies were identified which used cabbage leaves or cabbage leaf extracts; no overall benefit was found. Ultrasound treatment and placebo were equally effective. Use of Danzen (an anti-inflammatory agent) significantly improved the total symptoms of engorgement when compared to placebo as did bromelain/trypsin complex. Oxytocin and cold packs had no demonstrable effect on engorgement symptoms. Initial prevention of breast engorgement, through competent counselling on good latching, should remain the key priority.

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