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From the Bottle to the Grave: Realizing a Human Right to Breastfeeding through Global Health Policy

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FROM THE BOTTLE TO THE GRAVE: REALIZING A HUMAN RIGHT TO BREASTFEEDING THROUGH GLOBAL HEALTH POLICY

Benjamin Mason Meier[†] & Miriam Labbok[‡]

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With millions dying each year from a lack of optimal feeding in the developing world, breastfeeding—the optimal form of infant and young child feeding—holds the potential to save more lives than any other public health intervention. Yet despite this unrivaled lifesaving potential, achievable at a comparatively minimal cost, international law has been unable to develop the global policies necessary to ensure the protection, promotion, and support of breastfeeding. As international law has faltered, human rights advocacy has been conspicuously absent in debates on this pressing public health issue.

Although human rights scholarship has acknowledged public health as integral to the human right to health, it has rarely analyzed global breastfeeding policy. This dearth of breastfeeding scholarship transcends human rights specialties, with leading elaborations of health rights,¹ reproductive rights,² women's rights,³ and children's rights⁴ refraining from any significant discussion on

¹ See, e.g., BRIGIT C.A. TOEBES, *THE RIGHT TO HEALTH AS A HUMAN RIGHT IN INTERNATIONAL LAW* (1999) (failing to mention breastfeeding in discussion on the human right to health).

² See, e.g., Rebecca J. Cook et al., *REPRODUCTIVE HEALTH AND HUMAN RIGHTS: INTEGRATING MEDICINE, ETHICS AND LAW* (2003) (containing no significant discussion of breastfeeding); *REPRODUCTIVE HEALTH AND HUMAN RIGHTS: THE WAY FORWARD* (Laura Reichenbach & Mindy Jane Roseman eds., 2009) (same).

³ See, e.g., *WHERE HUMAN RIGHTS BEGIN: HEALTH, SEXUALITY, AND WOMEN IN THE NEW MILLENNIUM* (Wendy Chavkin & Ellen Chesler eds., 2005) (surveying global advances in human rights, but containing no significant discussion of breastfeeding); Audrey R. Chapman, *Monitoring Women's Right to Health Under the International Covenant on Economic, Social and Cultural Rights*, 44 AM. U. L. REV. 1157 (1995) (advocating new approaches to monitoring women's right to health that do not include breastfeeding).

⁴ See, e.g., Aoife Nolan, *The Child's Right to Health and the Courts*, in *GLOBAL HEALTH*

this simple and obvious public health strategy for health promotion. In the absence of a scholarly foundation for human rights in breastfeeding policy, international law has wavered in addressing the global public health harms of breast milk substitute use in the developing world.⁵ Analyzing the shortcomings of international law in addressing this pervasive threat from commercial infant formulas, this Article seeks to incorporate breastfeeding protection, promotion, and support pursuant to the international legal obligations of the human right to health, advancing these legal obligations through a rights-based approach to global breastfeeding policy.

This Article outlines a theoretical framework for a human right to breastfeeding, laying the normative foundation to propose an institutional framework for rights-based global breastfeeding policy. Beginning with the public health harms stemming from a global failure to realize optimal infant feeding, Part I reviews research on breastfeeding's benefits, highlighting the dangers of breast milk substitutes in the developing world and the actions of formula corporations to subvert national health policy. In moving from these national efforts to international law, Part II traces the evolution of global health policy in responding to the marketing of breast milk substitutes and in promoting breastfeeding practice in accordance with public health standards. Given the limited success of these global breastfeeding policies, Part III envisions a human right to breastfeeding, delineating the rights-holders and duty-bearers of such a right in a globalized world. To operationalize this rights-based approach to breastfeeding, Part IV proposes global health policy partnerships to develop international legal mechanisms through which states might translate a right to breastfeeding into global breastfeeding policy reflective of the public health harms of breast milk substitutes in the developing world.

I. BREASTFEEDING AS PUBLIC HEALTH

Breastfeeding is the keystone supporting the successful continuation of a healthy intergenerational life-cycle, preventing infectious disease, facilitating birth spacing, and reducing chronic disease. However, many families use commercial infant formula, imperiling these health benefits to maternal, infant, and child health.

AND HUMAN RIGHTS 135 (John Harrington & Maria Stuttaford eds., 2010) (including no meaningful discussion of breastfeeding).

⁵ The terms 'breast milk substitutes' and 'formulas' are used interchangeably in this Article to refer to those commercial products that seek to replicate and replace breast milk.

Through aggressive marketing in an increasingly deregulated market, formula manufacturers have created a multi-billion dollar industry worldwide, pushing their product far beyond their original markets and causing irreversible health harms, especially in the developing world. Given consistent evidence of poor health outcomes from breast milk substitutes (even under optimal environmental conditions, but with deadly consequences under suboptimal conditions), breastfeeding advocates have long sought to promote exclusive breastfeeding as a universal norm, to be overridden only when medically necessary.

This Part provides background on the public health benefits of breastfeeding and reviews the inherent and consequential dangers associated with undermining breastfeeding through the promotion of infant formula. Breastfeeding has been shown to have a positive, pervasive role in public health—across maternal health and child health, across health promotion and disease prevention, across communicable disease and chronic disease—with breast milk substitutes undercutting these multifaceted benefits. Due to exploitative dependencies on formula and deadly consequences from their use, breast milk substitutes are particularly dangerous in the developing world, where poor sanitation, malnutrition, and poverty conspire to cause the death of millions. Analyzing how social norms regarding breastfeeding are influenced by the marketing methods of transnational infant formula and baby food corporations, this Part concludes that national health policy responses remain woefully inadequate to address formula marketing and to protect, promote, and support breastfeeding.

A. Maternal and Child Health, Development, and Survival

Analytic reviews have repeatedly revealed the enormous impact of breastfeeding on global child health, nutrition, development, and survival. With nearly nine million child deaths each year—primarily in low-income countries, with half in Sub-Saharan Africa⁶—this understanding has drawn attention to the substantial morbidity and mortality burdens attributed to suboptimal breastfeeding conditions: 1.4 million deaths and 43.5 million disability-adjusted life-years

⁶ UNICEF, THE STATE OF THE WORLD'S CHILDREN SPECIAL EDITION: CELEBRATING 20 YEARS OF THE CONVENTION ON THE RIGHTS OF THE CHILD 15, 18 (2009); Press Release, World Health Org. Regional Office for Africa, WHO Regional Director for Africa Urges Intensified Immunization Efforts to Reduce Child Deaths (Dec. 14, 2009), available at <http://www.afro.who.int/en/media-centre/pressreleases/2077-who-regional-director-for-africa-urges-intensified-immunization-efforts-to-reduce-child-deaths.html>.

(DALYs) annually.⁷ This infant death toll is largely attributable to infectious diseases, including diarrhea, pneumonia, measles, malaria, and HIV/AIDS, all of which can be reduced by optimal breastfeeding. These analyses conclude that exclusive breastfeeding for the first six months of life, with continued breastfeeding for at least one year, is the single intervention that could save the largest number of children's lives globally, preventing fifteen percent of child deaths and overcoming health setbacks from preterm and low birth weight deliveries.⁸ Therefore, the World Health Organization (WHO) recommends exclusive breastfeeding for the first six months of life, with continued age-appropriate breastfeeding in both developed and developing countries.⁹

Evolutionarily honed to provide all the nutrients necessary for the survival, growth, and protection of the baby,¹⁰ human milk is a living tissue, with breastfeeding continuing the biological "dyad" established in utero between the infant and mother and providing optimal nutrition for the development and growth of the child.¹¹ Human milk contains all of the nutrients critical to infant growth—a unique balance of proteins, carbohydrates, water, antibodies, hormones, micronutrients, and macronutrients—with the balance of these components adjusting during each feeding and over the course of lactation to provide the most appropriate nutritional content to the infant.¹² Even when the mother's nutrition is poor, the components

⁷ Robert E. Black et al., *Maternal and Child Undernutrition: Global and Regional Exposures and Health Consequences*, 371 LANCET 243, 254 (2008).

⁸ See Gareth Jones et al., *How Many Child Deaths Can We Prevent This Year?*, 362 LANCET 65, 67 (2003); see also Joy E. Lawn et al., *Why Are 4 Million Newborn Babies Dying Each Year?*, 364 LANCET 399, 400–01 (2004) (discussing breastfeeding's influence on survival after the neonatal period). Adding continued breastfeeding with appropriate complementary feeding, it has been found that one of every five child deaths could be averted. *Id.*

⁹ World Health Org., *Acceptable Medical Reasons for Use of Breast-milk Substitutes*, WHO Doc. WHO/FCH/CAH/09.01 (2009), available at http://www.who.int/nutrition/publications/infantfeeding/WHO_NMH_NHD_09.01_eng.pdf; World Health Org., *The Optimal Duration of Exclusive Breastfeeding: A Systematic Review*, at 20, WHO Doc. WHO/NHD/01.08 (2002) (prepared by Michael S. Kramer & Ritsuko Kakuma), available at http://www.who.int/nutrition/publications/optimal_duration_of_exc_bfeeding_review_eng.pdf.

¹⁰ Except where such distinctions have human rights import, the authors use the terms "child," "infant," and "baby" interchangeably.

¹¹ Cutberto Garza & Mercedes De Onis, *A New International Growth Reference for Young Children*, 70 AM. J. CLINICAL NUTRITION 169S, 170S (1999); see also Pat Hoddinott, David Trappin & Charlotte Wright, *Clinical Review: Breast Feeding*, 336 BRIT. MED. J. 881, 881–82 (2008) (describing the long- and short-term benefits of breastfeeding).

¹² RUTH LAWRENCE & ROBERT LAWRENCE, *BREASTFEEDING – A GUIDE FOR THE MEDICAL PROFESSIONAL* 105–06 (6th ed. 2005). These balanced proteins in breast milk also assist in absorbing other essential nutrients, including lipids, amylase, and complex carbohydrates. Bo Lönnerdal, *Nutritional and Physiologic Significance of Human Milk Proteins*, 77 AM. J. CLINICAL NUTRITION 1537S, 1539S (2003).

and caloric content of her milk is not significantly changed,¹³ with breastfeeding continuing to provide optimal infant nutrition despite adverse maternal conditions.¹⁴

As a means of providing nutrition while protecting health, breastfeeding supplies irreplaceable immunological benefits and protections to the immunologically fragile newborn through the protective factors of human milk.¹⁵ Numerous studies demonstrate the impact of breastfeeding on reducing the risk of ear infections, non-specific gastroenteritis, and severe lower respiratory tract infections.¹⁶ Breastfeeding provides this anti-infective protection—through the production of oligosaccharides, interferon (which has been found to fight viruses), immunoglobulin A, lactoferrin, lysosyme and other enzymes, as well as living cells—and promotes the production of lactobacilli and other helpful bacteria in infant intestines, which protects against the growth of a variety of disease causing organisms.¹⁷

In addition to breastfeeding's well-understood impact on early growth and child survival, recent studies have shed light on breastfeeding's significant impact on long-term growth and development.¹⁸ Compounding the harms of under-nutrition and disease, recent data suggest a correlation between shorter

¹³ See Sandra L. Huffman et al., *Breast-Feeding Patterns in Rural Bangladesh*, 33 AM. J. CLINICAL NUTRITION 144, 153 (1980) (“No association [has been] found between suckling time and maternal nutritional status, infant illness, maternal illness, or sex of child.”).

¹⁴ See Bo Lönnerdal, *Breast Milk: A Truly Functional Food*, 16 NUTRITION 509, 509 (2000) (noting that “breast milk provides a multitude of unique components and nutrients in a well-balanced supply, leading to health, growth, and development that is difficult or impossible to mimic with any other kind of diet”).

¹⁵ See generally Miriam H. Labbok et al., *Breastfeeding: Maintaining an Irreplaceable Immunological Resource*, 4 NATURE REV. IMMUNOLOGY 565 (2004) (discussing the complex nutritional, immunological, and psychological benefits of breast milk—benefits that cannot be replicated by formula).

¹⁶ See, e.g., Clement Ahiadeke, *Breast-Feeding, Diarrhoea and Sanitation as Components of Infant and Child Health: A Study of Large Scale Survey Data from Ghana and Nigeria*, 32 J. BIOSOCIAL SCI. 47, 59 (2000) (concluding that infants who were fully breastfed were best protected from the contaminating effects of unhygienic water); Juraci A. César et al., *Impact of Breast Feeding on Admission for Pneumonia During Postneonatal Period in Brazil: Nested Case-Control Study*, 318 BRIT. MED. J. 1316, 1320 (1999) (“In Brazil infants who were not breast fed were 17 times more likely than those receiving breast milk alone to be admitted for pneumonia.”); Deborah D. Marino, *Water and Food Safety in the Developing World: Global Implications for Health and Nutrition of Infants and Young Children*, 107 J. AM. DIETETIC ASS'N 1930, 1930 (2007) (noting that breastfeeding is regarded as “the most basic intervention to protect infants from infectious disease”).

¹⁷ MICHAEL C. LATHAM, HUMAN NUTRITION IN THE DEVELOPING WORLD 61–65 (1997) (describing the advantages of breastfeeding over bottle-feeding).

¹⁸ See, e.g., Richard Horton, *Maternal and Child Undernutrition: An Urgent Opportunity*, 371 LANCET 179, 179 (2008) (introducing a series of studies on maternal and child undernutrition and noting that breastfeeding is one of the most valuable interventions in combating nutrient deficiencies).

breastfeeding duration and increased risk of obesity in childhood and later life.¹⁹ Further, premature breastfeeding cessation reduces an infant's defense against atopic dermatitis, asthma, type 1 and 2 diabetes, childhood leukemia, sudden infant death syndrome (SIDS), and necrotizing enterocolitis.²⁰

Supporting health and growth, breastfeeding also facilitates neural development and increased cognitive development. After controlling for genetic, socioeconomic, behavioral, and environmental factors, breastfed children score significantly higher than formula-fed children on a variety of intelligence tests (e.g., IQ scores and academic grades) throughout childhood, with these benefits enhanced by increased breastfeeding duration.²¹

As the holistic benefits of exclusive breastfeeding become clear, it becomes correspondingly clear that less than full breastfeeding has become a global public health harm. Although well over 99% of women are physiologically capable of breastfeeding their infants,²² suboptimal breastfeeding, especially non-exclusive breastfeeding in the first six months of life, continues to result in incomparable death and disease burdens.²³ While it remains a valid maxim that "breast is best" for all babies, this is especially true for those born prematurely, living in poverty, or fed formula under less than hygienic conditions such as those prevalent in the developing world.²⁴

Compared to the exclusively breastfed infant, children who are never breastfed bear about fourteen times the risk of dying in the first six months of life; among older children (from six months to two years of life), the non-breastfed child is about two times more likely

¹⁹ See Molly M. Lamb et al., *Early-Life Predictors of Higher Body Mass Index in Healthy Children*, 56 ANNALS NUTRITION & METABOLISM 16, 16 (2009); Molly W. Metzger & Thomas W. McDade, *Breastfeeding as Obesity Prevention in the United States: A Sibling Difference Model*, 22 AM. J. HUM. BIOLOGY. 291, 295 (2010).

²⁰ See STANLEY IP ET AL., AGENCY FOR HEALTHCARE RESEARCH & QUALITY, AHRQ Pub. No. 07-E007, BREASTFEEDING AND MATERNAL AND INFANT HEALTH OUTCOMES IN DEVELOPED COUNTRIES 3-6 (2007), available at www.ahrq.gov/downloads/pub/evidence/pdf/brfout/brfout.pdf.

²¹ James W. Anderson et al., *Breast-Feeding and Cognitive Development: A Meta-Analysis*, 70 AM. J. CLINICAL NUTRITION 525 (1999); Michael S. Kramer et al., *Breastfeeding and Child Cognitive Development: New Evidence from a Large Randomized Trial*, 65 ARCHIVES GEN. PSYCHIATRY 578 (2008); A. Lucas et al., *Randomised Trial of Early Diet in Preterm Babies and Later Intelligence Quotient*, 317 BRIT. MED. J. 1481 (1998).

²² PATRICIA A. HAGGERTY & SHEA O. RUTSTEIN, BREASTFEEDING AND COMPLEMENTARY INFANT FEEDING, AND POSTPARTUM EFFECTS OF BREASTFEEDING 26 (1999), available at <http://www.measuredhs.com/pubs/pdf/CS30/CS30.pdf>.

²³ Horton, *supra* note 18, at 179.

²⁴ See James C. Baker, *The International Infant Formula Controversy: A Dilemma in Corporate Social Responsibility*, 4 J. BUS. ETHICS 181, 182 (1985) (examining infant formula marketing in less-developed countries).

to die.²⁵ These benefits and harms illustrate the importance not only of breastfeeding but of exclusive breastfeeding for the first six months of life as a means to infant health and survival.

Despite initial concern that breastfeeding might serve as a detrimental mode of vertical transmission of HIV (i.e., transmission from mother to child), current evidence confirms that exclusive breastfeeding provides relative benefits in reducing the rate of HIV transmission via breastfeeding in developing countries.²⁶ Breastfeeding remains a conduit for the transmission of HIV, but this risk pales in comparison with the risk of disease and death from breast milk substitutes in places where high risks of infection, poor hygiene, and low water quality coexist.²⁷ In fact, several studies have found that HIV-free survival does not differ for HIV-exposed infants who were breastfed when compared to those who were formula fed from birth,²⁸ with exclusive breastfeeding shown to improve HIV-free survival. When balancing the advantages and disadvantages of breastfeeding in the developing world, global consensus documents continue to recommend exclusive breastfeeding for the first six months of life as the best choice for HIV-positive mothers.²⁹

Complementing these infant benefits, maternal health benefits (while less discussed and less studied) show that breastfeeding can support women through the third stage of labor by helping contract the uterus, return the mother to pre-pregnancy health status,

²⁵ WHO Collaborative Study Team on the Role of Breastfeeding on the Prevention of Infant Mortality, *Effect of Breastfeeding on Infant and Child Mortality Due to Infectious Diseases in Less Developed Countries: A Pooled Analysis*, 355 LANCET 451, 451 (2000).

²⁶ See Hoosen M. Coovadia et al., *Mother-to-Child Transmission of HIV-1 Infection During Exclusive Breastfeeding in the First 6 Months of Life: An Intervention Cohort Study*, 369 LANCET 1107, 1113 (2007) (concluding that “exclusive breastfeeding carries a significantly lower risk of HIV transmission than do all types of mixed breastfeeding”); Peter J. Liff et al., *Early Exclusive Breastfeeding Reduces the Risk of Postnatal HIV-1 Transmission and Increases HIV-Free Survival*, 19 AIDS 699, 703–04 (2005) (analyzing the correlation between exclusive breastfeeding and a reduced risk of HIV transmission).

²⁷ LATHAM, *supra* note 17, at 72 (noting that, in poor living conditions, “the many advantages of breastfeeding far outweigh the risk to the infant of AIDS infection through breast-milk from an HIV-positive mother”).

²⁸ Louise Kuhn et al., *High Uptake of Exclusive Breastfeeding and Reduced Early Post-Natal HIV Transmission*, 12 PLOS ONE 1363 (2007); Taha Taha et al., *The Effect of Human Immunodeficiency Virus and Breastfeeding on the Nutritional Status of African Children*, 29 PEDIATRIC INFECTIOUS DISEASE J. 514 (2010) (concluding that HIV-positive women should continue breastfeeding).

²⁹ See, e.g., WORLD HEALTH ORG., GUIDELINES ON HIV AND INFANT FEEDING (2010); H.M. Coovadia & R.M. Bland, *Preserving Breastfeeding Practice Through the HIV Pandemic*, 12 TROPICAL MED. & INT’L HEALTH 1116 (2007) (supporting continued breastfeeding among HIV-positive women); Anna Coutsoudis et al., *HIV, Infant Feeding and More Perils for Poor People: New WHO Guidelines Encourage Review of Formula Milk Policies*, 86 BULL. WORLD HEALTH ORG. 210, 213 (2008) (recommending that impoverished HIV-infected mothers should exclusively breastfeed infants for at least the first six months).

and heighten specific immune defenses in the postpartum period.³⁰ In decreasing maternal harms caused by short birth-to-pregnancy intervals, optimal breastfeeding also suppresses ovulation as effectively as modern methods of contraception, thereby allowing for greater spacing between pregnancies.³¹ Long-term maternal health benefits include reduced risk of type 2 diabetes and breast and ovarian cancers.³² Although breastfeeding does necessitate additional caloric intake by the mother, studies have found maternal eating to be far more nutritionally efficient than infant formula feeding, leading to programmatic recommendations to “feed the mother and breastfeed the baby,” especially in developing country settings.

With research clearly demonstrating the individual and public health pathways through which breast milk is the optimal feeding option for infants and mothers, it is equally clear that breastfeeding is the nutritional intervention that would result in the greatest reduction of DALYs, or years of healthy life lost to illness and death.³³ Given the incomparable and inimitable benefits of breastfeeding, the support of early, exclusive, and continued breastfeeding—with age appropriate complementary feeding—is therefore considered the “gold standard” for public health, reflecting both the important nutrients and protections of breast milk and the unmitigated dangers of breast milk substitutes.

B. Breast Milk Substitutes, Disease, and Death

While scientific evidence shows that formula is inherently inferior to breast milk—unable to replicate the immunological or living cells necessary to protect infants from an infectious environment—far greater consequential harm is inflicted when formula is used under sub-optimal environmental conditions. Commercial formulas generally meet minimal safety standards under international law,³⁴

³⁰ See Maureen Wimberly Groer et al., *Immunity, Inflammation and Infection in Post-Partum Breast and Formula Feeders*, 54 AM. J. REPROD. IMMUNOLOGY 222, 230 (2005).

³¹ M.H. Labbok et al., *The Lactational Amenorrhea Method (LAM): A Postpartum Introductory Family Planning Method with Policy and Program Implications*, 10 ADVANCES IN CONTRACEPTION 93, 94 (1994).

³² See IP ET AL., *supra* note 20, at 119, 136, 141. As a counterfactual, a lack of breastfeeding, or ending breastfeeding prematurely, is associated with an increased risk of maternal postpartum depression. *Id.* at 130–31.

³³ Zulfiqar A Bhutta et al., *What Works? Interventions for Maternal and Child Undernutrition and Survival*, 371 LANCET 417, 430 tbl. 13 (2008) (concluding that full support for breastfeeding would reduce mortality by 11.6% in the first year of life, 9.9% in the first two years, and 9.1% in the first three).

³⁴ Cf. Codex Alimentarius, *Standard for Infant Formula and Formulas for Special Medical Purposes Intended for Infants*, Codex Stan 72 – 1981 (rev. 2007), available at http://www.codexalimentarius.net/download/standards/288/CXS_072e.pdf.

notwithstanding recurring product recalls;³⁵ however, due to the dangers of mixing formula with unclean water, high bacterial contamination of bottles and teats, and improper dilution from inadequate educational and financial resources, the process of bottle-feeding has unnecessarily harmful consequences in parts of the developing world. Because formula may be the only source of nutrition for the infant, whose immune system is already compromised without the support of breast milk, undetected outbreaks in the developing world have proven especially dangerous for entire generations.

Mixing formula with unsanitary water dangerously elevates the infant's risk for diarrheal and other diseases.³⁶ With more than 1.1 billion people lacking access to safe drinking water,³⁷ more than three million children under the age of five die annually from a combination of water-borne disease, under-nutrition, and indoor air pollution.³⁸ WHO has found widespread fecal contamination in rural water supplies in the developing world, with this contamination posing acute risk to infants, who are generally at greater risk of infection, particularly when they lack the immunological benefits of breastfeeding.³⁹ As impoverished mothers are more likely to lack access to clean water and facilities, these factors put infants in poverty at greater risk of bottle bacterial contamination and unsafe water consumption, leading to infant illness, long-term under-nutrition, and death.

Compounding the risk of water-borne illness, dangers of bottle-feeding contamination occur during formula preparation and increase the infant's exposure to infectious disease. Studies have shown that a high percentage of feeding bottles (82%) and teats (64%) in parts of the developing world are contaminated with common pathogens such as *Escherichia coli*, *Salmonella*, and other major contributors to childhood illnesses.⁴⁰ High contamination rates

³⁵ In the most pressing of recent product recalls, China found that melamine added to milk was the cause of at least six deaths and 294,000 illnesses, some that will impair health for the life of the child. Michael Wines, *Tainted Dairy Products Seized in Western China*, N.Y. TIMES, July 10, 2010, at A6.

³⁶ Black et al., *supra* note 7, at 250.

³⁷ Ashok Gadgil, *Drinking Water in Developing Countries*, 23 ANN. REV. ENERGY ENV'T 253, 265 (1998).

³⁸ *Id.* at 256.

³⁹ *See id.* at 257-58; *see also* Jamie Bartram et al., *Focusing on Improved Water and Sanitation for Health*, 365 LANCET 810, 810 (2005) (noting that 88% of diarrheal disease is attributed to unsafe drinking water).

⁴⁰ *E.g.*, Annie Cherian & Ravindra Venkatesh Lawande, *Recovery of Potential Pathogens from Feeding Bottle Contents and Teats in Zaria, Nigeria*, 79 TRANSACTIONS ROYAL SOC'Y TROPICAL MED. & HYGIENE 840, 841 (1985).

are often attributed to improper bottle washing, but even bottles that are washed and disinfected in poor environmental settings have been found to possess a high level of contamination.⁴¹ Contamination also stems from the powdered formula itself, which, when stored under the suboptimal conditions present in the developing world, is often susceptible to bacterial contamination even before it is mixed with water.⁴² Whereas recalls of contaminated formula have occurred in the United States and Europe,⁴³ the spread of food-borne illness outbreaks are difficult to identify and control in the developing world, especially for environmentally sensitive food products like baby formula, due to a lack of surveillance infrastructures for product safety.⁴⁴

And even if the water, bottle, and product could be freed from contamination, formula continues to pose great risk to infant health due to improper formula dilution. Over-dilution of formula occurs with high frequency, leading to under-nutrition and exacerbating the consequences of water-borne contamination. Few commercial formula containers provide proper mixing instructions in local languages, much less for illiterate or semi-literate users.⁴⁵ Without an understanding of the harms of inaccurately diluting formula,⁴⁶ many mothers in the developing world over-dilute when they cannot afford the necessary amount of formula powder.⁴⁷ With women given free samples of formula at the time of birth—leading them to become dependent on formula and to stop producing breast milk—many of these mothers cannot afford additional formula and are forced to

⁴¹ T.B. Morais et al., *Bacterial Contamination of the Lacteal Contents of Feeding Bottles in Metropolitan São Paulo, Brazil*, 76 BULL. WORLD HEALTH ORG. 173, 177 (1998).

⁴² See D. Drudy et al., *Enterobacter sakazakii: An Emerging Pathogen in Powdered Infant Formula*, 42 FOOD SAFETY 996, 997 (2006).

⁴³ See Jos van Acker et al., *Outbreak of Necrotizing Enterocolitis Associated with Enterobacter sakazakii in Powdered Milk Formula*, 39 J. CLINICAL MICROBIOLOGY 293, 295 (2001).

⁴⁴ See M.A. Usera et al., *Multiple Analysis of a Foodborne Outbreak Caused by Infant Formula Contaminated by an Atypical Salmonella Virchow Strain*, 17 EUR. J. CLINICAL MICROBIOLOGY & INFECTIOUS DISEASES 551, 551 (1998).

⁴⁵ See M. David Ermann & William H. Clements II, *The Interfaith Center on Corporate Responsibility and Its Campaign Against Marketing Infant Formula in the Third World*, 32 SOC. PROBS. 185, 189–90 (1984) (criticizing the marketing of infant formula to impoverished customers).

⁴⁶ Reasons for over dilution may be from improper maternal training and education, illiteracy, and misunderstandings of the dangers of germs and bacterial contaminants. Dani Surjono et al., *Bacterial Contamination and Dilution of Milk in Infant Feeding Bottles*, 26 J. TROPICAL PEDIATRICS 58, 61 (1980).

⁴⁷ P. Bhalla et al., *Hyponatraemic Seizures and Excessive Intake of Hypotonic Fluids in Young Children*, 319 BRIT. MED. J. 1554 (1999) (discussing the dangers of providing children with excessive quantities of diluted formulas).

extend their sample product through dilution.⁴⁸ Pervasive throughout the developing world, 20% of mothers who used formula were found to have diluted the formula over 40% more than recommended.⁴⁹ As an indicator of health complications, infants fed over-diluted formula are at a serious risk of not absorbing adequate levels of calories and nutrients,⁵⁰ exacerbating the harms of unhygienic bottle conditions and crippling an infant's defenses against starvation, disease, and, ultimately, death.

Yet despite these unrivaled harms from manufactured breast milk substitutes—harms that can be avoided through the protection, promotion, and support of natural breastfeeding processes—the rapacious marketing of these substitutes by a recalcitrant formula industry has stymied national efforts to regulate these products and prevent health harms.

C. Formula Industry Marketing and National Regulation

Through the course of the past 150 years, a burgeoning infant formula industry has introduced an uncontrolled and poorly analyzed marketing program to construct breast milk substitutes as the global norm for infant feeding and displace the commercial competition posed by breastfeeding. With interests entrenched in the foreign policies of developed countries, developing countries have been hard pressed to create health policy that would disadvantage the formula industry. As controversies regarding human milk substitutes have erupted, the industry has used its political power to prevent the rise of national regulatory frameworks to respond to this corporate threat to public health.

Although physicians expressed concern with declining rates of breastfeeding as early as the late nineteenth century—as women in the developed world sought the freedom to work during the height of industrialization—an industry arose to sell animal milk to these working women, mixing those milks with a specific formulation of water, sugars, and other ingredients and marketing this new

⁴⁸ In a Turkish study, for example, 51% of mothers using formula incorrectly diluted the powder. See Ayse H. Potur & Nahide Kalmaz, *An Investigation into Feeding Errors of 0–4-Month-Old Infants*, 42 J. TROPICAL PEDIATRICS 173, 174 (1996); see also Linda S. Adair et al., *The Duration of Breast-Feeding: How Is It Affected by Biological, Sociodemographic, Health Sector, and Food Industry Factors?*, 30 DEMOGRAPHY 63, 78 (1993) (examining the mechanisms through which the formula industry discourages breastfeeding).

⁴⁹ Potur & Kalmaz, *supra* note 48, at 174.

⁵⁰ Judith Labiner-Wolfe et al., *Infant Formula-Handling Education and Safety*, 122 PEDIATRICS S85, S85 (2008) (analyzing “the extent to which mothers learn about proper handling of infant formula from health professionals and package labels”).

commercial product as baby “formula.”⁵¹ Initially employing direct-to-consumer advertising, including free samples and promotions in women’s magazines, the industry soon saw the advantages of bearing a medical imprimatur and began sponsoring scientific conferences and seeking physician endorsements. In the absence of regulation, such marketing techniques led the public to increasingly believe that artificial formulas were superior to natural breastfeeding, and by the early 1970s, breastfeeding initiation rates by U.S. mothers reached a nadir of 25%.⁵² This industry-led behavior would take root throughout the world.

Notwithstanding this achievement in public relations, with the medical professions and the public at large, it was becoming increasingly apparent that breast milk substitutes were causing unprecedented health harms, associated with widespread malnutrition and death in the developing world. Since Cicely Williams’s groundbreaking 1939 speech on “Milk and Murder,”⁵³ public health analysts have come to an evolving awareness of the ways in which formula marketing exploits the ignorance of consumers and overpowers health education on breastfeeding. Recognizing the potential of breastfeeding as a child survival intervention, public health advocates began to recognize the ways in which misleading advertising by formula manufacturers impacts health at a global level.⁵⁴

Despite longstanding knowledge of these global harms, the formula industry has nevertheless pursued advertising campaigns designed to attract the attention of the widest possible audience in the developing world, purchasing pages in women’s magazines and medical journals while supplying physicians with free samples and booklets to be distributed to patients. These marketing practices are

⁵¹ See JACQUELINE H. WOLF, *DON’T KILL YOUR BABY: PUBLIC HEALTH AND THE DECLINE OF BREASTFEEDING IN THE NINETEENTH AND TWENTIETH CENTURIES* 189 (2001) (describing pediatrician Joseph Brennemann’s speech to the American Pediatric Society to promote breastfeeding over the use of breast milk substitutes); Jacqueline H. Wolf, *The First Generation of American Pediatricians and Their Inadvertent Legacy to Breastfeeding*, 1 *BREASTFEEDING MED.* 172, 175 (2006).

⁵² Alan S. Ryan et al., *A Comparison of Breast-Feeding Data from the National Surveys of Family Growth and the Ross Laboratories Mothers Surveys*, 81 *AM. J. PUBLIC HEALTH* 1049, 1050 (1991); Deborah L. Kaplan & Kristina M. Graff, *Marketing Breastfeeding—Reversing Corporate Influence on Infant Feeding Practices*, 85 *J. URB. HEALTH* 486 (2008).

⁵³ See generally *PRIMARY HEALTH CARE PIONEER: THE SELECTED WORKS OF DR. CICELY D. WILLIAMS* (Naomi Baumslog ed., 1986).

⁵⁴ See, e.g., Miriam Labbok & Erica Nakaji, *Breastfeeding: A Biological, Ecological, and Human Rights Imperative for Global Health*, in *WOMEN’S GLOBAL HEALTH AND HUMAN RIGHTS* 421, 430 (Padmini Murthy & Clyde Lanford Smith eds., 2009) (noting that despite increased publicity for breastfeeding, advertising by the formula industry remains extremely influential).

ubiquitous in a new mother's life, and are especially targeted at intervening in the three phases of maternal care when messaging most successfully reduces rates of breastfeeding initiation, duration, and exclusivity:

- 1) during prenatal care, by providing women with industry-produced infant feeding information and free formula offers;
- 2) at the hospital, by giving mothers free formula during the hospital stay and at hospital discharge; and
- 3) during postnatal visits to physicians and hospitals, by encouraging acceptance of nonmedically indicated uses of formula with breastfeeding infants.⁵⁵

Playing on fears of infant death and faith in medical science, these aggressive marketing techniques exploited and influenced social norms during a time of increased urbanization, associating bottle-feeding with modernity, success, and health⁵⁶ and stigmatizing public breastfeeding as a "vulgar" behavior.⁵⁷ With public advertisements and physician endorsements reducing mothers' confidence in their own breast milk and their own ability to breastfeed, formula feeding began to permeate all levels of society until even poor and rural women were rejecting breastfeeding for formula.⁵⁸ Capitalizing on the linkages between formula manufacturers and medical associations in the developing world, formula companies began to employ doctors and nurses to speak with women about the advantages of formula at the time of birth, creating a system by which women would be separated from their babies after birth and would find it nearly impossible to initiate breastfeeding during the crucial post-natal period.

Where states have sought to regulate these practices and strengthen support for breastfeeding to protect the public's health, few have been able to place any restrictions on the marketing of breast milk substitutes because of industry involvement in domestic politics. For example, although the Philippine government created regulations to

⁵⁵ Kaplan & Graff, *supra* note 52 (reviewing several studies looking at the impacts of various formula-marketing techniques on breastfeeding practices).

⁵⁶ See Ermann & Clements, *supra* note 45, at 189.

⁵⁷ Janet E. Oglethorpe, *Infant Feeding as a Social Marketing Issue: A Review*, 18 J. CONSUMER POL'Y 293, 300 (1995) (finding that "the search for a new modern identity" influenced the rejection of breastfeeding "as obsolete, uncivilized, and vulgar").

⁵⁸ See *id.* at 300-02.

limit advertising for infant and young child foods, this 2006 effort occasioned immediate, direct, and vociferous pressure from the Pharmaceutical and Health Care Association of the Philippines and others who brought suit against the government to block these rules.⁵⁹ With the U.S. Chamber of Commerce petitioning Filipino President Gloria Macapagal-Arroyo directly—warning of “the risk to the reputation of the Philippines as a stable and viable destination for investment” if she did not “re-examine [this] regulatory decision”⁶⁰—the Philippine Supreme Court reversed the government’s regulations four days later, overturning its own decision and granting a temporary restraining order against the Department of Health.⁶¹ Such activity has not been unique to the Philippines. Formula and infant food lobbying has employed political pressure in many countries as a means of guaranteeing the unrestricted marketing of breast milk substitutes. In the world’s largest market, the massive market penetration of China has led breastfeeding rates to plummet as Chinese women have come to believe in the medical inadequacy of breast milk,⁶² an unfounded fear exacerbated by formula marketing.⁶³ With national governments and health associations proving impotent to control this scourge, a dynamic only exacerbated by the deregulatory advent of neoliberal economic policies, the \$20 billion infant feeding industry is able to protect its profits even as those with the least control over their own health are made to suffer.

Given the strong correlation between weak national policy environments and diminished infant and maternal health, the harms of the commercial formula industry have long cried out for the creation of effective global health policy to restrict the use of breast milk substitutes through the protection, promotion, and support of breastfeeding.

⁵⁹ See Rene R. Raya, *The Philippine Breastfeeding Struggle Continues*, 371 LANCET 794, 794 (2008). Breast milk substitute corporations, which had previously agreed to refrain from government lobbying, took no visible, public role in these proceedings to benefit their markets.

⁶⁰ United Nations Children’s Fund [UNICEF], *Breastfeeding Advocates Form Consolidated Action Against Formula Companies* (Nov. 13, 2006), <http://www.unicef.org/philippines/news/061101.html> (quoting the statement of Thomas Donahue, President, U.S. Chamber of Commerce, to Gloria Macapagal-Arroyo, President of the Philippines on Aug. 11, 2006).

⁶¹ Carlos H. Conde, *Breastfeeding: A Philippine Battleground*, INT’L HERALD TRIB., July 18, 2007, <http://www.nytimes.com/2007/07/17/world/asia/17iht-phils.1.6692639.html?scp=1&sq=Breastfeeding:%20A%20Philippine%20Battleground&st=cse>.

⁶² Fenglian Xu et al., *Breastfeeding in China: A Review*, 4 INT’L BREASTFEEDING J. 6, 16–17 (2009).

⁶³ Anna Coutsoudis, Hoosen Coovadia & Judith King, *The Breastmilk Brand: Promotion of Child Survival in the Face of Formula-Milk Marketing*, 374 LANCET 423, 423–24 (2009).

II. EVOLUTION OF GLOBAL HEALTH POLICY TO REGULATE BREAST MILK SUBSTITUTES

Recognizing the mounting harms of breast milk substitutes, the development of global health policy to protect, promote, and support breastfeeding began in the 1960s, and, for the next five decades, would reflect the efforts of health advocates and international organizations to unite the global community under shared objectives for attaining maternal and child health. With an expanding understanding of the ways in which waning breastfeeding practices were related to underlying societal factors—including the aggressive marketing of breast milk substitutes, the development of industrial working conditions, and the weakening of primary health care systems—this policy evolution traces international efforts to curb the multinational formula industry through global health policies grounded in human rights. These advances in rights-based policy culminated in 1979, with WHO and UNICEF’s Joint Meeting on Infant and Young Child Feeding bringing together an unprecedented number of actors to discuss the public health harms of the global decline of breastfeeding and to develop the first international regulatory framework for the formula industry: the International Code of Marketing of Breast-Milk Substitutes (the Code).⁶⁴ Since its adoption by the World Health Assembly in 1981, the Code has given rise to a series of policies addressing the systemic factors underlying the protection, promotion, and support of a woman’s decision to breastfeed. However, given the inherent legal limitations of the Code—and the loopholes exploited in the continued marketing of breast milk substitutes—continuing shifts away from WHO’s original human rights framework for breastfeeding have enduring normative implications for the development and implementation of global breastfeeding policy.

A. Global Response to an Individual Harm

Where breastfeeding was once the global norm, the rising global market for breast milk substitutes—and attendant discovery of widespread malnutrition in developing nations—would create an imperative for the development of global infant feeding policy.⁶⁵ With the UN Protein Advisory Group (PAG) instituted in the 1960s to

⁶⁴ WHO/UNICEF International Code of Marketing of Breast-Milk Substitutes, W.H.A. Res. 34.22, W.H.O. Doc. WHA34.22 (1981) [hereinafter *The Code*], available at www.who.int/nutrition/publications/code_english.pdf.

⁶⁵ See generally Maria Jansson, *Feeding Children and Protecting Women: The Emergence of Breastfeeding as an International Concern*, 32 *WOMEN’S STUD. INT’L F.* 240 (2009).

investigate nutrition deficiency in tropical populations,⁶⁶ PAG hosted a seminal 1970 conference in Bogotá, Columbia to bring together UN member agencies, health practitioners, and industry representatives to discuss:

- The emphasis and importance of prolonged breastfeeding;
- Preliminary guidelines for promotion of infant formulas;
- The development of low-cost protein-rich weaning foods; and
- Possibilities for public health and industry “joint action.”⁶⁷

At the meeting’s conclusion, representatives of the formula industry were advised to label their products clearly (with particular focus on sanitary uses) and to promote breastfeeding, rather than discourage it as a means to sell artificial substitutes.⁶⁸ While there remained concern that breast milk substitutes could lead to widespread harm under unsanitary environmental conditions, the industry’s “nutritional supplements” were nevertheless considered a viable means to address the pressing concern for global malnutrition. Even as PAG acknowledged the deleterious risks of formula to impoverished families, its official position continued to respect breast milk substitutes as an adequate (albeit inferior) alternative for women who chose not to breastfeed.⁶⁹ Similarly, even with WHO joining with the Food and Agriculture Organization (FAO) in 1963 to develop the first Codex Alimentarius—to date, the most comprehensive set of standards guiding international food quality—the industry retained wide latitude in setting global policies and monitoring their own practices.⁷⁰ Despite official denunciations of industry tactics in deterring breastfeeding, these corporate actors

⁶⁶ See DERRICK B. JELLIFFE & E.F. PATRICE JELLIFFE, PROGRAMMES TO PROMOTE BREASTFEEDING 229 (1988); Maggie McComas, *Origins of the Controversy*, in *INFANT FEEDING: ANATOMY OF A CONTROVERSY 1973–1984*, at 29, 30–31 (John Dobbing ed., 1988).

⁶⁷ McComas, *supra* note 66, at 31.

⁶⁸ *Id.* at 32 (“Industry was not so much being lectured to as encouraged. Those ‘proposals for action’ were largely prescriptive . . . in nature, reflecting the positive contribution that the promotion of commercial products could make to safe infant nutrition. Health professionals and the international agencies seemed ready to treat Industry as an equal partner in the effort to solve problems of nutrition in the Third World.”).

⁶⁹ *Id.* at 33; see also S. PRAKASH SETHI, *MULTINATIONAL CORPORATIONS AND THE IMPACT OF PUBLIC ADVOCACY ON CORPORATE STRATEGY: NESTLE AND THE INFANT FORMULA CONTROVERSY* 50 (1994).

⁷⁰ Kelley Lee, *Civil Society Organizations and the Functions of Global Health Governance: What Role Within Intergovernmental Organizations?*, 3 *GLOBAL HEALTH GOVERNANCE* 14–15 (2010); see also Codex Alimentarius, *supra* note 34.

continued to be accepted as beneficent partners in addressing global malnutrition.

However, with the rise of epistemic communities rallying around the determinants of infant malnutrition,⁷¹ grassroots organizations in multiple countries would become catalysts for international action to regulate breast milk substitutes.⁷² A series of confrontations on the harms of breast milk substitutes—beginning with publications lambasting Nestlé's infant food marketing practices in Britain⁷³ and Switzerland,⁷⁴ the latter resulting in Nestlé's 1974–1976 libel suit against the Swiss NGO AgDW—would enflame conflicts between breastfeeding advocacy organizations and breast milk substitute corporations, conflicts that began as early as the 1930s and extend to the present day.⁷⁵ Mirroring confrontations over multinational marketing practices for essential medicines, this advocacy focused on corporate decisions in the developed world that affected those in the developing world.⁷⁶ Seeking first to impact these practices in the developed world, faith-based and consumer-protection activists mobilized to affect global breastfeeding practices through direct pressure on the industry's corporate shareholders. When these efforts failed to produce anything more than cosmetic changes in formula marketing strategies,⁷⁷ a rigorous letter-writing campaign in the United States evoked the attention of Senator Edward Kennedy,

⁷¹ See MARGARET E. KECK & KATHRYN SIKKINK, *ACTIVISTS BEYOND BORDERS: ADVOCACY NETWORKS IN INTERNATIONAL POLITICS* (1998) (analyzing the role of transnational activist communities in bringing about change in international human rights between 1968 and 1993); Emanuel Adler & Peter M. Haas, *Conclusion: Epistemic Communities, World Order, and the Creation of a Reflective Research Program*, 46 INT'L ORG. 367, 367–68 (1992) (describing the actions of "epistemic communities" in international relations).

⁷² See SETHI, *supra* note 69, at 60.

⁷³ See, e.g., Mike Muller, *The Baby Killer: A War on Want Investigation into the Promotion and Sale of Powdered Baby Milks in the Third World* (1974), available at <http://faculty.msb.edu/murphydd/cric/Readings/Nestle-Baby-Killer%20by%20Mike%20Muller,%20War%20on%20Want,%201974.pdf> (attacking the marketing efforts of the formula industry and its effect on women's attitudes toward breastfeeding).

⁷⁴ ARBEITSGRUPPE DRITTE WELTE [Third World Action Group] (AgDW), *NESTLE KILLS BABIES* (1974).

⁷⁵ See generally NAOMI BAUMSLAG & DIA L. MICHELS, *MILK, MONEY, AND MADNESS: THE CULTURE AND POLITICS OF BREASTFEEDING* 154 (1995); SETHI, *supra* note 69, at 5; ELLEN J. SOKOL, *THE CODE HANDBOOK: A GUIDE TO IMPLEMENTING THE INTERNATIONAL CODE OF MARKETING OF BREASTMILK SUBSTITUTES* 6 (1997).

⁷⁶ Gill Walt, *WHO Under Stress: Implications for Health Policy*, 24 HEALTH POLICY 125, 134–36 (1993).

⁷⁷ Maggie McComas, *The US Campaign*, in *INFANT FEEDING*, *supra* note 66, at 57–59 (noting efforts to sue Bristol Myers (producer of Enfamil) to change corporate practices and discussing the reasoning by which courts dismissed the suit because shareholders failed to demonstrate that their financial interests were damaged by such practices); cf. BAUMSLAG & MICHELS, *supra* note 75, at 157 (recognizing that Bristol Myers agreed to take their milk nurses out of Jamaica, where they were soliciting business in public hospitals); SETHI, *supra* note 69, at 88–89 (illustrating how Abbott agreed to take "mothercraft nurses" out of nursing uniforms).

whose 1978 hearings on breast milk substitutes subjected corporate representatives to intense questioning on their responsibilities to ensure that their products were not marketed in areas where safe and sanitary use was not possible.⁷⁸ Despite this public questioning, industry representatives successfully deflected responsibility without repercussion, replying simply that they bore no obligation to prevent harms from the use of their products where those harms arose because of structural and environmental factors in the developing world.

Such American and European failures to enact domestic regulation on the safe use of breast milk substitutes⁷⁹ made clear that even well-mobilized national responses were inadequate to regulate the entrenched special interests of the formula industry and secure the global health benefits of breastfeeding.⁸⁰ As these intractable national conflicts proved repeatedly immune to domestic resolution, actors from both sides requested WHO involvement to resolve national debates through international regulation.⁸¹

With the UN dedicating 1978 as the International Year of the Child and the public broadly recognizing the health concerns of breast milk substitutes (expressed both in landmark publications and WHO discourses), the time was seen as ripe to enact solutions through global health policy.⁸² To develop this policy, an unprecedented 1979 WHO/UNICEF Joint Meeting on Infant and Young Child Feeding in Geneva⁸³—based on previous educational workshops throughout the world—drew actors on all facets of breastfeeding policy and engaged both sides of the breast milk substitutes controversy.⁸⁴ Over the

⁷⁸ See BAUMSLAG & MICHELS, *supra* note 75, at 157 (discussing advocates' letter writing campaign and Senator Kennedy's role as the chairman of the Senate Subcommittee on Health and Scientific Research).

⁷⁹ See Maggie McComas, *Into the Political Arena*, in *INFANT FEEDING*, *supra* note 66, at 67, 72–73 (explaining that draft U.S. legislation on infant formula marketing regulations, the Infant Nutrition Act of 1979, failed as part of the larger difficulty of regulating multinational corporations, especially actors like Nestlé, which were not headquartered in the United States).

⁸⁰ See SETHI, *supra* note 69, at 67 (finding that “[p]roxy battles had almost no chance of succeeding” in changing the overall practices of industry due to the limitations of financial resources and the scale of advocacy organizations).

⁸¹ See Kathryn Sikkink, *Codes of Conduct for Transnational Corporations: The Case of the WHO/UNICEF Code*, 40 INT’L ORG. 815, 822 (1986) (discussing the joint WHO/UNICEF meetings on breast-milk substitutes in 1979 and the subsequent development of the Code of Marketing for Breast-Milk Substitutes in 1980).

⁸² DERRICK B. JELLIFFE & E.F. PATRICE JELLIFFE, *HUMAN MILK IN THE MODERN WORLD: PSYCHOSOCIAL, NUTRITIONAL, AND ECONOMIC SIGNIFICANCE* 19 (1978).

⁸³ See Manuel Carballo, *The World Health Organization's Work in the Area of Infant and Young Child Feeding and Nutrition*, in *PROGRAMMES TO PROMOTE BREASTFEEDING*, *supra* note 66, at 235, 239 (identifying interventions that would be discussed in the Code: greater attention to prenatal, maternity, and early postnatal care practices, social support to mothers, labeling of milk substitutes, and discontinuing formula distribution in medical facilities).

⁸⁴ See Edward Baer & Leah Margulies, *Infant and Young Child Feeding: An Analysis of the WHO/UNICEF Meeting*, 11 STUD. FAM. PLAN. 72, 74 (1980) (discussing distinct working

objections of the formula industry (which had combined corporate efforts under the International Council of Infant Food Industries), several general themes emerged, including the superiority of breastfeeding for health and development, the need for health workers to promote breastfeeding practices, and the harm of corporate marketing in reducing breastfeeding.⁸⁵ These themes would soon form the basis of global breastfeeding policy.

B. UN Specialized Agencies and the Development of the International Code of Marketing of Breast-Milk Substitutes

Building from this thematic consensus, WHO was tasked with developing global guidelines for breastfeeding protections and industry marketing practices. To advance this public health policy goal, WHO sought to invoke human rights to encourage breastfeeding and discourage formula marketing, studying alternative regulatory frameworks for child nutrition at the intersection of the right to health and right to food.⁸⁶ Conferring with health experts, government delegations, NGOs, and industry representatives, WHO's rights-based efforts resulted in the 1981 Code,⁸⁷ the first set of international guidelines to govern the public health implications of breastfeeding. Through the Code, WHO sought global commitments to protect, promote, and support breastfeeding and to create standards for the appropriate marketing and use of breast milk substitutes. In doing so, the Code invokes breastfeeding as a principal component of the human right to health, finding that women and children have a right to access adequate nutrition as part of their right to attaining and maintaining the highest attainable standard of health.⁸⁸

The Code encompasses eleven articles to frame rights-based national frameworks. In implementing these articles, the Code seeks principally to regulate breast milk substitutes, defined as the "partial or total replacement of breast milk," pressing states to:

groups for the meeting, the most contentious of which—the rational marketing and distribution of breast milk substitutes—offered concessions on “halt[ing] . . . sales promotion” and limiting promotional benefits to health professionals but did not prohibit practices such as distribution of free samples and maintenance of relationships with health facilities).

⁸⁵ *Id.*

⁸⁶ SAMI SHUBBER, *THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES: AN INTERNATIONAL MEASURE TO PROTECT AND PROMOTE BREAST-FEEDING 5* (1998).

⁸⁷ The Code, *supra* note 64.

⁸⁸ *See id.* pmb1. (stating that every child and woman has the right “to be adequately nourished”).

- Support the role of education and full disclosure as a means to promote breastfeeding and encourage proper bottle feeding,⁸⁹ weakening the industry's marketing of substitutes as a nutrition source equivalent to breast milk.
- Stipulate inappropriate marketing practices, including advertising to the general public, direct or indirect communications with pregnant women or members of their families, tactics that incentivize purchase and consumption (including free formula samples),⁹⁰ and "gifts of articles or utensils which may promote the use of breast-milk substitutes or bottle-feeding."⁹¹
- Improve health care systems to promote breastfeeding by removing conflicts of interest between health care facilities and breast milk substitute marketers and by limiting donations of formula to health facilities only for use when infants must be fed breast milk substitutes.⁹²
- Recognize the pivotal role of health workers in encouraging, protecting, and promoting breastfeeding by restricting their financial or material incentives⁹³ to "imply or create a belief that bottle-feeding is equivalent or superior to breast-feeding."⁹⁴
- Prohibit bonuses or quota systems that incentivize individual manufacturers and distributors to promote substitutes aggressively⁹⁵ or to perform "educational functions in relation to pregnant women or mothers of infants and young children."⁹⁶
- Require labeling notices to inform consumers of the superiority of breastfeeding and the limitations of breast milk substitutes through: (1) necessary information about appropriate use, (2) clear instructions on safe preparation, and

⁸⁹ See *id.* art 4.

⁹⁰ See *id.* art 5.

⁹¹ *Id.* art 5.4; see also SHUBBER, *supra* note 86, at 110 (discussing WHO's position on the "health implications of direct advertising of breast-milk substitutes").

⁹² See The Code, *supra* note 64, art. 6.

⁹³ See *id.* arts. 7.1, 7.3.

⁹⁴ *Id.* art. 7.2.

⁹⁵ See *id.* art. 8.1.

⁹⁶ *Id.* arts. 13, 8.2.

(3) understandable messages on health hazards from unsafe use.⁹⁷

Invoking government responsibility to protect the principles and aims of the Code—through cooperative global partnerships, coordinated by WHO, UNICEF, and other agencies of the UN⁹⁸—the Code calls on all actors to monitor compliance and grants NGOs explicit, formal responsibility for evaluating implementation and indentifying violations.⁹⁹

In realizing the human right to health, the Code's substance draws on a rich international legal history at the intersection of health and human rights, influenced most proximally by the 1978 Declaration of Alma-Ata¹⁰⁰ and the 1979 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).¹⁰¹ The Declaration of Alma-Ata reaffirmed the fundamental right to health and framed primary health care as a system for health protection that "forms an integral part both of the country's health system . . . and of the overall social and economic development of the community."¹⁰² The Code borrows from the Declaration of Alma-Ata's health obligations, including education, promotion of food supply and proper nutrition, maternal and child health care, and protections that contribute to a sustainable public health system, seeking to incorporate breastfeeding into these obligations for health.¹⁰³

By codifying a unique rights-based lens through which to examine women's health, CEDAW provides a complementary framework for socioeconomic protections and reproductive rights. Bridging positive and negative rights for health, CEDAW safeguards "the function of reproduction" and "adequate nutrition during pregnancy and lactation," obligates governments to take action to prevent discrimination against women on the basis of pregnancy, maternity leave, and marital status, and calls on states to introduce

⁹⁷ *Id.* art. 9.

⁹⁸ *Id.* art. 11.1.

⁹⁹ *Id.* art. 11.4.

¹⁰⁰ International Conference on Primary Health Care, Sept. 6–12, 1978, *Declaration of Alma-Ata*, available at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf [hereinafter *Declaration of Alma-Ata*].

¹⁰¹ Convention on the Elimination of All Forms of Discrimination Against Women [CEDAW], *opened for signature* Dec. 18, 1979, arts. 11, 12, 1249 U.N.T.S. 13, 18–19 (entered into force Sept. 3, 1981). For a discussion of this history of health and human rights and its connection to global breastfeeding policy, see *infra* notes 161–74 and accompanying text.

¹⁰² *Declaration of Alma-Ata*, *supra* note 100, at VI (reaffirming the WHO Constitution's declaration of health as a human right, with the object of this right defined as "complete physical, mental, and social well-being, and not merely the absence of disease or infirmity").

¹⁰³ See SHUBBER, *supra* note 86, at 18; see also The Code, *supra* note 64, pmb1.

socioeconomic support to protect maternal health.¹⁰⁴ The Code acknowledges these socioeconomic constraints to breastfeeding, protecting the mother's rights by supporting her decision to choose when and how to feed her infant.¹⁰⁵ In order to preserve the mother's autonomy through primary health care, the Code strengthens structural support for breastfeeding, such as basic health education, an independent health system, and protections against marketing bias.

With the Code seeking to realize a woman's right to choose the method and manner of her infant feeding through primary health care systems, it calls on the global community to support the rights of women in their respective capacities.¹⁰⁶ Recognizing the linkages between the decline of breastfeeding, increase in unnecessary consumption of breast milk substitutes, and disparate health outcomes experienced by women and children globally,¹⁰⁷ the Code acknowledges the vital roles to be played by all actors of the global community, including:

- NGOs that observe, monitor, and support feeding practices;
- Health systems that structure the mother's early postnatal behaviors;
- Governments that safeguard the rights of mother and child through national legislation and basic education on the benefits of breastfeeding;
- Communities and families that support and encourage the mother's decision to breastfeed; and
- The formula industry.¹⁰⁸

Although the state possesses the full obligation to ensure the integrity of the Code, the UN (through WHO, UNICEF, and other agencies) would be available to support these national implementation

¹⁰⁴ See CEDAW, *supra* note 101, arts. 11–12; see also Naomi Bromberg Bar-Yam, *Breastfeeding and Human Rights: Is There a Right to Breastfeed? Is There a Right to Be Breastfed?*, 19 J. HUM. LACTATION 357, 358 (2003) (“While breastfeeding is not mentioned specifically in the convention [CEDAW], it is understood by the drafters and readers of those documents as part of maternity.”).

¹⁰⁵ See SHUBBER, *supra* note 86, at 57.

¹⁰⁶ See The Code, *supra* note 64, art. 11.

¹⁰⁷ See Susan George, *Nestle Alimentana SA: The Limits to Public Relations*, 13 ECON. & POL. WKLY. 1591, 1592 (1978) (detailing the correlation between the rise of the use of breast-milk substitutes and the rise of health harms among children in developing countries).

¹⁰⁸ See Shubber, *supra* note 86, at 89–91.

measures, and given these responsibilities across the international community, the Code calls for global cooperation to support a mother's fully informed decision to breastfeed.¹⁰⁹

Despite these strong recommendations for an enabling environment conducive to breastfeeding, developed countries worked to vitiate the Code of any enforceable accountability mechanisms, with a multi-level compromise resulting in declaratory language that was neither sufficiently specific nor legally enforceable. First, with the underlying profit-maximization goals of formula industry in fundamental conflict with the rights to the highest attainable standard of health for the mother and child,¹¹⁰ tensions between corporate and NGO positions resulted in vague final language inapposite to the strict regulations necessary for the protection, promotion, and support of breastfeeding.¹¹¹ Second, with drafters torn between (1) fears that the Code would fail to achieve consensus within the World Health Assembly,¹¹² (2) pressures from U.S. government representatives,¹¹³ and (3) efforts by NGOs to preserve the Code in its entirety,¹¹⁴ the Code was ultimately put forward as a non-binding "recommendation," thereby sacrificing the Code's legal enforceability (as a binding "convention" or "regulation") to achieve its political

¹⁰⁹ See *id.*; see also The Code, *supra* note 64, art. 7 (recognizing the need for global cooperation "aimed at the improvement of maternal, infant and young child health and nutrition").

¹¹⁰ See BAUMSLAG & MICHELS, *supra* note 75, at 148 ("In the infant-feeding arena, private profit and public health are at odds. . . . For optimal growth and development, a baby's best interests are met when it receives the nutrition and immunologically protective benefits of breastfeeding. The goal of the baby food industry is to maximize its market size by maximizing the number of mothers who buy the products and the length of time they use them.").

¹¹¹ See SOKOL, *supra* note 75, at 9–10. The rift between advocates and the formula industry resulted in WHO and UNICEF's serving as mediators in policy development. SHUBBER, *supra* note 86, at 134–38 (describing WHO and UNICEF's roles in mediating a dispute over how to define phrases in the Code); Helen C. Armstrong & Ellen Sokol, *The International Code of Marketing of Breastmilk Substitutes: What It Means for Mothers and Babies World-Wide*, in INTERNATIONAL LACTATION CONSULTANT ASSOCIATION INDEPENDENT STUDY MODULE 6 (2001).

¹¹² See SOKOL, *supra* note 75, at 10 (delineating the lawmaking options available under WHO's constitutional authority).

¹¹³ See *id.* at 11 (discussing bargaining between WHO officials and the United States, which wielded power over 25% of the WHO's budget, had the power to influence other member votes, and feared future legislative action in the pharmaceutical market); see also BAUMSLAG & MICHELS, *supra* note 75, at 162–63 (observing that the United States did not want to quash the lucrative infant food market, which, at the time, drew \$2 billion a year); Sikink, *supra* note 81, at 825 (corroborating revenue figures and estimating that \$600 million annually was then generated from sales in developing countries).

¹¹⁴ See SHUBBER, *supra* note 86, at 32 (noting that WHO officials wanted to present the Code as a regulation, but chose recommendation status because of concerns that nations would not commit to binding regulation). Additionally, drafters wanted to avoid any potential dilution of the original language and intent, seeking a compromise by which the Code would have a timeline to achieve effectiveness as a recommendation, promulgating a regulation only if the non-binding approach failed. *Id.* at 33.

feasibility.¹¹⁵ Ultimately, these two compromises represented limiting weaknesses in the Code's ability to develop and implement its rights-based mission.

On May 21, 1981, eighteen months after its initial conception, the 34th World Health Assembly adopted the Code, with 118 countries in favor, 3 abstentions, and the United States casting the only opposing vote.¹¹⁶ This powerful dissent would set the stage for much of the struggle to create multilateral support for global breastfeeding policy in years to follow, with Northern European countries supporting policies and funding activities in alignment with the Code and U.S. aid avoiding targeted support for these efforts.

C. Post-Code Advances in Global Breastfeeding Policy

In the years following the Code's near-unanimous adoption, and in spite of voluntary manufacturer and distributor agreements to conform to its tenets, the formula industry has continued to shirk these recommended changes to corporate practice.¹¹⁷ At the national level, bureaucratic inertia in national ministries, unawareness of the Code's existence by national policymakers, and lack of legal competency in drafting the Code into national regulation¹¹⁸ all would limit the translation of global policy into national law.¹¹⁹ Compounding these institutional roadblocks, national governments faced regulatory interference from a recalcitrant formula industry.¹²⁰ By 1984, only seven states had incorporated the Code in national law, with legislative weaknesses enabling breast milk substitute corporations to subvert their voluntary agreements.¹²¹ While continuing to publicly proclaim the sanctity of their commitments, the formula industry merely modified marketing practices to circumvent

¹¹⁵ See SOKOL, *supra* note 75, at 11. For a discussion of the international legal distinction between a 'recommendation' and either a 'convention' or 'regulation,' see *infra* note 294 and accompanying text.

¹¹⁶ BAUMSLAG & MICHELS, *supra* note 75, at 162–63.

¹¹⁷ See Corey Silberstein Shdaimah, *Why Breastfeeding Is (Also) a Legal Issue*, 10 HASTINGS WOMEN'S L.J. 409, 441 (1999) (noting that although "manufacturers and distributors of breastmilk substitutes were involved in negotiating the Code and agreed to conform to its principles . . . there have been many alleged violations of the Code on their part").

¹¹⁸ SOKOL, *supra* note 75, at vii; UNICEF, INNOCENTI RESEARCH CTR., CELEBRATING THE INNOCENTI DECLARATION ON THE PROTECTION, PROMOTION AND SUPPORT OF BREASTFEEDING: PAST ACHIEVEMENTS, PRESENT CHALLENGES AND PRIORITY ACTIONS FOR INFANT AND YOUNG CHILD FEEDING 16 (2d ed. 2006) [hereinafter CELEBRATING THE INNOCENTI DECLARATION]; Leah Margulies, *The International Code of Marketing of Breastmilk Substitutes: A Model for Assuring Children's Nutrition Rights Under the Law*, 5 INT'L J. CHILD. RTS. 419, 430 (1997).

¹¹⁹ JELLIFFE & JELLIFFE, *supra* note 66, at 354–55.

¹²⁰ See *supra* Part I.C.

¹²¹ BAUMSLAG & MICHELS, *supra* note 75, at 166; Sikink, *supra* note 81, at 835.

the Code, in some cases, reinterpreting the Code's language to escape its intent, and in other cases, openly violating its provisions.¹²² Among the countless violations compiled by NGOs, breast milk substitute corporations were found to be:

- Continuing to compromise the independence and objectivity of national health systems and health professionals;¹²³
- Reinterpreting the Code as pertaining only to "infant" foods, thereby permitting the promotion of "follow up" formulas for children past infancy (and implicitly promoting infant formulas for all children);¹²⁴ and
- Failing to promote breastfeeding without time limit, encouraging the discontinuation of breastfeeding after only a few weeks.¹²⁵

With the International Baby Foods Action Network (IBFAN), an activist coalition, establishing an International Code Documentation Centre (ICDC) to track and monitor national and local level progress of Code compliance, thousands of documented violations laid bare the Code's claim to regulatory authority over breastfeeding and breast milk substitutes.¹²⁶ In the absence of enforcement mechanisms, the Code's recommendation framework proved ineffective, limiting its influence on corporate practice.

Following eight contentious years of efforts to implement the Code, the UN General Assembly adopted the Convention on the Rights of the Child (CRC),¹²⁷ concretizing the state's legal and moral responsibilities to realize the child's right to health. The 1989 CRC promulgated a right to health that included specific breastfeeding obligations pursuant to state responsibilities for children's health:

¹²² BAUMSLAG & MICHELS, *supra* note 75, at 167.

¹²³ Armstrong & Sokol, *supra* note 111, at 18 (discussing the dissemination of inaccurate health information on infant feeding that continued to be produced by the formula industry and distributed to mothers in hospitals).

¹²⁴ *Id.* at 10.

¹²⁵ *See id.* at 7 ("A manufacturer's emphasis on breastfeeding in the newborn period builds credibility for the company as an advisor on infant feeding. But the same leaflet, by omitting the discussion of later stages, may prepare the mother to abandon breastfeeding in a few weeks.").

¹²⁶ *See* INT'L COUNCIL ON HUMAN RIGHTS POLICY, BEYOND VOLUNTARISM: HUMAN RIGHTS AND THE DEVELOPING INTERNATIONAL LEGAL OBLIGATIONS OF COMPANIES 144-45 (2002); Emily Lee, *The World Health Organization's Global Strategy on Diet, Physical Activity, and Health: Turning Strategy into Action*, 60 FOOD & DRUG L.J. 569, 598 (2005).

¹²⁷ Convention on the Rights of the Child [CRC], *opened for signature* Nov. 20, 1989, 1577 U.N.T.S. 3 (entered into force Sept. 2, 1990).

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures

. . . (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, *the advantages of breast-feeding*, hygiene and environmental sanitation and the prevention of accidents.¹²⁸

This codification of breastfeeding obligations in the canon of human rights, buttressed by the near-universal state ratification of the CRC,¹²⁹ would transmute breastfeeding from aspirational health intervention to international legal policy.¹³⁰

Yet despite this human rights activity in support of breastfeeding, a number of successive post-Code breastfeeding policies shifted the agenda from a rights-based framework to a purely public health approach. WHO's 1982 "Growth Monitoring, Oral Rehydration, Breast-Feeding, and Immunization Initiative" (GOBI Initiative) pushed global health policy away from the primary health care approach of the 1978 Declaration of Alma-Ata to the scaled-down paradigm of "Selective Primary Health Care."¹³¹ This shift toward child nutrition and health objectives rather than underlying determinants of breastfeeding employed a cost-effectiveness lens to the detriment of rights-based approaches.¹³² Translating human rights obligations to measurable public health indicators following the

¹²⁸ *Id.* art. 24(1)–(2) (emphasis added).

¹²⁹ Robert S. Lawrence et al., *Poverty, Food Security, and the Right to Health*, 15 *GEO. J. POVERTY L. & POL'Y* 583, 585 (2008) (recognizing the CRC as "the most widely ratified of the international treaties and conventions forming the corpus of international human rights law").

¹³⁰ SHUBBER, *supra* note 86, at 52–53.

¹³¹ Theodore M. Brown, Marcos Cueto & Elizabeth Fee, *The World Health Organization and the Transition from "International" to "Global" Public Health*, 96 *AM. J. PUB. HEALTH* 62, 67 (2006) (noting UNICEF's distortion of WHO's primary health care agenda under "Selective Primary Health Care"); see also Marcos Cueto, *The Origins of Primary Health Care and Selective Primary Health Care*, 94 *AM. J. PUB. HEALTH* 1864, 1868–70 (2004).

¹³² See WHO, *THE WORLD HEALTH REPORT 2002: REDUCING RISKS, PROMOTING HEALTHY LIFE* 109 (2002), available at http://www.who.int/whr/2002/en/whr02_en.pdf (noting a continued concern with ensuring the effectiveness of cost-based approaches).

introduction of the CRC, the Interagency Group for Action on Breastfeeding (IGAB)—supported by WHO, USAID, and the Swedish International Development Cooperation Agency (SIDA)—developed the 1990 UNICEF Innocenti Declaration with the purpose of reflecting the spirit of the CRC but revising breastfeeding goals to reflect readily measurable targets.¹³³ The Innocenti Declaration called for three actions recognized through prior policies: implementation of the Code, support for women’s labor rights to maternity and related breastfeeding leave, and national commitment to breastfeeding policy. Adding an additional element, “Ten Steps for Successful Breastfeeding,” the Innocenti Declaration prescribed these “best practices” for breastfeeding, which would be memorialized in a World Declaration and Plan of Action.¹³⁴ While seeking to support women’s rights in the maternity setting through these breastfeeding practices, however, the construction of this policy would dilute breastfeeding policy’s foundations in the right to health.

With the addition of health targets to the human rights framework for breastfeeding, the development of global breastfeeding policy now added a new framework to the dynamic debate and diversity of perspectives on rights-based approaches to health. The debates of the World Alliance for Breastfeeding Action (WABA)—a coalition of breastfeeding specialists, advocates, and organizations—demonstrated the need to address the perceived conflict between a child’s right to breastfeed and a mother’s right to choose her method of infant feeding, raising attention to the separate rights of women and infants.¹³⁵ While international NGOs (including WABA, IBFAN, La Leche International, and the International Lactation Consultant Association) grappled with a rights-based approach to breastfeeding protection, promotion, and support—mirroring a larger contemporaneous movement for rights-based approaches to health policy¹³⁶—UNICEF and WHO focused primarily on addressing the

¹³³ INNOCENTI RESEARCH CENTRE, 1990–2005 CELEBRATING THE INNOCENTI DECLARATION ON THE PROTECTION, PROMOTION AND SUPPORT OF BREASTFEEDING, at vii (2005).

¹³⁴ U.N. Econ. & Soc. Council [ECOSOC], Comm’n on Human Rights [CHR], *World Declaration on the Survival, Protection and Development of Children and Plan of Action for Implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s*, U.N. Doc. E/CN.4/1991/59 (Dec. 12, 1990) [hereinafter *World Declaration*].

¹³⁵ See George Kent, *Human Rights and Infant Nutrition*, in WORLD ALLIANCE FOR BREASTFEEDING ACTION [WABA], REPORT OF WABA GLOBAL FORUM 2, at 178, 179–83 (Lakshmi Menon ed., 2004) [hereinafter Kent, *Infant Nutrition*] (discussing WABA’s stance on breastfeeding and human rights as it evolved during the mid-1990s).

¹³⁶ See generally Sofia Gruskin, Edward J. Mills & Daniel Tarantola, *History, Principles, and Practice of Health and Human Rights*, 370 LANCET 449 (2007).

practical barriers identified by the Code.¹³⁷ Rather than looking to the human right to health, UNICEF and WHO's 1992 Baby-friendly Hospital Initiative (BFHI) advanced an operational framework for hospitals to actively encourage breastfeeding and lactation, as set out in the programmatic guidelines of the World Declaration and Plan of Action.¹³⁸ Attempting to overcome the barriers to lactation and breastfeeding that arise during the critical hours when lactation and feeding behaviors are first established (e.g., hospitals separating mother and infant after birth or distributing breast milk substitute samples),¹³⁹ the BFHI policy framework, providing for a "Baby Friendly" designation where hospitals complied with set guidelines, had only limited effectiveness in the absence of mandatory national systems with regulatory accountability.¹⁴⁰

UNICEF's involvement with human rights has proven more complicated, with its organizational leadership structuring institutional support for rights-based approaches to breastfeeding. Initially spearheading international efforts to draft the CRC during the 1980s, UNICEF enjoyed the political popularity that resulted from its resounding adoption.¹⁴¹ But once adopted, UNICEF found it difficult to actualize a rights-based agenda in its field offices where rights were seen as independent of its traditionally programmatic approach.¹⁴² Furthermore, intra-organizational conflicts between rights-based supporters and technical staff, driven by UNICEF's institutional aversion to politicizing itself to achieve a rights-based agenda, led UNICEF to deemphasize the rights-based framework. Moving forward with public health indicators unbound by normative constraints, UNICEF reformulated its policies in infant and young child feeding under the World Declaration and Plan of Action.¹⁴³ This shift was evident in UNICEF's 1994 Innocenti Global Seminar,

¹³⁷ BREASTFEEDING: THE TECHNICAL BASIS AND RECOMMENDATIONS FOR ACTION (Randa J. Saadeh et al. eds., 1993).

¹³⁸ WHO, UNICEF & Wellstart Int'l, *The Baby-Friendly Hospital Initiative—Monitoring and Reassessment: Tools to Sustain Progress*, WHO Doc. WHO/NHD/99.2 (1999).

¹³⁹ Margulies, *supra* note 118, at 431.

¹⁴⁰ Adriano Cattaneo & Roberto Buzzetti, *Effect on Rates of Breastfeeding of Training for the Baby Friendly Hospital Initiative*, 323 BRIT. MED. J. 1358 (2001); Bindeshwar Prasad & Anthony M de L Costello, *Impact and Sustainability of a "Baby Friendly" Health Education Intervention at a District Hospital in Bihar, India*, 310 BRIT. MED. J. 621 (1995).

¹⁴¹ JOEL E. OESTREICH, POWER AND PRINCIPLE: HUMAN RIGHTS PROGRAMMING IN INTERNATIONAL ORGANIZATIONS 45–49 (2007) (discussing UNICEF's institutional neglect for rights-based approaches leading up to a 1997 change in leadership and 1998 "Executive Directive on Human Rights and UNICEF").

¹⁴² *Id.* at 43.

¹⁴³ See George Kent, *Breastfeeding: A Human Rights Issue?*, 44 DEVELOPMENT 93, 94 (2001) [hereinafter Kent, *Human Rights Issue?*] (discussing the Innocenti Declaration's continued support in the 1990 World Summit for Children).

where tensions between rights-based and target-oriented approaches were formally recognized. Citing UNICEF's traditional role in breastfeeding promotion and "strengths as an organization . . . to [establish] measurable targets . . . to [evaluate] programmes on the basis of progress made in achieving those targets," this Seminar acknowledged UNICEF's reluctance to take action where measurable targets could not easily be developed and evaluated.¹⁴⁴ Furthermore, the Seminar's participants perceived a targeted approach, disconnected from human rights indicators, to offer a clearer set of public health indicators to monitor achievement:

Agreement was reached that there was no dichotomy between the monitoring of rights and the monitoring of the goals. However, the general view was that the monitoring of progress towards the goals tended to support and complement the monitoring of child rights—not the other way around. Attainment of the goals would itself be an indicator of progress towards the fulfilment of rights. Whereas the decade and mid-decade goals are almost all quantifiable, time-bound and concerned with survival, health and educational objectives, the rights of children laid out in the Convention [on the Rights of the Child] are all-embracing and timeless. Advocacy of the Convention may assist in advancing towards the achievement of goals; thus operational policy does not insist on 'goals first, then rights.' But of all possible goals, fulfilment of rights is the ultimate.¹⁴⁵

Looking beyond a rights-based approach, UNICEF concluded that "not pursuing goals that are relatively easily achievable and which benefit millions of children is perhaps a worse dereliction of duty—if not violation of the spirit of the CRC—than focusing on violations of certain child rights for which there are no readily feasible actions."¹⁴⁶

This focus on operational, target-based approaches rather than human rights underscored UNICEF's efforts to be responsive to the international community for quantifiable health improvements. Consequently, the human rights agenda found itself relegated within UNICEF, whereby the right to health was invoked only where necessary and in accordance with preconceived public health goals. As breastfeeding policies continued to gain favor in nutrition program

¹⁴⁴ MAGGIE BLACK, UNICEF INT'L CHILD DEV. CTR., INNOCENTI GLOBAL SEMINAR, MONITORING THE RIGHTS OF CHILDREN: SUMMARY REPORT 9 (1994).

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

efforts under a human right to food, breastfeeding would play a decreasing role in rights-based maternal and child health policies under an expanding reproductive rights framework. Highlighting this neglect, global health policy efforts avoided specific mention of breastfeeding in the 1994 International Conference on Population and Development (Cairo Declaration),¹⁴⁷ 1995 Fourth World Conference on Women (Beijing Platform for Action),¹⁴⁸ and 2000 Millennium Development Goals (MDGs).¹⁴⁹ Although advocates continued to press states under the human rights framework for national policies that would create healthy environments supportive of breastfeeding,¹⁵⁰ these advocates did not find international legal support to address the rights-based intricacies of national breastfeeding policies. By contrast, evolving global breastfeeding policy frameworks—in the 2001 WHO Infant and Young Child-Feeding in Emergencies and the 2003 Global Strategy for Infant and Young Child Feeding¹⁵¹—synergized additional operational targets with the original 1990 Innocenti Declaration, which was reaffirmed in 2005 under the 2nd Innocenti Declaration.¹⁵²

¹⁴⁷ Int'l Conference on Population & Dev. [ICPD], Cairo, Egypt, Sept. 5–13, 1994, *Programme of Action*, ¶¶ 7.2, 7.3, U.N. Doc A/CONF.171/13 (Oct 18, 1994). *But cf.* Rosalind Pollack Petchesky, Commentary, *From Population Control to Reproductive Rights: Feminist Fault Lines*, 3 REPROD. HEALTH MATTERS 152, 154 (1995) (noting that the Cairo Declaration's adoption of the WHO definition of reproductive health "paves the way for an integrated, comprehensive model of programmes and services that includes . . . breastfeeding").

¹⁴⁸ Fourth World Conference on Women, Beijing, China, Sept. 4–15, 1995, *Beijing Declaration and Platform for Action*, U.N. Doc A/CONF.177/20 (Oct. 17, 1995).

¹⁴⁹ United Nations Millennium Declaration, G.A. Res. 55/2, U.N. GAOR, 55th Sess., 8th plen. mtg., U.N. Doc. A/RES/55/2 (Sept. 8, 2000); *see also* Millennium Development Goals (Sept. 8, 2003), <http://unstats.un.org/unsd/mi/pdf/mdglist.pdf>. The absence of breastfeeding in the U.N.'s 2000 Millennium Declaration is particularly paradoxical, as six of the eight MDGs are directly applicable to breastfeeding and breastfeeding policy—addressing extreme hunger (MDG #1), reducing child mortality (MDG #4), improving maternal health (MDG #5), combating disease (MDG #6), environmental sustainability (MDG #7), and providing the basis for global partnerships (MDG #8)—wherein breastfeeding can be seen as a multi- or inter-sectoral intervention for pervasive benefits across the MDGs. M. Labbok, *Breastfeeding: A Woman's Reproductive Right*, 94 INT'L J GYNECOLOGY & OBSTETRICS 277, 278 (2006); John Tobin, *Beyond the Supermarket Shelf: Using a Rights Based Approach to Address Children's Health Needs*, 14 INT'L J. CHILD. RTS. 275, 296 (2006).

¹⁵⁰ WABA, World Alliance for Breastfeeding Int'l Workshop, *Quezón City Declaration*, Quezón City, Phil., June 1–5, 1998, *available at* <http://www.worldallianceforbreastfeedingaction.org/whatwedo/womenandwork/planacti.htm>; *see also* Kent, *Infant Nutrition*, *supra* note 135, at 180 ("States that are parties to the ICESCR, CRC and related international human rights agreements have an obligation to respect, protect, facilitate and fulfill these rights relating to child nutrition. They are obligated to remove obstacles to breastfeeding and to appropriate complementary feeding, and they are obligated to create supportive social and economic environments for both parents and children that will assure good nutrition.").

¹⁵¹ WHO, GLOBAL STRATEGY FOR INFANT AND YOUNG CHILD FEEDING (2003), *available at* http://www.paho.org/english/ad/fch/ca/GSIYCF_infantfeeding_eng.pdf [hereinafter WHO GLOBAL STRATEGY].

¹⁵² CELEBRATING THE INNOCENTI DECLARATION, *supra* note 118.

Predominated by operational targets, the right to health was only mentioned superficially in these policies.¹⁵³

While programmatic policy efforts have corresponded with increasing exclusive breastfeeding rates throughout the world—from 34% to 41% between 1990 and 2004, leading to attendant decreases in maternal and child mortality¹⁵⁴—much more needs to be done to raise breastfeeding rates commensurate with global health imperatives. Despite the progress made since the Code's adoption, weak accountability mechanisms plague the implementation and enforcement of global health policy for breastfeeding protection, promotion, and support.¹⁵⁵ Given these limitations of global health governance, corporations have continued to ignore global breastfeeding policy,¹⁵⁶ with recent reports recognizing that the most egregious Code violations persist: thirteen of the sixteen largest formula companies substantially violated the Code by marketing to health workers; eight continued to distribute free samples; and Nestlé remained one of the worst violators of the Code, leading low-income women in the developing world to believe that breast milk substitutes provide the best nourishment for their babies.¹⁵⁷ To alleviate these limitations, new human rights frameworks will be necessary to build support for improved global health policy to restrict the use of breast milk substitutes through the protection, promotion, and support of breastfeeding.

III. A HUMAN RIGHT TO BREASTFEEDING

In the continuing evolution of global breastfeeding policy, the legal obligations of the human right to health offer valuable normative frameworks for developing and implementing necessary international legal standards through global health policy. Yet against

¹⁵³ Innocenti Declaration on Infant and Young Child Feeding (2005), available at http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=7388&Itemid=

¹⁵⁴ Y. Sguassero, *Optimal Duration of Exclusive Breastfeeding: RHL Commentary*, WHO REPROD. HEALTH LIB., (March 28, 2008), http://apps.who.int/rihl/pregnancy_childbirth/care_after_childbirth/yscom/en/index.html. While trends indicate global increases in breastfeeding, breastfeeding continues to be practiced unequally across countries and regions. See UNICEF, PROGRESS FOR CHILDREN 10 (2006), available at http://www.unicef.org/progressforchildren/2006n4/files/PFC4_EN_8X11.pdf.

¹⁵⁵ See Tony Waterston & James Tumwine, *Monitoring the Marketing of Infant Formula Feeds: Manufacturers of Breast Milk Substitutes Violate the WHO Code—Again*, 326 BRIT. MED. J. 7381 (2003); see also IBFAN, STATE OF THE CODE BY COUNTRY (2006), available at <http://www.ibfan.org/art/298-11.pdf>; IBFAN, STATE OF THE CODE BY COUNTRY (2004), available at <http://www.ibfan.org/art/298-10.pdf>; IBFAN, STATE OF THE CODE BY COUNTRY (2001), available at <http://www.ibfan.org/art/298-1.jpg>.

¹⁵⁶ Joanna Moorhead, *Milking It*, GUARDIAN, May 15, 2007, at 7.

¹⁵⁷ IBFAN, STATE OF THE CODE BY COMPANY (2006), available at <http://www.ibfan.org/art/298-9.pdf>.

a backdrop of industry intransigence and infant death, breastfeeding has been obscured in recent international legal frameworks and scholarly analyses for the right to health. While rights advocates have long recognized the importance of breastfeeding to the realization of human rights for health,¹⁵⁸ recent frameworks for health rights have ignored this simple and obvious area of global health policy, limiting international legal analysis of breastfeeding solely to a right to food.¹⁵⁹ Without normative foundation in the right to health—as breastfeeding proponents turned from the obligations of human rights law, seeking to tie breastfeeding to a larger focus on public health outcomes in the absence of normative foundations¹⁶⁰—international organizations have struggled to develop enforceable global policies to stem the resurgent tide of breast milk substitutes in the developing world, leaving millions sick and dying in its insalubrious wake.

Although the right to health originally sought to prioritize breastfeeding among public health interventions, states and international organizations have neglected even to mention breastfeeding in their most recent elaborations of the right to health. With international legal obligations for a human right to health arising out of the creation of the UN and WHO at the end of the Second World War—with the War, and Depression that preceded it, heightening threats to maternal and infant health—the UN’s 1948 Universal Declaration of Human Rights (UDHR) proclaimed a right to health with the explicit clarification that “[m]otherhood and childhood are entitled to special care and assistance.”¹⁶¹ Codifying this right to health in international law, the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) advanced both a right to “be free from hunger” and a right to “the highest attainable standard of physical and mental health,” committing states under the right to health to specific obligations for “the reduction of the stillbirth-rate and for the healthy development of the child.”¹⁶² As the harms of breast milk substitutes became clear

¹⁵⁸ See, e.g., Arne Oshaug et al., *Human Rights: A Normative Basis for Food and Nutrition-Relevant Policies*, 19 FOOD POL’Y 491 (1994) (describing early support for human rights supportive of nutrition health).

¹⁵⁹ See, e.g., George Kent, *Child Feeding and Human Rights*, INT’L BREASTFEEDING J., Dec. 16, 2006, at 1 [hereinafter Kent, *Child Feeding*], available at <http://www.internationalbreastfeedingjournal.com/content/1/1/27>.

¹⁶⁰ See *supra* notes 131–46 and accompanying text.

¹⁶¹ Universal Declaration of Human Rights [UDHR], G.A. Res. 217A, at 76, art. 25(2), U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 12, 1948). For a description of the debates leading to the inclusion of maternal and child health in article 25, see JOHANNES MORSINK, *THE UNIVERSAL DECLARATION OF HUMAN RIGHTS: ORIGINS, DRAFTING, & INTENT* 257–58 (1999).

¹⁶² International Covenant on Economic, Social and Cultural Rights [ICESCR], arts. 11(2),

in the years following the development of these ICESCR obligations, the protection, promotion, and support of breastfeeding was taken up as an integral part of the right to health, incorporated as a critical component of “primary health care” in both the 1978 Declaration of Alma-Ata and 1979 CEDAW.¹⁶³ Drawing on these rights-based elaborations in global breastfeeding policy, the Code opens by “[a]ffirming the right of every child and every pregnant and lactating woman to be adequately nourished as a means of attaining and maintaining health.”¹⁶⁴ Despite a dramatic shift away from primary health care, with the collapse of the Declaration of Alma-Ata and WHO’s Health for All Strategy at the start of the neoliberal era (1979–1980),¹⁶⁵ breastfeeding retained a prominent place under the right to health,¹⁶⁶ with the 1989 CRC obligating states to support “the advantages of breast-feeding” as part of the right to health for both mothers and children.¹⁶⁷

In this momentum to advance global breastfeeding policy, however, these policies lost their human rights compass. Where breastfeeding proponents shifted from human rights frameworks to public health outcomes,¹⁶⁸ human rights advocates felt no imperative to address breastfeeding under the right to health. As human rights institutions moved away from breastfeeding in their considerations of reproductive health, the increasing isolation of human rights for breastfeeding regressed to abject neglect. Culminating this neglect, the UN’s 2000 General Comment 14 (the UN Committee on Economic Social and Cultural Rights’ authoritative interpretation of the ICESCR’s health obligations) made no mention of breastfeeding in its normative clarification of

12(1), 12(2)(a), *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3, 7, 8 (entered into force Jan. 3, 1976). For an argument that this latter provision supports policies for the “promotion of breastfeeding through education and support services,” see Mehlika Hoodbhoy et al., *Exporting Despair: The Human Rights Implications of U.S. Restrictions on Foreign Health Care Funding in Kenya*, 29 *FORDHAM INT’L L.J.* 1, 23 (2005).

¹⁶³ See *supra* notes 100–04 and accompanying text.

¹⁶⁴ The Code, *supra* note 64, pmbi.; see also Margulies, *supra* note 118, at 423–28 (describing the rights-based foundation of the Code).

¹⁶⁵ See *supra* notes 131–32 and accompanying text (discussing the GOBI approach to global health policy and the rise of Selective Primary Health Care).

¹⁶⁶ See JUDITH RICHTER, *HOLDING CORPORATIONS ACCOUNTABLE: CORPORATE CONDUCT, INTERNATIONAL CODES, AND CITIZEN ACTION* 85–87 (2001) (discussing the CRC’s impact on Code implementation, beginning in 1990).

¹⁶⁷ CRC, *supra* note 127, art. 24(2)(e) see also *supra* notes 128–30 and accompanying text (discussing the development of breastfeeding obligations in the CRC).

¹⁶⁸ See *supra* notes 141–46 and accompanying text (clarifying UNICEF’s shift from human rights norms to public health indicators).

“maternal, child and reproductive health,”¹⁶⁹ effectively writing breastfeeding out of the right to health.¹⁷⁰ This trivialization of breastfeeding has only been exacerbated in the context of HIV/AIDS, where, despite continuing evidence on the comparative public health advantages of continued breastfeeding,¹⁷¹ rights-based analyses have pressed for a discontinuation of breastfeeding support.¹⁷² Given this loss of normative support under the right to health—with current health rights analyses avoiding breastfeeding altogether¹⁷³—breastfeeding is losing its preeminence in the hierarchy of health interventions. What was once one of the leading public health successes of the modern era has fallen entirely from WHO’s revitalized primary health care agenda.¹⁷⁴

Despite this recent avoidance of breastfeeding in the specific legal obligations of the right to health, current analysis on health rights provides theoretical foundation for considering the harms of breast milk substitutes in the developing world. Based upon the theoretical reasoning of a capability approach to the right to health, this Part proposes a human right to breastfeeding, defining and delineating the unique rights-holders and duty-bearers under this framework for realization of the right to health. With human rights framing these obligations, this Part advances a right to breastfeeding—as a pillar of the right to health—by which the mother/child dyad can make claims against the international community for global health policies that respect, protect, and fulfill breastfeeding under international law.

¹⁶⁹ ECOSOC, Comm. on Econ., Soc. & Cultural Rights [CESCR], *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment No. 14*, ¶ 14, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter *General Comment 14*].

¹⁷⁰ Additionally, the CESCR’s general comment on the right to food provides no guidance on human rights in breastfeeding; ‘breastfeeding’ is mentioned only in passing as a type of “feeding pattern.” See ECOSOC, CESCR, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment 12*, ¶ 9, U.N. Doc. E/C.12/1999/5 (May 12, 1999).

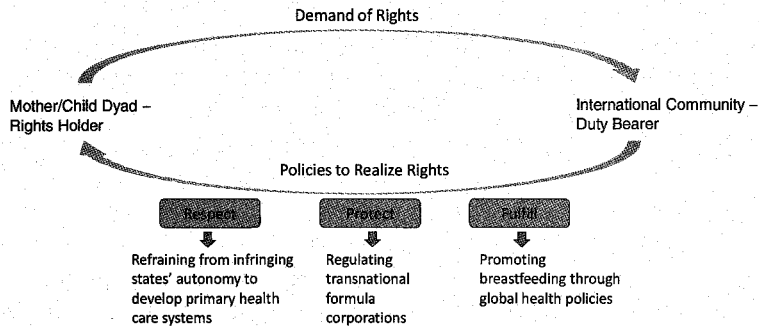
¹⁷¹ See *supra* notes 26–29 and accompanying text.

¹⁷² E.g., Agnès Binagwaho, *The Right of Children in Developing Countries to Be Born and Live HIV-Free*, 10 HEALTH & HUM. RTS. 149, 151 (2008) (arguing for a woman’s choice to pursue “replacement feeding”).

¹⁷³ See, e.g., ECOSOC, CHR, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur*, U.N. Doc. E/CN.4/2003/58 (Feb. 13, 2003) (prepared by Paul Hunt) [hereinafter ECOSOC, *Report of the Special Rapporteur*] (failing to mention breastfeeding in outlining the content of the human right to health).

¹⁷⁴ See World Health Org. *The World Health Report 2008—Primary Health Care: Now More Than Ever* (2008), available at http://www.who.int/whr/2008/whr08_en.pdf (making no mention of breastfeeding). In contrast to WHO’s approach, UNICEF has recently reengaged with a rights-based approach to breastfeeding. See Richard Horton, *UNICEF Leadership 2005–2015: A Call for Strategic Change*, 364 LANCET 2071, 2072 (2004) (criticizing UNICEF’s turn toward a rights-based approach to children’s health).

The Mother/Child Dyad has a right against the International Community in relation to Breastfeeding



Pursuant to this framework, linking rights-holders and duty-bearers through obligations reflective of the complex reality of breastfeeding in a globalized world, states can come together with the normative authority necessary to develop global health policy to realize a human right to breastfeeding.

A. Breastfeeding, Capability, and the Right to Health

Support for breastfeeding comports with a capability approach to the right to health. Where scholarship once focused on autonomy as a basis for health rights,¹⁷⁵ this early emphasis on autonomy gave way to a focus on equity in the distribution of health care.¹⁷⁶ In response to this focus on equity untethered to functioning, scholarship has moved to recognize the normative primacy of individual capability for health.¹⁷⁷ This “capability approach” frames policy as a means to expand freedom—as both the primary end and principal means of public policy—seeking to remove barriers to functioning that leave people with little choice or opportunity to exercise their reasoned

¹⁷⁵ See, e.g., ALASTAIR V. CAMPBELL, *MEDICINE, HEALTH AND JUSTICE: THE PROBLEM OF PRIORITIES* 48 (1978) (explaining, under Kant’s theory of autonomy, that “priority should be given to those medical interventions most likely to increase autonomy amongst those least able to exercise it without outside help” (emphasis omitted)).

¹⁷⁶ See, e.g., NORMAN DANIELS, *JUST HEALTH CARE* (1985) (presenting a normative argument for equity in the distribution of health care); G.A. Cohen, *Equality of What? On Welfare, Goods, and Capabilities*, in *THE QUALITY OF LIFE* 9, 28 (Martha C. Nussbaum & Amartya Sen eds., 1993) (arguing for the equalization of access to advantage).

¹⁷⁷ See, e.g., AMARTYA SEN, *DEVELOPMENT AS FREEDOM* 3 (1999) (finding the end goal of development to be individual fulfillment and capability for, *inter alia*, health); see also Martha C. Nussbaum, *Nature, Function and Capability: Aristotle on Political Distribution*, in *ARISTOTELES’ “POLITIK”* 152, 165 (Günther Patzig ed., 1990) (extending a capability approach to functions of health); Norman Daniels, *Justice, Health, and Healthcare*, *AM. J. BIOETHICS*, Spring 2001, at 2 (noting the progressive harmonization of ethical frameworks in health policy).

agency. In the context of health policy, the “health capability approach” seeks to enable health agency, increasing an individual’s opportunity to achieve good health by emphasizing those functionings necessary to pursue a life one has reason to value.¹⁷⁸ Encompassing those determinants of health that structure a person’s ability to be healthy,¹⁷⁹ such an approach redistributes health resources to reduce disparities in “basic” or “central” health capabilities, prioritizing those interventions empirically shown to free individuals from preventable morbidity and mortality through the shared benefits of public health.¹⁸⁰

Rather than focusing on breastfeeding as part of a “natural law”¹⁸¹ or a means to achieve either equitable distribution¹⁸² or maximum utility¹⁸³ in health, a capability approach to breastfeeding policy seeks to achieve the freedom necessary to meet individual goals, evaluating these individual goals on the basis of their effects on both individual health agency and public health outcomes. As a theoretical basis for framing health policy in the progressive realization of the right to health,¹⁸⁴ a capability approach to the right to health emphasizes

¹⁷⁸ Jennifer Prah Ruger, *Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements*, 18 *YALE J.L. & HUMAN.* 273, 289 (2006) [hereinafter Ruger, *Toward a Theory*]; Jennifer Prah Ruger, *Health, Capability, and Justice: Toward a New Paradigm of Health Ethics, Policy and Law*, 15 *CORNELL J.L. & PUB. POL’Y* 403, 474–81 (2006) [hereinafter Ruger, *Health, Capability, and Justice*] (analyzing the “efficiency-equity tradeoff” in creating a framework for allocating health resources).

¹⁷⁹ Jennifer Prah Ruger, *Aristotelian Justice and Health Policy: Capability and Incompletely Theorized Agreements* (1998) (unpublished Ph.D. dissertation, Harvard University) (on file with author).

¹⁸⁰ See generally JENNIFER PRAH RUGER, *HEALTH AND SOCIAL JUSTICE* (2009); Jennifer Prah Ruger, *Health Capability: Conceptualization and Operationalization*, 100 *AM. J. PUBLIC HEALTH* 41 (2010) (offering a health capability paradigm as a way of shaping health systems and allocating scarce resources).

¹⁸¹ E.g., Michael C. Latham, *Breastfeeding—A Human Rights Issue?*, 5 *INT’L J. CHILD. RTS.* 397, 400 (1997) (“That the right to breastfeed is even being discussed or challenged, is strange, and even aberrant. It is a challenge to nature, to natural law and natural practice, and to our ecology and environment.”).

¹⁸² See, e.g., Cesar G. Victora et al., *Applying an Equity Lens to Child Health and Mortality: More of the Same Is Not Enough*, 362 *LANCET* 233 (2003) (arguing that health is a social primary goal and thus breastfeeding is a means to achieve equity between rich and poor).

¹⁸³ See, e.g., Shdaimah, *supra* note 117, at 410–11 (noting that breastfeeding provides direct economic benefits to the community by lowering the incidence of health problems because it is beneficial to both mother and infant health).

¹⁸⁴ RUGER, *supra* note 180, at 312–25 (applying an Aristotelian vision of “human flourishing” to Sen’s capability approach in operationalizing the progressive realization of the right to health).

In accordance with the principle of progressive realization, enacted through article 2 of the ICESCR, a state must take steps to operationalize the right to health only “to the maximum of its available resources, with a view to achieving progressively the full realization of the rights.” ICESCR, *supra* note 162, art. 2 (emphasis added); see also *General Comment 14, supra* note 169, ¶ 30 (recognizing that the ICESCR “acknowledges the constraints due to the limits of available resources” in realization of the right to health).

preventive care to the extent that such care reduces escapable morbidity and mortality and distributes resources in a cost-effective manner.¹⁸⁵ Such an approach can provide a normative basis for grounding a right to breastfeeding within the right to health, increasing capability for healthy functionings through the protection, promotion, and support of breastfeeding.

In prioritizing breastfeeding policy pursuant to the right to health, a capability approach would seek to address vulnerable populations in national policies, with breastfeeding overcoming vulnerability by increasing autonomy for health between mother and child. As recognized in the 1994 Cairo Declaration and the 1995 Beijing Platform for Action (focusing on the gendered dimensions of health rights), both women and children should be considered vulnerable groups, in need of supplementary protection during the breastfeeding stage, particularly in impoverished communities in the developing world.¹⁸⁶ As a result, breastfeeding—once considered a private good, impacting only lifestyle choices—must now be reevaluated as a public good, requiring a public health-based approach to protect the vulnerable from harmful market forces.¹⁸⁷ In ameliorating these vulnerabilities through equitable, cost-effective interventions,¹⁸⁸ regulatory frameworks should seek to protect individuals from the autonomy-diminishing marketing of breast milk substitutes, thus

¹⁸⁵ Ruger, *Health, Capability and Justice*, *supra* note 178, at 411 (noting, in the distribution of scarce resources, that “some limits are necessary and individuals and society, through shared health governance, must use these resources parsimoniously by evaluating efficiency”).

¹⁸⁶ Ilise L. Feitshans, *Is There a Human Right to Reproductive Health?*, 8 TEX. J. WOMEN & L. 93, 129 (1998). This assumption of vulnerability for women and children was extended and furthered by the 2000 MDGs, which focus explicitly on maternal and child health. LYNN FREEDMAN ET AL., UN MILLENNIUM PROJECT, WHO’S GOT THE POWER? TRANSFORMING HEALTH SYSTEMS FOR WOMEN AND CHILDREN (2005) (discussing how to accomplish the Millennium Development Goals that focus on maternal and child health). In many ways, it is these vulnerabilities that led the formula industry to seek out markets in the developing world as health education reduced formula markets in the developed world. THÉODORE H. MACDONALD, HEALTH, TRADE AND HUMAN RIGHTS 61 (2006) (describing examples of breast milk substitute companies shifting focus from first-world to third-world markets).

¹⁸⁷ Cf. Jennifer Prah Ruger, *Global Tobacco Control: An Integrated Approach to Global Health Policy*, 48 DEVELOPMENT 65 (2005) (recognizing tobacco control as a means to influence health capability); Allyn L. Taylor & Douglas W. Bettcher, *WHO Framework Convention on Tobacco Control: A Global “Good” for Public Health*, 78 BULL. WORLD HEALTH ORG. 920, 925 (2000) (“Traditionally, prevention or treatment of noncommunicable diseases was considered to be mostly a private good, since the risk factors associated with such diseases, including use of tobacco, are related to individual choices in lifestyle.”).

¹⁸⁸ See Julie Smith, *Mothers’ Milk and Markets*, 19 AUSTL. FEMINIST STUD. 369, 372, 374–76 (2004) (noting that breastfeeding promotion is one of the most cost-effective public health interventions, benefiting additionally by avoiding the societal costs of breast milk substitutes).

moving from individual agency to collective agency through public policy for the public's health.

Infants clearly have the most to gain from the protection and promotion of breastfeeding, as their inherent fragility denies them the autonomy to claim their own rights and define their own capability in the absence of state intervention.¹⁸⁹ Vulnerable to disease, disadvantaged within families, and powerless to speak out, infants often suffer relative to other family members, diminishing their freedom to lead valuable lives in the years to come.¹⁹⁰ With a single source responsible for the entirety of an infant's nutritional intake, the relative quality of that source is dispositive in building the health necessary for infant functioning. Given a capability approach to the right to health, breastfeeding can be seen as central to an infant's ability to function (and his or her capabilities as an adult) and should thereby be a priority in capability-driven health policy.¹⁹¹ It is these infants—suffering mortality that is self-evidently premature—who should be prioritized in policies designed to alleviate preventable sickness and death.¹⁹² Where a focus on “basic capabilities” seeks to achieve normal functioning, a lack of breastfeeding diminishes that functioning among infants, often fatally, as a direct consequence of the use of breast milk substitutes in the developing world. Without the infant health provided through breastfeeding, all other functionings are lost.¹⁹³

Additionally, mothers stand to gain capability from a rights-based focus on breastfeeding. Under a capability approach to the right to health, health policy should support individuals' capability for healthy functioning, creating conditions necessary for health agency—the ability to engage directly with health determinants to prevent

¹⁸⁹ THÉODORE H. MACDONALD, *THE GLOBAL HUMAN RIGHT TO HEALTH: DREAM OR POSSIBILITY?* 109 (2007) [hereinafter MACDONALD, *DREAM OR POSSIBILITY?*] (“Children are rarely in a position to demand the rights that are due them, even if they know that they have such rights and it is up to legal sanctions to define and defend those rights.”).

¹⁹⁰ See AMARTYA SEN, *POVERTY AND FAMINES: AN ESSAY ON ENTITLEMENT AND DEPRIVATION* 29 (1981) (noting disproportionate undernourishment of children within the family and arguing for the capabilities of infants).

¹⁹¹ Jennifer Prah Ruger, *Health and Social Justice*, 364 *LANCET* 1075, 1075 (2004) [hereinafter Ruger, *Health and Social Justice*] (noting, under a capability view of health, that “public policy should focus on the ability to function, and that health policy should aim to maintain and improve this ability by meeting health needs”).

¹⁹² See *id.* at 1077 (“Premature mortality implies placing special emphasis on efforts to avert deaths from preventable causes that do not allow individuals to live a life of normal length . . .”).

¹⁹³ See Jennifer Prah Ruger, *Normative Foundations of Global Health Law*, 96 *GEO. L.J.* 423, 431 (2008) [hereinafter Ruger, *Normative Foundations*] (arguing that health capabilities are prerequisites to other capabilities).

mortality and morbidity.¹⁹⁴ The protection, promotion, and support of breastfeeding meets this need for individual health agency, empowering women to meet the health needs of their children and removing barriers to freedom that leave women without opportunity to exercise their agency.¹⁹⁵ Where the manipulative marketing of breast milk substitutes impinges on health agency, mothers should have the ability to make decisions unbridled by these societal influences.¹⁹⁶ To create a healthy environment for effective decision making, the right to health could prioritize underlying social determinants of breastfeeding, following General Comment 14's prioritization of underlying determinants of health and finding that "the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health."¹⁹⁷ To overcome the determinants that structure women's unnecessary use of breast milk substitutes, a right to breastfeeding would support health information, educational services, and marketing regulations by which autonomous mothers can make informed choices.¹⁹⁸ This information model is the approach taken in the Code, which, like early approaches to the harms of smoking, is premised on the notion that "[i]f women are given good information, and have all the obstacles to breastfeeding eliminated, they are likely to make good choices."¹⁹⁹

But how are we to think about these choices and how would a human rights lens distinguish a "good" from a "bad" choice? A capability approach seeks to achieve that which individuals value, but what if an individual values harmful things (or, more likely, cannot

¹⁹⁴ See Ruger, *Health, Capability, and Justice*, *supra* note 178, at 407.

¹⁹⁵ See generally Jacqueline H. Wolf, *What Feminists Can Do for Breastfeeding and What Breastfeeding Can Do for Feminists*, 31 SIGNS 397 (2006).

¹⁹⁶ See Kent, *Child Feeding*, *supra* note 159, at 4 ("The difficulties [of breastfeeding] sometimes are so serious and so extensive that they must be viewed as problems of society."). In fact, it was this reasoning on health agency that was pressed by women's rights advocates, on the heels of CEDAW, to advance the Code as rights-based regulation to overcome the lack of information and the inadequacies of education that made impoverished women vulnerable to the misleading marketing of the formula industry. Sami Shubber, *The International Code of Marketing of Breast Milk Substitutes*, 36 INT'L DIG. HEALTH LEGIS. 877 (1985).

¹⁹⁷ *General Comment 14*, *supra* note 169, ¶ 9. This obligation extends the guarantee of the CRC, which sought to assure access to education and support "in the use of basic knowledge of child health and nutrition, [and] the advantages of breastfeeding." CRC, *supra* note 127, art. 24(2)(e).

¹⁹⁸ See Bar-Yam, *supra* note 104, at 359 ("Governments have the responsibility to inform so that parents can make informed choices for their children."); Kent, *Child Feeding*, *supra* note 148.

¹⁹⁹ Kent, *Infant Nutrition*, *supra* note 135, at 183.

understand the value of healthy things)? Human rights law does not contemplate such a detrimental choice for health.²⁰⁰

A rights-based focus on choice to the exclusion of capability fails to recognize that the choice of mothers to use formula is socially constructed,²⁰¹ implicating the need for social restraint where education is insufficient to prevent extreme harm and restraint is necessary and promote public health. Under a capability approach, the state has a paternalistic responsibility to keep individuals from making empirically harmful decisions—those decisions that are extremely hazardous and cause irreversible damage—and to protect public health through obligatory mechanisms for the common good.²⁰² Given the extent to which commercial interests have exploited women's ignorance in causing fatal harms from uninformed decisions,²⁰³ it is not sufficient simply to give women access to civil and political rights;²⁰⁴ policies must protect, promote, and support societal efforts that would buttress the decision to breastfeed in unhealthy environments in the developing world. Although the initial decision not to breastfeed might comport with an individual woman's subjective utility assessment (i.e., might make her happier), this initial decision to accept formula at the time of birth imperils her ability to produce breast milk in the future, with this autonomy-diminishing dependency on formula warranting policy intervention to prevent unforeseen future harms.²⁰⁵ The state can neither prevent nor compel

²⁰⁰ See, e.g., Bar-Yam, *supra* note 104, at 359 ("The CRC assumes that parents act in the best interests of their children, that is in the nature of being parents.").

²⁰¹ See *supra* Part I.C (discussing the social structures that contribute to and impinge upon breastfeeding).

²⁰² In framing an ethical basis for the prevention of such public health hazards, Dan Beauchamp has argued that:

[p]ublic health, ideally, should not be concerned with explaining the successes and failures of differing individuals (dispositional explanations) in controlling the hazards of this world. Rather these failures should be seen as signs of still weak and ineffective controls or limits over those conditions, commodities, services, products or practices that are either hazardous for the health and safety of members of the public, or that are vital to protect the public's health.

Dan E. Beauchamp, *Public Health as Social Justice*, in *HEALTH AND SOCIAL JUSTICE* 267, 274 (Richard Hofrichter ed., 2003).

²⁰³ As noted by WHO Director-General H. Nakajima before the 1992 World Health Assembly: "Advertising infant formulas as a substitute for breast milk favours uninformed decision-making, by-passing the advice and supervision of the mother's physician or of health workers." SHUBBER, *supra* note 86, at 110.

²⁰⁴ *But cf.* Thomas W. Pogge, *Can the Capability Approach Be Justified?*, 30 *PHIL. TOPICS* 167, 183 (2002) (arguing that "if our social institutions assured women of equal and equally effective civil and political rights, of equal opportunities, of equal pay for equal work, women could thrive fully even without any special breaks and considerations").

²⁰⁵ See Albert Weale, *Invisible Hand or Fatherly Hand? Problems of Paternalism in the New Perspective on Health*, 7 *J. HEALTH POL. POL'Y & L.* 784, 800 (1983) (recognizing that

actions by a mother, but the right to health clearly would not support a woman's choice under circumstances where that choice would be likely to cause harm to herself and her infant child.²⁰⁶

Thus, while a woman does not bear an obligation to breastfeed, the right to health would support limitations on a woman's autonomy to choose breast milk substitutes in environments where those substitutes can be shown to lead to empirically harmful effects for the infant and mother. Without blaming the maternal victim for societal conditions,²⁰⁷ breast milk substitutes cannot be considered a viable choice in developing country settings in which that choice is consequentially harmful. Like the regulation of inherently harmful tobacco products,²⁰⁸ such consequentially harmful formula products are amenable to autonomy-constraining regulation for the public's health, ameliorating societal obstacles to the protection, promotion, and support of health agency through breastfeeding.²⁰⁹ While a woman need not be compelled to breastfeed, the infant must be afforded the only healthy option—breast milk—either given directly from a mother,²¹⁰ expressed under healthy bottle conditions,²¹¹ or provided independently through a milk bank.²¹² In public health

“the freedom to commit obviously imprudent actions may have the consequence of creating conditions in which continuing autonomy can no longer be maintained” and detailing the conditions under which “free decisions are unlikely to be the best guide to a person's interests”). This ethical framework for state intervention to limit unhealthy dependencies is similar to the rights-based justification for tobacco control, wherein the addictive properties of nicotine result in autonomy-diminishing effects that warrant paternalistic support through public policy. See Benjamin Mason Meier, *Breathing Life into the Framework Convention on Tobacco Control: Smoking Cessation and the Right to Health*, 5 YALE J. HEALTH POL'Y L. & ETHICS 137, 160–62 (2005).

²⁰⁶ Cf. Kent, *Human Rights Issue?*, *supra* note 143, at 97 (“The state should interfere in the parent-child relationship only in extraordinary situations, when there is extremely compelling evidence that the parents are acting contrary to the best interests of the child.”).

²⁰⁷ See Beauchamp, *supra* note 202, at 270 (“Victim-blaming misdefines structural and collective problems of the entire society as individual problems, seeing these problems as caused by the behavioral failures or deficiencies of the victims.”).

²⁰⁸ See generally Meier, *supra* note 205 (discussing the prioritization of tobacco cessation pursuant to the right to health).

²⁰⁹ See Latham, *supra* note 181, at 401 (analogizing the use of breast milk substitutes to other acts that harm the public's health). *But cf.* Kent, *Child Feeding*, *supra* note 159, at 8 (“The task of human rights, and governance generally, is not to prescribe optimal behavior. Rather, their function is to establish outer limits, saying that people's behavior should not go beyond certain extremes. Thus, people are allowed to smoke and eat unhealthy food, even though it is not best for them.”).

²¹⁰ JAN RIORDAN, *BREASTFEEDING AND HUMAN LACTATION* 15–23 (3d ed. 2005) (noting the developmental advantages of breast feeding, either from the mother or a wet nurse).

²¹¹ See WHO GLOBAL STRATEGY, *supra* note 151, at 10 (discussing healthy alternatives for expressing breast milk where breastfeeding is not possible).

²¹² See Lois D.W. Arnold, *Global Health Policies that Support the Use of Banked Donor Human Milk: A Human Rights Issue*, INT'L BREASTFEEDING J., Dec. 12, 2006, at 1, available at <http://www.internationalbreastfeedingjournal.com/content/pdf/1746-4358-1-26.pdf> (comparing

environments in which infant morbidity and mortality figures make it clear that breast milk substitutes are likely to lead to unnecessary and extreme harm, a right to breastfeeding necessarily implicates a right to be free from such empirically harmful substitutes, and states bear a duty to regulate the distribution and sale of substitutes within these populations, curtailing individual autonomy to support health agency for mother and child.²¹³

B. A New Rights-Holder for a New Right

Given this inextricable link between the mother's and the child's health capability, the rights-holder for this right to breastfeeding must be reconceptualized under the human right to health to encompass this intertwined reality. In developing rights-based health policy where the mother and child are functionally interconnected in their breastfeeding needs, the mother/child dyad can be seen as the appropriate rights-holder for a right to breastfeeding.

Those who have previously considered breastfeeding under the human rights framework have often posited a conflict between a child's right to health and a woman's freedom from breastfeeding, pitting the positive obligations of the CRC against the negative obligations of CEDAW:

The idea of "breastfeeding as a human right" is ambiguous; it can refer to the rights of the infant or of the mother. . . . Certainly they do not always "agree" on when to start or when to stop feeding. The infant may be insensitive to the inconvenience or even pain he or she may sometimes cause. The mother may also be unhappy about being drawn away from work, or from her husband, or from other children, or from rest. There sometimes can be real differences in interests between mother and child.²¹⁴

Under this antagonistic paradigm, states have been reluctant to pursue rights-based breastfeeding policy where it was seen either to infringe

national milk bank policy efforts). *But cf.* Linda C. Fentiman, *Marketing Mothers' Milk: The Commodification of Breastfeeding and the New Markets for Breast Milk and Infant Formulas*, 10 NEV. L.J. 29 (2010) (noting the lack of regulation in the commodification of human breast milk).

²¹³ *E.g.*, Latham, *supra* note 181, at 410 (discussing a Papua New Guinea law that made infant feeding bottles available only by prescription).

²¹⁴ Kent, *Human Rights Issue?*, *supra* note 143, at 93.

the freedoms of the autonomous woman or to deny health to the vulnerable infant.²¹⁵

Viewing breastfeeding to encompass two separate rights-holders, scholars have looked to the distinct rights of mother and child: to breastfeed and to be breastfed.²¹⁶ Thus, the 1990 Innocenti Declaration supports two rights, by which “all women should be enabled to practise exclusive breastfeeding and all infants should be fed exclusively on breastmilk from birth to four to six months of age.”²¹⁷ To overcome the policy impasse created by these respective rights, scholars have attempted to balance the human rights of mother and child to arrive at a harmonizing policy framework that would maximize the rights of both mother and infant.²¹⁸

Working under this perceived conflict, breastfeeding proponents have sought to argue that breastfeeding can be seen as a woman’s right, independent of the child’s right, noting the advantages of breastfeeding to a woman’s own health and “framing the issue as a woman’s right to choose and succeed with breastfeeding.”²¹⁹ Thus, the 1990 World Summit for Children calls for the “[e]mpowerment of all women to breast-feed their children.”²²⁰ With women benefiting directly and indirectly from breastfeeding—by, *inter alia*, avoiding unnecessary formula expenditures, controlling post-partum pregnancies, and reducing risks of several cancers²²¹—it was argued that women’s health benefits could independently justify breastfeeding.²²²

Notwithstanding this women-centered framing of breastfeeding, women’s rights advocates have sometimes bristled at the suggestion that mothers are empowered through breastfeeding, with these advocates seeking instead to free women from the constraints of carrying, bearing, and nursing children so that they can function in

²¹⁵ See Elisabet Helsing, *Breastfeeding: Baby’s Right and Mother’s Duty?*, in 1 FOOD AND HUMAN RIGHTS IN DEVELOPMENT 323, 339 (Wenche Barth Eide & Uwe Kracht eds., 2005).

²¹⁶ See Bar-Yam, *supra* note 104, at 358–60 (delineating women’s rights from children’s rights in breastfeeding policy); Latham, *supra* note 181, at 402 (disaggregating the rights of infants from the rights of mothers).

²¹⁷ CELEBRATING THE INNOCENTI DECLARATION, *supra* note 118, at 51.

²¹⁸ See Helsing, *supra* note 215; Kent, *Infant Nutrition*, *supra* note 135.

²¹⁹ Labbok, *supra* note 149, at 278; see also Labbok & Nakaji, *supra* note 54.

²²⁰ *World Declaration*, *supra* note 134, at 21.

²²¹ See *supra* notes 30–32 and accompanying text (discussing maternal health benefits from breastfeeding).

²²² Describing this critical feminist discourse in support of breastfeeding, Latham notes that “Western feminists have often opposed breastfeeding, on the false basis that it lessens women’s freedom and is ‘unliberating,’” countering that breastfeeding is empowering for women, and, as such, “a woman’s right to breastfeed, then becomes a part of her reproductive rights and it is related to her sexuality.” Latham, *supra* note 181, at 403, 404.

society as equals to men.²²³ In opposition to such a conception of women's freedom, those breastfeeding advocates less sensitive to rights of women have argued—based upon the CRC's consideration of “the best interest of the child”²²⁴—that the infant's right to health simply holds higher value than the mother's “choice” not to breastfeed:

[H]ow can a mother's right to exercise “freedom of choice” about how she feeds her infant (which presumably means the freedom *not* to breastfeed) be seen as equal to or, in fact, take precedence over the baby's right to his mother's milk?²²⁵

It is in this context that the Innocenti Declaration seeks to ease this perceived tension between an infant rights-holder and a maternal duty-bearer by presenting breastfeeding as contributing independently to the health of both the infant and mother.²²⁶ By the 2002 Global Strategy for Infant and Young Child Feeding, however, experts acknowledged shared and intertwined interests, with WHO and UNICEF finding that “mothers and babies form an inseparable biological and social unit; the health and nutrition of one group cannot be divorced from the health and nutrition of the other.”²²⁷

Given this acknowledgement that the mutually exclusive dichotomy of rights-holder and duty-bearer does not encompass the reality in which mother and child function as a rights-bearing unit during infancy,²²⁸ this reality can be re-characterized such that “the mother-infant pair, taken together, have certain rights in relation to outside parties, such as rights to certain kinds of information and services and the rights to be protected from undue influences from outside interests.”²²⁹ Through this complex intersectionality in which

²²³ See Bar-Yam, *supra* note 104, at 358 (“One of the recurring concerns of the women's rights movement has been understanding and implementing a balance between women as equal, because they can function in society as men do, and women as special because they carry, bear, and nurse children.”); Jules Law, *The Politics of Breastfeeding: Assessing Risk, Dividing Labor*, 25 SIGNS 407, 411 (2000) (arguing, in the context of U.S. breastfeeding policy, that “the risk/benefit calculations in infant-feeding literature are often strongly skewed by their presumption of a traditional division of domestic labor”).

²²⁴ CRC, *supra* note 127, art. 3(1).

²²⁵ Kent, *Infant Nutrition*, *supra* note 135, at 182.

²²⁶ *World Declaration*, *supra* note 134.

²²⁷ WHO GLOBAL STRATEGY, *supra* note 151, at 3.

²²⁸ *But cf.* Allan Rosenfield & Deborah Maine, *Maternal Morality-A Neglected Tragedy: Where is the M in MCH?*, 326 LANCET 83, 83 (1985) (noting that, prior to birth, the causes and remedies of maternal death are “quite different from those of child death”).

²²⁹ Kent, *Infant Nutrition*, *supra* note 135, at 183; *see also* Bar-Yam, *supra* note 104, at 359 (“Parents and their children are not independent entities, they are linked to one another by the responsibility of parents to make choices for their children—responsible choices informed by their knowledge, values, and heritage.”).

mother and infant function as an inseparable collective, human rights must come to acknowledge these shared interests and, more importantly, identify specific moments when these interests are no longer intertwined, warranting a more adversarial analysis.

Whereas human rights were initially conceived following the Second World War solely as individual rights—with an individual rights-bearer left to make claims against a national duty-bearer (and thereby provide external restraint on a presumptively tyrannical sovereign)—deeper understandings of social construction have forced a reexamination of this individualistic conception of human rights.²³⁰ In this evolving conception of rights-holders, groups have made claims on behalf of various rights-bearing units: from the family, to the community, up to the nation itself.²³¹ With policy designed around these collective units,²³² scholars have recognized the need for collective rights, rights of groups that more accurately encapsulate infringements of human dignity.²³³ Framing a more realistic representation of human dignity in the context of breastfeeding, the intertwined rights of mother and child can be seen as a collective whole that is greater than the sum of its parts. Although there will inevitably be times when the rights of the atomistic mother and child conflict, it is clear in the context of breastfeeding that the incomparable collective rights benefits far outweigh any conflicting individual rights claims.

Thus, the mother/child dyad can be viewed as the appropriate rights-holder in setting rights-based breastfeeding policy. While others have proposed a “group right” of the mother and child in breastfeeding policy, such rights were previously considered by combining the independent rights of mother and child, rather than framing the right as one of the collective dyad.²³⁴ By viewing the

²³⁰ See JACK DONNELLY, *UNIVERSAL HUMAN RIGHTS IN THEORY AND PRACTICE* 23 (2d ed. 2003).

²³¹ See David Wippman, *The Evolution and Implementation of Minority Rights*, 66 *FORDHAM L. REV.* 597 (1997) (analyzing frameworks of collective “minority rights” under international law).

²³² See Martha Albertson Fineman, *Cracking the Foundational Myths: Independence, Autonomy, and Self-Sufficiency*, 8 *AM. U. J. GENDER SOC. POL’Y & L.* 13, 17–19 (2000) (proposing a caregiver/dependent dyad as a foundation of family law).

²³³ See, e.g., Ronald R. Garet, *Communitarianism and Existence: The Rights of Groups*, 56 *S. CAL. L. REV.* 1001 (1983) (positing the intrinsic value of group rights as distinct from a grouping of individual rights); Benjamin Mason Meier & Larisa M. Mori, *The Highest Attainable Standard: Advancing a Collective Human Right to Public Health*, 37 *COLUM. HUM. RTS. L. REV.* 101 (2005) (proposing a collective right to public health as a means to realize public goods for health); Jeanne M. Woods, *Justiciable Social Rights as a Critique of the Liberal Paradigm*, 38 *TEX. INT’L L.J.* 763 (2003) (proposing collective claims for a globalized world).

²³⁴ Kent, *Child Feeding*, *supra* note 159, at 8 (framing a group right as “the right of the

dyad as the uniquely situated collective rights-holder in the context of breastfeeding, health policy can more accurately reflect those harmed by threats to breastfeeding and better protect the bond that joins mother and child.

To realize the rights of this dyad, health rights must look beyond the individual unit of analysis, examining the societal context—the public health environment—in which autonomy is structured, breastfeeding obstacles are institutionalized, and individual decisions are made.²³⁵ Focusing on these societal determinants of health, it becomes clear that societal systems supportive of breastfeeding are necessary to make breastfeeding a viable choice and to give the mother/child dyad the autonomy to lead a life they value.²³⁶

C. Duty-Bearers in a Globalized and Interconnected World

With policy empowering or disempowering the mother/child dyad in a world increasingly affected by societal determinants of health, scholars must examine the extent to which the realization of a collective right to breastfeeding is structured by national—and increasingly, global—forces, and re-conceptualize the duty-bearers necessary to develop policies for this new rights-holder.

Looking beyond the state in framing these obligations, the duty-bearer for a right to breastfeeding must be reframed to place legal responsibility on the international community, including individual states, international organizations, and public-private partnerships.

Where once rights flowed only from an individual rights-holder to a state duty-bearer, it was thought that such obligations on the

mother and the child together,” pursuant to which “[c]hildren have the right to be breastfed, in the sense that no one may interfere with their mothers’ right to breastfeed them” (emphasis omitted).

²³⁵ See Anthony McMichael & Robert Beaglehole, *The Global Context for Public Health*, in *GLOBAL PUBLIC HEALTH: A NEW ERA* 1, 3 (Robert Beaglehole ed., 2003) (noting that “[t]he individual-level perspective fails to conceptualise the population’s health both as something that reflects prevailing ecological conditions and as a public good that affects social functioning, community morale, and collective economic performance”); Latham, *supra* note 181, at 413 (recognizing that societies affect norms to initiate, sustain, and maintain breastfeeding); Smith, *supra* note 188, at 372 (“Infant feeding decisions by the mother are made in a social, cultural and institutional context in which breastfeeding is sexualised and hindered, where maternity facilities, industrial conditions and the workplace are not accommodating to the needs of breastfeeding mothers, and in which mothers often do not have family or peer support for breastfeeding.”).

²³⁶ See Lawrence et al., *supra* note 129, at 594 (discussing the effect of social services on individual empowerment for nutrition).

international community could not exist because state sovereignty obviated transnational rights violations:

The failure of the international human rights movement to address the responsibility of a state for human rights of persons in other states may reflect only the realities of the state system. States are not ordinarily in a position either to violate or to support the rights of persons in other states.²³⁷

Globalization has laid bare such hermetic conceptions of sovereignty, with the unregulated trade and marketing of breast milk substitutes exposing the failure of national regulation to support individual health capability.²³⁸ While obligations on the international community undeniably impinge upon the sovereignty of both developing and developed states, such tensions pose little conflict where developing nations are incapable of realizing the health rights of their peoples alone and where developed nations are not faced with shouldering these transnational obligations individually.

Although the state remains principally responsible for the realization of health rights,²³⁹ human rights cannot maintain a state-centric fixation when public health is now largely determined at the global level.²⁴⁰ Understandings of global goods as underlying determinants of health “ha[ve] pushed us away from our early preoccupation with diverse forms of risk behavior, understood in largely individualistic terms, toward a new understanding of vulnerability as socially, politically, and economically structured, maintained, and organized.”²⁴¹ Where once only communicable

²³⁷ LOUIS HENKIN, *THE AGE OF RIGHTS* 44 (1990).

²³⁸ See *supra* notes 54–63 and accompanying text (discussing the impact of widespread marketing for breast-milk substitutes and industry resistance to government regulation). Comparative legal analyses have noted that those states that face the greatest public health harms from breast milk substitutes are often the same states that have the least control over the health of their peoples.

²³⁹ See Ruger, *Normative Foundations*, *supra* note 193, at 433 (noting, in framing a normative basis for global health equity, that “[i]ndividual nation-states have primary and prior obligations to deal with health inequalities and sources of health threats”).

²⁴⁰ See JEFFREY D. SACHS, *THE END OF POVERTY: ECONOMIC POSSIBILITIES FOR OUR TIME* 226 (2005) (recognizing the effect of global forces on individual autonomy); Benjamin Mason Meier & Ashley M. Fox, *International Obligations Through Collective Rights: Moving from Foreign Health Assistance to Global Health Governance*, 12 *HEALTH & HUM. RTS.* 61 (2010) (discussing the gap between the increasing influence of global forces on human rights and the decreasing role of individual states in realizing those rights); McMichael & Beaglehole, *supra* note 235, at 9 (noting that, with the advent of globalization, “the fundamental social, economic, and environmental determinants of population health are increasingly supranational”).

²⁴¹ Richard Parker, *Administering the Epidemic: HIV/AIDS Policy, Models of Development, and International Health*, in *GLOBAL HEALTH POLICY, LOCAL REALITIES: THE FALLACY OF THE LEVEL PLAYING FIELD* 39, 41 (Linda M. Whiteford & Lenore Manderson eds.,

disease surveillance and treatment were included among global public goods for health,²⁴² there is a growing awareness that globalized development processes have served to transmute non-communicable disease prevention and health promotion from private goods into global public goods.²⁴³ As in the case of breast milk substitutes, whereas poor breastfeeding and weaning practices are based on individual behaviors, these individual health behaviors are increasingly structured by global forces.²⁴⁴ Yet despite an evolving understanding of these global determinants of breast milk substitutes and global impediments to breastfeeding in the developing world, breastfeeding policy, as with most non-communicable disease control, remains under the auspices of national governments, even as globalized forces have undermined national regulations.²⁴⁵

In the case of breastfeeding policy, many of the harms of breast milk substitutes are inflicted by transnational formula corporations, which are accountable under the law of no individual state and have not traditionally been the subject of international human rights regulation.²⁴⁶ Much like the lead paint and tobacco industries before them, the formula industry has sought to undermine regulation on a state-by-state basis (where they can more easily sway governmental bodies) and to direct research and lobbying power to undermine global consensus on the harms of their product. Where these

2000).

²⁴² See Dyna Arhin-Tenkorang & Pedro Conceição, *Beyond Communicable Disease Control: Health in the Age of Globalization*, in PROVIDING GLOBAL PUBLIC GOODS: MANAGING GLOBALIZATION 484, 485–86 (Inge Kaul et al. eds., 2003) (discussing policy responses to the spread of communicable diseases prior to the 1950s).

²⁴³ See Lincoln C. Chen et al., *Health as a Global Public Good*, in GLOBAL PUBLIC GOODS: INTERNATIONAL COOPERATION IN THE 21ST CENTURY 284, 285 (Inge Kaul et al. eds., 1999) (examining the concept of global public goods for health).

²⁴⁴ See Coovadia & Bland, *supra* note 29, at 1117 (“Exclusive breastfeeding, which has universal appeal and produces benefits throughout the world, may be considered a ‘global good.’”).

²⁴⁵ Cf. Lee, *supra* note 126, at 569 (“[I]t is clear that the forces of globalization, international trade, and transnational marketing continue to undermine national laws and policies aimed at addressing the global [obesity] epidemic.”). An exception to the national regulation of noncommunicable disease involves smoking-related disease, for which the 2003 Framework Convention on Tobacco Control (WHO’s first international treaty) has set a valuable precedent for promoting health in a globalizing world. See generally Allyn L. Taylor et al., *International Law and the International Legislative Process: The WHO Framework Convention on Tobacco Control*, in GLOBAL PUBLIC GOODS FOR HEALTH: HEALTH ECONOMIC AND PUBLIC HEALTH PERSPECTIVES 212 (Richard Smith et al. eds., 2003) [hereinafter GLOBAL PUBLIC GOODS]; see also *infra* Part IV.B (discussing the need for international law to overcome weaknesses in national breastfeeding policy).

²⁴⁶ See MACDONALD, HEALTH, TRADE AND HUMAN RIGHTS, *supra* note 186, at 61–81; Robert E. Mazur, *Realization or Deprivation of the Right to Development Under Globalization? Debt, Structural Adjustment, and Poverty Reduction Programs*, 60 GEOJOURNAL 61, 65 (2004).

transnational actors engage in the inappropriate marketing of breast milk substitutes—often in flagrant violation of global health policies—they often do so with impunity for the rights violated.²⁴⁷ To the extent that these corporations have assumed any responsibility for human rights standards, they continue to be found in voluntary, and largely ineffective, codes of corporate conduct,²⁴⁸ as was the approach taken in breastfeeding policy through the nonbinding recommendations of the Code.²⁴⁹ This growing chasm between global forces and domestic responsibility in health rights highlights the utility of an international duty-bearer to account for international obligations to realize underlying determinants of breastfeeding in a globalized world.

Collective rights offer an extant legal framework by which human rights obligations can be placed on the international community to scale up primary health care systems and thereby reduce inequities in global health through the protection, promotion, and support of breastfeeding.²⁵⁰ Since the ability of states to realize their human rights obligations at the domestic level is constrained by the actions and institutional arrangements of the international community, the realization of such international obligations will require a restructuring of international institutions. At the international level, these obligations could be operationalized to enforce global health commitments, channel foreign assistance toward breastfeeding, and ensure cooperation in global health policy.

In clarifying these international obligations based on the right to health's delineation of state obligations pursuant to General Comment 14—drawn from similar approaches to “respect, protect, and fulfill” all economic, social and cultural rights²⁵¹—it is possible to extend these dimensions of health obligation from the domestic to the international sphere.²⁵²

²⁴⁷ See MACDONALD, DREAM OR POSSIBILITY?, *supra* note 189, at 114 (discussing mechanisms through which corporations have conjured up a human right to “commercial speech” to legitimate their rights-infringing activities); RICHTER, *supra* note 166, at 87–90 (recognizing the difficulties of imposing corporate human rights liability on the formula industry).

²⁴⁸ Helena Nygren-Krug, *A Human Rights-Based Approach to Non-Communicable Diseases*, in REALIZING THE RIGHT TO HEALTH 263, 267–71 (Andrew Clapham & Mary Robinson eds., 2009) (examining efforts to clarify the duties and roles of the private sector regarding the right to health and the need to hold corporations accountable).

²⁴⁹ See *supra* notes 110–15 and accompanying text.

²⁵⁰ Benjamin Mason Meier & Ashley M. Fox, *Development as Health: Employing the Collective Right to Development to Achieve the Goals of the Individual Right to Health*, 30 HUM. RTS. Q. 259 (2008) (applying the right to development as a collective right to support national health systems).

²⁵¹ *General Comment 14*, *supra* note 169, ¶ 37.

²⁵² See SIGRUN I. SKOGLY, BEYOND NATIONAL BORDERS: STATES' HUMAN RIGHTS

Under this analogous tripartite system, the international community has an obligation to respect the rights of the breastfeeding dyad by refraining from infringing upon states' obligations to develop capable and appropriate primary health care systems. This would place obligations on developed states and international financial institutions to avoid such actions as enforcing trade regimes that encourage developing states to open their markets to the unregulated sale of breast milk substitutes while privatizing health services in ways detrimental to sustainable health systems.²⁵³ By removing systemic barriers to breastfeeding and limiting the export of breast milk substitutes, international obligations can be viewed as restoring sovereignty to developing states to meet the basic public health needs of their peoples without interference, creating an enabling environment for states to realize their domestic obligations for the right to health.²⁵⁴

Similarly, the international community has an obligation to protect developing states through the regulation of transnational private actors that undermine state governance for breastfeeding policy. Transnational corporations have pursued increasingly deregulated policy environments for breast milk substitutes, limiting states' ability to govern in the absence of global cooperation.²⁵⁵ With global tobacco control creating a precedent for international law to combat non-communicable diseases, international law can be seen as necessary to realize health rights against the autonomy-diminishing impacts of commercial interests.²⁵⁶ To protect states from deregulatory and monopolistic practices that harm the public's health, the international community can promulgate binding formula

OBLIGATIONS IN INTERNATIONAL COOPERATION (2006) (outlining a normative framework for international human rights obligations); *see also* Kent, *Child Feeding*, *supra* note 159, at 7–8 (laying out “extra-jurisdictional obligations” to realize breastfeeding).

²⁵³ *See* Margot E. Salomon, *Global Responsibility for Human Rights: World Poverty and the Development of International Law 192–93* (2007).

²⁵⁴ *See generally* Meier & Fox, *supra* note 240.

²⁵⁵ *Supra* Part I.C; *see also* Joyce V. Millen & Timothy H. Holtz, *Dying for Growth, Part I: Transnational Corporations and the Health of the Poor*, in *DYING FOR GROWTH: GLOBAL INEQUALITY AND THE HEALTH OF THE POOR* 177, 184 (Jim Yong Kim et al. eds., 2000) (noting that “in their effort to lure foreign companies to their borders, governments began to engage in a downward, standard-lowering bidding cycle, or ‘race to the bottom,’ whereby the needs of their citizens, especially the poor, were typically subordinated to the needs of the foreign companies”).

²⁵⁶ *See* Roger S. Magnusson, *Non-Communicable Diseases and Global Health Governance: Enhancing Global Processes to Improve Health Development*, *GLOBALIZATION & HEALTH*, May 22, 2007, at 1, 6–7, available at <http://globalizationandhealth.com/content/pdf/1744-8603-3-2.pdf> (discussing the Framework Convention on Tobacco Control and its importance in combating the influence of tobacco companies in developing nations).

marketing standards under international law, creating global public health frameworks to prevent the formula industry from seeking safe haven for harm in any country.²⁵⁷

Finally, as the realization of international obligations in a globalized world will require cooperative partnerships across the international community, WHO can be viewed as a natural institutional mechanism to fulfill the obligations of the international community for global breastfeeding policy. WHO, as the leading normative authority in global health governance, can serve a dual role in fulfilling international obligations pursuant to health rights: engendering international cooperation to facilitate breastfeeding (such as developing model national breastfeeding legislation)²⁵⁸ and coordinating funding efforts to support national primary health care systems (assuring that national policy efforts promote and facilitate breastfeeding).²⁵⁹ Where such cooperation and coordination necessitates the incorporation of these public health obligations in global health policy, WHO—drawing on its constitutional mandate to promote the right to health—has an opportunity to codify such breastfeeding obligations through international law. Such action would galvanize engagement across states and donors to overcome this threat to maternal and infant health through rights-based global breastfeeding policy.

IV. A RIGHTS-BASED APPROACH TO GLOBAL BREASTFEEDING POLICY

Viewing a right to breastfeeding as a pillar of the right to health and a foundation on which to frame global breastfeeding policy, breastfeeding proponents can create accountability for the obligations of the international community to realize the mother/child dyad's right to breastfeeding and achieve the highest attainable standard of health. Implemented through the inclusion of

²⁵⁷ See generally NICOLA JÄGERS, CORPORATE HUMAN RIGHTS OBLIGATIONS: IN SEARCH OF ACCOUNTABILITY (2002) (arguing that corporations bear human rights obligations); Jack Donnelly, *Human Rights, Globalizing Flows, and State Power*, in GLOBALIZATION AND HUMAN RIGHTS 226 (Alison Brysk ed., 2002) (discussing the effect of globalization on human rights through the usurpation of state power).

²⁵⁸ See generally David P. Fidler, *Constitutional Outlines of Public Health's "New World Order,"* 77 TEMPLE L. REV. 247 (2004) (arguing that international responses to recent disease outbreaks have moved toward constitutional structures of governance for global health).

²⁵⁹ Sisule F. Musungu, *Developing Countries and the Promotion of the Right to Health in Multilateral Institutions: A Review of Developments in Trade and Health Institutions*, in REALIZING THE RIGHT TO HEALTH, *supra* note 248, at 368, 369 (finding that "international assistance and cooperation to support the progressive realization of economic, social and cultural rights is more likely to come from international organizations such as the World Health Organization (WHO), in the case of the right to health, than bilateral development agencies").

breastfeeding protection, promotion, and support in global health policy, international human rights law would frame institutional arrangements through which rights-holders can realize their rights through more effective systems of global health governance.

Health rights demand international cooperation,²⁶⁰ a promise laid out explicitly in the UDHR's seminal proclamation that "[e]veryone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized."²⁶¹ With a focus on assistance to the developing world—highlighted by the CRC's promotion of international cooperation with "particular account . . . taken of the needs of developing countries"²⁶² and extended by General Comment 14's emphasis on international assistance and cooperation to "enable developing countries to fulfil their core and other obligations"²⁶³—a rights-based approach to breastfeeding could buttress global efforts to assist the developing world in addressing global health disparities caused by a lack of breastfeeding.²⁶⁴ Such assistance and cooperation for global health policy (a) can be fulfilled through global health partnerships, which (b) can work with WHO to develop international legal regulation that (c) can be employed by human rights treaty-monitoring bodies to evaluate breastfeeding outcomes. This Part clarifies how a right to breastfeeding can be operationalized through these global partnerships, international regulations, and human rights evaluations.

A. Intersectoral Policy Development Through Global Health Partnerships

Building from the right to health, the protection, promotion, and support of breastfeeding mandates interdisciplinary partnerships reflective of the indivisibility of rights, an indivisibility often

²⁶⁰ See HENRIK KARL NIELSEN, *THE WORLD HEALTH ORGANISATION: IMPLEMENTING THE RIGHT TO HEALTH* 37 (1999) (concluding that "the realisation in fact of the right to health presupposes an institutional framework through which action can be taken in order to combat health problems in individual countries").

²⁶¹ UDHR, *supra* note 161, art. 28; see also Cees Flinterman, *Three Generations of Human Rights*, in *HUMAN RIGHTS IN A PLURALIST WORLD* 75, 79 (Jan Berting et al. eds., 1990) ("A social and international order, as mentioned in article 28 [of the UDHR], embodies the idea that a full promotion and protection of human rights in a particular state is dependent upon worldwide solidarity or to use that old-fashioned term 'brotherhood' (*fraternité*).").

²⁶² CRC, *supra* note 127, art. 24(4).

²⁶³ *General Comment 14*, *supra* note 169, ¶ 45 (footnote omitted).

²⁶⁴ See ECOSOC, *Report of the Special Rapporteur*, *supra* note 173, ¶ 28. ("States are obliged to respect the enjoyment of the right to health in other jurisdictions, to ensure that no international agreement or policy adversely impacts upon the right to health, and that their representatives in international organizations take due account of the right to health, as well as the obligation of international assistance and cooperation, in all policy-making matters." (citing *General Comment 14*, *supra* note 169, ¶¶ 38–39)).

proclaimed in human rights scholarship but neglected in global health policy.²⁶⁵ Given the intersectionality inherent in breastfeeding,²⁶⁶ global breastfeeding policy necessitates intersectional obligations under the vector of rights related to breastfeeding.²⁶⁷ Implementing these intersectional obligations through global health governance partnerships, the proliferation of actors taking up the mantle of global health policy²⁶⁸ creates an imperative for interagency collaboration across the UN and among other international organizations.²⁶⁹ Such a collaborative, interdisciplinary partnership to realize a right to breastfeeding through global policy would be in accordance with the UN's cross-cutting approach to human rights programs, policies, and activities²⁷⁰ and its "common understanding" on human rights in development,²⁷¹ both of which seek to mainstream human rights throughout UN agencies. Creating an intersectional rights-based framework for the protection, promotion, and support of breastfeeding will require the collaboration of various actors, including: UN specialized agencies with rights-based institutional mandates to address the magnitude of this harm, civil society organizations to supply technical information and professional

²⁶⁵ See Stephen Lewis, *Promoting Child Health and the Convention on the Rights of the Child*, 2 HEALTH & HUM. RTS. 77, 77-78 (1997) (recognizing the CRC's post-Cold War embrace of the indivisibility of rights for the realization of children's health).

²⁶⁶ See Miriam Labbok, *Transdisciplinary Breastfeeding Support: Creating Program and Policy Synergy Across the Reproductive Continuum*, INT'L BREASTFEEDING J., Aug. 4, 2008, at 1, available at <http://www.internationalbreastfeedingjournal.com/content/pdf/1746-4358-3-16.pdf> (arguing that effective and sustainable action in breastfeeding, as well as other health rights associated with the mother/child dyad, depend on the identification of synergies and promotion of mutual strengths).

²⁶⁷ Annaliijn Conklin & Benjamin Mason Meier, *A 'Vector of Rights' Approach for Public Health: Towards an Intersectional Human Rights Framework for Considering the Prevention and Treatment of Harms to Girl Child Soldiers*, 13 AUSTRAL. J. HUM. RTS. 65, 66 (2008) (considering the "intersectionality" of rights in the context of the public health harms of girl child soldiers).

²⁶⁸ Lawrence O. Gostin & Allyn L. Taylor, *Global Health Law: A Definition and Grand Challenges*, 1 PUB. HEALTH ETHICS 53, 60 (2008) ("One of the most striking characteristics of the emerging domain of global health law is the proliferation of organizations contributing to the elaboration of this increasingly complex and multi-faceted field.").

²⁶⁹ Allyn L. Taylor, *Governing the Globalization of Public Health*, 32 J.L. MED. & ETHICS 500, 500 (2004) ("[G]lobalization is creating a heightened need for new global health governance structures to promote coordinated intergovernmental action."). *But see* ROSALIND POLLACK PETCHESKY, *GLOBAL PRESCRIPTIONS: GENDERING HEALTH AND HUMAN RIGHTS* 113 (2003) (noting that "transnational health and human rights movements have still not achieved an institutionalized process at the global level . . . that could enforce the principle of health as a human right superior to corporate property rights over life-saving medicines (or services)").

²⁷⁰ The Secretary-General, *Report of the Secretary-General on Renewing the United Nations: A Programme for Reform, Delivered to the President of the General Assembly*, U.N. Doc. A/51/950 (July 14, 1997).

²⁷¹ UNITED NATIONS, *THE HUMAN RIGHTS BASED APPROACH TO DEVELOPMENT COOPERATION TOWARDS A COMMON UNDERSTANDING AMONG UN AGENCIES* (2003).

support, and non-governmental organizations to provide avenues for advocacy, accountability, and grassroots education.

International Organizations	
The World Health Organization (WHO)	Directs and coordinates partnership actors, providing a forum for collaborating organizations to share and synthesize information into appropriate rights-based global health policy
The Food and Agriculture Organization of the United Nations (FAO)	Works pursuant to the 1992 FAO/WHO International Conference on Nutrition to develop policies for access to food and nutrition for the mother/child dyad
United Nations Children's Fund (UNICEF)	Advocates for the child's right to health, transcending traditional sectors to address determinants of health such as education, poverty, and gender discrimination
The United Nations Educational, Scientific and Cultural Organization (UNESCO)	Addresses maternal rights to education regarding the most appropriate, safe, and beneficial infant-feeding techniques
World Bank	Provides funding for rights-based programs and economic perspectives on policy initiatives for breastfeeding promotion
The United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)	Merges UN agencies with authority to support policy development on women's issues, assists in national implementation, and facilitates the realization of women's rights
The International Labor Organization (ILO)	Promotes workplace protections for breastfeeding women and improves social protection for working mothers

Civil Society Organizations (CSOs)	
The International Federation of Gynecology and Obstetrics (FIGO)	Brings together obstetricians and gynecologists to raise the standard of care for breastfeeding women
American Academy of Pediatrics (AAP)	Provides cooperative forums through which pediatricians share information to improve infant and child health through breastfeeding
The International Confederation of Midwives (ICM)	Organizes worldwide coalitions of midwives to collaborate and share information about breastfeeding in the birthing process
The International Lactation Consultant Association (ILCA)	Disseminates information on the delivery of breastfeeding services, bringing together certified lactation consultants and other professionals who provide care specific to breastfeeding mothers
The Academy of Breastfeeding Medicine (ABM)	Facilitates physician collaboration on issues of breastfeeding management and physician education
Non-governmental Organizations (NGOs)	
World Alliance for Breastfeeding Advocacy (WABA)	Works under the framework of the Innocenti Declarations to advocate for education on and promotion of breastfeeding
International Baby Food Advocacy Network (IBFAN)	Evaluates national and corporate compliance with the International Code of Breast-milk Substitutes
La Leche League International (LLL)	Provides information about breastfeeding and organizes breastfeeding education, awareness, and support campaigns

Partnering together with traditional human rights institutions (such as the Office of the UN High Commissioner for Human Rights), these organizations can collaborate with states to catalyze the development of global breastfeeding policies to save lives and improve health outcomes for millions of mothers and children in the developing world. As global health policy has become increasingly fragmented—with traditional public health institutions like WHO and UNICEF joined by civil society organizations, public-private partnerships, transnational corporations, private donors, and NGOs—actors have been forced to compete for scarce resources and attention in a crowded health policy landscape, leading to redundancy and ineffectiveness.²⁷² Global health partnerships provide a solution to the problems of these overlapping efforts, coordinating intersectoral efforts from multiple organizations and forming collaborative relationships built on efficient division of labor to realize shared goals.²⁷³ Through such collaborative efforts, these partnerships allow for the collection of information and ideas from all stakeholders,²⁷⁴ reducing redundancies in programs, establishing best practices, and streamlining negotiations.²⁷⁵ As proposed through the coordinated global health partnership outlined below, organizations would be better able to channel funds from donors and allocate resources and responsibilities efficiently as a means to realize breastfeeding policy,²⁷⁶ alleviating the burden placed on national health systems by the uncoordinated efforts of multiple donors²⁷⁷ and securing additional assistance by raising awareness on the benefits of breastfeeding and the dangers of breast milk substitutes.²⁷⁸

²⁷² Nicole A. Szlezák et al., *The Global Health System: Actors, Norms and Expectations in Transition*, PLOS MED, Jan. 2010, at 1, 1, <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000183>; Ilona Kickbusch et al., *Global Health Diplomacy: The Need for New Perspectives, Strategic Approaches and Skills in Global Health*, 85 BULL. WORLD HEALTH ORG. 230 (2007).

²⁷³ See K. Buse & G. Walt, *Global Public-Private Partnerships: Part I—A New Development in Health?*, 78 BULL. WORLD HEALTH ORG. 550 (2000) (describing how collaborations are utilized “to achieve a shared health-creating goal on the basis of a mutually agreed division of labour”).

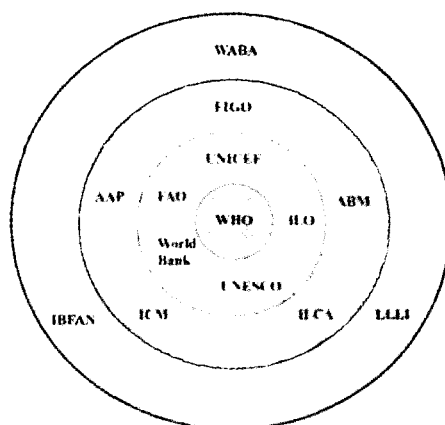
²⁷⁴ Suerie Moon et al., *The Global Health System: Lessons for a Stronger Institutional Framework*, PLOS MED, Jan. 2010, at 1, 2, <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000193>.

²⁷⁵ Szlezák et al., *supra* note 272, at 1.

²⁷⁶ Moon et al., *supra* note 274, at 1–2.

²⁷⁷ David Fidler, *Architecture Amidst Anarchy: Global Health’s Quest for Governance*, GLOBAL HEALTH GOVERNANCE, Spring 2007, at 1, 8, available at http://ghgj.org/Fidler_Architecture.pdf (noting that the “net result of many uncoordinated governance efforts is sub-optimal and perhaps even regressive”).

²⁷⁸ See Kent Buse & Andrew M. Harmer, *Seven Habits of Highly Effective Global Public-Private Health Partnerships: Practice and Potential*, 64 SOC. SCI. & MED. 259, 261 (2007) (discussing how global health partnerships contribute significantly to develop awareness,



Fostering accountability across nations through the governing structure of a partnership,²⁷⁹ WHO would provide a uniquely credible cooperative forum, serving as the leading global authority on health and, with a mandate at the intersection of health and human rights, anchoring such a new rights-based breastfeeding partnership in its expertise, legitimacy, and legal authority.²⁸⁰ With experience in hosting other global health partnerships—as the host organization for such partnerships as the Roll Back Malaria Partnership²⁸¹ and the Global Partnership to Stop TB²⁸² (and historically as the institution that launched the global initiative to eradicate polio²⁸³)—WHO provides the most appropriate setting for the revitalized development of global breastfeeding policy, coordinating partners across health and human rights issues that do not fall exclusively under the purview of any one organization. Taking lessons from its previous global health partnership experiences, WHO can facilitate the establishment of this partnership by drawing on the initial support of those developing nations most negatively affected by breast milk substitutes, employing the global health partnership to promote breastfeeding on the global policy agenda and moving toward World Health Assembly

funding, research and development, and international standards to tackle various diseases).

²⁷⁹ See Moon et al., *supra* note 274, at 2 (discussing the role of partnerships in developing and implementing workable frameworks to achieve specific health outcomes).

²⁸⁰ Taylor, *supra* note 269, at 507.

²⁸¹ It should be noted that the Roll Back Malaria Partnership arose from a fragmented policy landscape much like the one that characterizes the issue of breastfeeding today. See David N. Nabarro & Elizabeth M. Tayler, *The "Roll Back Malaria" Campaign*, 280 SCIENCE 2067, 2067 (1998).

²⁸² KAREN CAINES ET AL., DFID HEALTH RES. CTR., *ASSESSING THE IMPACT OF GLOBAL HEALTH PARTNERSHIPS* 32 (2004).

²⁸³ See R. Bruce Aylward et al., *Global Health Goals: Lessons from the Worldwide Effort to Eradicate Poliomyelitis*, 362 LANCET 909, 909 (2003).

endorsement of a plan to develop new international legal regulation by which to establish global health policy for breastfeeding.

B. WHO & International Legal Regulation

Rather than developing codes of corporate conduct as nonbinding recommendations, the establishment of a right to breastfeeding will require the codification of rights-based global breastfeeding policy through international law.

Although the Code proved enormously influential in the protection, promotion, and support of breastfeeding, serving as a forceful declaration of global consensus in breastfeeding policy, there is a need to codify these declaratory statements so that they can form the basis of rights-based accountability under international law. Where it was long known that the marketing and promotion of breast milk substitutes—and corresponding abandonment of breastfeeding—was leading to widespread violations of health rights, the Code provided a path for states to transform general human rights commitments into specific national law, turning this tide of death through global health policy.²⁸⁴ To the extent that the Code has faltered, however, it has done so because of its legal status as a “recommendation” and, as such, its lack of authority under international law and lack of accountability for domestic implementation.²⁸⁵ While the Code establishes internationally recognized standards that WHO member states are urged to incorporate into national law,²⁸⁶ this “urging” lacks the force of international law.²⁸⁷ As a matter of international legal concern, the Code is neither a treaty nor a binding rule pursuant to the WHO Constitution,²⁸⁸ rather, this recommendation is at best a form of “soft

²⁸⁴ Margulies, *supra* note 118, at 425.

²⁸⁵ See Lee, *supra* note 126, at 598 (“The WHO’s experience in adopting this recommendation in the form of a Code appears to be yet another missed opportunity to apply and develop its available legal instrumentalities.”). Even where the Code has been codified in national law, it is routinely violated without an effective deterrent against corporate practices. See, e.g., IBFAN, BREAKING THE RULES, STRETCHING THE RULES 2004: EVIDENCE OF VIOLATIONS OF THE INTERNATIONAL CODE OF MARKETING BREASTMILK SUBSTITUTES AND SUBSEQUENT RESOLUTIONS (2004), available at <http://www.ibfan.org/art/302-3.pdf> [hereinafter IBFAN, BREAKING THE RULES] (uncovering paths through which commercial interests take advantage of loopholes in their commitments under the Code).

²⁸⁶ Margulies, *supra* note 118, at 421.

²⁸⁷ SHUBBER, *supra* note 86, at 28–30 (describing the lack of legal accountability under the Code). Although NGOs are now developing legislative models for breastfeeding promotion, see e.g., ELLEN SOKOL, THE CODE HANDBOOK: A GUIDE TO IMPLEMENTING THE INTERNATIONAL CODE OF MARKETING OF BREASTMILK SUBSTITUTES (2d ed. 2005), these models do little more than reproduce the Code, which, as discussed *supra* Part II.C, is inadequate for the realization of rights-based health policy.

²⁸⁸ See WHO CONST., arts. 19–23, reprinted in WHO, BASIC DOCUMENTS 1, 7–8 (40th ed.

law,” framed optimistically as “a de facto contract between certain nongovernmental organizations and the leading corporate seller of the product, Nestle.”²⁸⁹ Where states have failed in their national incorporation and enforcement of these hortatory pronouncements,²⁹⁰ the Code has been unable to realize a right to breastfeeding through its reliance on corporate self-regulation.²⁹¹

For those globalized determinants of breastfeeding impervious to state regulation, WHO’s international lawmaking offers states the opportunity to work collectively to uphold health rights by facilitating universal obligations, avoiding industry influence, and providing worldwide public health infrastructures.²⁹²

States have endowed the WHO Secretariat with constitutional authority to coordinate international health work and “propose conventions, agreements and regulations, and make recommendations with respect to international health matters.”²⁹³ Granted expansive international lawmaking authority to fulfill its constitutional mandate, states incorporated in the WHO Constitution three separate articles to delineate WHO’s complementary authorities to draft conventions (art. 19), regulations (art. 21), and recommendations (art. 23).²⁹⁴ Given legislative powers far beyond those of its institutional predecessors,²⁹⁵ WHO was designed to employ international law as a means to bind states to specific health measures and thus “to support, guide, and

1994) (delineating the sources and types of WHO lawmaking authority).

²⁸⁹ Jose E. Alvarez, *Positivism Regained, Nihilism Postponed*, 15 MICH. J. INT’L L. 747, 777 (1994) (reviewing G.M. DANILENKO, *LAW-MAKING IN THE INTERNATIONAL COMMUNITY* (1993)).

²⁹⁰ See INTERAGENCY GROUP ON BREASTFEEDING MONITORING (IGBM), *CRACKING THE CODE* (1997) (criticizing the slow and limited incorporation of the Code in national legislation).

²⁹¹ See MACDONALD, *DREAM OR POSSIBILITY?*, *supra* note 189, at 114–15; see also Latham, *supra* note 181, at 407 (arguing that self-regulation is ineffective and examining the shirked commitments made by corporations in the Code); see also *supra* Part II.C.

²⁹² See David P. Fidler, *The Globalization of Public Health: The First 100 Years of International Health Diplomacy*, 79 BULL. WORLD HEALTH ORG. 842, 844 (2001) (“Globalization undermines a state’s ability to control what happens in its own territory. Consequently, it is necessary to construct procedures, rules, and institutions through international law.”).

²⁹³ WHO CONST., *supra* note 288, art. 2.

²⁹⁴ Articles 19 and 21 of the WHO Constitution, granting regulation-making authority to WHO, have been employed very rarely, with many proposed international legal standards subsequently reclassified as article 23 “recommendations”—as was done with the Code, *supra* note 115 and accompanying text—further weakening international health law. LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* 241 (2d ed. 2008).

²⁹⁵ At the time of WHO’s inauguration, legal analysts found that WHO “has been granted considerably greater operational autonomy and quasi-legislative powers than its predecessors possessed,” with “procedures for ratification . . . strengthened under the WHO Constitution to obtain the maximum possible adherence to international health agreements.” Charles E. Allen, *World Health and World Politics*, 4 INT’L ORG. 27, 31 (1950).

coordinate” national public health efforts.²⁹⁶ Nevertheless, legal scholars long neglected concerted legal analysis of WHO authority, as WHO itself neglected to use international law as a means of furthering public health.²⁹⁷ Recently reversing this historical reluctance to apply international law for the public’s health, both the 2003 Framework Convention on Tobacco Control²⁹⁸ and the 2004 revision of the International Health Regulations²⁹⁹ have shown states the benefits of international law in global health governance, permitting effective multilateral public health measures to address multifaceted determinants of health.³⁰⁰ As with these recent interventions in communicable and non-communicable disease, the processes of globalization have exacerbated many of the challenges to breastfeeding while leaving individual states and regional bodies incapable of responding effectively in the absence of an institutionalized means of interstate cooperation.³⁰¹

In developing rights-based international health law for the protection, promotion, and support of breastfeeding, WHO is uniquely situated in centralized expertise and political influence to help resolve issues of health rights that are impervious to resolution at the state level.³⁰² Political independence has become a practical

²⁹⁶ Michel Bélanger, *The Future of International Health Legislation*, 40 INT’L DIG. HEALTH LEG. 1, 2 (1989).

²⁹⁷ Allyn Lise Taylor, *Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health*, 18 AM. J.L. & MED. 301 (1992); OBIJOFOR AGINAM, GLOBAL HEALTH GOVERNANCE: INTERNATIONAL LAW AND PUBLIC HEALTH IN A DIVIDED WORLD 70–74 (2005).

²⁹⁸ WHO, Framework Convention on Tobacco Control, W.H.A. Res. 56.1, 56th Ass., 4th plen. mtg., Agenda Item 13, WHO Doc. A56.VR/4, Annex (May 21, 2003), available at <http://whqlibdoc.who.int/publications/2003/9241591013.pdf> [hereinafter FCTC]; see Taylor, *supra* note 269, at 505 (recognizing the Framework Convention on Tobacco Control as an example of resurrected WHO governance through international law).

²⁹⁹ David P. Fidler, *International Law*, in GLOBAL PUBLIC GOODS, *supra* note 245, at 177, 185 (recognizing the International Health Regulations as an example where WHO has allowed states to “use international law to establish procedures through which states and non-state actors come to grips with specific global public health problems”).

³⁰⁰ Lee, *supra* note 126, at 570 (noting that WHO member states now “generally have accepted the increased legal role of the WHO in [the field of health policy], and the need for international law to address global health problems”); see also Ruger, *Health and Social Justice*, *supra* note 191, at 1080 (“The FCTC represents a growing trend in development policy toward an alternative paradigm that is broad, integrated, and multifaceted.”); cf. GOSTIN, *supra* note 294, at 240 (recognizing that many other “modern cutting-edge global health governance initiatives . . . eschew formal international legal regimes”).

³⁰¹ See, e.g., Lee, *supra* note 126, at 578 (“[T]he effects of globalization make it difficult for governments and other stake-holders to address the growing threat of obesity and related health conditions without collective agreement to certain principles, and without the leadership, coordination, and expertise offered by the WHO—the international agency dedicated to achieving public health on a global level.”); *supra* Part II (discussing the inadequacies of global health policy in addressing breastfeeding); see also Magnusson, *supra* note 256, at 13 (concluding that WHO can coordinate global health policy for chronic diseases).

³⁰² See COOK ET AL., *supra* note 2, at 192 (“[S]ince in the world’s prevailing global

necessity for WHO, with states relying on the WHO Secretariat to respond objectively to health threats, in a manner and at an expense commensurate to the risk and magnitude of the possible harm.³⁰³ By delegating authority to WHO to constrain and shape state behavior in areas of policy agreement, WHO—in drafting international legislation and serving as the Secretariat for that legislation—can act as a supranational executive body for breastfeeding and as an influential human rights actor in state decision making for health.³⁰⁴ This can allow WHO, acting in an agenda-setting capacity as a representative of the community of states, to develop accepted norms independently, (1) inducing a policy equilibrium that might not otherwise exist while taking an active role in resolving distributional conflicts, (2) responding quickly to changes in public health conditions, and (3) facilitating interstate cooperation to the benefit of the international community.³⁰⁵

A right to breastfeeding can galvanize the community of states to work together through WHO's international legal authority to overcome this incomparable non-communicable threat to global health. Despite WHO experience in coordinating state action through international law, setting a valuable precedent for future international delegation in global health policy,³⁰⁶ WHO has never before approached international lawmaking through human rights frameworks.³⁰⁷ This failure has denied WHO's strategies the

economy few if any countries exercise full fiscal sovereignty, governments may be amenable to international persuasion and inducement to invest in such [reproductive health] services compatibly with their human rights undertakings.”)

³⁰³ See generally WHO, *The Future of Financing for WHO: Report of an Informal Consultation Convened by the Inspector-General*, at 13, WHO Doc. WHO/DGO/2010.1 (Jan. 12–13, 2010), available at http://www.who.int/dg/who_futurefinancing2010_en.pdf.

³⁰⁴ Cf. Gostin & Taylor, *supra* note 268, at 57 (discussing challenges “to utilizing law as an effective tool for achieving global health with justice”).

³⁰⁵ See Peter A. Hall & David Soskice, *An Introduction to Varieties of Capitalism*, in *VARIETIES OF CAPITALISM* 10, 10 (Peter A. Hall & David Soskice eds., 2001) (noting the importance of “institutions that reduce the uncertainty actors have about the behavior of others and allow them to make credible commitments to each other”); see also Lisa L. Martin & Beth A. Simmons, *Theories and Empirical Studies of International Institutions*, 52 *INT’L ORG.* 729, 748 (1998) (“Those actors who have the most to gain from pursuit of general welfare—such as executives elected by a national constituency—will show the most interest in turning to international institutions under such circumstances [of differential ability to enact national regulation].”). *But c.f.* NIELSEN, *supra* note 260, at 61 (reasoning that “[t]he WHO Constitution does not provide for sanctions to be imposed on states which do not meet the requirements of the Constitution or in Conventions, Agreements or Regulations”).

³⁰⁶ *But see* David Bishop, *Lessons from SARS: Why the WHO Must Provide Greater Economic Incentives for Countries to Comply with International Health Regulations*, 36 *GEO. J. INT’L L.* 1173, 1214 (2005) (arguing, given the example of the Code, that “WHO should move away from legislation that limits international free enterprise and competition”).

³⁰⁷ See Virginia Leary, *Concretizing the Right to Health: Tobacco Use as a Human Rights*

normative frameworks and legal obligations necessary for their effectiveness.³⁰⁸ Ameliorating this historical neglect of rights-based approaches to health—reversing its lack of commitment to the right to health³⁰⁹ and harmonizing its legal authorities with human rights³¹⁰—the regulation of breast milk substitutes under WHO’s human rights authority would combine WHO’s constitutional authorities with the normative frameworks essential to addressing underlying determinants of breastfeeding in ways that are not possible under the Code. Through the development of an independent treaty devoted to breastfeeding—or, alternatively, the incorporation of a rights-based approach to breastfeeding in the recently proposed Framework Convention on Global Health³¹¹—it becomes possible to integrate human rights in WHO’s international legal authorities, endowing WHO’s budding international legal approach to health with the human rights frameworks necessary to support those least capable of achieving healthy functionings through breastfeeding and providing international legal standards by which human rights treaty monitoring bodies can assess national breastfeeding policies in the developing world.

C. Policy Reform Through Human Rights Treaty Monitoring Bodies

Using international legal frameworks as indicators of human rights norms, human rights treaty monitoring bodies can consider breastfeeding as part of their larger enforcement of human rights throughout the world.

Issue, in *RENDERING JUSTICE TO THE VULNERABLE* 161, 167 (Fons Coomans et al. eds., 2000) (noting that WHO has “shown little interest in approaching health issues through the lens of human rights”); *But cf.* Taylor, *supra* note 269, at 505 (recognizing that “notable strides were made to address the Organization’s [WHO’s] historical neglect of the linkage between health and human rights” during Dr. Gro Harlem Brundtland’s tenure as Director-General).

³⁰⁸ See Benjamin Mason Meier, *Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement*, 45 *STAN. J. INT’L L.* 1, 44–45 (2010) (analyzing WHO’s role in the development and implementation of health rights).

³⁰⁹ See Audrey R. Chapman, *Core Obligations Related to the Right to Health*, in *CORE OBLIGATIONS: BUILDING A FRAMEWORK FOR ECONOMIC, SOCIAL, AND CULTURAL RIGHTS* 185, 193–94 (Audrey Chapman & Sage Russell eds., 2002) (“Despite the rhetorical commitment to a right to health in various documents, WHO does not understand this language as imposing specific requirements.”); Michael Kirby, *The Right to Health Fifty Years On: Still Skeptical?*, 4 *HEALTH & HUM. RTS.* 6, 14 (1999) (“In the field of health rights, WHO has historically demonstrated an ambivalence about defining health in terms of human rights.”).

³¹⁰ Nygren-Krug, *supra* note 248, at 269 (finding that General Comment 14 “assumes that WHO focuses on policies, guidelines and other non-binding instruments to address health challenges, rather than legally binding instruments”).

³¹¹ See generally Lawrence O. Gostin, *Meeting Basic Survival Needs of the World’s Least Healthy People: Toward a Framework Convention on Global Health*, 96 *GEO. L.J.* 331 (2008).

Where the Code attempts to create accountability for its voluntary commitments, it does so largely through NGO networks,³¹² which, as discussed above, have achieved limited success in enforcing breastfeeding policy.³¹³ Despite a steady stream of reports identifying an unending array of Code violations,³¹⁴ corporations have continued their consequentially harmful practices with only superficial regard for their public health and human rights consequences.³¹⁵ If these harms could be brought before human rights treaty bodies, employing international law to clarify the obligations of a right to breastfeeding, advocates would be able to rely upon the legal imprimatur of the UN's official human rights reports to support a human right to breastfeeding.

The UN's human rights treaty body system provides unparalleled avenues for influencing policy within the international community.³¹⁶ With each human rights treaty body holding international legal authority for oversight in the performance of its respective treaty, the number of treaty monitoring bodies (and state participation with them) has grown rapidly in the past decades, creating an interwoven patchwork of rights-based accountability for policy reform.³¹⁷ Given the intersectional rights implicated by a right to breastfeeding, these overlapping rights can be ideally adjudicated by some combination of: the Committee on the Rights of the Child (the body responsible for clarifying state obligations and reviewing state reports under the CRC), the Committee on the Elimination of All Forms of Discrimination Against Women (the body responsible for clarifying state obligations and reviewing state reports under the CEDAW), and the aforementioned CESCR (the body responsible for clarifying state obligations and reviewing state reports under the ICESCR).³¹⁸ While

³¹² See Melissa E. Crow, *Smokescreens and State Responsibility: Using Human Rights Strategies to Promote Global Tobacco Control*, 29 YALE J. INT'L L. 209, 245 n.228 (2004) (noting how the Code's assignment of monitoring responsibilities to NGOs has "encouraged the development of an international network of NGOs that monitor and report on compliance with the Code").

³¹³ See *supra* notes 117–25 and accompanying text (describing the formula industry's continuing failure to comply with the Code).

³¹⁴ See, e.g., IGBM, *CRACKING THE CODE*, *supra* note 290; IBFAN, *BREAKING THE RULES*, *supra* note 285.

³¹⁵ *Supra* Part I.C.

³¹⁶ *But cf.* Gostin & Taylor, *supra* note 268, at 59 ("Although perceptions of sovereignty are slowly changing, state consent to strong and meaningful implementation mechanisms remains rare because states are concerned that international institutions charged with implementing legal obligations will interpret their authority to be more expansive than that granted to them by states, thereby impinging on state autonomy.").

³¹⁷ James Crawford, *The UN Human Rights Treaty System: A System in Crisis?*, in *THE FUTURE OF UN HUMAN RIGHTS TREATY MONITORING* 129, 129–31 (Philip Alston & James Crawford eds., 2000).

³¹⁸ Providing an additional avenue for advancing such rights, breastfeeding could be raised

many have called for the consolidation of these human rights treaty bodies³¹⁹—wherein a unified system would prove ideal for examining the interconnected health rights of mothers and infants implicated by breastfeeding policy—the existing treaty monitoring bodies nevertheless provide myriad, if overlapping, opportunities for elucidating and implementing a right to breastfeeding through human rights jurisprudence.

First, these human rights treaty monitoring bodies have the legal authority to clarify human rights norms through general comments on the articles of their respective treaties. These general comments (general recommendations under the CEDAW system) are developed through reference to international legal standards and national policy implementation, interpreting specific provisions of treaties as a means to guide states in operationalizing human rights.³²⁰ With general comments often requested of the committees by states or international organizations—as has been done regarding health through both the UN Sub-Commission on the Promotion and Protection of Human Rights and the UN Commission on Human Rights (now the UN Human Rights Council)—these committees seek to identify the scope and content of the right in question, outlining the state obligations deriving from these norms.³²¹ Through these negotiated documents, committees can elaborate the right to breastfeeding, with the goal of assisting states in setting priorities for the progressive realization of breastfeeding policy. For example, the Committee on the Rights of the Child, referencing WHO's 2003 Global Strategy for Infant and Young Child Feeding, clarified that "States parties have a responsibility to implement children's right to health by encouraging education in child health and development, including about the advantages of breastfeeding, nutrition, hygiene and sanitation."³²²

as an issue under the UN Human Rights Council's new Universal Periodic Review system, under which the Council reviews each state's entire human rights record every four years. Human Rights Council, G.A. Res. 60/251, 60th Sess., 72d plen. mtg., U.N. Doc. A/RES/60/251 (Apr. 3, 2006).

³¹⁹The Secretariat, *Concept Paper on the High Commissioner's Proposal for a Unified Standing Treaty Body*, HRI/MC/2006/CRP.1, Mar. 22, 2006. For a history of the ideas that led to this proposal for a unified human rights treaty body, see generally Michael O'Flaherty & Claire O'Brien, *Reform of UN Human Rights Treaty Monitoring Bodies: A Critique of the Concept Paper on the High Commissioner's Proposal for a Unified Standing Treaty Body*, 7 HUM. RTS. L. REV. 141 (2007).

³²⁰GERD OBERLEITNER, GLOBAL HUMAN RIGHTS INSTITUTIONS 100 (2007).

³²¹INTERNATIONAL HUMAN RIGHTS IN CONTEXT: LAW, POLITICS, MORALS 359 (Henry J. Steiner et al. eds., 2008) (quoting Paul Hunt).

³²²U.N. Comm. on the Rights of the Child [CRC], *General Comment No. 7: Implementing Child Rights in Early Childhood*, ¶ 27(b), U.N. Doc. CRC/C/GC/7/Rev.1 (Sept. 20, 2006) (citing WHO, GLOBAL STRATEGY FOR INFANT AND YOUNG CHILD FEEDING (2003) (discussing

These general comments, in turn, become the basis for the further elaboration of international law, national policy, and practice guidelines, with these evolving legal norms on breastfeeding amenable to further clarification through reporting by one of the UN's right-specific special rapporteurs.³²³

Second, these committees have the opportunity to review periodic state reports on national progress in human rights implementation. By requiring states to submit statistical reports on their progress in the realization of a right, states can reflect on their own policy weaknesses, and committees can examine these self-assessments and submit recommendations for policy reforms.³²⁴ While long regarded as structurally ineffective, these committees have recently seen prolific growth,³²⁵ overcoming the workload challenges of their growth through the coordination of state reporting guidelines and the harmonization of intersectional human rights reports.³²⁶ In this reporting resurgence, successes have already been partially seen under the Committee on the Rights of the Child, which—by allowing NGOs the opportunity to submit independent reports, termed “shadow reports” in providing alternative analyses on state progress—has recently looked to the standards set by the Code in examining the progressive realization of state obligations to protect breastfeeding.³²⁷

the CRC's breastfeeding obligations); *see also* U.N. COMM. ON THE RIGHTS OF THE CHILD ET AL., A GUIDE TO GENERAL COMMENT NO. 7: 'IMPLEMENTING CHILD RIGHTS IN EARLY CHILDHOOD' 15–16 (2006) (discussing the importance of breastfeeding to a child's health).

³²³ *See generally* Paul Hunt & Sheldon Leader, *Developing and Applying the Right to the Highest Attainable Standard of Health: The Role of the UN Special Rapporteur (2002–2008)*, in GLOBAL HEALTH AND HUMAN RIGHTS, *supra* note 4, at 28 (clarifying the role of UN special rapporteurs in human rights interpretation).

³²⁴ In addition to a state's report and committee's observations, several committees also allow for “constructive dialogue,” through which state representatives meet with the committee to discuss “implementation priorities” and “future goals.” *See, e.g.*, Committee on the Rights of the Child, Overview of the Working Methods of the Committee on the Rights of the Child, <http://www2.ohchr.org/english/bodies/crc/workingmethods.htm> (last visited Sept. 2, 2010).

³²⁵ AMNESTY INT'L, UNITED NATIONS: PROPOSALS TO STRENGTHEN THE HUMAN RIGHTS TREATY BODIES 4 (2003).

³²⁶ Eighteenth Meeting of Chairpersons of the Human Rights Treaty Bodies, *Harmonized Guidelines on Reporting Under the International Human Rights Treaties Including Guidelines on a Common Core Document and Treaty-Specific Targeted Document*, HR/IMC/2006/3 (May 10, 2006), available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G06/419/42/PDF/G0641942.pdf?OpenElement>.

³²⁷ Given the Code's standards and NGOs' advocacy, the Committee on the Rights of the Child has recently criticized state reports for failures to improve breastfeeding policy. *See, e.g.*, CRC, *Concluding Observations of the Committee on the Rights of the Child: Ecuador*, ¶ 58, U.N. Doc. CRC/C/ECU/CO/4 (Jan. 11–29, 2010), available at <http://www1.umn.edu/humanrts/crc/ecuador2010.html> (criticizing a decrease in breastfeeding rates and recommending dissemination of the Code); *see also* Elspeth Webb et al., *Using the UN Convention on the Rights of Children to Improve the Health of Children*, 19 PAEDIATRICS & CHILD HEALTH 430, 433 (2009); IBFAN, Press Release, The Committee on the Rights of the Child (CRC) Confirms

This consideration of breastfeeding could be extended to the Committee on the Elimination of Discrimination Against Women and CESCR, which have similar avenues for NGO participation and could examine obligations for the provision of post-natal services through national primary health care systems, reaching out to global health partnerships for breastfeeding to determine reasonable standards under each treaty's health norms.³²⁸ Expanded outward, if a larger group of developing states could be pressed to report on a more exacting set of breastfeeding policies to a wider array of human rights committees, these human rights redundancies would be more likely to support state implementation of a human right to breastfeeding.³²⁹

Finally, these human rights treaty monitoring bodies are paving the way for individual claims against states and international organizations, either through the human rights treaty body or, based on that body's standards, in national courts. Through human rights treaty bodies, individual complaint mechanisms are being developed to assess rights violations in health—most prominently through the Optional Protocol to the CEDAW³³⁰ and the recently adopted Optional Protocol to the ICESCR³³¹—allowing individual claimants to challenge a state's treaty compliance and allowing treaty bodies to adjudicate obligations for breastfeeding policy.³³² By assisting in human rights capacity building at the national level, treaty monitoring bodies engender advocacy expertise in rights-based policy reforms and provide comparative examples of those reforms

the Importance of Breastfeeding as a Human Right (Jan. 2010), available at <http://www.ibfan.org/art/CRC53.doc>.

³²⁸ Dhruvajyoti Bhattacharya, *The Perils of Simultaneous Adjudication and Consultation: Using the Optional Protocol to CEDAW to Secure Women's Health*, 31 WOMEN'S RTS. L. REP. 42 (2010); Scott Leckie, *The Committee on Economic, Social and Cultural Rights: Catalyst for Change in a System Needing Reform*, in THE FUTURE OF UN HUMAN RIGHTS TREATY MONITORING, *supra* note 317, at 129, 130 ("The Committee [CESCR] has gained growing support due to its openness to alternative information sources and its willingness, on occasion, to accept the credibility and reliability of this information, even when it contradicts reports or other representations by States Parties.").

³²⁹ See Lance Gable, *Reproductive Health as a Human Right*, 60 CASE W. RES. L. REV 957 (2010).

³³⁰ Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 54/4, U.N. GAOR, 54th Sess., Supp. No. 49, U.N. Doc. A/RES/54/4 (Oct. 15, 1999).

³³¹ Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, G.A. Res. 63/117, U.N. GAOR, 63d Sess., U.N. Doc. A/RES/63/117 (Dec. 10, 2008).

³³² See Sital Kalantry, Jocelyn E. Getgen & Steven Arrigg Koh, *Enhancing Enforcement of Economic, Social, and Cultural Rights Using Indicators: A Focus on the Right to Education in the ICESCR*, 32 HUM. RTS. Q. 253, 280–91 (2010) (proposing human rights indicators pursuant to the Optional Protocol to the ICESCR as a means to ascertain compliance with the interrelated rights underlying education policy).

across countries.³³³ Thus, breastfeeding advocates can embrace these international human rights standards to develop enabling legislation under national law—enforcing such laws through rights-based litigation³³⁴ and compensation funds for the harms of formula—thereby internalizing breastfeeding norms throughout the developing world.³³⁵

In framing such claims for accountability in the national and international enforcement of health rights,³³⁶ a focus on breastfeeding would provide concrete, measurable, and readily available national indicators by which states could accurately report the conditions of health in their respective territories. Through such indicators, international treaty monitoring bodies could better gauge these states' periodic reports on the realization of health rights, ensuring that these governments would be held accountable for realizing healthy conditions for breastfeeding. With human rights "justiciability" long plagued by "[v]exing questions of content, criteria, and measurement,"³³⁷ human rights indicators can provide measures for the enforcement of the progressive realization of breastfeeding policy.³³⁸ As international institutions move to propose structural indicators reflective of health rights³³⁹—until now, without any discussion of breastfeeding—these indicators can provide the basis for assessing state obligations for a right to breastfeeding before

³³³ See Rangita de Silva de Alwis, *Mining the Intersections: Advancing the Rights of Women and Children with Disabilities Within an Interrelated Web of Human Rights*, 18 PAC. RIM L. & POL'Y 293, 318 (2009) ("Recommendations or Comments help bolster civil society organizations' work to hold their governments accountable to fulfill their obligations under the treaties.").

³³⁴ Jerome Amir Singh et al., *Do Human Rights Matter to Health?*, 370 LANCET 521, 521–24 (2007) (noting the rise of rights-based litigation for economic, social and cultural rights).

³³⁵ See Katherine Sikkink, *Transnational Politics, International Relations Theory, and Human Rights*, 31 POL. SCI. & POL. 516, 519–20 (1998) (describing the process by which human rights norms emerge among advocates, become codified in international law, and are translated into national law).

³³⁶ Cf. AGINAM, *supra* note 297, at 36 (criticizing Western scholars for "unduly emphasis[ing] justiciability predicated on an individual making a claim against the state, before a court or tribunal, seeking redress for the violation of her rights").

³³⁷ Michael J. Dennis & David P. Stewart, *Justiciability of Economic, Social, and Cultural Rights: Should There Be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing, and Health?*, 98 AM. J. INT'L L. 462, 464 (2004).

³³⁸ See Gauthier de Beco, *Human Rights Indicators for Assessing State Compliance with International Human Rights*, 77 NORDIC J. INT'L L. 23, 24–25 (2008) (defining indicators and applying them to determine national compliance with human rights); see also Kilanry et al., *supra* note 332, at 259 (noting that "[i]ndicators enhance the effectiveness of the violations approach, particularly in the context of ESCRs [economic, social and cultural rights], because indicators assist in measuring progressive realization").

³³⁹ See Gunilla Backman et al., *Health Systems and the Right to Health: An Assessment of 194 Countries*, 372 LANCET 2047 (2008) (examining health systems in 194 countries and identifying features that indicate realization of the right to health).

human rights treaty bodies.³⁴⁰ Because a panoply of factors determine breastfeeding in the developing world, it becomes necessary under such indicators to move this rights-based adjudication from a focus on obligations of conduct (ostensibly measured through resource allocations)³⁴¹ to obligations of result,³⁴² with these results easily quantified through disaggregated national public health indicators.³⁴³ In the context of breastfeeding, human rights treaty monitoring bodies could examine a nation's annual infant mortality rate (IMR)—the number of live newborns who die before one year of age (per 1,000 live births)—comparing IMRs across time, population, and region as a means of holding states accountable for unnecessary and inequitable infant death.³⁴⁴ Much like the strong causal link between tobacco use and lung cancer, IMRs in the developing world are strongly correlated (inversely) with breastfeeding rates³⁴⁵ and can serve as an accurate indicator of policy effectiveness at the national level.³⁴⁶ Thus, by examining public health indicators, human rights analysts could appreciate the significance of anomalies in infant mortality and correlate these disparities with underlying determinants of breastfeeding. Through such an analysis, state commitments to a human right to breastfeeding can be used to limit the marketing and

³⁴⁰ Given the interdisciplinary sophistication necessary to establish quantitative and qualitative indicators for a right to breastfeeding, the authors do not seek here to propose a specific set of indicators or guidelines to assess the progressive realization of breastfeeding policy.

³⁴¹ See Robert E. Robertson, *Measuring State Compliance with the Obligation to Devote the "Maximum Available Resources" to Realizing Economic, Social and Cultural Rights*, 16 HUM. RTS. Q. 693, 702–03 (1994) (noting "serious deficiencies" in using resource utilization to measure state compliance with economic, social and cultural rights).

³⁴² See MATTHEW C.R. CRAVEN, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: A PERSPECTIVE ON ITS DEVELOPMENT 108 (1995) ("The distinction between obligations of conduct and result is complicated by the fact that some of the specified 'steps' may also be seen to be independent norms imposing separate obligations of result.')

³⁴³ See Benjamin Mason Meier, *Employing Health Rights for Global Justice: The Promise of Public Health in Response to the Insalubrious Ramifications of Globalization*, 39 CORNELL INT'L L.J. 711, 766–67 (2006) (advocating the rights-based examination of "obligations of result" through public health indicators).

³⁴⁴ See Tom J. Farer, *Toward a Humanitarian Diplomacy: A Primer for Policy*, in TOWARD A HUMANITARIAN DIPLOMACY: A PRIMER FOR POLICY 1, 22 (Tom J. Farer ed., 1980) ("Development experts generally agree that life expectancy, infant mortality, and literacy are the most appropriate indicators for measuring the physical well-being of any country's population and for the measurement of progress towards higher levels of economic and social well-being for the general population.')

³⁴⁵ See Barry M. Popkin et al., *Survival in the Perinatal Period: A Prospective Analysis*, 25 J. BIOSOCIAL SCI. 359, 361 (1993) (noting that "[w]hen the infant is not breast-fed in the first 2–3 days postpartum . . . neonatal death rates often rise").

³⁴⁶ Jay S. Ovsiovtch, Note, *Reporting Infant and Child Mortality Under the United Nations Human Rights Conventions*, 46 BUFF. L. REV. 543, 545 (1998) ("Treaty-monitoring bodies cannot scrutinize the effectiveness of programs designed to reduce infant and child mortality unless adequate data is provided by the State Party.')

distribution of breast milk substitutes in the developing world. By regulating the formula industry as part of a larger, synergistic effort to develop a rights-based approach to global breastfeeding policy, states can translate this enforceable global policy into national public health systems reflective of a synoptic vision for breastfeeding protection, promotion, and support.

V. CONCLUSION

Despite a sweeping imperative for universal and enforceable human rights standards under international law, context matters in global breastfeeding policy. Both the rights of the rights-holder and the obligations of the duty-bearer depend upon local conditions. As noted in the context of the right to food:

[T]he right to food is more of a negative right in the wheat fields of Kansas than in Watts or East Los Angeles. Equal protection of the law is somewhat more positive in the South Bronx than in Stockholm. In Argentina, protection against torture was a very positive right indeed in the late 1970s. Today, it is a much more negative right.³⁴⁷

Such as it is with reproductive rights, which have long been construed as negative rights in the developed world, but which increasingly necessitate a positive rights-based approach in the developing world.³⁴⁸ Realizing these rights through national primary health care systems, advocates have an opportunity to press the international community to codify discrete breastfeeding obligations under the right to health and to implement these obligations through global health policy.

³⁴⁷ DONNELLY, *supra* note 230, at 30.

³⁴⁸ See Reilly Anne Dempsey & Benjamin Mason Meier, *Going Negative: How Reproductive Rights Discourse Has Been Altered from a Positive to a Negative Rights Framework in Support of "Women's Rights,"* in WOMEN'S GLOBAL HEALTH AND HUMAN RIGHTS, *supra* note 54, at 83.