unicef

for every child

PROTECTING BREASTFEEDING IN WEST AND CENTRAL AFRICA

ACKNOWLEDGMENTS

This publication was prepared by Ellen Sokol (Legal Consultant, UNICEF West and Central Africa Regional Office) with Anne-Sophie le Dain (formerly Nutrition Specialist, UNICEF West and Central Africa Regional Office) and produced by the UNICEF West and Central Africa Regional Office (WCARO). The authors would like to thank the following individuals and organizations in particular for their valuable contribution: UNICEF WCARO (Simeon Nanama and Arnaud Laillou), UNICEF PD Nutrition (Fatmata Fatima Sesay, Grainne Moloney and Katherine Shats); Alive & Thrive (Manisha Tharaney and Jill Emerson); WHO AFRO (Adelheid Onyango and Matilda Tingu), Helen Keller International (Akoto Osei and Elizabeth Zehner), IBFAN Africa (Nomajoni Ntombela) and Nutrition Specialists in West and Central Africa.

unicef

for every child

Protecting breastfeeding in West and Central Africa

©UNICEF Regional Office for West and Central Africa, 2022

TABLE OF CONTENTS

ABBREVIATIONS

ARCH	Assessment & Research on Child Feeding
ATNF	Access to Nutrition Foundation
BFHI	Baby-friendly Hospital Initiative
CCNFSDU	Codex Committee on Nutrition and Foods for Special Dietary Uses
ECCAS	Economic Community of Central African States
ECOWAS	Economic Community of West African States
FAO	Food and Agriculture Organization
GBC	Global Breastfeeding Collective
IBFAN	International Baby Food Action Network
ILO	International Labour Organization
NAFDAC	Nigeria, National Agency for Food and Drug Administration
NetCode	Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly Resolutions
NGO	Non-governmental Organization
SDGs	Sustainable development goals
The Code	International Code of Marketing of Breastmilk Substitutes
UNICEF	United Nations Children's Fund
WAHO	West Africa Health Organization
WCAR	West and Central Africa region
WCARO	West and Central Africa Regional Office
WHA	World Health Assembly
WHO	World Health Organization

LIST OF FIGURES, TABLES AND BOXES

EXECUTIVE SUMMARY

The UNICEF West and Central Africa Regional Office led the development of this regional report as part of the *Stronger* with *breastmilk only* initiative, to mark the 40th anniversary of the World Health Assembly's (WHA) adoption of the International Code of Marketing of Breastmilk Substitutes (the Code). The report looks at developments in the West and Central Africa Region (WCAR) in relation to two of the seven essential actions identified by the Global Breastfeeding Collective (GBC) as necessary at government level in order to achieve the WHA goal of increasing the global rate of exclusive breastfeeding to at least 50 per cent by the year 2025. The first of these actions is to adopt and monitor the Code, while the second is to implement paid family leave and workplace breastfeeding policies. The report also examines the challenges faced by governments, new developments, knowledge and available resources related to improving the implementation of the Code and maternity protection in the region.

Summary of Part I:

Implementation of the International Code of Marketing of Breastmilk Substitutes in WCAR

In 1981, the World Health Assembly adopted the International Code of Marketing of Breastmilk Substitutes out of concern that inappropriate marketing practices of breastmilk substitutes were contributing to the alarming decline in breastfeeding rates worldwide, as well as an increase in child malnutrition, morbidity, and mortality rates. The WHA urged member states to implement the International Code "in its entirety". Since 1981, the WHA has adopted other relevant resolutions relating to infant and young child feeding and the use of breastmilk substitutes, feeding bottles and teats and other foods marketed to infants and young children. In 2016, WHA Resolution 69.9 welcomed the WHO Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children (Guidance), which encompasses 7 recommendations that countries should adopt as part of any legal measure to implement the Code. The WHA resolutions enjoy the same status as the Code.

As of 2022, 18 countries in WCAR have a law, decree or regulations in place to implement the Code and its subsequent related resolutions, as compared to 13 countries identified in the UNICEF WCARO 2007 report marking the Code's 25th anniversary. The WHO/UNICEF/IBFAN Code implementation report of 2022 categorises the legal measures of 6 countries in the region as "substantially aligned"; eight countries as "moderately aligned", while four countries include "some provisions" of the Code

As of 2022, 18 countries in WCAR have a law, decree or regulations in place to implement the Code and its subsequent related resolutions [...] but many national laws and other measures are inadequate or not enforced.

and WHA resolutions. Six countries have yet to adopt any legal measure to implement the Code but five of them are at some stage in the process.

Most countries in the region have taken some action to implement the Code, but many national laws and other measures are inadequate or not enforced. This report analyses the challenges facing countries in the region in implementing the Code and identifies the resources available to support countries in making better progress towards this goal. Implementation of the Code involves a number of steps. First, countries must identify regulation of the marketing of breastmilk substitutes and related products as a priority and commit to adopting legislation, regulations, or other legal measures. The next step is to draft a legal measure that encompasses all elements of the Code and the relevant subsequent WHA resolutions. The introduction and aggressive marketing of new products that impact breastfeeding and digital marketing are among the most significant changes to occur in the years since the Code was adopted. For laws to effectively protect exclusive and continued breastfeeding, national measures regulating the promotion of breastmilk substitutes must cover all milks marketed for feeding infants and young children up to three years, including follow-up and growing-up milks. Legal measures must also address the inappropriate promotion of other foods and drinks targeting infants and young children, which harm optimal complementary feeding practices for these age groups. In addition, national laws based on the Code and resolutions should ensure that companies that market foods for infants and young children do not create conflicts of interest in health facilities or in the health care system.

In addition to drafting legal measures, countries must establish procedures and systems that allow them to monitor compliance with the law or regulations and to impose meaningful sanctions in the event of their violation. In 2014, WHO and UNICEF established the Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly Resolutions (NetCode). NetCode developed a toolkit to assist governments, institutions, and non-governmental organizations in monitoring and enforcing compliance with national measures or the Code itself in the absence of national legal measures. The NetCode protocol for ongoing monitoring describes the process of establishing a system for monitoring compliance that would ideally be integrated into existing country regulatory and enforcement systems. The protocol provides a step-by-step guide for countries to put a system in place so that violations can be detected, documented, investigated, validated, and punished and/or reported. Governments and civil society organizations can also conduct assessments of compliance with the Code, WHA resolutions and national laws. using the NetCode protocol for periodic monitoring or other existing monitoring tools.

In addition to drafting legal measures, countries must establish procedures and systems that allow them to monitor compliance with the law or regulations and to impose meaningful sanctions in the event of their violation.

The technical support of UNICEF, WHO and partner organizations can be instrumental for countries at any stage of Code implementation, including advocacy in getting Code implementation onto the national agenda, the drafting of legal measures, following the draft through the often-long process of approval and adoption and developing or strengthening capacity for monitoring and enforcement.

The list of "useful resources" provides additional tools and initiatives to support governments and organizations in implementing the Code and WHA resolutions. Advocacy tools are included that can be used to convince political leaders of the need to invest in strategies and social policies that protect, promote, and support breastfeeding. In partnership with Alive & Thrive and the World Health Organization (WHO),

UNICEF launched the multi-year Stronger with Breastmilk Only initiative with the aim of persuading countries in West and Central Africa to increase the number of exclusively breastfed infants in the region. The initiative focuses on advocacy and social behaviour change and engages multiple audiences at different levels. The Alive & Thrive "Cost of not breastfeeding tool" allows countries to estimate future economic losses associated with the absence of recommended breastfeeding practices.

Summary of Part II:

Supporting women and families in the workplace

Our review shows that 17 of the 24 countries in the region provide the minimum of 14 weeks maternity leave required by the ILO Maternity Protection Convention 183 (2000). Only Gambia meets the threshold of ILO Maternity Protection Recommendation 191 of 18 weeks by providing 24 weeks of maternity leave. The legislation in all countries in the region mandates that maternity leave should be paid (most at 100 per cent). ILO Convention 183 also established the right to paid breastfeeding breaks for women workers returning to work. In WCAR, 18 countries have legislation mandating paid breastfeeding breaks, while four countries provide for unpaid breaks with durations ranging from 6 to 18.5 months. Although Recommendation 191 calls for all employers to provide facilities for nursing at or near the workplace regardless of the number of workers, only two countries in the region mandate the provision of such facilities by employers with the designated minimum number of workers.

The greatest challenge to establishing maternity protection in the region is the large per centage of women working in the informal sector who are not able to benefit from these laws. Most countries have laws on maternity leave, but fewer than 10 per cent of working women in 12 WCAR countries are legally entitled to maternity leave; 10 to 32 per cent of working women are covered by such laws in 5 countries and 33 to 65 per cent are covered in 3 countries. In only one country, Equatorial Guinea, 66 to 89 per cent of working women are entitled to paid maternity leave. Some strategies to address this lack of maternity benefits for this large number of working women include greater reliance on social security, tax-funded cash transfers to women not covered under social security as well as the formalization of certain sectors of the informal economy, such as domestic workers.

The greatest challenge to establishing maternity protection in the region is the large percentage of women working in the informal sector who are not able to benefit from these laws.

INTRODUCTION

In 2007, the UNICEF Regional Office marked the 25th year of the International Code of Marketing of Breastmilk Substitutes (the Code) with the report "Protecting Breastfeeding in West and Central Africa".[i] In 2012, WHA member states unanimously adopted the goal of increasing the global rate of exclusive breastfeeding to at least 50 per cent by the year 2025. At the end of 2019, UNICEF along with Alive & Thrive and the World Health Organization (WHO), launched the multi-year Stronger with Breastmilk Only initiative, with the aim of driving the region towards this goal through the improved protection, support and promotion of breastfeeding practices in West and Central Africa.

The Global Breastfeeding Collective (GBC), a partnership of international organizations with the shared goal of promoting increased investment in breastfeeding worldwide, categorises the implementation of the Code and related WHA resolutions as an essential action that governments should take towards meeting the WHA goal. The implementation of the Code is also supported by the UN Convention on the Rights of the Child and its monitoring body, the Committee on the Rights of the Child.

> *The Global Breastfeeding Collective has also identified the adoption of maternity protection legislation and policies as an essential action that governments must take to meet the 2025 goal for exclusive breastfeeding.*

The Global Breastfeeding Collective has also identified the adoption of maternity protection legislation and policies as an essential action that governments must take to meet the 2025 goal for exclusive breastfeeding. The GBC calls on governments to build on the guidelines of the International Labour Organization (ILO) by enacting paid family (maternity and paternity) leave and by mandating workplace conditions that support mothers to breastfeed, such as dedicated breaks and facilities to breastfeed or express and store breastmilk.

In **Part 1** of this report we examine the current state of affairs in the region in terms of the overall implementation of the Code and related WHA resolutions, and why it remains a crucial government action towards improving infant and young child feeding, nutrition and, ultimately, survival, growth and development. In **Part II**, we review the status of individual countries in adopting legislation and policies that support working women to breastfeed optimally. The report also examines new developments, current knowledge and available resources related to the implementation of the Code and maternity protection.

i. Sokol, E, Aguayo, V., Clark D. (2007). *Protecting Breastfeeding in West and Central Africa: 25 Years Implementing the International Code of Marketing of Breastmilk Substitutes,* UNICEF WCARO, Dakar. https://pubmed.ncbi.nlm.nih.gov/18947028/

BACKGROUND

Breastfeeding improves the survival, health and development of all children everywhere.[1] The benefits of breastfeeding are most fully realised when babies are breastfed in the first hour from the moment of birth, exclusively for the first 6 months and continue to be breastfed up to two years of age or beyond while receiving nutritionally adequate and safe complementary foods. Exclusive breastfeeding in the first six months has the single largest potential impact on child mortality of any preventive intervention.[2]

One of six global nutrition targets established to improve maternal, infant and young child nutrition is to increase the rate of exclusive breastfeeding in the first six months of life to at least 50 per cent by 2025.[3] Furthermore, efforts to reach the global targets also contribute towards the achievement of many of the targets of the Sustainable Development Goals (SDGs), including improving nutrition and ending hunger, ensuring healthy lives, ending poverty and promoting economic growth.[4]

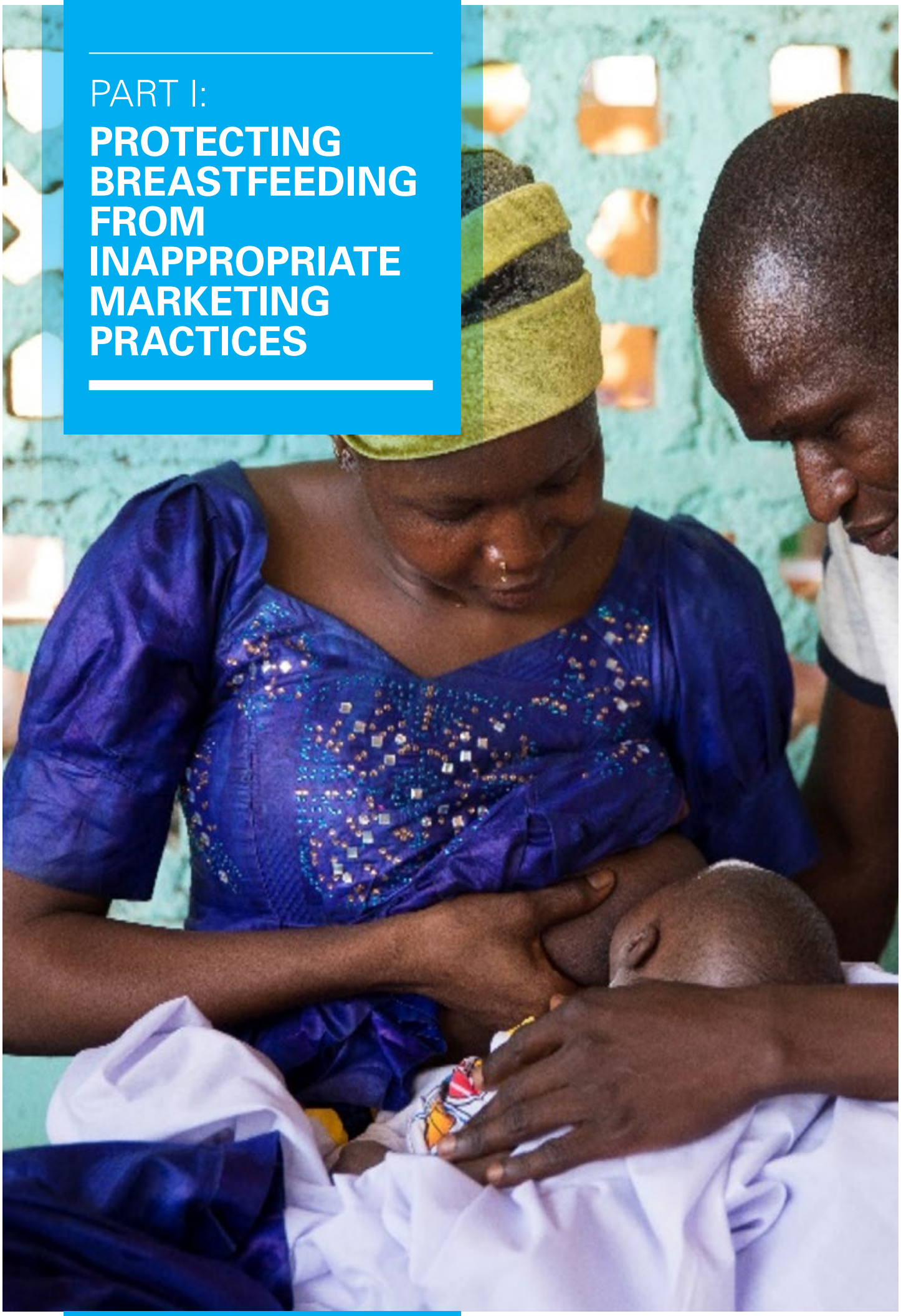
In West and Central Africa, breastfeeding is a universal practice with rates of children ever breastfed above 90 per cent for all countries.

Although many countries in the region have made significant progress, and the regional average is on the rise, only 45.6 per cent of newborns are put to the breast within the first hour of birth and 37 per cent of infants under six months of age are breastfed exclusively.

Although many countries in the region have made significant progress, and the regional average is on the rise, only 45.6 per cent of newborns are put to the breast within the first hour of birth and 37 per cent of infants under six months of age are breastfed exclusively. However, 66.2 per cent continue to be breastfed from 12-23 months of age.[5] Complementary feeding practices are also far from those recommended by the World Health Organization (WHO),[6] with sixty-three per cent of children aged 6-8 months receiving solid, semi-solid or soft foods, and almost eleven per cent of children aged 6-23 months receive a minimum acceptable diet, a core indicator that measures the number of children consuming foods from a minimum of five different food groups each day and those receiving the recommended minimum frequency of meals.[7]

PART I:

PROTECTING BREASTFEEDING FROM INAPPROPRIATE MARKETING PRACTICES



© UNICEF/UN0205719/Njiokiktjien VII Photo

The Code prohibits advertising and other types of promotion of breastmilk substitutes, feeding bottles and teats. It also aims to ensure that families are informed about the importance of breastfeeding and that products are properly labelled and meet a high standard of quality. Since adopting the Code in 1981, the World Health Assembly has adopted related resolutions that impact how the Code is implemented, to reflect trends in marketing as well as evolving scientific evidence on breastfeeding. Box 1 provides a summary of the provisions of the Code and relevant WHA resolutions.

Box 1.

Summary of the International Code and relevant WHA resolutions

Scope of the Code

- Infant formula
- Other milks marketed as suitable for feeding infants and young children up to 36 months old
- Other products marketed as suitable for feeding infants less than 6 months old
- Feeding bottles and teats

Companies that market products within the scope of the Code must abide by the following:

For the general public

- No advertising; samples; contact with marketing personnel; promotions at points of sale
- No cross-promotion or use of baby clubs, social media or other forms of direct promotion for their brands of food products for infants and young children
- Must abide by rules on the content of materials on infant and young child feeding

For health workers and the health care system

- No promotion in healthcare facilities
- No distribution of materials
- No education on infant and young child feeding to parents or caregivers
- No free supplies of products
- No donations of equipment or services
- No gifts or financial support to health staff
- No sponsorship of meetings of health professionals or of scientific meetings
- Product information for health professionals should be restricted to scientific and factual matters and never imply that feeding with breastmilk substitutes is equivalent or superior to breastfeeding

Labels of all products within the scope of the Code

- Must not discourage breastfeeding
- Must not include nutrition or health claims
- Must include preparation instructions and warnings about health hazards of inappropriate preparation

Infant formula labels

- Must clearly state the superiority of breastfeeding and the need for the advice of a health worker

- Must warn about the risk of intrinsic contamination of powdered infant formula with microorganisms
- Must not include pictures of infants, or other words or pictures idealising artificial feeding

Labels of other foods for infants and young children*

- Must state the appropriate age for introducing the product (which must not be less than 6 months)
- Must include statements about the importance of not introducing complementary feeding before 6 months of age and of continued breastfeeding for 2 years or more
- Must not include images, text, or other representations that are likely to undermine or discourage breastfeeding
- Must not include endorsements by a professional body
- Must not include nutrition or health claims
- Labels of complementary foods must be different from those used for breastmilk substitutes, including color schemes, designs, names, slogans and mascots

Implementation

- Governments must adopt measures to give effect to the Code
- Governments must ensure that the implementation of the Code and relevant WHA resolutions is monitored in a transparent, independent manner, free from commercial influence

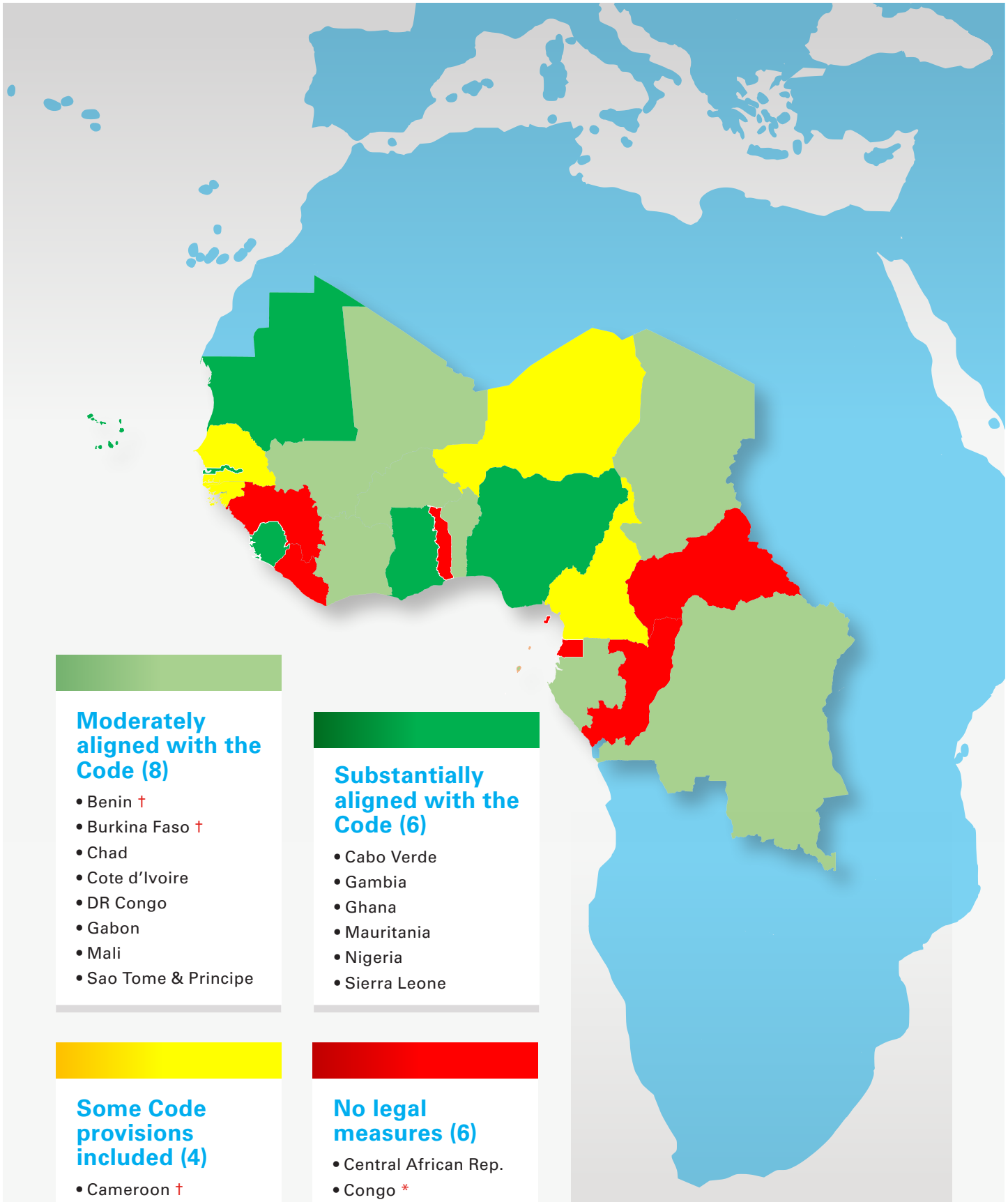
The Code and related WHA resolutions, although not binding international instruments, are recommendations from the highest international authority in the field of health. To give effect to these recommendations, countries must adopt or strengthen legislation or other enforceable measures. Governments must also monitor those measures and enforce them with effective sanctions in the event of their violation. The World Health Assembly has repeatedly called on governments to give effect to the Code and subsequent related resolutions, and the WHO/UNICEF/IBFAN Code implementation report of 2022 indicated that 144 of 194 countries around the world had adopted legal measures to implement at least some of the provisions of the Code and related resolutions. However, only 83 countries have clearly identified a body responsible for monitoring compliance and 91 countries have defined applicable sanctions for violations.[8]

The International Code of Marketing of Breastmilk Substitutes: Where do we stand?

As of March 2022, 18 of the 24 countries in West and Central Africa have a law, decree, or regulations in place on the marketing of breastmilk substitutes, compared to 13 countries in 2007 (**Figure 1**). Of those 18, however, only six countries (Cabo Verde, Gambia, Ghana, Mauritania, Nigeria, and Sierra Leone) have measures categorised as "substantially aligned with the Code" and WHA resolutions.[ii] The legal measures implemented in eight countries are considered "moderately aligned", while four include "some provisions" of the Code and WHA resolutions. Six countries in the region have yet to adopt any legal measures implementing the Code. As illustrated in Figure 1, six countries in the region are in the process of strengthening their legal instruments that implement the Code. Five of the six countries that have not yet adopted any legal measures have at least started the process.

* As required by the WHO Guidance on ending the inappropriate promotion of foods for infants and young children, 2016.

ii. The Code report uses an algorithm with a total of 100 points to score the alignment of each country law or other measure with the provisions of the Code and relevant subsequent WHA resolutions. According to the algorithm, the categories are defined as follows: ≥ 75 points: "substantially aligned with the Code"; 50 to < 75 points: "moderately aligned with the Code"; < 50 points : "some provisions of the Code included".



Moderately aligned with the Code (8)

- Benin †
- Burkina Faso †
- Chad
- Cote d'Ivoire
- DR Congo
- Gabon
- Mali
- Sao Tome & Principe

Substantially aligned with the Code (6)

- Cabo Verde
- Gambia
- Ghana
- Mauritania
- Nigeria
- Sierra Leone

Some Code provisions included (4)

- Cameroon †
- Guinea Bissau †
- Niger †
- Senegal †

No legal measures (6)

- Central African Rep.
- Congo *
- Equatorial Guinea *
- Guinea *
- Liberia *
- Togo *

† Steps taken to revise existing measure
* Steps taken to draft measure

Figure 1. Implementation of the Code in West and Central Africa

Sources: World Health Organization, Marketing of breast-milk substitutes: national implementation of the international code, status report 2022, WHO, Geneva 2022. Communications with UNICEF country offices

CHALLENGES AND OPPORTUNITIES

Political will

Whether a country is beginning the process of legislation, amending existing legal measures or establishing functioning systems for monitoring and enforcement, high-level commitment will be important and must be sustained throughout the process, despite the constant presence of competing priorities and pressures. Countries may also be faced with changes in government and even civil unrest or war.

The process in the region, at any stage, has not been easy. Initial support for action generally begins in the Ministry of Health, with professionals committed to improving maternal, newborn and child health. Support must be garnered not only from officials within the ministry, but also from a broad range of interested parties both in and out of government, including ministries of trade and commerce, health professionals, pharmacists, and NGOs. Infant food manufacturers and distributors may often use their political and economic influence to lobby government officials for weaker measures. Once initiated, the process must be sustained and seen through to completion, including the adoption of mandated decrees or regulations necessary for application of the law.

Drafting the law

The 1981 WHA resolution 34.22 adopting the Code urges Member States "to give full and unanimous support to the implementation [...] of the provisions of the International Code in its entirety as an expression of the collective will of the membership of the World Health Organization" and to "translate the International Code into national legislation, regulations or other suitable measures". In drafting such measures, countries must encompass, in addition to the provisions of the Code, the relevant resolutions that the WHA has adopted since 1981. In this section, we describe the developments that have occurred since the Code's adoption, as well as the WHA resolutions and WHO global guidance that address those developments.

Evolving marketing techniques

In response to the adoption of the Code in 1981, most companies modified their marketing strategies for infant formula in so-called "high risk countries"[9] by eliminating mass media advertisements and removing baby images from package labels. Companies also eventually stopped providing large amounts of infant formula to maternity wards and halted the use of 'milk nurses' who were health workers paid by companies to promote and sell products to new mothers in hospitals. Such actions, however, did not result in an end to the promotion of breastmilk substitutes.

> *Manufacturers have taken full advantage of the marketing potential of the internet, which did not exist when the Code was adopted.*

Companies that market breastmilk substitutes and other foods for infants and young children continually find new ways to promote their products in contravention of the Code and WHA resolutions.[10] Manufacturers have taken full advantage of the marketing potential of the internet, which did not exist when the Code was adopted. Social media sites such as Facebook, Twitter and Instagram have multiplied opportunities for reaching mothers and families with promotional messages.[11] Digital marketing is now routinely used by companies to market breastmilk substitutes and, in many countries,

is becoming the dominant form of marketing.[12] As the internet knows no borders, this type of promotion is difficult to regulate at national or even regional level. This problem is exacerbated by the low level of Code implementation in countries that are home to most manufacturers of breastmilk substitutes.

Although we have not seen reports from the region, some manufacturers, and distributors of breastmilk substitutes in other regions of the world have been exploiting the COVID-19 pandemic to promote their products. In Vietnam, for example, a company published an on-line advertisement for milk formula that juxtaposed the WHO warning of the high-level threat from COVID-19 with product pack shots and claims that the formula boosts the immune system and prevents infections caused by viruses and bacteria. In China, a company partnered with an aid organization to distribute sample packs containing breastmilk substitutes to mothers returning to work after the COVID-19 lockdown.[13]

New breastmilk substitute products

Prior to the adoption of the Code, infant formula was the main breastmilk substitute and was intended to replace breastmilk from birth through the first months of life.[iii] With standard infant formula falling squarely within the scope of the newly adopted Code, companies developed follow-up milks for older infants (typically 6-12 months) and promoted them without regard to the restrictions of the Code, many claiming that these products did not fall within its scope. Follow-up formula package designs serve to promote not only the new product, but standard infant formula as well by using similar brand names, colour schemes, slogans, mascots, and symbols. WHO refers to this practice of using one product to promote a different product as "cross-promotion."[14]

In response to the new marketing technique, many governments included follow-up milks within the scope of their national measures. Companies continued the trend by developing and promoting growing-up milks for children from one-to-three years old. Commercial promotion of milk formulas for older infants and young children serves not only to "cross promote" all formula products but also negates public health messages about the importance of continuing breastfeeding for up to two years and beyond. Moreover, these products provide no unique nutritional value but may contribute additional sugars to the diet and are much more expensive than cow's milk, which is the recommended alternative to breastmilk for children over 12 months old.[15]

Follow-up and growing-up milks have become widely available in the region. For example, in Dakar, Senegal, a study identified sales of 15 different brands of follow-up formula and 5 brands of growing-up milks. Most product labels showed evidence of common elements of cross-promotion.[16] In 2015, cable television advertisements for follow-up formula were aired nearly 100 times per month in Senegal.[17] Unsurprisingly, sales of breastmilk substitutes continue to climb. The 2016 Lancet study found that these products "seem to be resilient to market downturns" and that in 2014, global sales of milk formula were about US$44.8 billion and were projected to reach US$70.6 billion in 2019.[18] To put these numbers in perspective, the market for infant formula in 1987 was estimated at US$2 billion.[19] Globally, growing-up milk is the fastest growing category of breastmilk substitute; the volume sold in 2014 exceeded the combined volume of infant formula and follow-up formula.[20] Between 2006 and 2015, companies quadrupled their advertising of growing-up milks.[21]

Follow-up and growing-up milks have become widely available in the region

Foods for infants and young children

The Code applies to foods marketed as replacements for breastmilk, but some types of commercial promotion for complementary

iii. Infant formula is defined in Article 3 of the Code as "a breastmilk substitute formulated industrially… to satisfy the normal nutritional requirements of infants up to between four and six months of age."

foods and other foods and drinks for infants and young children may also be inappropriate and have provoked concern. Promotion for such food products is considered inappropriate if it "interferes with breastfeeding, contributes to obesity and non-communicable diseases, creates a dependency on commercial products, or is otherwise misleading.[22] Box 2 lists promotional practices that WHO deems inappropriate.

Box 2.

Inappropriate promotion of foods for infants and young children

- Product represented as suitable for infants younger than six months of age
- Product represented as equivalent or superior to breastmilk
- Cross-promotion of breastmilk substitutes, including use of same or similar brands, labels, colour schemes and logos
- Promotion of products with high levels of sugar, salts or fats
- Promotion of foods or portion sizes inconsistent with national food-based dietary guidelines
- Promotion of foods that do not meet applicable standards for composition, safety, quality and nutrient levels
- Promotion that discourages a diverse diet based on a wide variety of foods
- Promotion that undermines the use of suitable home-prepared and/or local foods
- Use of health and nutrition claims unless they are specifically permitted by law

WHO, Guidance on Ending the inappropriate promotion of foods for infants and young children, Implementation Manual, 2017.

The prevalence of inappropriate marketing practices for infant foods in WCAR has not been studied systematically, but the technique of cross-promotion by companies that market both breastmilk substitutes and infant foods has been observed in many countries, as well as the promotion of infant cereals and other foods for infants younger than six months of age. The Helen Keller International's Assessment & Research on Child Feeding (ARCH) study in Senegal, for example, found that 78 per cent of commercially produced complementary food labels contained elements that cross-promoted the manufacturer's breastmilk substitute products, while 20 per cent recommended an age of introduction of less than 6 months.[23]

The Helen Keller International's Assessment & Research on Child Feeding (ARCH) study in Senegal found that 78 per cent of commercially produced complementary food labels contained elements that cross-promoted the manufacturer's breastmilk substitute products, while 20 per cent recommended an age of introduction of less than 6 months.

Conflict of interest for health facilities and health workers

Companies continue to use health professionals and facilities to familiarise families with their brand names and products, despite the Code's

prohibition of the use of health care facilities for product promotion. Companies continue to distribute posters, booklets and other materials associated with infants and young children or bearing company or product names. In both Niger and Gabon, at least one company supplies health workers with lab coats embroidered with the name of its infant milk.[24] Companies also pay regular visits to health facilities, taking advantage of the narrow exception in the Code for the provision of product information to health workers. In Cote d'Ivoire, 63% of staff interviewed for a 2019 study had been contacted by one or more company representatives in the prior 6 months.[25] In Sierra Leone, 8 of 10 health facilities surveyed had been visited by company representatives once a week in the preceding six months.[26]

Furthermore, loopholes in the Code that allowed manufacturers and distributors to "make contributions to health workers for fellowships, study tours, research grants, attendance at professional conferences and the like" and to donate equipment and materials have allowed companies to create a "gift relationship" with health professionals, other health workers and their associations that leads to an implied obligation to reciprocate.[27] Companies are known to support health workers in the region to attend meetings, seminars or workshops related to feeding infants and young children. A recent study of Code violations in Cote d'Ivoire found that more than half of the 42 health care facilities studied reported being contacted by breastmilk substitute companies for the purpose of assisting health staff to attend events or workshops outside the healthcare facility.[28]

A recent study of Code violations in Cote d'Ivoire found that more than half of the 42 health care facilities studied reported being contacted by breastmilk substitute companies for the purpose of assisting health staff to attend events or workshops outside the healthcare facility.

WHA relevant resolutions and WHO Guidance

To date, the World Health Assembly, which meets yearly, has adopted 19 resolutions related to the Code. These resolutions urge governments to adopt or adapt national laws and policies to implement the Code. They also serve to clarify and keep the Code up to date with marketing trends and evolving scientific evidence on breastfeeding.

In 2010, the WHA recognised that the promotion of breastmilk substitutes and some commercial foods for infants and young children were continuing to undermine progress towards optimal infant and young child feeding and urged Member States to "end inappropriate promotion of foods for infants and young children."[29] To provide clarity, WHO developed the Guidance on ending inappropriate promotion of foods for infants and young children (2016 Guidance).[30] The Guidance defines 'promotion' broadly to include "the communication of messages that are designed to persuade or encourage the purchase or consumption of a product or raise awareness of a brand". The definition identifies the internet among the more traditional mass media channels. If implemented, the subsequent WHA resolutions and the seven recommendations of the Guidance will move countries closer to ending all inappropriate promotion of breastmilk substitutes and other foods for infants and young children.

Box 3.

WHO Guidance on ending inappropriate promotion of foods for infants and young children

Scope of the Guidance

The term "foods" used in this Guidance refers to "all commercially produced food or beverage products (including complementary foods) that are specifically marketed as suitable for feeding infants and children from 6 months up to 36 months of age." This Guidance does not replace the International Code, but does clarify which products are also covered by the Code and subsequent resolutions.

Recommendation 1

Optimal infant and young child feeding should be promoted as outlined in the Guiding principles for complementary feeding of the breastfed child and those for feeding the non-breastfed child.

Recommendation 2

The term *breastmilk substitute* should be understood to include any milk that is marketed for feeding infants and young children up to the age of 3 years (including follow-up formula and growing-up milks). It should be clear that the International Code and subsequent WHA resolutions cover these products and they should not be promoted.

Recommendation 3

Foods for infants and young children that do not function as breastmilk substitutes should be promoted only if they meet all relevant national, regional and global standards for composition, safety, quality and nutrient levels and are in line with dietary guidelines.

Recommendation 4

The messages used to promote foods for infants and young children should support optimal feeding and inappropriate messages should not be included.

Recommendation 5

There should be no cross-promotion to promote breastmilk substitutes indirectly via the promotion of foods for infants and young children.

Recommendation 6

Companies that market foods for infants and young children should not create conflicts of interest in health facilities or throughout health systems. Similarly, health workers, health systems, health professional associations and nongovernmental organizations should avoid such conflicts of interest.

Recommendation 7

The WHO set of recommendations on the marketing of foods and non-alcoholic beverages to children* should be fully implemented, with particular attention being given to ensuring that settings where infants and young children gather are free from all forms of marketing of foods high in saturated fats, trans-fats, free sugars or salt. *WHO. Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children. Geneva: World Health Organization; 2010.

Defining 'breastmilk substitutes'

Several of the subsequent WHA resolutions addressed deficiencies related to the scope of the Code. In 1986, WHA had already noted that food or drink given before complementary feeding is required may interfere with breastfeeding and should not be promoted or encouraged and that follow-up milks are not necessary.[31] The 2016 Guidance provides additional clarity for countries in defining the scope of their national measures to implement the Code. Recommendation 2 of the Guidance defines breastmilk substitutes as including "any milk that is marketed for feeding infants and young children up to the age of 3 years." This definition ensures that provisions regulating commercial promotion will apply to follow-up formula as well as milk formula marketed for young children up to the age of three years.

> *Guidance defines breastmilk substitutes as including "any milk that is marketed for feeding infants and young children up to the age of 3 years."*

Of the 18 countries in the region that have national measures to implement the Code, 12 expressly cover follow-up formula or define their scope to include milks marketed for infants and young children up to 12 or in some cases 24 months.[iv] Five of those countries specifically include milk for infants and young children up to 36 months old as recommended in the Guidance.[v] The remaining five countries define the scope with the term "breastmilk substitutes" as defined in the Code.[vi] Countries can avoid ambiguity by incorporating the definition for "breastmilk substitutes" from Recommendation 2 of the Guidance into the scope of their national laws.

Countries in the region should also be aware of the Codex Alimentarius standards for food products that fall within the scope of the Code and WHA resolutions. The Codex Alimentarius Commission is a joint body of the World Health Organization and the Food and Agriculture Organization (FAO) that develops international food standards. Countries refer to these standards when adopting legislation and they are often used by international trade bodies such as the World Trade Organization to settle trade disputes. The food standards related to the Code are under the purview of the Codex Committee on Nutrition and Foods for Special Dietary Uses (CCNFSDU) and include those for infant formula,[32] follow-up formula,[33] and a few standards and guidelines related to other foods for infants and young children.[34]

There is not yet a Codex Alimentarius standard for the product commonly known as "growing-up milk" or "toddler milk" and intended for young children. The standard for follow-up formula, however, is currently under review and will have a section applicable to the product for young children.[vii] The draft revised standard defines follow-up formula for older infants as a breastmilk substitute, which is aligned with the 2016 Guidance and ensures that this product is subject to the marketing restrictions of the Code. The draft definition for the drink product for young children is silent as to whether or not it is a breastmilk substitute, but does however include a footnote stating: "in some countries these products are regulated as breastmilk substitutes." The revised standard also adds new requirements for the labelling of these products, including that the text, images and colours of labels should be distinct enough to enable consumers to differentiate between infant formula, follow-up formula for older infants and milks for young children.[35]

Countries should appreciate the importance of regular participation in the process for setting international foods standards. This committee's decisions have an important impact on the

iv. Countries include Benin, Cameroon, Cape Verde, Chad, Cote d'Ivoire, Gabon, Gambia, Ghana, Mauritania, Nigeria, Sao Tome & Principe and Senegal.

v. Countries include Chad, Gambia, Mauritania, Nigeria and Sao Tome & Principe.

vi. The countries include Burkina Faso, DR Congo, Guinea Bissau, Mali and Niger.

vii. The draft standard does not use the term "growing-up milk". It names the product for 12-36 months "Drink or Product for Young Children with Added Nutrients" or "Drink or product for Young Children" or "any appropriate designation indicating the true nature of the product, in accordance with national or regional usage."

health and well-being of infants and young children in the region, yet the meetings are often dominated by trade interests of high-income countries and the participation of manufacturers of breastmilk substitutes and other infant foods in country delegations.[36]

Guidance on promotion of foods for older infants and young children

Recommendation 3 of the 2016 Guidance applies to foods and drinks for infants and young children that are not breastmilk substitutes. According to the recommendation, these products should be promoted commercially only if they meet relevant standards for composition, safety, quality, and nutrient levels and are in line with national dietary guidelines. Recommendation 4 applies to promotional messages conveyed by advertisements, promotion and sponsorship, brochures, online information, and package labels. Messages used to promote such foods that meet the relevant standards must "support optimal feeding and inappropriate messages should not be included." Box 4 summarises the requirements and restrictions of Recommendation 4.

Box 4.

Recommendation 4: Messages for the promotion of foods for infants and young children

Wherever they appear, promotional messages for these products must:

- Include a statement on the importance of continued breastfeeding for up to two years or beyond and the importance of not introducing complementary feeding before 6 months of age
- Include the appropriate age for introduction of the food (never less than 6 months)
- Be easily understood with all label information visible and legible

Promotional messages should not:

- Include images or text that may suggest use for infants under the age of 6 months
- Include images or text likely to undermine or discourage breastfeeding
- Include images or text that recommend or promote bottle feeding
- Convey an endorsement by a professional or other body unless specifically approved by appropriate regulatory authorities

Recommendation 5 of the Guidance states that "there should be no cross-promotion to promote breastmilk substitutes indirectly via the promotion of foods for infants and young children." Packaging and materials used to promote complementary foods must not be the same or similar to those used for breastmilk substitutes. Companies that market breastmilk substitutes should also refrain from using baby clubs, social media, or other forms of direct promotion for their brands of food products for infants and young children.

Ending conflicts of interest in the health care system

In 1996, WHA expressed concern about inappropriate financial support for professional training in infant and child health and urged governments "to ensure that the financial support for professionals working in infant and young child health does not create conflicts of interest, especially with regard to the WHO/UNICEF Baby Friendly Hospital Initiative".[37] WHA re-emphasised the need to ensure against

conflicts of interest from financial support for health professionals in 2005[38] and again reminded governments in 2008 of the need to avoid conflicts of interest.[39] The 2016 Guidance enhances the earlier recommendations by identifying the types of behaviours that constitute a conflict of interest within the health care system. Recommendation 6 of the Guidance states that companies should not create conflicts of interest throughout the health system and that health workers, health systems, health professional associations and nongovernmental organizations should avoid conflicts of interest. Box 5 lists the activities that should not take place in health facilities or throughout health systems.

Box 5.

Inappropriate promotion of foods for infants and young children

- Provision of free products, samples or reduced-price foods for infants or young children to families through health workers or health facilities, except:
  - **As supplies distributed through officially sanctioned health programmes**
    Products distributed in such programmes should not display company brands
- Donation or distribution of equipment or services to health facilities
- Gifts or incentives to health care staff
- Use of health facilities to host events, contests, or campaigns
- Gifts or coupons to parents, caregivers, and families
- Direct or indirect provision of education to parents and other caregivers on infant and young child feeding in health facilities
- Provision of information for health workers other than that which is scientific and factual
- Sponsorship of meetings of health professionals and scientific meetings

Existing legal measures in WCAR vary in their regulation of the relationship between industry and health care institutions, health workers and their associations. These are among the most difficult provisions to formulate and are often subject to intense lobbying by industry and health workers alike. In addition, data and up-to-date information about interactions that raise potential conflicts of interest is difficult to obtain.

The Guidance provides clarity in steering those involved with infant and young child feeding away from engagements with the baby food industry. Each country drafting or revising legal measures will need to include health professionals and their associations in the process. Periodic and ongoing monitoring will help countries to be better informed about this type of marketing. The infant food industry should have no role in drafting measures to protect health due to the obvious conflict of interest. For their part, governments need to ensure that no undue influence is exerted on decision makers that may adversely affect the public.

The Guidance provides clarity in steering those involved with infant and young child feeding away from engagements with the baby food industry.

Implementation of 2016 Guidance in WCAR

In 2020, Hellen Keller International, with the support of UNICEF WCARO carried out an assessment in 23 countries in the region[viii] of the level of awareness and extent of integration of the seven recommendations of the WHO Guidance into national regulations, acts, policies, strategies and plans.[40] The assessment gathered data from both an online survey and a desk review of relevant country documents. Nearly all the 41 respondents to the online survey from 16 countries were aware of the Code but many fewer were familiar with the Guidance. The assessment also found that none of the 23 countries had incorporated all seven recommendations into national measures. The research also highlighted the difficulty for countries to implement Recommendation 3 due to the lack of national and regional standards that cover composition, safety, quality and nutrient levels for foods for infants and young children as well as the absence of dietary guidelines for these food products.

Lack of monitoring and enforcement

It is not enough to simply have measures in place that implement the provisions of the Code and relevant WHA resolutions; laws and regulations must be monitored and enforced. To this end, governments must designate competent authorities that can clearly define responsibilities and powers to investigate and enforce. There must be a designated team of trained inspectors, monitoring tools and a dedicated budget or funding. A majority of the 18 countries in the region that have taken the important step of adopting a legal instrument to implement the Code lack a sufficient mechanism for monitoring and enforcement.

> *It is not sufficient to have measures in place to implement the provisions of the Code and relevant WHA resolutions.*

Nigeria is one of few examples in the region with a functioning system. In Nigeria, the National Agency for Food and Drug Administration (NAFDAC) is the agency designated by law as responsible for monitoring and enforcement. Within the Agency, an intersectoral technical committee was established, which developed monitoring questionnaires, checklists and training manuals. The agency trained technical staff, health workers as well as journalists and other media practitioners in their use. Each of the 36 NAFDAC state offices has a designated desk officer to oversee application of the regulations on marketing of breastmilk substitutes. A mobile application for monitoring and reporting violations in real time is currently being finalised.

Cote d'Ivoire adopted a set of a set of legal instruments in 2021 aimed at the application of its 2013 decree on the marketing of breastmilk substitutes, which included the creation of a commission for the authorisation to market the designated products[41] and the definition of the required conditions for authorisation.[42] A national committee for the promotion, protection and support of breastfeeding and early childhood development was also established.[43]

Technical support for monitoring and enforcement

Technical support is available to governments in establishing a system to monitor compliance with existing legal measures. In 2014, WHO and UNICEF established the Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly Resolutions (NetCode). NetCode developed a toolkit to assist governments, institutions and non-governmental organizations in monitoring and enforcing compliance with national measures or the Code itself in the absence of national legal measures. One of its essential tools is the NetCode protocol for ongoing monitoring.[44] This protocol describes the

viii. The assessment did not include Mauritania.

process for establishing a system of compliance monitoring that would ideally be integrated into existing national regulatory and enforcement systems. The protocol provides a step-by-step guide for countries to put a system in place so that violations can be detected, documented, investigated, validated, and punished and/or reported.

Governments and civil society organizations can also conduct periodic assessments of compliance with the Code, WHA resolutions and national laws. The NetCode protocol for periodic monitoring is a tool that can be used to quantify the level of compliance with national laws or the Code and resolutions at a particular moment in time.[45] A Code monitoring kit is also available from the International Baby Food Action Network (IBFAN), and has often been used by NGOs involved in infant and young child nutrition.[46] The information obtained from periodic monitoring can be used to advocate for adoption of measures in countries where they do not yet exist or can reveal gaps and limitations of national measures so that they may be strengthened. Monitoring can also help governments to identify priority areas for enforcement and/or name and shame companies that fail to comply.

Some countries in the region have plans underway to conduct monitoring studies or to assess how to integrate monitoring into their existing enforcement capabilities, and a few have already used the available monitoring tools. In 2019, Cote d'Ivoire commissioned a study in Abidjan health care facilities using the NetCode tool for periodic monitoring.[47] The results will be used to strengthen monitoring and enforcement in the country. The Access to Nutrition Foundation (ATNF) used the tool to assess the marketing of breastmilk substitutes in Nigeria in 2018.[48] In Senegal, as part of its ARCH project, Helen Keller International assessed promotion at points-of-sale and in healthcare facilities, as well as television advertisements for breastmilk substitutes and complementary foods. [49]

NetCode developed a toolkit to assist governments, institutions and non-governmental organizations in monitoring and enforcing compliance with national measures or the Code itself in the absence of national legal measures.

Other support and resources

Technical support from UNICEF, WHO and partner organizations can be instrumental for countries at any stage of Code implementation, including in advocacy to get Code implementation onto the national agenda, drafting legal measures, following the draft through the often-long process of approval and adoption as well as in developing or strengthening capacity for monitoring and enforcement. Some available resources that can assist governments and organizations include the WHO implementation guide for the 2016 Guidance,[50] and the IBFAN Code Essentials Guide.[51] As part of the efforts to protect breastfeeding and save lives, in 2022, UNICEF, WHO, Alive & Thrive, HKI and IBFAN, in collaboration with the West African Health Organization (WAHO), have developed a regional model law for regulating the marketing of breastmilk substitutes, foods for infants and young children and related feeding utensils in the region.[52] The French and English versions of the Model Law are included in the list of "useful resources" at the end of this report. It can be disseminated widely and where needed used to guide national counterparts in drafting new or adjusting existing national regulations to ensure that all children are protected from aggressive marketing by breastmilk substitutes companies.

Advocacy tools are also available to convince political leaders of the need to invest in strategies and social policies that protect, promote, and support breastfeeding. Policies that lead to optimal infant and young child

feeding save lives, improve health for both mothers and children, and lower health care costs and loss of future wages from reduced cognitive capacity. The regional initiative "Stronger with breastmilk only" focuses on advocacy and social behaviour change to drive countries in West and Central Africa towards the global goal of achieving the target of 50 per cent of mothers exclusively breastfeeding through the first six months by 2025. Materials have been developed to engage multiple audiences at different levels.[53]

Another key tool for advocacy is the Alive & Thrive "Cost of not breastfeeding tool", which allows countries to estimate future economic losses associated with the absence of recommended breastfeeding practices. The costs of not breastfeeding have been estimated at US$ 300 billion per year globally.[54]

The revitalisation of the Baby Friendly Hospital Initiative (BFHI) can also stimulate national action around implementation of the Code. Although application of the Code was always a major component of BFHI, it was not included in the original Ten Steps to Successful Breastfeeding. However, full compliance with the Code and relevant WHA resolutions is now included in step one.[55]

In parallel with adopting and enforcing legal measures based on the Code, policy makers should ensure that health workers are aware and informed about their responsibilities to support optimal infant and young child feeding, and to avoid activities that lead to conflicts of interest, such as accepting financial benefits from companies that market products within the scope of the Code and related national legislation. Policymakers themselves, whether in government, UN agencies or civil society must also be wary when accepting funds or support from infant food companies for education or initiatives related to nutrition, as such collaborations or partnerships may be inconsistent with public health nutrition goals.

Media outreach should also be developed and supported to inform the public, infant food manufacturers and distributors about the Code and national measures. For those countries that have yet to take action to implement the Code, particular efforts are needed to identify and overcome the obstacles. It will also be important for regional platforms such as the Economic Community of West African States (ECOWAS), the Economic Community of Central African States (ECCAS) and the West African Health Organization (WAHO) to better incorporate the promotion, protection and support for breastfeeding into their agendas. Parliamentarians can also play a role in the region through their West and Central Africa regional network for nutrition and by forming national networks for nutrition.

PART II:

SUPPORTING WOMEN AND FAMILIES IN THE WORKPLACE

© UNICEF/UN0205719/Njiokiktjien VII Photo

Maternity Protection: Where do we stand?

Many women indicate that returning to work is one of the main reasons they stop breastfeeding exclusively or at all.[56] Mothers should not have to choose between work and the health and well-being of their infants. Enacting or expanding maternity protection legislation is a vital element of government action to better enable mothers to breastfeed exclusively for the first six months and to continue breastfeeding into the second year and beyond. Supportive workplace policies enable parents to meet their children's health, nutritional and developmental needs and also improves maternal health outcomes.[57] Economic benefits also accrue to families, businesses, and society. Paid maternity leave has been shown to increase women's participation in the workforce, ensure income security and increase wages. Businesses benefit from better performance and commitment to work, lower turnover and absenteeism, healthier workers and an improved image as a socially responsible company.[58]

Mothers should not have to choose between work and the health and well-being of their infants. Enacting or expanding maternity protection legislation is a vital element of government action to better enable mothers to breastfeed exclusively for the first six months and to continue breastfeeding into the second year and beyond.

Most countries base maternity protection legislation on the International Labour Organization (ILO) Maternity Protection Convention, 2000 (No. 183), and its accompanying Recommendation (No. 191). At a minimum, countries should adopt legislation assuring working women a period of paid maternity leave as well as job protection.[59] The ILO convention mandates a minimum of 14 weeks leave while Recommendation No. 191 calls for an 18-week minimum. Legislation and policies should also enable women to continue breastfeeding in the workplace by mandating breaks for breastfeeding or milk expression as well as private, clean and comfortable facilities to breastfeed or to express and safely store their breastmilk.[60]

In WCAR, 17 of 24 countries provide the minimum of 14 weeks maternity leave. Gambia exceeds the ILO recommendation by providing 24 weeks leave[61] **(Table 1)**. The legislation in all countries in the region mandate that the leave should be paid (most at 100 per cent).

Number of weeks paid leave	Countries
< 14	Cape Verde, Equatorial Guinea, Ghana, Guinea Bissau, Nigeria, Sao Tome & Principe, Sierra Leone
14-17	Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Congo DRC, Cote d'Ivoire, Gabon, Guinea, Liberia, Mali, Mauritania, Niger, Senegal, Togo
>17	Gambia

Table 1. Duration of paid maternity leave in WCAR

International Labour Organization. (2014). Maternity and paternity at work: law and practice across the world. ILO, Geneva, Appendix II. https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/@publ/documents/publication/wcms_242615.pdf

Eighteen countries in the region mandate paid breastfeeding breaks when mothers return to work and four countries provide for unpaid breaks. Only one country does not entitle women to breastfeeding breaks **(Figure 2)**. The duration of the entitlement to breaks in the 22 countries ranges from 6 to 18.5 months **(Figure 3)**. Even though Maternity Protection Recommendation 191 calls for all employers to provide nursing or childcare facilities at or near the workplace regardless of the number of workers, only two countries mandate the provision of such facilities, and only for enterprises with over 25 or 50 workers.[62] Paid paternity leave in the region is either short (20 days or less) or non-existent.[63] Annex 1 provides information by country regarding most of the elements of the Maternity Protection Convention and Recommendation 191.

Challenges and opportunities

In nearly all countries in the region, maternity protection measures do not go far enough in enabling working parents to nourish and care for their infants and young children. Most working parents in the region do not benefit from maternity or parental benefits, as the laws only apply to women in the formal sector or those working full time. In Africa, women are more likely to be engaged in the informal economy. According to a recent analysis, 74 per cent of women in contrast to 61 per cent of men in sub-Saharan Africa are more likely to be employed in lower-paying, informal jobs.[64] ILO estimates that around 830 million women workers around the world are not adequately protected in case of maternity and that 80 per cent of those workers are in Africa and Asia.[65] In half of the WCAR countries, less than 10 per cent of working women are legally entitled to maternity leave. **(Table 2)**.

According to the ILO, an increasing number of countries are engaged in developing strategies to address the lack of maternity benefits for this large number of working women, although much more effort is required to achieve universal coverage. Solutions include moving national maternity benefit schemes away from full employer liability towards more reliance on social security and tax-financed cash transfers for women not covered by social security.[66] Other countries are considering formalising certain sectors of the informal economy such as domestic workers.[67]

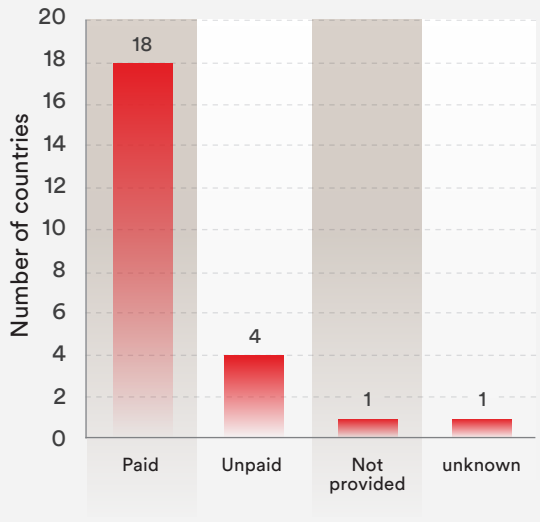


Figure 2. Statutory provision of breastfeeding breaks

International Labour Organization. (2014). Maternity and paternity at work: law and practice across the world. ILO, Geneva, Appendix VII. https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/@publ/documents/publication/wcms_242615.pdf

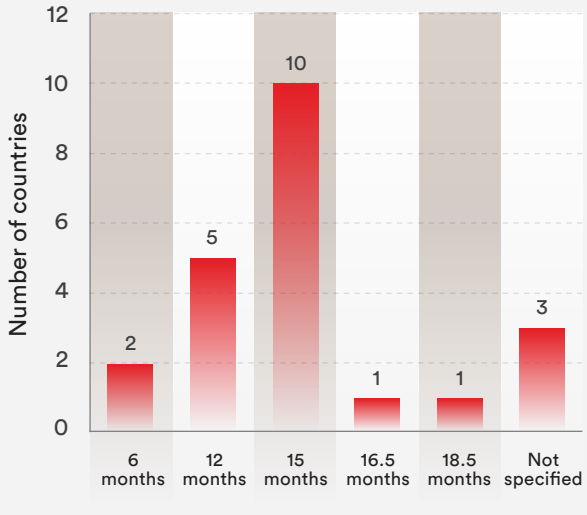


Figure 3. Duration of entitlement to breastfeeding breaks

International Labour Organization. (2014). Maternity and paternity at work: law and practice across the world. ILO, Geneva, Appendix VII. https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/@publ/documents/publication/wcms_242615.pdf

According to the ILO, an increasing number of countries are engaged in developing strategies to address the lack of maternity benefits for this large number of working women, although much more effort is required to achieve universal coverage.

Even for those women who benefit from paid maternity leave, the length of leave is inadequate to support optimal breastfeeding. Longer leave enables working mothers to breastfeed for longer periods of time.[68] Women with six months or more maternity leave are at least 30 per cent more likely to maintain any breastfeeding for at least the first six months of their baby's life. A one month increase in paid leave leads to more than a two-month increase in the duration of breastfeeding.[69] Moreover, a recent study in lower- and middle-income countries found that each additional month of paid maternity leave was associated with nearly eight fewer infant deaths per 1,000 live births.[70]

In addition to the health benefits that accrue from longer periods of maternity leave, recent research from Indonesia and the Philippines demonstrates the cost effectiveness of government financial investment in maternity protection measures. In Indonesia, Alive & Thrive supported research to help the country estimate the costs and financial benefits of expanding paid maternity leave and providing breastfeeding facilities in the workplace. The study showed that governments' costs are lower than the potential savings that would result from reduced child mortality and morbidity, maternal cancer rates and cognitive loss.[71]

In the Philippines, where a substantial number of women work in the informal sector, a recent study looked at the costs to the government of establishing a publicly financed maternity cash transfer programme for the informal sector. The study concluded that the estimated costs of such a programme (less than 9% of

Percent of women workers covered by maternity leave laws	Number of countries
0-9	12
10-32	5
33-65	3
66-89	1
90-100	0
No data	3

Table 2. WCAR coverage of maternity leave laws (% of employed women).

International Labour Organization. (2014). Maternity and paternity at work: law and practice across the world. ILO, Geneva, Appendix III. https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/@publ/documents/publication/wcms_242615.pdf

In nearly all countries in the region, maternity protection measures do not go far enough in enabling working parents to nourish and care for their infants and young children.

the total budget of the Department of Health) would seem "affordable especially in light of the economic gains from positive health and non-health outcomes associated with improved breastfeeding rates and female labour force participation."[72] Countries in the region need to be supported to estimate costs of expanding paid maternity leave and the provision of breastfeeding facilities at the workplace in order to determine cost-effectiveness of such measures.

As a leading partner in the Global Breastfeeding Collective, UNICEF calls for governments, "to enact paid family leave and workplace breastfeeding policies, building on the International Labour Organization's maternity protection guidelines as a minimum requirement, including provisions for the informal sector." UNICEF also calls on governments and businesses to invest in family-friendly policies that give children the best start in life while also boosting productivity and women's empowerment (**Box 6**).

Box 6.

UNICEF Call to Action: Investing in family-friendly policies

1. Paid Parental Leave to Care for Young Children

Sufficient paid leave to all parents and guardians, in both the formal and informal economies, to meet the needs of their young children. This includes paid maternity, paternity, and parental leave, and leave to care for sick young children.

2. Supporting breastfeeding

Supporting the ability of mothers to breastfeed exclusively for six months, as recommended by global endorsed standards, and to continue breastfeeding for as long as they choose.

3. Affordable, Accessible and Quality Childcare

Ensuring that all children have access to affordable, quality childcare and early education.

4. Child benefits

Providing child benefits and adequate wages to help families provide for young children.

https://www.unicef.org/early-childhood-development/family-friendly-policies

Such policies require cooperation among governments, UN agencies, civil society and the private sector. Governments can go beyond legislation by supporting benefits for working mothers and fathers through national social security systems, tax incentives and subsidies to businesses for workplace changes. Governments can also work with industry to support public childcare facilities for employees of businesses and even ensure access to workers in the informal economy.

In Bangladesh, for example, UNICEF helped to launch the Mothers@Work programme, aimed at increasing working mothers' ability to return to work and continue breastfeeding. The programme has been rolled out in 80 factories that employ women of reproductive age.[73] UNICEF also supported development of a model baby-friendly workplace initiative at a tea plantation in Kenya. A study of the effects of interventions to support breastfeeding in the workplace in Kenya showed that the probability of exclusive breastfeeding among children under

6 months increased fourfold over those not benefitting from the interventions.[74] In Rwanda, UNICEF partnered with the tea industry to create family-friendly workplace policies such as the establishment of early childhood development centres at tea plantations.[75] UNICEF also adapted a guide to help employers create breastfeeding rooms and other policies to support breastfeeding in the workplace.[76] It is hoped that evidence generated from such initiatives can demonstrate the "feasibility, effectiveness and cost-effectiveness of supporting breastfeeding in the workplace and showcase its benefits for children, families, communities and businesses."[77]

CONCLUSION

Progress in West and Central Africa is encouraging but far from complete to fully protect breastfeeding and provide all children with the best start in life. Since our publication marking 25 years of the Code, the number of countries in the region that have adopted legislation to implement the Code has increased and many of the remaining countries are taking substantive actions towards that goal, but much more is needed. Governments in the region require support in ensuring that existing or new legal measures incorporate all provisions of the Code and subsequent WHA resolutions, including the 2016 Guidance. National measures must be drafted to include all milk formula promoted for feeding infants and young children up to the age of three years.

Restrictions on the way that foods and drinks for older infants and young children are marketed, including complementary foods, must also be incorporated into national laws. Governments need to assess national measures to determine if digital marketing strategies are effectively prohibited as well as promotional strategies that target health workers. The absence of monitoring and enforcement mechanisms to implement existing national laws and regulations is also a significant barrier to progress in ending the inappropriate marketing of breastmilk substitutes and other foods for infants and young children.

Governments also need advocacy and support to adopt or strengthen maternity protection legislation and other family-friendly policies to better enable women to continue breastfeeding and care for their children when they return to work. It is vital that all key stakeholders across the region act and make breastfeeding a public health and developmental priority in order to improve the health, well-being and prosperity of children and nation. This momentum will pave the way for success in protecting, supporting and promoting optimal breastfeeding practices for every child in West and Central Africa and will contribute to the achievement of the global nutrition targets.

USEFUL RESOURCES

Source	Access to key resources
Breastfeeding	
Alive & Thrive	Policy brief: The Global cost of not breastfeeding
Alive & Thrive	Cost of not breastfeeding tool
Global Breastfeeding Collective	Global Breastfeeding Collective website
Lancet	Breastfeeding Series 2016
UNICEF and partners	Stronger with Breastmilk Only campaign website
World Health Organization/UNICEF	Global nutrition targets 2025: breastfeeding policy brief
World Health Organization	Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative (2018)
International Code of Marketing of breastmilk substitutes	
Changing Markets	Report: Milking it: How milk formula companies are putting profits before science (2017)
Food and Agriculture Organization/ World Health Organization	Codex Alimentarius International food standards
Global Breastfeeding Collective	Advocacy brief: Breastfeeding and the International Code of Marketing of Breastmilk Substitutes
Helen Keller International	Assessment & Research on Child Feeding
IBFAN-ICDC	Code and Resolutions (Compilation 2018)
IBFAN-ICDC	Breaking the rules, stretching the rules 2017: Evidence of Code Violations from June 2014 to June 2017
IBFAN-ICDC	IBFAN monitoring kit 2019 (Available for purchase)
IBFAN-ICDC	Code Essentials 2: Guidelines for policy makers on Implementing the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions with Model Law

Save the Children UK	Report: Don't push it: Why the formula milk industry must clean up its act (2018)
UNICEF WCARO	Sokol, E, Aguayo, V., Clark D. (2007). *Protecting Breastfeeding in West and Central Africa: 25 Years Implementing the International Code of Marketing of Breastmilk Substitutes,* UNICEF WCARO, Dakar. https://pubmed.ncbi.nlm.nih.gov/18947028/
World Health Organization	International Code and WHA resolutions
World Health Organization	Guidance on ending the inappropriate promotion of foods for infants and young children (2016)
World Health Organization	Guidance on ending the inappropriate promotion of foods for infants and young children: Implementation manual (2017)
World Health Organization	Marketing of breastmilk substitutes: National implementation of the international code, status report (2022)
World Health Organization/UNICEF	How the marketing of formula milk influences our decisions on infant feeding (2022)
World Health Organization	Scope and impact of digital marketing strategies for promoting breast-milk substitutes. WHO, Geneva (2022)
World Health Organization	NetCode toolkit (2017)
UNICEF/WAHO, Regional Model Law for West and Central Africa regulating the marketing of breastmilk substitutes, foods for infants and young children and related feeding utensils (2022)	https://www.aliveandthrive.org/en/resources/regional-model-law-for-regulating-the-marketing-of-bms
Maternity Protection	
Global Breastfeeding Collective	Advocacy brief: Breastfeeding and family-friendly policies
Global Breastfeeding Collective	Maternity leave legislation in support of breastfeeding: case studies around the world
International Labour Organization	Maternity and paternity at work: law and practice across the world (2014)
UNICEF	Policy Brief: Family-friendly policies, redesigning the workplace of the future

APPENDIX: ANNEX 1

Maternity protection UNICEF WCAR	Coverage in law maternity leave (% of employed women)a	Maternity leave duration	Amount of maternity leave cash benefits (% of previous earnings)	Source of funding	Paternity leave duration and cash benefits as % of previous earnings
Benin	0-9	14 weeks	100%	Mixed (50% social insurance; 50% employer)	10 days 100%
Burkina Faso	0-9	14 weeks	100%	Social security (social insurance)	10 days 100%
Cameroon	10-32	14 weeks	100%	Social security (social insurance) and employer must make up difference.	10 days 100%
Cape Verde	33-65	9 weeks	90%	Social security (social insurance)	None
Central African Republic	0-9	14 weeks	50%	Social security (social insurance)	10 days 100%
Chad	0-9	14 weeks	100%	Social security (social insurance)	10 days 100%
Congo	0-9	15 weeks	100%	Mixed (50% social insurance; 50% employer)	10 days 100%
Congo DRC	0-9	14 weeks	66,70%	Employer liability	2 days 100%
Cote d'ivoire	10-32	14 weeks	100%	Social security (social insurance)	10 days 100%
Equatorial Guinea	66-89	12 weeks	75%	Social security (social insurance)	None
Gabon	33-65	14 weeks	100%	Social security (social insurance)	10 days 100%
Gambia	33-65	24 weeks [b]	100%	Employer liability	10 days with pay [b]
Ghana	10-32	12 weeks	100%	Employer liability	None
Guinea	0-9	14 weeks	100%	Mixed (50% social insurance; 50% employer)	None
Guinea Bissau	0-9	9 weeks	100%	Mixed. The employer is mandated to pay the difference between social security benefits and previous earnings.	None
Liberia	***	14 weeks [c]	100% [c]	Employer liability [c]	None [c]
Mali	0-9	14 weeks	100%	Social security (social insurance)	3 days 100%
Mauritania	10-32	14 weeks	100%	Social security (social insurance)	10 days 100%
Niger	0-9	14 weeks	100%	Mixed (50% social insurance; 50% employer)	None
Nigeria	0-9	12 weeks	50%	Employer liability	None
Sao Tome & Principe	***	9 weeks	100%	Social security (social insurance) (If a woman is not covered by social insurance but otherwise qualifies for maternity leave, her employer is responsible for the full payment of her maternity leave cash benefits).	None
Senegal	10-32	14 weeks	100%	Social security (social insurance)	None
Sierra Leone	***	12 weeks	100%	Employer liability	5 days without pay
Togo	0-9	14 weeks	100%	Mixed (50% social insurance; 50% employer)	10 days 100%

Note:

*** information is not available, could not be identified or is not applicable.

a. The number of workers to whom the law applies as of 2010.

b. Source of data for Gambia: Gambia, Womens Act 2010 and Gambia Labour Act, 2007.

c. Source of data for Liberia: Liberia, Decent Work Act , 2016 I Liberia: Work Act March 2016.

Source for all data unless otherwise indicated: International Labour Organization, 'Maternity and paternity at work: law and practice across the world', International Labour Organization, Geneva, 2014.

Protection from unlawful dismissal during pregnancy	Protection from unlawful dismissal during maternity leave	Right to return to work	Entitlement to breastfeeding breaks	Duration breastfeeding breaks (months)	Total daily duration breastfeeding breaks (minutes)	Provision of breastfeeding facilities mandated
Yes	Yes	Not guaranteed	Unpaid	18,5	60	No
Yes	Yes	Not guaranteed	Paid	16,5	90	No
Yes	Yes	***	Paid	15	60	No
Yes	Yes	***	***	***	***	***
No	No	***	Paid	15	60	Yes, if more than 50 female workers
Yes	No	Not guaranteed	Paid	15	60	No
No	No	Not guaranteed	Paid	15	60	No
Yes	Yes	Not guaranteed	Paid	Not specified	60	No
Yes	Yes	Yes, same position	Paid	15	60	No
Yes	Yes	Yes, same position	Paid	Not specified	60	No
Yes	Yes	Not guaranteed	Paid	12	120	No
Yes b	Yes b	Yes, same terms and conditions [b]	No	***	***	No
Yes	Yes	Not guaranteed	Paid	12	60	No
Yes	Yes	Not guaranteed	Unpaid	15	60	No
No	No	Not guaranteed	Paid	12	60	No
***	***	Yes, same terms and conditions [c]	paid [c]	6 [c]	60 [c]	No
No	Yes	Not guaranteed	Paid	15	60	No
Yes	Yes	Not guaranteed	Paid	15	60	N0
Yes	Yes	Not guaranteed	Unpaid	12	60	Yes, if more than 25 Female workers
Yes	Yes	***	Paid	Not specified	60	No
No	No	Not guaranteed	Paid	12	60	No
No	Yes	***	Paid	15	60	No
***	***	***	Unpaid	6	60	No
Yes	Yes	Not guaranteed	Paid	15	60	No

REFERENCES

1. Victora, C. G., Bahl, R., Barroset, A., et al. for The Lancet Breastfeeding Series Group. (2016). Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *Lancet*, 387, 475–90. https://doi.org/10.1016/S0140-6736(15)01024-7

2. Jones, G., Steketee, R. W., Black, R.E., et al. Bellagio Child Survival Study Group. (2003). How many child deaths can we prevent this year? *Lancet*, 362, 65–71. https://doi.org/10.1016/S0140-6736(03)13811-1

3. World Health Organization. (2014). *Comprehensive implementation plan on maternal, infant and young child nutrition*. WHO, Geneva.

4. UN General Assembly. (2015). *Transforming our world: the 2030 Agenda for Sustainable Development*. https://www.refworld.org/docid/57b6e3e44.html

5. United Nations Children's Fund. *UNICEF Database on Infant and Young Child Feeding*. https://data.unicef.org/resources/dataset/infant-young-child-feeding/

6. Pan American Health Organization. (2003). *Guiding principles for complementary feeding of the breastfed child*. PAHO, Washington D.C. and World Health Organization. (2005). *Guiding principles for feeding non-breastfed children 6–24 months of age*. WHO, Geneva.

7. United Nations Children's Fund. *UNICEF Database on Infant and Young Child Feeding*. https://data.unicef.org/resources/dataset/infant-young-child-feeding/

8. World Health Organization. (2022). *Marketing of breastmilk substitutes: national implementation of the international code, status report 2022*. WHO, Geneva. https://apps.who.int/iris/bitstream/handle/10665/354221/9789240048799-eng.pdf?sequence=1&isAllowed=y

9. Access to Nutrition Foundation. (2018). *Access to Nutrition Global Index,* p.20. ATNF, Utrecht.

10. World Health Organization, United Nations Children's Fund. (2022). *How the marketing of formula milk influences our decisions on infant feeding*. WHO, Geneva and UNICF, Geneva https://www.who.int/publications/i/item/9789240044609; International Baby Food Action Network-International Code Documentation Centre. (2017). *Breaking the rules, stretching the rules 2017: Evidence of Code Violations from June 2014 to June 2017*. IBFAN, Penang; Save the Children. (2018). *Don't push it: Why the formula milk industry must clean up its act*. Save the Children, London. https://resourcecentre.savethechildren.net/document/dont-push-it-why-formula-milk-industry-must-clean-its-act/; Zehner, E., Champeny, M. (Guest ed.). (2019). Marketing and Consumption of Commercial Foods Fed to Young Children in Low and Middle-income Countries. *Maternal & Child Nutrition,* 15, Supplement 4. https://onlinelibrary.wiley.com/toc/17408709/2019/15/S4; Zehner, E., Champeny, M., (Guest ed.). (2016). Availability, Promotion and Consumption of Commercial Infant Foods. *Maternal & Child Nutrition,* 12, Supplement 2. https://onlinelibrary.wiley.com/toc/17408709/2016/12/S2

11. World Health Organization, United Nations Children's Fund. (2022). *How the marketing of formula milk influences our decisions on infant feeding*. WHO, Geneva and UNICF, Geneva. https://www.who.int/publications/i/item/9789240044609; Save the Children. (2018). *Don't*

push it, Why the formula milk industry must clean up its act, p.22. Save the Children, London. https://resourcecentre.savethechildren.net/document/dont-push-it-why-formula-milk-industry-must-clean-its-act/

12. World Health Organization. (2022). *Scope and impact of digital marketing strategies for promoting breast-milk substitutes.* WHO, Geneva. https://www.who.int/publications/i/item/9789240046085
13. Ching, C., Zambrano, P., Nguyen, T., et al. (2021). Old Tricks, New opportunities: How companies violate the International Code of Marketing of Breast-Milk Substitutes and undermine maternal and child health during the COVID-19 pandemic. *International Journal of Environmental Research and Public Health,* 18 (5). https://doi.org/10.3390/ijerph18052381
14. World Health Organization. (2016). *Guidance on ending the inappropriate promotion of foods for infants and young children,* A69/7 Add. 1, WHO, Geneva.
15. Lott, M., Callahan, E., Welker Duffy, E., et al. (2019). Healthy beverage consumption in early childhood: Recommendations from key national health and nutrition organizations. Technical Scientific Report, p.24. Healthy Eating Research, Durham, NC. https://healthyeatingresearch.org/wp-content/uploads/2019/09/HER-HealthyBeverageTechnicalReport.pdf
16. Pereira, C., Ford, R., Feeley, A., et al. (2016). Cross-sectional survey shows that follow-up formula and growing-up milks are labelled similarly to infant formula in four low- and middle-income countries. *Maternal & Child Nutrition,* 12, Supplement 2, 95. https://doi.org/10.1111/mcn.12269
17. Champeny, M., Hou, K., Diop, E., et al. (2019). Prevalence, duration, and content of television advertisements for breast milk substitutes and commercially produced complementary foods in Phnom Penh, Cambodia and Dakar, Senegal. *Maternal & Child Nutrition,* 15(5). https://doi.org/10.1111/mcn.12781
18. Rollins, N., Bhandari, N., Hajeebhoy, N., et al. (2016). Breastfeeding 2. Why invest, and what it will take to improve breastfeeding practices? Lancet, 387, 491-504. https://doi.org/10.1016/S0140-6736(15)01044-2
19. Mokhiber, R. (1987). Infant formula: hawking danger in the third world. *Multinational Monitor,* 8(4) https://multinationalmonitor.org/hyper/issues/1987/04/formula.html
20. World Health Organization. (2017). *Guidance on ending the inappropriate promotion of foods for infants and young children: Implementation manual,* p.38. WHO, Geneva. https://apps.who.int/iris/bitstream/handle/10665/260137/9789241513470-eng.pdf
21. Pearson, C. (2020). Formula companies are cashing in on 'toddler milk.' Don't fall for it. *Huffington Post*. 4 February 2020. www.huffpost.com/entry/formula-companies-are-cashing-in-on-toddler-milk-dont-fall-for-it_l_5e39c36cc5b6914853f838e8
22. World Health Organization. (2017). *Guidance on ending the inappropriate promotion of foods for infants and young children: Implementation manual,* p.2. WHO, Geneva. https://apps.who.int/iris/bitstream/handle/10665/260137/9789241513470-eng.pdf
23. Sweet, L., Pereira, R., Ford, R., et al. (2016). Assessment of corporate compliance with guidance and regulations on labels of commercially produced complementary foods sold in Cambodia, Nepal, Senegal and Tanzania. *Maternal & Child Nutrition,* 12, Supplement 2, 106-125. https://doi.org/10.1111/mcn.12268
24. Communication with UNICEF country offices.

25. Emerson, J., Kouassi, F., Kouamé, R., et al. (2021). Mothers' and health workers' exposure to breastmilk substitutes promotions in Abidjan, Côte d'Ivoire. *Maternal & Child Nutrition,* 17(4), 7. https://doi.org/10.1111/mcn.13230

26. Save the Children. (2012). *Breast-milk Substitutes Threaten Young Lives: 2012 Research into Use of Breast-milk Substitutes in Sierra Leone.* Save the Children, Freetown.

27. Wright, C., Waterston, A. (2006). Relationship between paediatricians and infant formula companies. *Archives of Disease in Childhood,* 91(5), 383-385. https://dx.doi.org/10.1136%2Fadc.2005.072892

28. Kouassi F. (2020). *Rapport d'étude, Evaluation des violations du Code de commercialisation des substituts du lait maternel dans les structures de santé, Abidjan, Cote d'Ivoire,* p.16. BEDSAH Int, Alive & Thrive, Programme National de Nutrition, Abidjan.

29. World Health Assembly. (2010). *Resolution WHA63.23.* WHO, Geneva.

30. World Health Organization. (2016). *Guidance on ending the inappropriate promotion of foods for infants and young children,* A69/7 Add. 1. WHO, Geneva. The WHA welcomed the Guidance by Resolution WHA69.9 and called on governments to implement its recommendations.

31. World Health Assembly. (1986). *Resolution WHA39.28.* WHO, Geneva.

32. Codex Alimentarius Commission, *Standard for Infant Formula,* Standard 72-1981.

33. Codex Alimentarius Commission, *Standard for Follow-up Formula,* Standard 156-1987.

34. Codex Alimentarius Commission, *Standard for canned baby foods,* Standard 73–1981; *Standard for processed cereal-based foods for infants and young children,* Standard 74–1981; *Guidelines on formulated complementary foods for older infants and young children,* Guideline 8—1991.

35. Codex Alimentarius Commission, *Proposed draft revised Standard for follow-up formula* (CXS 156-1987) in Report of the forty- second session of the codex committee on nutrition and foods for special dietary uses, December 2021. https://www.fao.org/fao-who-codexalimentarius/sh-proxy/en/?lnk=1&url=https%253A%252F%252Fworkspace.fao.org%252Fsites%252Fcodex%252FMeetings%252FCX-720-42%252FFINAL%252520REPORT%252FREP22_NFSDUe.pdf

36. See Boatwright, M., Lawrence, M., Russell, C., (2021). The Politics of Regulating Foods for Infants and Young Children: A Case Study on the Framing and Contestation, of Codex Standard-Setting Processes on Breast-Milk Substitutes. *Int J Health Policy Management,* x(x), 1-18. https://dx.doi.org/10.34172/ijhpm.2021.161

37. World Health Assembly. (1996). *Resolution WHA49.15.* WHO, Geneva.

38. World Health Assembly. (2005). *Resolution WHA58.32.* WHO, Geneva.

39. World Health Assembly. (2008). *Resolution WHA61.20.* WHO, Geneva.

40. Helen Keller International, *Legal assessment of adoption of World Health Assembly Resolution 69.9- Review of Country Regulations, Policies, Strategies and Plans,* UNICEF WCAR and Helen Keller International, Dakar 2021.

41. Cote d'Ivoire. (2021). *Arrêté n° 687/MSHPCMU/ MCI /MFFE portant création, composition, attribution et fonctionnement, de la Commission d'Autorisation de Commercialisation des Substituts de Lait Maternel.*

42. Cote d'Ivoire. (2021). *Arrêté n° 689/MSHPCMU/MCI fixant les conditions d'autorisation de commercialisation des substituts du lait maternel.*

43. Cote d'Ivoire. (2021). *Arrêté n° 001/SGPR/CAB portant création, attributions, organisation et fonctionnement du Comité National pour la promotion, la protection, le soutien à l'allaitement et au développement de la petite enfance (CNAPE).*

44. World Health Organization, United Nations Children's Fund. (2017). *NetCode toolkit, Monitoring the marketing of breastmilk substitutes: protocol for ongoing monitoring systems.* WHO, Geneva. https://www.who.int/publications/i/item/9789241513180

45. World Health Organization, United Nations Children's Fund. (2017). *NetCode toolkit, Monitoring the marketing of breastmilk substitutes: protocol for periodic assessments.* WHO, Geneva. https://www.who.int/publications/i/item/9789241513494

46. International Baby Food Action Network-International *Code Documentation Centre*. (2019). Code Monitoring Kit, IBFAN, Penang.

47. Kouassi, F. (2020). *Rapport d'étude, Evaluation des violations du Code de commercialisation des substituts du lait maternel dans les structures de santé, Abidjan, Cote d'Ivoire.* BEDSAH Int, Alive & Thrive, Programme National de Nutrition, Abidjan.

48. Access to Nutrition Foundation. (2018). *Marketing of Breastmilk Substitutes: Nigeria 2018,* ATNF, Utrecht. https://accesstonutrition.org/app/uploads/2020/02/BMS_ATNF-Nigeria-BMS-Marketing-_Full_Report_2018.pdf

49. Champeny, M., Hou, K., Diop, E., et al. (2019). Prevalence, duration, and content of television advertisements for breast milk substitutes and commercially produced complementary foods in Phnom Penh, Cambodia and Dakar, Senegal. *Maternal & Child Nutrition,* 15(5). https://doi.org/10.1111/mcn.12781; Champeny, M., Pereira, C., Sweet, L., et al. (2016). Point-of-sale promotion of breastmilk substitutes and commercially produced complementary foods in Cambodia, Nepal, Senegal and Tanzania. *Maternal & Child Nutrition,* 12 (supplement 2). https://doi.org/10.1111/mcn.122772

50. World Health Organization, (2017). *Guidance on ending the inappropriate promotion of foods for infants and young children: implementation manual.* WHO, Geneva.

51. International Baby Food Action Network – International Code Documentation Centre. (2018). *Code Essentials 2: Guidelines for Policy makers on implementing the International Code of Marketing of Breastmilk Substitutes.* IBFAN Penang, 2018. http://www.babymilkaction.org/wp-content/uploads/2020/12/201802-CE2-2nd-Edition-Final.pdf

52. West and Central African Regional Model Law for Breastmilk substitute code, UNICEF 2022.

53. See https://www.breastmilkonly.com/

54. Alive & Thrive. *Cost of not breastfeeding*. https://www.aliveandthrive.org/en/the-cost-of-not-breastfeeding. See Walters, D., Phan, L., Mathisen, R. (2019). The cost of not breastfeeding: Global results from a new tool. *Health Policy and Planning*, 34(6). doi: 10.1093/heapol/czz050

55. World Health Organization. (2018). *Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative.* WHO, Geneva.

56. International Labour Organization. (2014). *Maternity and paternity at work: law and practice across the world.* p.102. ILO, Geneva, https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/@publ/documents/publication/wcms_242615.pdf

57. Bütikofer, A., Riise, J., Skira, M. (2021). The Impact of Paid Maternity Leave on Maternal Health. *American Economic Journal: Economic Policy,* 13 (1), 67-105. DOI: 10.1257/pol.20190022

58. United Nations Children's Fund. (2020). *Breastfeeding support in the workplace: A global guide for employers.* UNICEF, NY.

59. International Labour Organization. (2000). *Maternity Protection Convention 2000,* (No.183), Articles 4 & 6. ILO, Geneva.

60. International Labour Organization. (2000). *Maternity Protection Convention 2000,* (No.183), Article 10; *Maternity Protection Recommendation 2000,* (No. 191), paragraph 9. ILO, Geneva.

61. Gambia, *Women's Act 2010*, § 20.

62. International Labour Organization. (2014). *Maternity and paternity at work: law and practice across the world,* Appendix VII. ILO, Geneva.

63. International Labour Organization. (2014). *Maternity and paternity at work: law and practice across the world,* Appendix IV, ILO, Geneva.

64. Bonnet, F., Vanek, J., Chenet, M. (2019). *Women and Men in the Informal Economy:* A Statistical Brief. WIEGO, Manchester, UK. https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/publication/wcms_711798.pdf

65. International Labour Organization. (2014). *Maternity and paternity at work: law and practice across the world,* p.30. ILO, Geneva.

66. International Labour Organization. (2016). *Maternity cash benefits for workers in the informal economy: Social Protection for All Issue Brief.* ILO, Geneva. https://www.ilo.org/beijing/what-we-do/publications/WCMS_537934/lang--en/index.htm

67. Global Breastfeeding Collective. (2019). *Maternity leave legislation in support of breastfeeding - case studies around the world.* WHO, Geneva. https://www.who.int/publications/i/item/WHO-NMH-NHD-19.25

68. Alive & Thrive. (2012). *Expanding Viet Nam's maternity leave policy to six months: an investment today in a stronger, healthier tomorrow.* Alive and Thrive, Washington DC. https://www.aliveandthrive.org/sites/default/files/attachments/Policy-Brief-on-Maternity-Leave_April-2012-English.pdf

69. United Nations Children's Fund. (2019). *Policy Brief, Family-friendly policies, redesigning the workplace of the future.* UNICEF, NY. https://www.unicef.org/media/95051/file/Family-friendly-policies-EN.pdf

70. Nandi, A., Hajizadeh, M., Harper, S., et al. (2016). Increased duration of paid maternity leave lowers infant mortality in low- and middle-income countries: A quasi-experimental study. *PLoS Medicine,* 13(3). https://doi.org/10.1371/journal.pmed.1001985

71. Siregar, A., Pitriyan, P., Walters, D., et al. (2019). The financing need for expanded maternity protection in Indonesia. *International Breastfeeding Journal,* 14(27). https://doi.org/10.1186/s13006-019-0221-1

72. Ulep, V.G., Zambrano, P., Datu-Sanguyo, J., et al. (2021). The financing need for expanding paid maternity leave to support breastfeeding in the informal sector in the Philippines. *Maternal & Child Nutrition,* 17(2). https://doi.org/10.1111/mcn.13098

73. International Labour Organization. (2019). *Mothers@Work: supporting breastfeeding mothers in the workplace.* ILO, Geneva. https://www.ilo.org/dhaka/Informationresources/Publicinformation/features/WCMS_714837/lang--en/index.htm?ssSourceSiteId=pardev

74. Kimani-Murage, E., Wilunda, C., Macheria, T., et al. (2021). Effect of a baby-friendly workplace support intervention on exclusive breastfeeding in Kenya. *Maternal & Child Nutrition,* 17(4). https://doi.org/10.1111/mcn.13191

75. United Nations Children's Fund. (2019). *New champions of early childhood development emerge in Rwanda.* UNICEF, NY. https://www.unicef.org/rwanda/stories/new-champions-early-childhood-development-emerge-rwanda

76. United Nations Children's Fund. (2020). *Breastfeeding support in the workplace: a global guide for employers.* UNICEF, New York. https://www.unicef.org/documents/breastfeeding-support-workplace-global-guide-employers

77. United Nations Children's Fund. (2018). *Let's make it work: Breastfeeding in the workplace – Using Communication for Development to make breastfeeding possible among working mothers.* UNICEF, New York. https://www.healthynewbornnetwork.org/hnn-content/uploads/Mother_BabyFriendlyWorkplaceInitiativeC4D_web1_002_.pdf

PROTECTING BREASTFEEDING IN WEST AND CENTRAL AFRICA

unicef

for every child