

Health diplomacy and public policy in Nigeria: The impact of the International Code of Marketing of Breast Milk Substitutes

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Abstract

The relationship between diplomacy and improvement in health has been an important theme contained within the literature on governance and development since the end of the Cold War. While it is true that prospects for health development are enhanced through medical and public health knowledge and technology, several scholars have understood the link between diplomacy and social, political and economic development. This article examines this theme by analysing the connection between health diplomacy and the development of public policy in Nigeria. It traces and analyses the impact of the multilateral negotiation within the World Health Organization (WHO), notably the International Code of Marketing of Breast milk Substitutes, which was adopted to counter the adverse effects of infant formula. The article is descriptive and analytical. It has utilised various sources, including government records, reports of intergovernmental organisations, as well as information obtained from fieldwork conducted in the WHO headquarters in Geneva and in Nigeria between 2011 and 2012 to explore the contributions of the WHO to the development of Nigeria's health sector. The article argues that health diplomacy has been and remains a major influence on public policy in Nigeria. The article concludes that a religious implementation of the International Code of the Marketing of Breast Milk Substitutes would increase the breastfeeding rate in Nigeria.

Keywords: breastfeeding, breast milk substitutes, health diplomacy, Nigeria, public policy, World Health Organization

Sumário

A relação entre diplomacia e melhoria na saúde tem sido um tema importante contido na literatura sobre governação e desenvolvimento, desde o fim da Guerra Fria. Enquanto é verdade que o panorama de desenvolvimento de saúde fortalecido através do conhecimento médico e de saúde pública e tecnologia, vários eruditos perceberam a ligação entre diplomacia e desenvolvimento social, político e económico. O autor deste estudo, examina este tema analisando a conexão entre diplomacia na saúde e o desenvolvimento das políticas públicas na Nigéria.

Este traça e analisa o impacto da negociação multilateral dentro da Organização Mundial da Saúde (OMS), notavelmente o Código Internacional de Marketing de Substitutos do Leite Materno (ou leite do peito), que foi adoptado para conter os efeitos adversos da fórmula infantil. O estudo é descritivo e analítico e aplica várias fontes, incluindo arquivos do governo, relatórios de organizações inter-governamentais, assim como informação de trabalho de campo feito na

sede da OMS em Genebra e Nigéria entre 2011 e 2012, para explorar as contribuições da OMS no desenvolvimento do sector de saúde na Nigéria. O artigo argumenta que diplomacia na saúde foi e continua sendo uma grande influência nas políticas públicas na Nigéria. O artigo conclui que a implementação religiosa do Código Internacional de Marketing de Substitutos do Leite Materno poderia aumentar as taxas de aleitamento materno na Nigéria.

Palavras chave: aleitamento materno, substitutos de leite materno, diplomacia na saúde, Nigéria, políticas públicas, Organização Mundial da Saúde

Introduction

Breastfeeding has been recognised to be a crucial factor in the physical and mental development of the child. Breast milk is said to provide a form of immunisation against infection. It is also a natural form of family planning. Although these benefits and others have long been acknowledged, breastfeeding has declined considerably over the last two decades. This trend is associated with growing urbanisation with its concomitant absorption and adherence to modern tastes, which has encouraged mothers to adopt bottle-feeding. It has been argued that bottle-feeding threatens the lives of millions of children, particularly in the developing world. It is expensive and bottle fed children are said to be more likely malnourished and susceptible to diarrheal infections, arising from the use of unsafe water and unsterilised equipment when preparing the formula. This harmful practice should not be allowed to continue unchecked. To this end, several campaigns organised to defend and promote breastfeeding and to stop the spread of artificial substitutes, which gathered momentum during the 1980s. International efforts targeted the damaging marketing practices of infant formula manufacturers and also supported a worldwide boycott of company products (Global Health Watch 2, 2008).

The WHO, as the leading United Nations health agency, was not left out of this campaign to stop artificial feeding and to accomplish this task, the WHO relied heavily on its legal instrument. It is instructive to note that the Constitution of WHO provides for three legal instruments, namely conventions and agreements, regulations and recommendations. Article 2(k) of the constitution authorises the WHO to:

Propose conventions, agreements and regulations and make recommendations with respect to international health matters and to perform such duties as may be assigned by thereby to the Organisation and are consistent with its objective (WHO, Constitution of the World Health Organization, 1948)

The policy outcomes of these WHO instruments are clear examples of health diplomacy based on its global reach and its negotiation process. They are also examples of various state and non-state actors coming together to create a legally binding tool to govern global health. This has led Kickbusch *et al* to argue that global health diplomacy still takes place within the WHO (Kickbusch,



Silberschmidt, & Buss, 2007). A glaring manifestation of this was the multilateral negotiation that gave birth to the WHO International Code of the Marketing of Breast Milk Substitutes in 1981. The WHO Assembly adopted it as a recommendation.

It is a truism in international law that states are the most important actors. It is the responsibility of the states to translate an international agreement into national laws or policies and develop enforcement mechanisms. In fact, international agreements are mere blueprints for action but it is not until lawmakers put decisions into practice at home that they become functional. It is against this background that this paper examines the extent to which the WHO International Code of Marketing of Breast Milk Substitutes has influenced public policy, particularly health policies in Nigeria.

Conceptual and theoretical framework

Within the purview of this paper, two major concepts frequently recur: health diplomacy and public policy. Discussing the concept of health diplomacy requires a definition of the term in order to provide a perspective. Health diplomacy in international relations does not seem to have a specific meaning. As a matter of fact, it can vary in meaning according to the context in which it is used. It focuses on the linkage between health and foreign policy. It is also part of the 'new diplomacy' that emerged following the expansion of foreign policy into new sector and issues since the end of the Cold War (Lee & Gomez, 2011). This is not to say that the term is entirely novel in international relations. On the contrary, the practice of health diplomacy in the modern sense dates back to the second half of the 19th century; it only gained importance and popularity in the past two decades.

Health diplomacy has conjured disparate interpretations in the contemporary period. A proper understanding of health diplomacy is best done by a meticulous survey of its two broad conceptions. First are those definitions focusing on the field being driven by globalisation, diverse actors beyond nation states, health negotiations and the health impact of non-health negotiations. For example, Kickbusch *et al* defined health diplomacy as the "multi-level and multi-actor negotiation processes that shape and manage the global policy environment for health"(Kickbusch, Silberschmidt, & Buss, 2007, p. 230). Second are conceptions that de-emphasise both negotiations and the primary role of global health. They dwell basically on efforts aimed at improving health of a country on the receiving end within the larger context of supporting the providing country's national interest. In other words, they emphasise the use of health interventions as instruments to advance foreign policy interests. For example, Fauci defines health diplomacy as 'winning the hearts and minds of people in poor countries by exporting medical care expertise and personnel to those who need it most'(Fauci, 2007, p. 1169). Tommy Thompson, the former United States Secretary and Human Services, promoted the use of what he termed 'medical diplomacy' as an important element of the government's anti-terrorism strategy (Thompson, 2005). Thompson remarked "what better way to knock down the hatred, the barriers of ethnic and religious groups that are afraid of America, and hate America, than to offer good medical policy and good health to these countries"(Thompson, 2005). For instance, the US\$63 billion, six-year Global Health Initiatives under Obama Administration fits within this approach, serving as part of what the former US

Secretary of State Hilary Clinton describes as the “three Ds of smart power” – defence, diplomacy and development (Clinton, 2010).

These definitions take a more holistic view of both health and the international community. It moves beyond an explicit focus on particular disease and instead recognises how various manifestations of ill health can have negative consequences for the international community. It would be wise to agree with Buss and Ferreira that health diplomacy addresses health issues that transcend national borders and expose countries to global influences (Buss & Ferreira, 2010). It also ensures a better, more coherent coordination between the government’s health policies and external relations sector, not only in advocating the acceptance of health-related goals in the millennium development goals, but also ensuring that those are incorporated into the countries’ health and development plans.

Today, health diplomacy manifests itself in three ways: first, as disaster diplomacy, which involves providing relief to areas ravaged by natural disasters like earthquakes, tsunamis and drought (Ratzen, 2005); the second form deals with one country or a group of countries engaged in developing healthcare infrastructure in a country or a group of countries (Youde, 2008); and the third form (and the one that is the focus of this article) concerns international agreements and conventions designed to bring many parties together to address health concerns (Youde, 2008). An important part of health diplomacy takes place within the WHO. It is significant to state that improvement in global health had been negotiated within the WHO in such multilateral negotiations like the International Code of the Marketing of Breast Milk Substitute.

Several definitions of public policy abound. However, for brevity, we shall quote the simple definition of public policy by Thomas Dye. According to him, public policy is what government chose to do or not do (Dye, 1975, p. 1). He went further to assert that:

Government do many things. They regulate conflict within society, they organise society to carry on conflicts with other societies, they distribute a great variety of symbolic rewards and material services to members of the society and extracts money from the society, most at times in the form of taxes. Thus, policies may regulate behaviour, organise bureaucracies, distribute benefits, extract taxes or all of these things at once. . . (Dye, 1975, p. 1)

Stella Theodoulou (Theodoulou, 1995, p. 2) has identified five elements present in the concept of public policy: It should distinguish between what government intend to do and what they actually do; that governmental inactivity is as important as governmental activity. It ideally involves all levels of government and is not necessarily restricted to formal actors. Informal actors are also important. Public policy is pervasive and is not only limited to legislation, executive orders, rules and regulations. It is an intentional course of action with an accomplished end goal as its objective. It is both long-term and short-term. It is an ongoing process; it involves not only the decision to enact a law but also the subsequent actions of implementation, enforcement and evaluation.

From the aforesaid, it can be argued that public policy is a governmental programme found in a nation’s law or in public statements by a functionary of government. Since, it is a product of governmental process and activities, it affects a large spectrum of issues and sectors of the



society. It includes the economy, housing, defence, healthcare and education, among others. Public policies are in essence designed to resolve societal problems, particularly those considered to require public or collective action. It is generally agreed that public policy deeply affects the lives of every individual in society. Accordingly, Nigerian society is ordered and directed towards a desired end or goals by the State through public policies. Such policies, therefore, play a significant role in the State, which is also instrumental to the development and underdevelopment of a particular state.

The collective and public good theory shall be adopted to guide this discussion. In the global context, collective or public goods are goods exhibiting a significant degree of public interest across national boundaries (Woodward & Smith, 2003). Kaul Inge, Grunberg, Stern, M.A. have argued that they may be tangible such as 'natural commons' like the high seas, atmosphere, ozone shield and the polar regions (Kaul, Grunberg, & Stern, 2003). They also include 'human made commons' such as universal norms, principles, knowledge and the internet, or intangible norms such as 'global conditions' ranging from peace, health and financial stability, to free trade environmental sustainability and freedom from poverty (Kaul I., 2000).

The use of collective and public goods involves activities and choices that are interdependent. Decisions by one state have effects on other states. This means that states can suffer unanticipated negative consequences because of the actions of others. A central concern in collective or public good theory, therefore, revolves around the question of who provides the public goods. Without collective action mechanisms, there is a risk that such goods will not be adequately provided. Thus, if they are provided, the goods exist and everyone can enjoy them.

Collective and public goods theory can be used to explain the role of the WHO in producing global public goods. The promotion of global health is a positive form of engagement within the global community due to health's status as a 'global public good', a universal right for all. For example, promoting infant and child nutrition, controlling the spread of emerging infectious diseases, expanding the access to benefits of biotechnology, enhancing food security, and preventing further environmental degradation, are all global public health goods. The collective and public good theory sees international organisations such as the WHO as playing positive roles in facilitating cooperation and managing public health goods. They believe that the UN and its agencies have helped to check power politics by creating some degree of shared interests in place of national interests, and have provided a forum for international cooperation and promotion of human progress.

Background to the International Code of the Marketing of Breast Milk Substitutes

The establishment of a bottle-feeding culture can be traced to the development of industrial replacement products (Global Health Watch 2, 2008). The activities of infant formula manufacturers, particularly Nestle (the largest producer of infant formula) since the late 19th century, undermined

the confidence of women in their ability to breastfeed. Thus, through social marketing, Nestlé created a benign acceptance of its products. In many parts of the developing world, including Nigeria, special promotions and the provision of free samples drew women into the practice of artificial feeding (Global Health Watch 2, 2008). By the 1970s, it was estimated that only 20% of Kenyan babies and 6% of Malaysian babies were predominantly breast-fed (WABA, 2006). The situation in Nigeria is not too different. The breastfeeding rate gradually dropped from 80% in the 1970s and 1980s to as low as 15% today (Anuforo, 2013). According to WHO global data on infant and young child feeding in Nigeria, 22.3% of children were exclusively breast-fed for less than four months, while 17.2% were exclusively breast-fed for less than six months in the year 2003 (WHO, Data Bank on Infant and Young Child Feeding in Nigeria, 2010). The Nigerian Demographic and Health Survey stated in 2008 that 17% of children were exclusively breast-fed for less than four months, while 13% were exclusively breast-fed for less than six months (NPC, 2009). The result of a study in 2010 showed that advertising of infant formula in Nigeria had a significant effect on mothers' choice of infant feeding. The indication is that infant formula advertisements affected the practise of exclusive breast feeding (Onyechi & Nwabuzo, *The Effect of Milk Formula Advertisement on Breastfeeding and other Infant Feeding Practice in Lagos Nigeria*, 2010).

The concern for the decline in breastfeeding and harmful effects of bottle-feeding dates back to the late 1960s and early 1970s. During this period, it began to manifest in the writings and activities of health professionals. For instance, in 1972, the United Nations Protein Advisory Group (PAG) issued a statement emphasising the critical importance of breastfeeding in the social and economic conditions that prevail in many developing countries (UNPAG, 1973). There was also the belief, especially in the early 1970s, that it would be possible to work with industry in regulating their marketing activities so that these would not impede breastfeeding.

Reports by non-governmental organisations and articles in journals began to appear in the mid 1970s concerning the continued unethical promotion activities of industry. In 1974, the British-based development organisation *War and Want* published a report titled 'The Baby Killer' (Chetley, 1979). This report linked the incidence of malnutrition to the promotional practices of industry. Also, the Swiss Berne Third World Action Group published its German translation of the *War and Want* report 1974 with the title 'Nestlé kills Babies' (Chetley, 1979). In response to this, Nestlé sued the group for libel. The trial ended in June 1976 with Nestlé being awarded a minimal sum for libel on the part of the Berne Group. However, the judge remarked that the verdict was no acquittal and that Nestlé should rethink its advertising policies (Helsing and Traylor, 1984). The significance of the Nestlé case is that it served to garner publicity for the cause of critics of the industry. It also helped to further shape world public opinion concerning the negative effects of aggressive advertising and promotional policies of industry relative to infant malnutrition. In 1975, a West German film, 'Bottle Babies', documented aggressive industry promotion of infant formula and its effects on infant health in Kenya (Helsing and Traylor, 1984). It should be emphasised that the aforementioned publications were landmarks in the work of action groups critical of industry policies and activities.



Another important action in the campaign to influence changes in industry policies was the organisation of a boycott against Nestlé and its products as well as its subsidiaries in June 1977 in the United States. The boycott was started and coordinated by a group called the Infant Formula Action Coalition (INFACT) based in the US (Helsing & Traylor, 1984). The boycott also spread to other countries, notably Western Europe, the United Kingdom, Sweden, and the then Federal Republic of Germany. The industry was not left out in this process; it was also on the offensive. In 1975, it formed its own lobby group, the International Council of Infant Food Industries (ICIFI). ICIFI published its own code of ethics relative to marketing practices. However, the code was criticised as an attempt to disarm critics rather than a serious attempt to regulate the harmful effects of aggressive marketing activities.

The process for the adoption of the International Code of Marketing of Breast Milk Substitute involved an intensive consultation and negotiation between the concerned parties. The major stakeholders were the WHO, representatives of governments, intergovernmental organisations, non-governmental organisations, industry or experts in the fields of concern to the issues. The process also took the form of debates between religious, consumer-activist and local action groups on the one hand, and industry on the other.

The WHO's involvement in infant and child nutrition

Two reasons underlie the WHO's involvement in child and infant nutrition. The first is the urge to counter the negative health implications of formula feeding. Research on the risk of formula feeding found an increased risk of gastric and respiratory infectious diseases, higher levels of non-communicable diseases such as diabetes, and lower IQ capacity and visual acuity (Malcove, 2005). Other studies have demonstrated mortality rates of up to 25% higher for artificially fed compared to breastfed children (Victoria, 1989). Evidence, however, shows that exclusive breastfeeding for the first months of life reduce both mortality and the risk of transmission (Guise, 2005). Another reason is the fact that the WHO has a particular responsibility for realising the right to food through measures within the health field. This responsibility stems naturally from the organisation's definition of health in the preamble to its Constitution as "a state complete physical, mental and social wellbeing and not merely the absence of disease" (WHO, Constitution of the World Health Organisation, 1948). This views health as a positive goal, not only as a negation of disease. Hence, the attainment of health requires that people's right to food is realised.

Article 12 of the International Covenant of Economic Social and Cultural Right confirms the right to health as "the highest attainable standard of social and mental health." The second part of the article states that steps should be taken by the state parties to the Covenant to achieve the full realisation of the right to health, which include "the provision for the reduction of the stillbirth and of infant mortality and for the healthy development of the child" (UN, 1966). In this way, the Article immediately draws the attention to the most vulnerable group of all: young children, and more specifically infants. It is in harmony with the well-known fact that young children are the ones who are most susceptible to ill health as a consequence of an inadequate food supply, quantitatively

and qualitatively. It is therefore no surprise that WHO has been particularly active regarding the nutrition of infants and young children. Of central importance have been the efforts to promote and protect breastfeeding against artificial bottle-feeding.

The WHO's concern for the decline in breastfeeding began in 1974 when the World Health Assembly (WHA) passed a resolution which related the general decline of breastfeeding throughout the world to socio-cultural and other factors. For the first time, the resolution, urged member countries to review sales promotion activities on baby foods and to introduce appropriate remedial measures, including advertisement codes and legislation where necessary. In 1978, the WHA, in its resolution, reaffirmed its concern about the continuing decline in breastfeeding and inappropriate sales promotion of breast-milk substitutes. Among its recommendations was one that member states should give priority to preventing malnutrition in infants and children by supporting and promoting breastfeeding, taking legislative and social action to facilitate breastfeeding by working mothers, and regulating inappropriate sales promotion of infant foods that could be used to replace breast milk (WHA, 1978).

Another major development was the WHO/UNICEF meeting on infant and young child feeding, held in Geneva from 9 to 12 October 1979. One of the conclusions reached at the meeting was that poor infant feeding practices and its consequences was one of the world's major problems and a serious obstacle to social and economic development. The meeting also issued recommendations under all the five categories listed above. However, the recommendation of the highest importance was that "there should be an international code of marketing of infant formulas and other products used as breast milk substitutes"(WHO, Meeting on Infant and Young Child Feeding, 1979). This meeting was significant in many respects. First, it attracted about 150 participants representing governments, organisations and bodies within the UN system, other intergovernmental organisations, experts in medicine and nutrition and the infant food industry. Second, the industry, through the ICIFI Chairman present at the meeting, pledged to abide by these recommendations, some of which went further in regulating promotion activities than the code eventually did(WHO, Meeting on Infant and Young Child Feeding, 1979).

The 33rd WHA in May 1980 endorsed the statements and recommendations agreed by consensus at the joint meeting of the WHO/UNICEF and made particular mention of the recommendation that "there should be an international code of marketing of infant formula and other products used as breast milk substitutes". The WHA also requested the Director General to prepare such a 'Code' in close consultation with member states and with all other parties concerned. In order to develop an international code of marketing of breast milk substitutes in line with the Health Assembly request, several consultations were held with all interested parties. Member states of WHO, as well as groups and individuals who had been represented at the October 1979 meeting, were requested to comment on successive drafts of the code, and further meetings were held between February and September 1980.

In January 1981, the WHO Executive Board endorsed the fourth draft of the Code and gave its unanimous support to a resolution to the WHA that it should adopt the Code as a recommendation rather than a regulation. The Code was finally adopted in May 1981 by the 34th WHA by 118



votes: one member state, the United States, voted against the Code and three member states, Argentina, Japan and Republic of Korea, abstained. The United States opposed the WHO Code from the beginning, stating that its provisions were unrealistic, unworkable, that they operated against child health, served as an attack on the free market, and violated the right for free speech. Perhaps this is best summed up in a statement by Elliot Abrams, US Assistant Secretary of State for International Organisations Affairs, prior to the vote in May 1981:

The Code causes us serious problem[s] both on constitutional and legal grounds. It seeks to prescribe certain commercial practices, such as advertising and association between consumers and manufacturers which contradict our constitutional guarantee for free speech and freedom of association and our anti-trust laws, it does not provide the flexibility governments, companies and health workers need in accordance with varying legal, social, economic or cultural conditions of the member states of [the] WHO (Abrams, 1981, p. 54).

Despite these criticisms, it has been argued that the efforts of the WHO to protect the child through an International Code of Marketing of Breast milk Substitutes provided an example of an attempt at infants' right to food. It also served to create a public awareness of the causes of infant malnutrition in the world, especially in the developing countries. The Code (the WHO, International Code of Marketing of Breast Milk Substitutes, 1981) sets out detailed provisions with regard to:

Information and education on infant feeding. The Code urged governments to ensure that objective and consistent information is provided on infant and young child feeding, both to the families and to others involved in infant and young child nutrition. It also maintained that information and educational materials should clearly state the benefits and superiority of breastfeeding, the social as well as financial cost of using infant formula, the health hazards associated with artificial feeding, and instruction for the proper use of infant formula.

Promotion of breast milk substitutes and related products to the public and mothers. The Code explicitly stated that there should be no advertising or other form of promotion to the public and that manufacturers and distributors should not provide to pregnant women, mothers or members of their families samples of products. Promotion through any type of sales device, including special displays, discount coupons and special sale, was prohibited. In addition, no company personnel should seek direct or indirect contact with or provide advice to pregnant women or mothers.

Promotion of breast milk substitutes and related products to health workers and in health care settings. The Code advocated for a total prohibition of any type of promotion of products that fall within their scope in the health services. Furthermore, donations of free or subsidised supplies of breast milk substitutes or other products, as well as gifts or personal samples to health workers, should not be allowed in any part of the health care system. Also, information provided by the manufacturers and distributors to health professionals regarding products should be restricted to scientific and factual matters.

Labelling and explaining the benefits of breast milk. The Code stated that no pictures idealising the use of breast milk substitutes were permitted on the labels of the product. Information on artificial feeding, including that on labels, should explain the benefits of breastfeeding and the cost and dangers associated with the necessary or improper use of infant formula and other breast milk substitutes. Moreover, unsuitable products for feeding infants such as sweetened condensed milk, should not be promoted.

The implementation and monitoring of the Code. The Code also mandated governments to act on the Code, taking into consideration subsequent relevant WHA resolutions. The governments could adopt legislation, regulations or other measures such as national policies and codes. The Code is a minimum requirement and therefore government could adopt additional measures to those set out in the Code and make them legally binding.

It is pertinent to state that there is one version of the Code. However, there have been a number of WHA resolutions adopted since 1981 that referred to the marketing and distribution of breast milk substitutes. Noteworthy is the fact that the WHO has continued to promote infant and young child nutrition, including technical support to national governments for implementing the Code. For this purpose, the Innocenti Declaration was adopted, which set operational targets for the Code's implementation within member states. The WHO and UNICEF jointly organised the Baby Friendly Initiative (BFI), which focused on the role of health services in the promotion of safe motherhood, child survival and primary health care. The initiative gave a number of criteria that hospitals needed to obtain to achieve baby friendly status. Among the criteria was a ban on distributing free or low cost supplies of breast milk substitutes.

In 2002, the WHO member states endorsed a Global Strategy for Infant and Young Child Feeding. The Global Strategy included nine operational targets consistent with the International Code of Marketing of Breast Milk Substitutes and subsequent WHA resolutions, the Innocenti Declaration on the protection and support of breastfeeding, and the BFHI. To ensure full implementation of all its components, the Global Strategy requested governments to appoint a national coordinator with appropriate authority and to constitute an effective broad-based body to lead coordinated multi-sectoral implementation of the strategy by all concerned.

The institutionalisation of the WHO International Code of Marketing of Breast Milk Substitutes in Nigeria

It is obvious that if health diplomacy is to become applicable, there is a need to implement the outcome of such negotiations at the national level. And the only way to achieve this is through public policy. As a matter of fact, Nigeria domesticated the Code in 1986 and backed it legally with Marketing (Breast milk Substitutes Act No. 41 of 1990) as amended by Act No. 22 of 1999. According to the UNICEF report, Nigeria is grouped among the countries that have enacted legislations or other legal measures encompassing many of the provisions of the Code (UNICEF, 2011). In May 1999, the Federal Government reviewed and amended the Code of Marketing of Breast milk Substitutes. This gave birth to the National Agency for Drug Administration and



Control (NAFDAC)- Marketing of Infant and Young Child Foods and other Designated Products Regulations 2005, which was gazetted, launched and disseminated to stakeholders, including infant food manufacturers in 2006. This amendment introduced stiffer fines and a clearer definition of breast milk substitutes. One major challenge was the monitoring and enforcement of the Code. To address this problem, the government embarked on the development of a system for monitoring the marketing of breast milk substitutes undertaken by NAFDAC National Committee on Food and Nutrition (NCFN) and UNICEF.

In accordance with the Innocenti Declaration, which set operational targets for the implementation of the Code of marketing of breast milk substitutes and recommended that all governments should develop national breastfeeding policies, a Nigerian National Breastfeeding Policy was adopted in 1998. The policy recommended exclusive breastfeeding for the first six months. A national breastfeeding coordinator was appointed. The coordinator provided an effective focal point. However, after two years, the office of the National Coordinator for Breastfeeding became non-functional. This was due to the persistent deployment of personnel in the Ministry of Health, which rendered that office redundant (the WHO Assessment Report on Infant and Young Child Feeding in Nigeria, 2008). In addition, inadequate funding also undermined the effectiveness of the coordinator.

The BFHI has encouraged hospitals and facilities providing maternity care to follow the ten steps. It was recommended that hospitals and maternity facilities that need to purchase breast milk substitutes should do so at full price through normal procurement channels, accepting no fee or low cost supplies. According to WHO Assessment Report in 2008, 1052 of 21562 hospitals and facilities offering maternity services were designated baby friendly. Furthermore, the result of an evaluation of BFHI in 2000 revealed favourable changes in lactating mothers' knowledge and practices of breastfeeding. The evaluation showed an exclusive breastfeeding rate of 62% at four months and 59% at six months in a sample of babies born in BFHI hospitals. However, it has been argued that should a similar survey be carried out today, it was unlikely that figures like these would be obtained. This is because the initiative lost its initial momentum. It was no longer pursued by the same vigour, as was the case when it was initially introduced. This is evidenced by only 39% of six-month-old children being exclusively breast-fed in 2012 (Anuforo, 2013).

In 2005, Nigeria adopted a comprehensive National Policy on Infant and Young Child Feeding. The provisions of WHO recommendations such as the International Code of Marketing of Breast Milk Substitutes and other initiatives such as the Innocenti Declaration on the protection, promotion and support of breastfeeding and the BFHI were recognised in the articulation of this policy. The policy was adopted to fill the revealed gaps in policy provisions on infant and young child feeding in the available national policies on nutrition and maternal child health. A comprehensive national policy in Nigeria became imperative in view of the HIV/AIDs pandemic and the possibility of transmission of HIV through inappropriate feeding options. In relation to the Code of Marketing of Breast Milk Substitutes, the policy stated that:

All health workers shall be made aware of, and comply with the national code of marketing of breast milk substitutes which prohibits promotional schemes by infant formula manufacturers directed at consumer and health workers e. g. posters, free samples, donations. The use of artificial milks or other breast milk substitutes shall not be encouraged except in exceptional circumstances and by prescription only (Nigeria, 2005).

The policy also recognises that there are children in special circumstances who need further attention and extra support to meet their nutritional requirements. In addition, there are situations under which breast milk substitutes or other artificial feeding may be necessary. These groups include: infants and young children of HIV mothers; sick infants and young children, particularly those with persistent diarrhoea and those living with HIV/AIDs; low birth weight infants; motherless/ adopted infants and young children; infants and young children in emergency situations; and infants with cleft-palate.

Other policies included the National Plan of Action on Food and Nutrition in Nigeria 2005, which was aimed at improving the nutritional status of all Nigerians with particular emphasis on the most vulnerable groups such as children, women and the elderly. The National Policy on Food and Nutrition in Nigeria 2002 also emphasised the need to promote, encourage and support exclusive breastfeeding for the first six months, and promote the continuation of breastfeeding well into the second year of life.

It is important to note that despite legislative provisions, effective implementation of the Code has been poor. Nestlé and other companies have continued to promote infant foods through other means. Under the guise of its Nestlé Nutrition Services, Nestlé continues to sponsor doctors meetings and many strategies are being used to push the company's products in Nigeria. In addition, an attempt has been made by these companies to circumvent the strong condemnation they receive from the global health community. To this end, many companies have formed partnerships with United Nation's agencies to combat malnutrition. They have succeeded in linking their brand with the humanitarian image of the UN agencies in order to benefit from the aid funds pouring into these agencies from donor governments. For instance, Global Alliance for Improved Nutrition (GAIN)'s global health partnership opens its website with the message, 'Improving nutrition can also seriously benefit your business by creating growth in new and existing markets'(Global Health Watch 2, 2008).

Another major setback is the fact that civil society groups have not monitored compliance with the Marketing (Breast Milk) Substitutes Act. In India for instance, two civil society groups, the Breastfeeding Promotion Network of India (BPNI) and Association for Consumer Action on Safety and Health (ACASH), have been instrumental in exposing the unlawful practices of baby food manufacturing companies. In 1994 and 1995, the Government of India issued a notification in the Gazette of India to authorise BPNI and ACASH and two other national semi-government organisations to monitor compliance and they empowered them to initiate legal action (Global Health Watch 2, 2008). The situation in Nigeria is completely different. The non-involvement of



the civil society groups in Nigeria could be seen as an oversight of how sustained advocacy and action by such groups can influence public opinion and decision-making.

Other factors have militated against the successful implementation of the Code in Nigeria. These include the problem associated with public policy implementation in the country. It has been observed that despite the availability of public policies that seek to improve the life of the average Nigerian, the State lacks the political will to realise such policy objectives. The argument is that even if the set objectives stand to benefit the public, some groups of people, usually the influential ones in government, will jeopardise or frustrate the implementation of such public policies.

Another problem is that the Nigerian state downplays the crucial issues of implementation design of public policies. This trend translates to the advent of public policies without clear-cut modalities or mechanisms for implementation. In most cases, the government formulates national policies without adequate enlightenment and education. Corruption is also a major issue in the politics of public policy implementation in Nigeria. In fact, when corruption penetrates the implementation process, public policies become mutated and the desired goals may not be achieved. Most public policies are formulated but corruption ruins them and makes the implementation process impossible. Another problem of implementation may arise when the target beneficiaries are not involved in the formulation of policies that affect their lives. It should be noted that for policies to be successful, they should involve target groups and they should allow for a participatory system whereby policy makers plan with the people rather than for the people in meeting their needs. Such participation would give the target group a sense of belonging and get them committed to successful implementation of the policy. In addition, the failure of policy makers to take into consideration the social, political, economic and administrative variables when analysing for policy formulation could also mar the implementation process. It should be noted that some government agencies and institutions lack the requisite manpower and financial resources to implement these policies. High-level poverty and low literacy, as well as socio-cultural practices, have also constituted a serious albatross to the effective implementation of the Code in the country.

Conclusion

This paper has established that health diplomacy has been and remains one of the factors that have influenced public policy in Nigeria. It has examined reasons for the WHO's involvement in infant and child nutrition, as well as various resolutions passed to that effect before the adoption of the Code in 1981. It has discussed the various legislations and policies adopted in Nigeria as a way of domesticating the Code. However, it is important to stress that legislation is insufficient; most public policies require action and enforcement to effectuate them. It is public policy implementation that is one of the challenges of the Nigerian state.

The Nigerian experience demonstrates that the civil society has not done much to checkmate the activities of infant formula companies. Sustained advocacy by civil society groups can influence public opinion and decision makers towards implementation of that Code. Health messages about the positive advantages of breastfeeding require constant re-articulation and therefore should be

encouraged. Health workers should also ensure that women of childbearing age be adequately informed at the prenatal stage on the dangers of breast milk substitutes. In addition, nutrition education at antenatal and early registration should be encouraged to enable mothers to make informed decisions on infant feeding. It must be emphasised however, that campaigns and activist initiatives are doomed to fail if the political will to address such situation does not exist. The government should therefore show more concern in order to avoid the problems associated with the ineffective implementation of public policies. This is important so that breastfeeding, with its attendant power to influence the life course of children and prevent diseases that constitute a burden to health services, will be promoted.

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