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Campaign for Promotion of Breastfeeding: Evolution, Experience and Future Directions

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This paper traces the breast-feeding promotion-campaign in India in the context of traditional breast-feeding practices and market forces that affect the practice of breast-feeding. It calls for partnership between health personnel, voluntary organizations, law enforcing agencies and the media for more effective outcomes in favor of breast-feeding. Drawing from findings of research on breast-feeding, the author observes that a campaign for promotion of breast-feeding in India must necessarily address itself to cultural practices that interfere with it.

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Introduction

Breast-feeding is the most important form of infant nutrition. Unfortunately there has been a steady decline in breast-feeding practices in the post-industrialized era. Breast milk substitutes, a major threat to breast-feeding, are indeed a big business. The global market in 1983 was estimated to be 3.3 billion dollars Chetley, 1996 and in 1991 over 6 billion Anand, 1996. In India, it is estimated to be 180 million pounds, growing at 6 per cent every year Prakash, 1992. The invasion of the markets with a product seeking to substitute (though poorly) nature's gift to the new born child evoked public resentment in the form of various campaigns.

While this has been the visible context of the campaign for the promotion of breast-feeding in India there are several other socio-cultural practices that interfere with optimal breast-feeding. This paper deals with the visible and not-so-visible aspects of the campaign in India, traces its evolution and identifies the key action components for an effective campaign.

The Visible Context

In the Indian context, as in other countries, aggressive marketing of breast milk substitutes by commercial interests triggered campaigns for promotion of breast-

feeding. Additionally, the promotion of breast milk substitutes by medical professionals challenged traditional breast-feeding practices.

The trend is further reinforced by increasing urbanization processes that do not accommodate the needs of the feeding mother and the infant. With the breakdown of the joint family system, there is an absence of significant other older women in the family who can advise the young mother (particularly if the child is the first born). This often increases the mother's vulnerability and insecurity in breast-feeding the child. The pressures of urban life create stress in women, which interferes with breast-feeding. Distance between the workplace of the mother and residence also demands functional adaptations in coping with breast-feeding. For example, where a mother cannot reach the baby during the day while at work, she can express the milk into a clean cup which can be fed later to the child and give more emphasis on night feeding.

Increasing hospital deliveries are significantly responsible for decline in breast-feeding where medical personnel do not actively promote breast-feeding, but advocate breast-feeding substitutes instead. Under such circumstances, women are less likely to breast-feed their babies. The baby food industry cleverly sought to promote its products through health care facilities. An all-India market study by UNICEFACASH (Anand, 1996) revealed that the incidence of free samples prevailed all over India - it was highest in the country's capital, New Delhi, followed by Eastern, Western and Southern India. Seventy-two per cent of the free samples were given by Nestle; other companies being Dalmia Dairy (24 per cent), Wockhardt (19 per cent) and Raptokos Brett (1 8 per cent). They even sponsored major events for professional medical and nutrition bodies to win their support. Large commercial interests coupled with the teaching of formula milk feeding in medical colleges became major barriers in the promotion of breast-feeding.

Studies on Infant Feeding Reveal the Not-visible Context

The responses of pediatricians, nutritionists, and social scientists to the onslaught of bottle feeding in India, was reflected in the spate of studies on breast-feeding practices and child nutrition in India in the seventies and eighties. [1]

These studies provide interesting insights into the socio-cultural aspects of breast-feeding. From the wide range of studies available, it is evident that there is a strong tradition of breast-feeding in India, especially in the rural areas. Simultaneously, a dramatic decline in breast-feeding is well documented in the urban and semi-urban environment. The rural-urban migration of the poor, the increased interaction of this group with the concomitants of modernization including mass media communication networks, access to job opportunities,

commercial products and their availability, set into a process a consumeristic behavior based on imitation rather than need or rational decision-making. An inverse relationship is observed between socioeconomic status and breast-feeding: the lower income groups pay a heavier price from being deprived of breast milk, for they miss the natural immunity it provides. They are vulnerable to infection not just from unhygienic surroundings, but also due to unsterilized bottles and nipples, unpotable water, excessive dilution of formula due to poverty, and illiteracy. Babies that are exclusively breast-fed are less likely to suffer from diarrhea and upper respiratory illnesses Chitkara and Gupta, 1987; Fernandes, Kathuria and Mondkar, 1991; Gopujkar, Chaudhari, Ramaswami, Gore and Gopalan, 1984. The practice of breast-feeding in addition to satisfying the nutritional needs of the baby also creates a strong mother-child bonding.

Bottle-feeding is a growing phenomenon in rural tribal areas. The bottle feeding culture, though initiated by the power milk industry, is not restricted to feeding powder milk. One can see infants and children being given water, fresh milk, fruit juices and clear soups in feeding bottles. The feeding bottle is an important factor in the infamous malnutrition infection cycle, often reported to be a major cause of infant and child mortality. With scarcity of water and firewood, it is impossible to expect people to sterilize bottles after each feed. Besides, under all circumstances, cup feeding is more hygienic though bottle-feeding may be more convenient.

If mothers are able to meet the hygiene requirements of bottle-feeding, they have a choice to do so, but this should be on an informed basis. They must know that all types of allergy, insulin dependent diabetes mellitis, lymphoma, obesity, sudden infant death syndrome, which are non-infective disorders, are known to increase with bottle feeding.

Appropriate spacing of children has been a crucial concern of the Family Planning Program in India. Studies show that breast-feeding acts as a contraceptive in 98 per cent of women for the first six months, and in 85 to 90 per cent of mothers till they menstruate. These trends invite broader concerns in the breast-feeding promotion campaign in India, besides seeking control over expansion of powder milks, follow-up milks and processed weaning foods.

The campaigns for promotion of breast-feeding arose out of global concern against processed milk substitutes for infants. The World Health Organization (WHO) and the United Nations International Children's Fund (UNICEF) have played a catalytic role in the campaign through advocacy, information and social mobilization.

Code of Marketing for Infant Formulae

During the seventies, several citizens' Groups all over the world started campaigning for controls on advertising and marketing baby foods. In 1972, the International Organization of Consumers Unions (IOCU) submitted a draft code of practice on the advertising of infant foods to FAO/WHO. As the campaign gained momentum, the threat of manufactured breast milk substitutes were taken cognizance of by the WHO and the UNICEF. An international meeting was called 1979 by WHO and UNICEF on infant and young child feeding. Two major outcomes of the meeting were: formation of the International Code of Marketing for Infant Formulae, 1981; and the formation of the International Baby Food Action Network (IBFAN).

The 1981 World Health Assembly adopted the code with an overwhelming majority of 188 to 1 votes. The one dissenting vote was from the United States of America (USA). The possible reason for opposition was the fear of damage to the infant formula companies many of which were in the USA. The code in its entirety was approved as recommendation to all member governments.

In 1986, the same Assembly passed a resolution banning, free and subsidized supplies to hospitals and maternity homes and discouraged the use of follow-up formula for children over six months of age. It urged a total ban on donated and subsidized supplies of infant milk powder. At one point, the UNICEF had actively assisted powder milk industries to reestablish themselves after they were destroyed in the Second World War, on the condition that they would provide free or subsidized powder milk to developing countries. Thus with experience, these agencies had to make functional adaptations in policy and program.

In India, active movements were started by voluntary and consumer groups, including the Consumer Guidance Society of India (CGSI) and the Voluntary Health Association of India (VHAI). They formed a network called the National Alliance for the Nutrition of Infants (NANI). With suasion from these groups, the Government of India adopted code in the form of a resolution in December 1983. The Infant Milk Foods and Feeding Bottles Bill was passed in the Lok Sabha in 1989. It was reintroduced in 1991 but lapsed again for the same reason. In 1992, the 'Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act was finally passed. It came into force from August 1, 1993. It prohibits:

- Distribution of free samples to mothers;
- Advertising to the public;

- Promotion in health care facilities;
- Distribution of gifts or samples to health workers;
- Promotion of words and pictures that idealize bottle feeding;
- Advice to mothers by company sales staff;
- Financial assistance to health organizations or associations of doctors to organize conferences, seminars, and so on; and
- Incentives to sales personnel/retailers based on volume of sales.

The Central Government, has authorized four voluntary organizations to monitor the Act. These are the Central Social Welfare Board, the Indian Council for Child Welfare, the Association for Consumers Action on Safely and Health, and the Breast-feeding Promotion Network of India (BPNI).

Manufacturers are now adapting their promotion strategies in several ways to evade action under the law. So far two cases have been booked under the Act. Johnson and Johnson is charged with promoting bottle feeding by selling feeding bottles at a discount and giving retailers one feeding bottle free with every dozen sold. Nestle is charmed with encouraging the early use of complimentary foods.

Johnson and Johnson tried to promote its products through an article, 'The teat that is stranger than fiction' in the magazine *Health and Nutrition,* published from Mumbai. The claim that their, 'FDA approved liquid silicone nipple' is anti colic was baseless. The claim that the product was approved by FDA was later disowned by the company. The Act, by itself, will not serve much purpose. It is necessary to make it work. Therefore, in 1995, the World Breast Feeding Week in India was observed alone the theme, 'Making the Act Work' to bring about greater public awareness.

The Innocent Declaration, 1992

The Convention of the Rights of the Child, led to the formulation of the Innocent Declaration where 32 governments and ten UN agencies participated. The Innocent Declaration set four national targets to achieve by 1995:

1. To appoint a national level coordinator and establish a multisectoral national committee with representatives from the government, non-government organizations and the health profession.

2. TO ensure that the health care institutions concerned with maternity services practice the ten steps to successful breast-feeding set out in the WHO/UNICEF statement.

3. To effect changes in marketing breast milk substitutes.

4. Enact legislation to protect the rights of working women to breast-feed their child.

Recognizing hospital deliveries of children as a major reason for decline in traditional breast-feeding patterns, the Innocent Declaration requires every facility providing maternity services and care for newborn infants to follow the '10 Steps to Successful Breast-feeding".

1. Have a written breast-feeding, policy that is routinely communicated to all the health care staff.

2. Train all health care staff in skills necessary to implement this policy.

3. Inform all pregnant women about the benefits and management of breast-feeding.

4. Help mother initiate breast-feeding within half an hour of birth.

5. Show mothers how to breast-feed and how to maintain lactation even if they should be separated from their infants.

6. Give newborn infants no food or drink other than breast milk, unless medically indicated.

7. Practice rooming-in that is allow mothers and infants to remain together 24 hours a day.

8. Encourage breast-feeding on demand.

9. Give no artificial teats/pacifiers to breast-fed infants.

10. Foster the establishment of breast-feeding support groups and refer mothers to them on discharge from hospital/clinic.

The Innocent Declaration led to the World Summit for Children, which finally led to the formation of the World Alliance for the Breast-feeding Action (WABA), a consortium of major international NGOs in 1991.

Baby Friendly Hospitals

One important aspect of actually moving towards the targets set by the Innocent Declaration is the Baby Friendly Hospital Initiative (BFHI) launched in 1992. India has been one of the first supporters of the BFHI. Even before the BFHI came into India, the country's first Human Milk Bank had been established, in the mid-eighties, in the Lokmanya Tilak Hospital, Mumbai. However, this is an isolated example and cannot be interpreted as a response of hospitals to promote breast-feeding. India, in its National Program of Action for Children, set itself the goal to ensure that at least 1000 hospitals became 'Baby Friendly', by 1995. One-third of this target was achieved.

In 1993, a National Task Force for the BFHI was formed with representatives from voluntary and professional bodies. Under this project a training manual and video was produced. This global internal and external assessment criteria were adapted to the Indian context.

In the first phase, the activity spanned five cities, and core trainers and assessors were created. In the first eighteen months, eighteen hospitals were classified officially as being BFHI, and the campaign spread to other areas. Taking into consideration the size and diversity of the country, the National Task Force moved to decentralize the campaign. During 1993 and 1994 coalitions were formed with the State Governments, professionals and the NGOs in fourteen states and state-level task forces were set up to look into training, dissemination of materials/information and to bring about change. This resulted in the increase of Baby Friendly Hospitals from 103 at the start of 1995 to a current number of 376 UNICEF, 1995. The UNICEF 1995 Progress Report on BFHI highlights the following:

- Substantial support of the medical professional establishment (the Indian Medical Association even offers a correspondence lactation course to its members).

- Decentralization of operations to reach out to hospital also and community health personnel.

- To target hospitals/maternity facilities so as to cover medical institutions with maternity services having over 1000 births per year.

- The State Governments of Tamil Nadu and Orissa have instructed all hospitals/maternity facilities within the two states to incorporate the BFHI program into their services.

The BPNI was formed in December, 1991. The network was an outcome of a ten-day workshop, 'Recent Advances in Human Lactation and Breast-feeding Management', jointly organized by the Indian Academy of Pediatrics (IAP), Federation of Obstetrics and Gynecological Societies of India (FOGSI) and Association for Consumer Action on Safety and Health (ACASH). The BPNI has a membership of 653 spread over 150 cities in India. It has 20 state and 100 city coordinators. It is primarily involved in:

- Training of medical personnel;
- Organizing World Breast-feeding Week (WBW) with WABA;
- Publications;
- Training materials;
- Research;
- Video production;
- Monitoring the implementation of the Infant Milk Substitutes, Feeding Bottles and Infant Foods Act (1992); and
- Introduction of topics related to breast-feeding in medical schools related professional training.

The BPNI is also involved with the National Task Force of' the BFHI. It trains personnel and monitors the BFHI BPNI, 1996a.

The Maharashtra Branch of the BPNI recognized the need to tie up with the state health machinery, to be able to make headway in government run health infrastructure, which forms a large chunk of services. Out of this need, emerged the Maharashtra Breast-feeding Promotion Initiative (MBPI), in May 1994. Its terms of reference are formulation, support and monitoring of groups for the three components of training, BFHI assessment and the monitoring of the Act.

As a result of the government resolution passed in April 1995, a committee comprising representatives from government departments and professional bodies has been constituted under the chairpersonship of the Director General, Health Services. This is a welcome initiative, for it offers an opportunity to several bodies in the state to contribute to the promotion of breast-feeding, like the BPNI, Directorate of Medical Education and Research, Indian Medical Association (IMA), Indian Academy of Pediatrics (IAP), FOGSI, National

Neonatal Forum, Trained Nurses Association of India (TNAI), Indian Association of Preventive and Social Medicine, Association of Consumer's Action on Safety and Health and the NICEF.

Legislation Favorable to Breast-feeding

Articles 42, 47, 39, and 15(3) in the Constitution of India provide the basic framework for legislation concerning maternity. They place emphasis on the provision of maternity relief at the workplace; state responsibility for nutrition and improvement of public health and ensure that the health and strength of men and women workers as well as children as a whole are not exploited; and that children are given opportunities and facilities to develop into healthy citizens with freedom and dignity.

The Factories Act, 1948; the Mines Act, 1950; the Plantations Act, 1951; the Bidi and Cigar Workers Act, 1966; the Contract Labor Act, 1970; the Inter-state Migrant Workers Act, 1980 - all provide for the setting up of creches at the workplace. A creche at the workplace helps the working mother to breast-feed the baby. The present legislations are linked to the number of working women in a given establishment. Instead, the criteria should be the number of eligible infants and children of all employees.

The two main Acts dealing with maternity benefits are the Employees State Insurance Act, 1948, and the Maternity Benefit Act, 1961. There have been several amendments to these Acts since they came into force. Maternity leave of 12 weeks is permitted. The mother can distribute this before/after delivery as per her convenience. In some states like Punjab and Haryana, 24 weeks of maternity leave is permitted. The difficulty with these maternity benefits is that they apply only to the organized sector, while the vast majority of women in the unorganized sectors cannot avail of them.

It is well-known that legislation is supportive to public awareness and education. By itself it can achieve little. The role of the Government in the campaign has been mainly by way of enacting favorable legislations. Besides this, it has program of supplementary feeding for pregnant and lactating mothers. It has Generally been supportive of voluntary organizations, though financial support has been minimal.

The Role of Professional Bodies

Medical education on infant feeding dealt in minute detail on the preparation of formula feeds for different acre groups of infants. Breast-feeding was never dealt with. It was perhaps taken for granted. Thus, professionals were trained to

advise on bottle-feeding. Further, it was no secret that the infant milk industry used health professionals to promote their products.

In this context, it is interesting to note that the movement for promotion of breast-feeding in India is lead by pediatrician today. Since 1980, the IAP has been moving towards independence from the baby food industry. Around this period, Nestle, the third largest producer of substitute breast milk products had offered a donation to an IAP official. The Academy unanimously refused the offer as they saw a conflict of interest. The Academy's workshops on consumer protection and lactation management are held without aid from the baby food industry. The pediatric quiz for undergraduate students is also now conducted by the Academy in place of Nestle and Wipro, the companies that had been doing it for several years (Anand, 1996).

In 1994, a brand leader among, multinational formula companies in India offered to pay all the expenses of the Academy's 8th Asian Congress of Pediatrics (estimated to be Rs. 10-15 million). The offer was turned down. The IAP being a medical professional body, has been responsible for roping in several other medical professional bodies like IMA, FOGSI, TNAI, and others (Anand, 1996). The IMA, with a membership of 1,00,000, has decided not to take any support from the baby food industry (Anand, 1996).

Some professionals in India have contributed chapters on infant and child feeding in medical textbooks, with an emphasis on promotion of optimal/correct breast-feeding. There have been no revisions in the curriculum.

According to one view, the curriculum does not state whether the subject of infant and child nutrition should or should not be dealt with. The abberation has occurred on account of contents in textbooks. Thus if this is corrected, the remaining will follow.

Role of Voluntary Organizations

In the 1970s, citizen groups and voluntary organizations alerted policy, makers of the dangers from the invasion of the Infant Milk Foods industry in developing countries, including India. Urged by these groups, under the banner of NANI, the Government of India adopted the Infant Milk Code as a policy in 1983.

The VHAI, an NGO with nationwide network, played an important role to monitor the implementation of the Code. A major campaign called Nutrition Information Service was initiated by the VHAI, in alliance with the UNICEF, to protect and promote breast-feeding in June 1983. Information was disseminated

all over the country in local languages to mothers, health workers and policy makers.

The Association for Consumers Action on Safety and Health, set up in 1986, is another voluntary organization which played a pioneering role in the movement for promotion of breast-feeding. Though it serves as an information center to educate, guide and disseminate information in the field of health and safety issues, its primary focus is on breast-feeding promotion which is reflected in its activities. It played an instrumental role in drafting the 1992 Act and is one of the agencies authorized by the Government of India to monitor the implementation of the Act. It is engaged in the training of health personnel and paraprofessionals, publication of relevant materials, preparation and dissemination campaign materials and formation of mother support groups for breast-feeding. The field level activities are restricted to Mumbai only. It is, perhaps, the only voluntary organization in the country which is engaged in advocacy, information dissemination, training and social mobilization for promotion of breast-feeding.

The planning Association of India started working on this issue through its Mobile Education and Service Units in response to a related government circular issued in 1993. It has programs with young mothers, mothers-in-law, and pregnant and lactating mothers. It also observes the World Breast-feeding week from August 1 to 7, every year. Besides the above, there are not many grassroots level voluntary organizations working in this filed in a sustained manner.

The Role of the UNICEF

The UNICEF has been one of the major global actors for promoting breast-feeding through a strategy of advocacy, information and social mobilization. It includes:

- Addressing international fora on importance of breast-feeding;

- Monitoring electronic and print media to understand current trends and maintain regular contact with media personnel;

- Advice and information in the form of materials (produced with Greeting Card Operation) to the national coordinators as well as the committees along with material when requested is given;

- Different communication tools to other change agents (medical professionals, leaders, mothers, and so on) have been prepared to enlist support; and

- Global attention and information dissemination on breast-feeding in the form of UNICEF publications.

The programs for promotion of breast-feeding in India are mainly supported by the UNICEF. The UNICEF also supports some activities of professional bodies which were formerly supported by the baby food industry.

Discussion

The efforts that have gone into the promotion of breast-feeding, well qualify to be called a campaign. Its origin is traced to the 1970s. Initiated by peoples' groups, professionals and supported by government efforts through legislations, there is adequate infrastructure related readiness of the system to promote breast-feeding today.

The disturbing facts on infant feeding practices, revealed by recent studies (IMA, 1991, cf.: ACASH and VHAI, 1996; BPNI, 1996b emphasizes the need for intensive education to change practices. A survey of current practices in the infant food market by the VHAI (1991) shows that the use of branded cereals by children of various age groups is growing, and it underscores the need for more intensive campaigning.

Currently, the campaign is mainly hospital-based. Human beings, at large, tend to be influenced by what happens in their family and neighborhood. Once wrong practices have taken root, the efforts in the hospital alone are not adequate to bring change. When significant others in the family and neighborhood discourage new practices and promote adherence to old ways, hospital initiatives alone cannot sustain change in practices by mothers. They are only one of the essential levels of action.

At the Community level, action has been rather limited. There have been some mass media campaigns, but posters and charts have limited scope here. A poster is not able to convey the detail of correct breast-feeding. Use of charts involving much writing (which the nature of this message demands) have limitations in illiterate populations. Video-cassettes seem to have greater potential. However, not many are available. With assistance from the UNICEF, some video cassettes have been prepared in Maharashtra. The message has been treated well in the cultural context of the state. It appears that there is need to prepare more cultural specific materials in various parts of the country. Besides there is need to produce materials considering the specific needs of various groups, for example, the message for the educated elite, higher socioeconomic status groups needs to be couched differently from that for a typical rural group.

Person-to-person contact is crucial in this campaign. Perhaps the current participants of the campaign realize this already, as the 1996 theme of the World Breast-feeding Week is 'Breast-feeding: A Community Responsibility'. Therefore, the future of the campaign is likely to depend on the linkages the professional bodies are able to build with those voluntary organizations having direct contact with communities.

At the community level, sustained efforts in awareness and education are necessary if related behavior is to be influenced. A study by Bharadwaj, Badrul and Zaheer (1991), showed that changes towards preferred breast-feeding practices were, marginal. On the other hand, a study by Bathija and Anand (1987, cf.: Anand, Nigam, Podar and Surekha, 1991, illustrates the positive effects of sustained perinatal counseling on breast-feeding practices. It is only through sustained intervention, that one can influence the attitudes and beliefs of the target population, which are critical elements of behavioral change.

The component must be integrated with continuing programs of community health. The message of breast-feeding was earlier integrated with the Child Health Program in 1979, where the Growth monitoring, Oral rehydration solution, Breast-feeding and Immunization (GOBI) strategy was adopted. Unfortunately, of the four components in GOBI, breast-feeding received minimal attention. It is claimed that the recent decline in the Infant Mortality Rate (IMR) is on account of the breakthrough in the immunization campaigns. It is also believed that promotion of breast-feeding could lead to a much further fall in IMR.

There is need to include this component in the training of community health workers, lady health visitors, auxiliary nurse midwives, traditional *dais,* and so on. The Mahila Mandals must also be geared and equipped to deal with issues of family health. This organization, though prevalent all over the country, has not really received the impetus/direction worth its potential. It is only with a broad-based approach that the intricate details of optimal breast-feeding can be effectively communicated.

There is no data to show how well or badly the Infant Milk Substitute industry is doing in comparison with the seventies. Manufacturers continue to be there and India continues to be a big market. It is clear that the consumer has not shunned these products. It is therefore hoped that the campaign will reach out, in a sustained manner, to individual consumers at the community level through community groups. The BFHI needs to be hastened in both private and governmental hospitals. The workplaces too need to be more friendly to breast-feeding mothers and must provide for nursing breaks, creches, maternity leave and other necessary benefits. In this multipronged strategy the campaign needs

to be supported by educational materials focussing on the needs of different groups. The professional bodies have indeed made a good beginning by disassociating themselves from the baby food industry.

At the content level, the campaign will have to take a stand on promotion of breast-feeding vis a vis risk of HIV transmission through milk of an infected mother and a mother who has AIDS. There is evidence to suggest that the HIV virus can be transmitted from an infected mother to an infant through breastmilk. The chances of this occurrence are estimated to be around 30 per cent. The WHO recommends that in-.the midst of malnutrition, poverty and poor hygiene in developing countries, the advantages of breast-feeding far outweigh the risk of HIV transmission through infected mother's breastmilk. While playing down this risk of HIV transmission in public campaigns may be helpful to prevent large-scale fear of breast-feeding, at the level of an infected mother - whether rich, poor, literate or illiterate - her right to make an informed choice must be respected. In other words, she must know the extent of risk involved and should knowingly choose her options. It would be unethical to impose the risk on the infant, on the assumption that the mother would anyway be unable to seek worthwhile alternatives as she is poor and illiterate. A highly motivated mother may be able to find alternatives, despite these barriers. She must be given a chance.

It is seen that pasteurization of breast milk destroys the HIV virus. Indigenous: pasteurizing techniques need to be researched and developed, to help an immunocompetent HIV infected mother to express her milk and pasteurize it before feeding. Is boiling for 20 minutes an alternative? What could be its adverse effects on the nutritional content? Or the effects of dilution with water to be able to boil it for a period as long as 20 minutes? Will ordinary storage for half an hour kill the virus, with exposure to air? These and many other questions are not addressed in Information, Education and Communication materials for public consumption. Perhaps the technical journals may have findings related to this. The campaign for promotion of breast-feeding deeds to cull these out from technical journals and make them available for public consumption.

Conclusion

From the foregoing discussion, it may be concluded that the breast-feeding promotion campaign in the Indian context needs to address itself to three crucial components. These are shown below with some specific areas of action under each component:

Infant Milk Substitutes

1. Supply Reduction: Legislative restrictions on advertisements, promotion and production.

2. Demand and Reduction: Awareness and education of people, control the promotion of products by health personnel.

3. Medical Bodies: Unanimous weaning away of health professionals from the economic gains of the baby food industry.

Optimal Breast-feeding

1. Awareness and education regarding correct feeding practices, its advantages to mother and child, through sustained interventions.

2. Awareness and education regarding proper nutrition during pregnancy and lactation, through sustained interventions.

3. Community support for the above mentioned interventions.

4. Baby Friendly Hospitals Initiative.

5. Mother friendly workplaces for breast-feeding supported by effective legislations.

6. Proper spacing of children.

7. Non-discriminatory attitudes towards the girl child and her upbringing.

8. Integrate the message in community health programs.

Timely and Appropriate Weaning

Awareness and education on weaning to prevent early and late weaning and to promote the use of natural weaning foods. \

1. Literacy and population control.

2. Income generation programs for women.

3. Non-discriminatory attitudes towards the girl child and her upbringing.

4. Discourage the use of feeding bottle under all circumstances.

5. Effective legislations to curb the manufacture and promotion of processed infant/weaning foods.

The current campaign needs to focus itself on building a stronger partnership between law enforcement agencies, professional bodies and voluntary organizations having contacts at the grassroots level. Thus a person-to-person contact can be established. This will help to break the socio-cultural barriers to optimal breast-feeding. Systematic communication strategies must be developed for individual, group and mass levels of communication, and these must take into consideration the; exact nature of the problem in various socioeconomic strata. Initiatives in hospitals are a very healthy beginning; they need to be intensified. Sustenance of the Baby Friendly status of hospitals is also a matter of concern.

The power of public opinion is immense. The campaign must empower people with the requisite knowledge, attitudes and skills for the promotion of breast-feeding. Only then will they be able to use their judgement in the face of new forms of onslaught by manufactures of infant milk substitutes, and an increasing consumeristic culture influenced by make-believe advertisements and rising incomes. It can also pave the way for better implementation of legislations/acts to promote breast-feeding.

The challenge of conflicting interests reigns supreme before professional bodies, where they are trying to become independent of any influence of the baby food industry, which is indeed big money! How determined they are, will decide the course of the future campaign.

How well health professionals, voluntary organizations and media combine to influence individuals, families and communities in favor of optimal breast-feeding will eventually determine the success of the campaign.

Notes (1) Some of these are: Aggarwal and Aggarwal, 1979; Ananda and Rama Rao, 1962; Arora and Kaul, 1973; Bhandari and Patel, 1973; Mishra, 1979; Roy and Roy, 1971 and Seth and Ghai, 1971.

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