

# Breastfeeding in Refugee Camps: A Child and Maternal Right?

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## ABSTRACT

In recognition of the health benefits breastfeeding offers for both mother and child, breastfeeding has been acknowledged in various International Human Rights Law instruments. Furthermore, against the backdrop of aggressive formula milk marketing campaigns, significant soft law provisions contained within the International Code of Marketing of Breast-milk Substitutes 1981 regulate and control the promotion of breastmilk substitutes. Refugee camps, however, remain aligned with pre-code practice, as formula milk is often one of the first donations to arrive in camps. Mothers, who are still affected by historical formula marketing campaigns, receive formula milk and perceive its availability and distribution as an endorsement over breastfeeding. In this article, International Human Rights Law is analysed, within the framework of the principle of the best interests of the child, to determine if the choice to breastfeed should be protected as a human right and how the indiscriminate supply of formula milk interacts with this choice in refugee camps.

**KEYWORDS:** refugees, human rights, breastfeeding, maternal rights, children's rights, nutrition

## 1. INTRODUCTION

Breastfeeding or natural feeding, often referred to as 'nursing', is the consumption of human milk by a child<sup>1</sup> via a woman's breast. The alternative to breastmilk is formula milk, which is normally based on processed skimmed cows' milk and presented as a powder which is then combined with boiling water—to kill any potential pathogens in

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1 The article uses the term 'child' to refer to an individual under the age of 4 years and 'baby' to note a child under the age of 2 years. Use of 'infant' indicates a child older than a month and less than 12 months old and 'newborn' indicates a child of less than 4 weeks of age. The term 'baby' therefore encompasses newborns and infants. Similarly, the term 'child' extends to and includes: newborns; infants; and 'babies' (as they are defined for the purposes of this paper).

the powder—to produce formula milk.<sup>2</sup> The health debates surrounding infant milk consumption are long-standing and the benefits of both breastmilk and breastfeeding have been established and recognised as universal among mothers and children.<sup>3</sup> This article seeks to outline the framework within which women who choose and wish to breastfeed<sup>4</sup> are enabled and supported to do so under International Human Rights Law (IHRL), considering the same category of women within the specific context of refugee camps where resources—both physical and human, in terms of specialised breastfeeding support—are limited, unreliable and dependent on various other factors for delivery.

There is no explicit right to breastfeed or to be breastfed, nor does this article argue that there should be. However, rights to be educated on infant feeding and supported if choosing to breastfeed are recognised under IHRL. Further, there are considerable soft law provisions prohibiting and regulating the promotion and availability of formula milk. Notwithstanding these provisions, formula milk is often one of the first donations to arrive by way of aid in refugee camps<sup>5</sup> and, owing to a multitude of factors which this article examines, this less nutritional form of infant feeding is inadvertently promoted, to the health detriment of vulnerable women and children. This article seeks to critically evaluate whether, when read together, pertinent IHRL provisions give scope to recognise the choice to breastfeed as a human right and if this right is being breached two-fold in refugee camps: (a) by allowing formula milk to be indiscriminately dispensed to mothers who have little knowledge of child feeding from a health perspective; and (b) by a lack of breastfeeding support, which is in itself a breach. Given that women and children predominate the composition of residents in refugee camps,<sup>6</sup> child feeding is a real and contemporary matter intersecting women's and children's rights, which United Nations International Children's Emergency Fund's (UNICEF) case studies have emphasised the importance of linking.<sup>7</sup>

The article is divided into six main sections. Following this introduction, Section 2 establishes the health benefits of breastmilk which underpin IHRL instruments that protect, promote and support breastfeeding. Following on from this, Section 3 then provides the background to the subject matter of this article: the indiscriminate supply of formula milk in refugee camps and the circumstance-specific shortfalls of this method of child feeding. Section 4 then turns to assessing and analysing pertinent IHRL provisions, leading into identifying concerns associated with formula milk promotion

2 World Health Organization, 'How to Prepare Formula for Bottle-Feeding at Home' (2007) *World Health Organization*, available at: [www.who.int/foodsafety/publications/micro/PIF\\_Bottle\\_en.pdf](http://www.who.int/foodsafety/publications/micro/PIF_Bottle_en.pdf) [last accessed 4 June 2020].

3 Wambach and Spencer, *Breastfeeding and Human Lactation*, 6th edn (2019) at 85–6.

4 For the avoidance of doubt: this article does not advocate for universal breastfeeding but approaches and considers women who wish to breastfeed. Maternal autonomy is key and this article fully recognises that women who do not wish to breastfeed should be under no obligation to do so and must be supported to formula feed. Further, this article also recognises that there are instances where a mother may be unable to breastfeed, for physical and/or psychological reasons.

5 Interview B.

6 Tuitt, 'Rethinking the refugee concept' in Nicholson and Twomey (eds), *Refugee Rights and Realities: Evolving International Concepts and Regimes* (1999) 106 at 106.

7 Madinger and Mayrides, 'Bolivia: Programming for children's rights' in Newman-Black and Light (eds), *The Convention: Child Rights and UNICEF experience at the country level* (1991) 13 at 23.

and its indiscriminate supply within refugee camps, questioning the appropriateness from an IHRL compliance standpoint. Section 5 subsequently analyses the arguments in favour of limiting the applicability of relevant IHRL provisions to support breastfeeding in emergency situations and takes a critical approach to the legality of reservations to IHRL provisions. Further, the section identifies general and refugee camp specific obstacles to breastfeeding which allows for the article to ascertain potential means to overcome such impediments. The article then sets out an overview of the human rights position of the choice to breastfeed in Section 6 and makes observations as to present shortcomings, making reference to measures needed to ensure IHRL compliance.

The study of infant feeding in refugee camps is one which engages an ongoing, yet underexplored discourse, which is highly topical in light of present emergency situations forcing people to flee their homes.<sup>8</sup> Since 2004, Europe has received hundreds of thousands of refugees, largely from Syria, Afghanistan and Iraq.<sup>9</sup> Further, formula milk contamination in European factories has led to infant fatalities in economically developing countries that import formula milk, highlighting the clear and lethal risks contamination poses on a global level. Illustratively, the French company, Lactalis, recalled its formula milk owing to suspected salmonella contamination with children in Bangladesh, China, Pakistan and Sudan amongst those affected.<sup>10</sup> Further, the themes examined by the article are topical and contemporary; refugee camps, as a result of recent waves of emergency migration caused by conflict on an unprecedented level,<sup>11</sup> are home to exceptionally vulnerable children and women. At the core of this examination lies the reality of avoidable infant deaths and a clear disregard for female and maternal autonomy, all of which are ongoing and live matters.

The article takes a feminist approach and advocates for gender consideration within refugee camps. This need is further compounded during the postpartum stage for women, when an infant is fully dependent on its primary caregiver, usually the mother.<sup>12</sup> The article posits that caregivers facilitate the realisation of their children's rights and certainly within the especial remit of breastfeeding, mother and child are a dyad. The health of an infant or child is not a distinct matter and 'cannot be isolated from the health and nutrition of women, their socioeconomic status and their roles as mothers.'<sup>13</sup>

The article identifies and analytically reads relevant international treaties and the rights they afford mothers and children as individuals, and as a unit, whilst working within the framework of 'the best interests of the child', which, whilst not strictly defined, has broad indicative parameters founded in case law.<sup>14</sup> Given the binding

8 Smith, 'Surge in Migration to Greece Fuels Misery in Refugee Camps', (2017) *Guardian*, available at: [www.theguardian.com/world/2017/sep/29/surge-in-migration-to-greece-fuels-misery-in-refugee-camps](http://www.theguardian.com/world/2017/sep/29/surge-in-migration-to-greece-fuels-misery-in-refugee-camps) [last accessed 4 June 2020].

9 Buonanno, 'The European Migration Crisis' in Dinan et al (eds), *The European Union in Crisis*, (2017) 100 at 101–3.

10 BBC, 'Lactalis baby milk in global recall over salmonella fears', *BBC News*, 11 December 2017, available at: [www.bbc.co.uk/news/business-42304757](http://www.bbc.co.uk/news/business-42304757) [last accessed 5 June 2020].

11 Buonanno, *supra* n 9.

12 Salter Ainsworth, 'Object Relations, Dependency, and Attachment: A Theoretical Review of the Infant-Mother Relationship' (1969) 40 *Child Development* 969 at 969–71.

13 World Health Organization, Preamble of International Code of Marketing of Breast-milk Substitutes 1981.

14 Freeman, *Human Rights* (2003) at 177–83.

nature of the Convention on the Rights of the Child 1989 (CRC),<sup>15</sup> the article critically analyses the contemporaneous means of child feeding in refugee camps as either led by or permitted by, states hosting refugee camps.

For the purposes of better understanding this multifaceted issue, empirical research was undertaken and interviews were conducted with experts in various fields.<sup>16</sup> Finally, consultation with midwifery texts allows the article to engage with pertinent medical and biological technicalities in order to approach this intersectional subject matter comprehensively.

## 2. BREASTFEEDING AS A HEALTH BENEFIT AND ITS MECHANISM

### A. Breastfeeding and Associated Health Benefits: Mother and Child

Breastmilk offers inimitable health benefits to a child: it is a near perfect diet owing to its unique composition of vitamins and minerals aligning with the needs of the child.<sup>17</sup> A mother's breastmilk is continually optimal for a child, as it naturally changes in composition to meet the child's evolving dietary needs<sup>18</sup> and can therefore be regarded as responsive in its character. Breastmilk also contains antibodies<sup>19</sup> that protect children from infection, long-term ill-health and death;<sup>20</sup> human milk oligosaccharides which are sugars indigestible to babies but crucial to the healthy gut microbiome and stimulate robustness of the immune system;<sup>21</sup> and stem cells which the child's body uses for physical repair.<sup>22</sup>

- 15 Article 3(1) Convention on the Rights of the Child 1989, 1577 UNTS 3: '[I]n all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.'
- 16 Consultation with Professor John Harrington, University of Cardiff 'Interview A'. Professor Harrington has undertaken considerable research on breastfeeding in Kenya as a matter of global health law. This has allowed for this article to consider state responsibility and IHRL compliance. Interviews were also conducted with the founder of the Nurture Project International, Brooke Bauer 'Interview B'. Bauer has established lactation support in refugee camps across Bangladesh, Greece and Iraq. The interview was conducted remotely from Iraq in two parts owing to a refugee-camp security breach which cut the initial interview short. Interviews with International Board Certified Lactation Consultants, Helen Gray 'Interview C' and Kate Main 'Interview D', provided an insight into the professional world of breastfeeding support. Gray has provided first-hand support to breastfeeding mothers in refugee settlements in France and Greece and is joint coordinator of the United Kingdom Working Group for the World Breastfeeding Trends Initiative. All interviews were audio recorded and where an interview reference follows with an asterisk (\*), this indicates subsequent email communication in order to obtain further information and/or clarification. Ethical approval was applied for and obtained from King's College London prior to this research commencing.
- 17 Wambach and Spencer, *supra* n 3 at 102–4.
- 18 *Ibid.* at 85 and 92.
- 19 *Ibid.* at 97–8.
- 20 World Health Organization, *Global Strategy for Infant and Young Child Feeding* (2003) at 7.
- 21 Plaza-Díaz, Fontana and Gil, 'Human Milk Oligosaccharides and Immune System Development' (2018) 10 *Nutrients* 1038.
- 22 Cheng *et al.*, 'Current Progress of Human Trials Using Stem Cell Therapy as a Treatment for Diabetes Mellitus' (2016) 5 *American Journal of Stem Cells* at 74–86.

Breastfeeding has been referred to as the ‘ultimate natural vaccine for babies’<sup>23</sup> as it provides needed antibodies to allow for the quicker recovery of sick children,<sup>24</sup> and breastmilk holistically supports a child’s immune system overall.<sup>25</sup> Further, breastmilk contains pain-relief qualities for children when consumed.<sup>26</sup> Breastfeeding has no hygiene requirements to administer safely.<sup>27</sup>

Children who are only fed breastmilk (‘exclusively breastfed’)<sup>28</sup> for the first six months of life, and then as a component of a healthy diet with solid foods, are better protected from common childhood illnesses which can lead to dehydration, malnutrition and diarrhoea which, if not treated effectively, can lead to infant mortality.<sup>29</sup> Further, exclusively breastfed children are at considerably less risk of infant mortality caused by Sudden Infant Death Syndrome,<sup>30</sup> defined as: ‘sudden death of a previously healthy infant in which no adequate cause of death is found . . . [and which] rests on the absence of an adequate cause of death.’<sup>31</sup>

Whilst formula milk holds nutritional value, as it contains added vitamins, prebiotic carbohydrates and fatty acids, it lacks antibodies<sup>32</sup> which render a child more vulnerable and prone to illness. Further, formula milk powder, is an unsterile concentrate, containing bacteria, such as *cronobacter*,<sup>33</sup> which needs to be killed with boiling water to produce formula milk safe for consumption.<sup>34</sup> Incorrect preparation can lead to a subsequent bacterial infection which can cause ‘serious illness in infants,’<sup>35</sup> and be ‘deadly’, often as a result of causing meningitis and/or sepsis.<sup>36</sup>

Breastfeeding also has a positive health impact on mothers both immediately after childbirth and later on in life. Initiating breastfeeding reduces maternal bleeding after childbirth and delays ovulation, meaning the conception of subsequent children can be delayed, reducing strain on the mother’s body.<sup>37</sup> This is of considerable benefit when contraception is not accessible.<sup>38</sup> Continuing breastfeeding reduces the risk of

23 Action Against Hunger, ‘Breastfeeding in a Refugee Camp: Humaira’s Story’, (2019) *Action Against Hunger*, available at: [www.actionagainsthunger.org.uk/blog/breastfeeding-refugee-camp-humairas-story](http://www.actionagainsthunger.org.uk/blog/breastfeeding-refugee-camp-humairas-story) [last accessed 5 June 2020].

24 Tomkins and Grant ‘Feeding Sick People, Especially Children’ in King et al. (eds), *Nutrition for Developing Countries*, 3rd edn (2015) 128 at 129.

25 Interview A.

26 Murtiningsih and Nurbayanti, ‘The Effects of Breastfeeding and Massage on Neonatus Pain During Intravenous Blood Sampling Procedures’ (2020) *Journal of Neonatal Nursing*.

27 Interview B.

28 This excludes all other liquids including water but does not take into account vitamin drop supplements.

29 World Health Organization, *supra* n 20 at 27.

30 Wambach and Spencer, *supra* n 3 at 272.

31 Robinson, ‘Emergency Services: First Responders’ in Cohen et al. (eds), *Investigation of Sudden Infant Death Syndrome* (2019) 43 at 43.

32 World Health Organization, *supra* n 2.

33 A deadly bacterium which lives in dry places including dry formula milk powder and is used for preservation purposes. See Centers for Disease Control and Prevention, ‘Cronobacter Infection and Infants’ *Centers for Disease Control and Prevention* (undated) [www.cdc.gov/cronobacter/infection-and-infants.html](http://www.cdc.gov/cronobacter/infection-and-infants.html) [last accessed 25 November 2020].

34 World Health Organization, *supra* n 2.

35 *Ibid.*

36 CDC, *supra* n 33.

37 Wambach and Spencer, *supra* n 3 at 481–3.

38 Interview A.

type II diabetes, cardiovascular issues and breast cancer, amongst other health complications.<sup>39</sup> Further, the psychological postpartum benefits of breastfeeding have been well-documented and include an improved mental state of the mother.<sup>40</sup> The emotional bond being intensified between mother and child is also well-documented.<sup>41</sup> It is necessary to note that formula feeding does not offer any health benefit to the mother, save for rare circumstances where breastfeeding would be detrimental to her own physical and/or mental health.<sup>42</sup>

In clear recognition of breastfeeding health benefits, the WHO recommends infants be exclusively breastfed for the first six months of life, citing it as the 'optimal way of feeding' and that breastmilk should form a component of a child's diet until the age of 2 years or beyond,<sup>43</sup> in order to maximise its impact.<sup>44</sup>

### **B. Mechanics of Breastfeeding: Supply/Demand**

Breastfeeding works on the basis of a supply and demand mechanism. Milk production, 'supply', is stimulated by a baby nursing, 'demand'. Unhindered access to nursing sends the clearest and most accurate message of the need to the mother's body to produce the correct amount of milk.<sup>45</sup> In order to calibrate the correct supply to demand, introducing formula milk is not advised as it interferes with the communication 'loop' between mother and child,<sup>46</sup> as a reduced need is communicated to the mother's body and her ability to produce breastmilk reduces accordingly. Breastfeeding 'on demand' (whenever an infant indicates hunger) is the recommended approach to optimise natural feeding.<sup>47</sup>

### **C. Exercising Maternal Choice**

Against the backdrop of the above two sub-sections and the clear health benefits of breastfeeding for both mother and child, this article aligns itself with well-established and researched views that, from a health perspective, and should the mother opt, an infant should be breastfed exclusively, given the heightened need for an optimum diet during the first crucial months of life. Moreover, the mother should be supported in opting to breastfeed.<sup>48</sup> Notwithstanding the nutritional reasons this article outlines, and which render breastfeeding preferential as a matter of public policy, this article firmly places maternal choice as the prevailing and determining factor in breastfeeding. Interviewee C aptly stated that '[W]omen are sovereign over their own bodies,

39 Pollard, *Evidence-Based Care for Breastfeeding Mothers*, 2nd edn (2011) at 4.

40 Chowdhury et al., 'Breastfeeding and maternal health outcomes: a systematic review and meta-analysis' (2015) 104 *Acta Paediatr* 96 at 97–8.

41 Wambach and Spencer, supra n 3 at 678–9 and Interview A.

42 Bentley, Aubrey and Bentley, *Infant Feeding and Nutrition for Primary Care* (2002) at 8.

43 World Health Organization, supra n 20 at 8.

44 Dennis, 'Breastfeeding Initiation and Duration: A 1990–2000 Review', (2002) 31 *Journal of Obstetric & Neonatal Nursing* 12 at 13–6.

45 Wambach and Spencer, supra n 3 at 258–60.

46 Ibid.

47 Wardley, Puntis and Taitz, *Handbook of Child Nutrition*, 2nd edn (1997) at 15.

48 Kramer and Kakuma, 'The Optimal Duration of Exclusive Breastfeeding: A Systematic Review' (2004) 554 *Advances in Experimental Medicine and Biology* 63 at 63.

governments should simply make sure they have the support needed to carry out their choices.<sup>49</sup>

Female autonomy must be respected and any decision to formula feed should therefore be enabled and facilitated as fully as possible. Equally, breastfeeding, or the desire to, also exists as a choice and a decision to be exercised as a matter of maternal autonomy. As with formula feeding, breastfeeding will likely require support, in various forms, given the complexities of the act, as explored in Section 6, firstly in broad terms, after which refugee camp specific consideration is then made.

(i) *Ensuring Adequate Support of Breastfeeding as International Practice*

The WHO asserts that their projected global health objectives can be realised, at least in part, by successful breastfeeding. Relatedly, the WHO states: ‘virtually all mothers can breastfeed, provided they have accurate information, and the support of their family, the health care system and society at large.’<sup>50</sup>

Strong soft law, to be outlined in depth at the outset of Section 4, has regularly been updated in World Health Assembly (WHA) resolutions that demonstrate the commitment to protecting and promoting breastfeeding,<sup>51</sup> and these provisions later informed the Innocenti Declaration of 1990 (‘Innocenti Declaration’). In turn, the Innocenti Declaration fuelled maternal and child-led health initiatives culminating in UNICEF and WHO launching the Baby Friendly Hospital Initiative in 1991.<sup>52</sup> However, given the unequivocal health benefits and the intention underpinning the relevant soft law, it is surprising that, as recently as 2016, the WHO stated laws to promote breastfeeding are ‘inadequate’ in most countries.<sup>53</sup>

There are, however, numerous practical obstacles to breastfeeding: the physical, practical/logistical and psychological. With access to information, support and expert assistance, these obstacles can largely be overcome.<sup>54</sup> In economically developed countries, a range of healthcare providers routinely shares the collective responsibility of enabling and assisting a mother to breastfeed. Over recent years, the increasing number of, and demand for,<sup>55</sup> lactation consultants—individuals normally with medical/healthcare backgrounds trained to support and enable breastfeeding<sup>56</sup>—has been cited to have had a ‘positive impact on breastfeeding for mothers of all income levels.’<sup>57</sup> Lactation consultants assist mothers to address and overcome common obstacles to breastfeeding, often in the early days/weeks of breastfeeding which is when most

49 Interview C.

50 Green and Dickinson, ‘The Economics of infant Feeding’ in Cohen and Wright (eds), *Research Handbook on the Economics of Family Law* (2011) 159 at 160.

51 UNICEF and World Health Organization, ‘Baby-Friendly Hospital Initiative: Revised, Updated and Expanded for Integrated Care’ (2009) at 1.

52 Ibid.

53 UNICEF, World Health Organization and the International Baby Food Action Network, ‘Laws to protect breastfeeding inadequate in most countries’, (2016) UNICEF, available at: [www.unicef.org/media/media\\_91075.html](http://www.unicef.org/media/media_91075.html) accessed 12 April 2020 [last accessed 6 June 2020].

54 Renfrew, Fisher and Arms, *Bestfeeding: How to Breastfeed Your Baby*, 3rd edn (2004) at 215.

55 Wardley, *supra* n 47 at 18.

56 Riordan, *Breastfeeding and Human Lactation*, 3rd edn (2005) at 31.

57 Riordan and Wambach, *Breastfeeding and Human Lactation*, 4th edn (2010) at 827.

women cease to breastfeed.<sup>58</sup> Further, lactation consultants seek to dispel common breastfeeding misconceptions and disseminate factual information in order to maximise the chances of a sustained and successful breastfeeding experience.<sup>59</sup>

### 3. BACKGROUND—THE INDISCRIMINATE SUPPLY OF FORMULA MILK IN REFUGEE CAMPS AND ITS APPROPRIATENESS

Despite formula milk being a tangible way of ensuring infants are fed, particularly in emergency situations—as illustrated by the often-immediate delivery of formula powder in aid packages following disasters and displacement<sup>60</sup>—it is rife with impracticalities within the specific circumstances presented by refugee camps. The risks posed to vulnerable children by formula milk in refugee camps are now explored and evaluated within the context of unregulated and, often, irregular supply.<sup>61</sup>

#### A. Refugee Camps

Refugee camps are temporary settlements for those fleeing persecution.<sup>62</sup> A refugee is an individual who has left their country of origin due to a well-founded fear of persecution and is subsequently able to avail themselves of the Convention Relating to the Status of Refugees (1951 Convention).<sup>63</sup> An asylum-seeker is an individual who is in the process of obtaining formal recognition from a 1951 Convention state party.<sup>64</sup> For ease of reference, this article will refer to all those in refugee camps—irrespective of immigration status—as refugees, on the basis of being located within a refugee camp.

Refugee camps across the world share a common feature: they are always intended to be finite in existence.<sup>65</sup> Their provisional and often quickly established nature is reflected in the transient setup of almost every aspect of their composition; an approach entrenched in anticipation that camps will be disbanded, residents will return to their country of origin safely or will be resettled in states parties as refugees. However, the reality is that some refugee camps become quasi-permanent owing to the length of time they house vulnerable individuals. Illustratively, Dadaab's three refugee camps in Kenya are referred to as a 'refugee complex' by the United Nations High Commissioner for Refugees (UNHCR) and have operated as a temporary home to refugees since 1991.<sup>66</sup>

58 Riordan, *supra* n 56 at 31.

59 *Ibid.* at 45–6.

60 Interview B.

61 This section focuses on the impact formula milk has on infants and children, as there is no physical health benefit derived for the mother (see above at section 2A), save for very extreme circumstances when breastfeeding would be adverse to the health, including mental health, of the mother.

62 Janmyr, *Protecting Civilians in Refugee Camps: Unable and Unwilling States, UNHCR and International Responsibility* (2013) at 119. See also [academic.oup.com/hrlr/advance-article/doi/10.1093/hrlr/ngaa046/6039453](https://academic.oup.com/hrlr/advance-article/doi/10.1093/hrlr/ngaa046/6039453), 'Complementary Protection and Encampment' (2021) 21 *Human Rights Law Review*.

63 Convention Relating to the Status of Refugees 1951, 189 UNTS 137.

64 Article 1A(2) Convention Relating to the Status of Refugees 1951.

65 Ramadan, 'Spatialising the refugee camp' (2012) 38 *Transactions of the Institute of British Geographers* 65 at 65.

66 UNHCR, 'Dadaab—World's biggest refugee camp 20 years old', (2012) UNHCR, available at: [www.unhcr.org/news/makingdifference/2012/2/4f439dbb9/dadaab-worlds-biggest-refugee-camp-20-years-old.html](http://www.unhcr.org/news/makingdifference/2012/2/4f439dbb9/dadaab-worlds-biggest-refugee-camp-20-years-old.html) [last accessed 4 June 2020].



Consequently, the infrastructure contains schools, shops and hospitals.<sup>67</sup> Children are born within camps,<sup>68</sup> and those born within camps go on to have their own children whilst still within a camp setting.<sup>69</sup>

However, irrespective of their stage of development, as refugee camps are routinely established within tight time-constraints and on unexpected foundations—owing to the nature of emergency situations, such as armed conflict, which force people to flee—they routinely suffer from certain problems. Refugee camps are often overpopulated, putting a strain on both resources and the living environment.<sup>70</sup> The cramped close quarters people live in afford little privacy, a global problem exacerbated by the fabric tent barriers commonly utilised.<sup>71</sup> Further, refugee camps are well known for extreme temperature fluctuations,<sup>72</sup> and inconsistent access to basic necessities including food, drinkable water and medical supplies.<sup>73</sup> The crowded environment and lack of cleaning facilities mean refugee camps 'are often subject to disease-ridden conditions'.<sup>74</sup>

### B. Formula Milk in Refugee Camps: Supply and Safe Production

The World Health Organization (WHO) states:

Inappropriate feeding practices lead to infant malnutrition, morbidity and mortality in all countries and . . . improper practice in the marketing of breast-milk substitutes . . . can contribute to this major public health problem.<sup>75</sup>

The WHO document, 'How to Prepare Formula for Bottle-Feeding at Home', clearly outlines the need for boiling water and sterilised equipment in order to eradicate the risk of harmful pathogens entering a child's digestive system, owing to their potential presence in the dry formula milk powder.<sup>76</sup> The guidance prefaces its instructions with a disclaimer that breastmilk is the recommended form of feeding on the basis of both nutritional values and also in order to mitigate the risk of infection and subsequent illness created by the inherent risks of formula feeding.

#### (i) Boiling Water

Refugee camps routinely have inconsistent and unreliable access to clean water.<sup>77</sup> Further, the means to boil water, such as access to fuel, a stove or wood to burn

67 Su-Ann Oh, 'Refugee Education in Thailand: Displacement, Dislocation and Disjuncture' in Demirdjian (ed), *Education, Refugees and Asylum Seekers*, 2nd edn (2012) 78 at 89.

68 Grayson, *Children of the Camp: The Lives of Somali Youth Raised in Kakuma Refugee Camp, Kenya* (2017) at 71–92.

69 UNHCR, supra n 66.

70 Van Damme, 'Do Refugees Belong in Camps? Experiences from Goma and Guinea' (1995) 346 *The Lancet* 360 at 361.

71 Interview B.

72 Smith, 'Greece: severe weather places refugees at risk at government under fire,' (2017) *Guardian*, available at: [www.theguardian.com/world/2017/jan/10/greece-severe-weather-places-refugees-at-risk-and-government-under-fire](http://www.theguardian.com/world/2017/jan/10/greece-severe-weather-places-refugees-at-risk-and-government-under-fire) [last accessed 20 April 2020].

73 Nicholson and Twomey, supra n 6 at 116.

74 Ibid.

75 World Health Organization, Preamble of International Code of Marketing of Breast-milk Substitutes 1981, supra n 13.

76 World Health Organization, supra n 2.

77 Hathaway, *The Rights of Refugees under International Law* (2005) at 477.

are not always available.<sup>78</sup> Given newborn babies feed at least eight times a day,<sup>79</sup> unreliable access to boiling water creates an immediate obstacle to safe formula milk supply and feeding. Illustratively, Interviewee C, met women in the remnants of the Dunkirk refugee camp, La Linière, who refrained from collecting and burning firewood to boil water. The reluctance stemmed from fires enabling French police to locate and evict the families ‘by destroying their sleeping bags and tents.’<sup>80</sup> Further, restricted access to water was also observed in the same campsite where approximately 100 men congregated and smoked cigarettes around the single water tap. Women were reluctant to approach and would wait for men from their own families to collect water from the tap. As a result, they were unable to make formula milk when needed and a bottle of formula milk could be left in high temperatures for several hours.<sup>81</sup> Once formula milk is made up, it becomes an ideal breeding ground for bacteria and needs to be consumed within an hour. The lack of refrigerators in refugee camps seriously increases the likelihood of bacterial growth and infection.<sup>82</sup>

Further, there have been accounts of women making formula milk with water from lakes and rainwater which pose a risk of serious infection, morbidity and mortality to children, particularly newborns and infants.<sup>83</sup> The inconsistent access to appropriate water, and the significant implicated ramifications, have both been specifically noted as undermining the safety of formula feeding within a refugee context from the outset.<sup>84</sup> Furthermore, water accessibility remains an issue throughout the lifespan of a refugee camp, in that a camp is dependent on external factors for basic amenity access at almost all times. In parallel, the need to obtain clean water for formula feeding also creates risk for women which will be further expanded upon in Section 5B.

(ii) *Appropriate Formula Quality and Quantity*

Formula milk powder is routinely supplied by aid distributors, governments and non-government organisations (NGOs) in refugee camps.<sup>85</sup> As outlined in Section 2B, once newborns and infants are introduced to formula milk, a dependency is created.<sup>86</sup> At this juncture, it is crucial to note that once newborns and infants have been initiated onto formula milk, a consistent supply is then needed to satisfy their nutritional needs for adequate growth.<sup>87</sup> Aid delivery blockages—for any reason—can result in limited or entirely inhibited aid supply to camps, which includes formula milk.<sup>88</sup> Interviewee C noted that the process of *becoming* a refugee and subsequently being forced to flee one’s

78 Interview C.

79 International Lactation Consultant Association, *Core Curriculum for Lactation Consultant Practice*, 3rd edn (2002) at 335.

80 Interview C\*.

81 Ibid.

82 Ibid.

83 Interview B.

84 Forbes Martin, *Refugee Women* (1995) at 38.

85 Interview B.

86 Interview A.

87 Ibid.

88 Kenyon Lischer, *Dangerous Sanctuaries: Refugee Camps, Civil War, and the Dilemmas of Humanitarian Aid* (2006) at 92.

country of residence and/or origin, saw a concurrent shift in the appropriateness of an infant feeding method:

'Formula feeding is common in Syria and could be done safely in their [subsequent refugee women] own kitchens but the mothers were not anticipating their homes being bombed. They fled with their formula-fed babies and how were they supposed to obtain formula milk on the move?'<sup>89</sup>

Within the context of refugee camps, alarming reports cite the panic and distress faced by formula feeding refugee mothers when formula milk powder became scarce or unavailable entirely. Accounts of mothers responding in dangerous and ill-educated manners have been the cause of multiple infant deaths in refugee camps. Interviewee B, the Founder of The Nurture Project International ('NPI'),<sup>90</sup> has encountered women in refugee camps who have diluted formula milk to a tenth of its intended and safe concentration when aid deliveries were reduced, as they misunderstood the effect of formula milk quality and attempted to create quantities of milk with which they were familiar.<sup>91</sup> Evidently, the quality of the milk was significantly compromised and infants faced both morbidity and mortality. NPI is also familiar with women who, when faced with the limited formula milk powder, have used any white powder available as a substitute, in the belief it would sustain their children.<sup>92</sup> Shocking accounts of newborns and infants being fed watered down coffee creamer have led to infant malnutrition and death in Mosul, Iraq.<sup>93</sup> Lack of formula powder has also led to mothers introducing maize meal and porridge to their children, both of which are nutritionally inappropriate for babies and incredibly harmful, especially for newborns and infants.<sup>94</sup> There are also reports of formula powder being sold on refugee camp 'black markets' during periods of shortage, at highly inflated prices, resulting in mothers and families paying disproportionate amounts of money, often sacrificing food for themselves and other children.<sup>95</sup>

In addition to this, there are reports of refugee camps receiving out of date formula milk donations, posing an immediate and serious risk to infants.<sup>96</sup> Exacerbating this is the matter of formula milk arriving with instructions in multiple European languages but not in languages that can be understood by the refugee population. Interviewees reported infants frequently being fed incorrectly made formula milk or the wrong milk entirely in error. Illustratively, newborns have been fed formula milk designed for older babies and which their kidneys cannot process, becoming seriously ill as a result.<sup>97</sup> Furthermore, tinned evaporated milk or sweet condensed milk, which offers no nutritional value, has been mistaken for liquid formula milk and fed to children.<sup>98</sup>

89 Interview C.

90 The Nurture Project International is a US based, grassroots, non-profit which provides Infant and Young Child Feeding support in emergency situations. More information is available at: [www.nurtureprojectinternational.org](http://www.nurtureprojectinternational.org)

91 Interview B.

92 Ibid.

93 Ibid. [\*]

94 Interview A.

95 Interview B\*.

96 Interview C.

97 Ibid.

98 Ibid.

Finally, from the viewpoint of those running refugee camps, storing formula milk is costly and takes up considerable space at the expense of other necessities, which can negatively impact refugee camp residents competing for storage space.<sup>99</sup>

(iii) *Available Equipment—Bottles and Teats*

Feeding formula milk requires several pieces of equipment: a bottle, a ‘teat’ that mimics a nipple, and a cap that acts as a protective cover. Formula milk can also be fed from small cups or containers,<sup>100</sup> which are easier to clean and reduce infection risk;<sup>101</sup> however, the notion of ‘bottle feeding’ is entrenched as a result of historical marketing campaigns, as further outlined in Section 6C(i) of this article. If unsterilised bottles and teats are used, babies can be exposed to harmful pathogens causing diarrhoea,<sup>102</sup> which is life-threatening to newborns and infants in the context of refugee camps.<sup>103</sup> It is extremely challenging to manage child diarrhoea in a refugee camp where families have limited, if any, access to showers and bathrooms. As washing machines are scarce, mothers often rely on baby wipes to clean infected stools and some communities rely on baby wipes to clean themselves in informal settings that lack washing facilities, significantly increasing the risk of cross-contamination.<sup>104</sup> Comparatively, citizens in residential homes are equipped to treat diarrhoea relatively promptly, and usually effectively, however, within a refugee camp, the health of children—and especially the health of newborns and infants—can quickly deteriorate.<sup>105</sup> Further reports of donated bottles and teats arriving in refugee camps with dried milk in them also clearly pose a health risk to infants and children.<sup>106</sup>

Formula milk is rife with complexities that are compounded within refugee camps and can be the cause of numerous health problems that do not occur when mothers breastfeed.<sup>107</sup> Women in economically developing countries are, or have historically been, exposed to aggressive misrepresentative advertising campaigns which prompted a regulatory overhaul of formula milk advertising, promotion, and depiction in the 1980s.<sup>108</sup> The same women, upon arrival in refugee camps, are offered formula milk powder by host state officials, NGOs and International Organisations (IOs). Women invariably interpret this aid allocation as an endorsement of the product and meaning that formula milk is advisable, suitable and even preferable to breastfeeding.

There are also nuanced scenarios to consider, for example, a woman may intend to breastfeed but when she has received formula milk from those in positions, or perceived

99 Forbes Martin, *supra* n 84 at 37–8.

100 World Health Organization, ‘How to Prepare Formula for Cup-Feeding at Home’, (2007) *World Health Organization*, available at: [www.who.int/foodsafety/document\\_centre/PIF\\_Cup\\_en.pdf?ua=1](http://www.who.int/foodsafety/document_centre/PIF_Cup_en.pdf?ua=1) [last accessed 5 June 2020].

101 Interview C\*.

102 CDC, *supra* n 33.

103 Interview C.

104 *Ibid.* [\*]

105 Interview A.

106 Interview C.

107 Forbes Martin, *supra* n 84 at 37–8.

108 Brady, ‘Marketing breast milk substitutes: problems and perils throughout the world’ (2012) 97 *Archives of Disease in Childhood* 529, at 529–32.

positions, of authority may see this as a recommendation to formula feed,<sup>109</sup> when, in actual fact, the state (or other agencies) do not recommend formula feeding to citizen mothers or, indeed, refugee mothers but the simple distribution of a product could imply, and therefore, in practice, amount to, endorsement.<sup>110</sup> Underpinning the acceptance of formula milk is a complex vulnerability contributed to by women in situations of 'poor security' accepting 'anything that is offered to them';<sup>111</sup> a sense of deference held by many refugee women to heed explicit or perceived direction from those in authority;<sup>112</sup> and the sustained belief that formula milk is superior to breastmilk as a result of aggressive formula milk campaigns in the 1930s and 1970s, as women were falsely informed their bodies produced inferior milk to formula milk, further expanded upon in the following section of this article. Unfettered distribution also reinforces the narrative that formula milk is a costly item, available freely in the economically developed world, and must therefore be the preferable option for more economically stable and advanced societies to which refugee mothers may aspire.

The overall landscape is multilayered and providing formula milk within this context can be 'disastrous',<sup>113</sup> given the likelihood of refugee women accepting formula milk without knowledge of safe administration and/or the tangible prospects of correlated hazards specific to the refugee camp setting. The unregulated approach of formula milk dissemination to refugee mothers has been criticised by paediatricians and academics as being irresponsible within this context.<sup>114</sup>

States have a responsibility to approach and oversee others who approach, refugees and refugee camps responsibly, sensitively and appropriately. Were a woman to receive formula milk in a maternity hospital after giving birth in a signatory country of the Code, it would amount to a breach. Yet, aid workers are permitted to distribute formula milk whilst wearing official uniforms. The discrimination is evident: refugee mothers are offered formula milk within a framework which lacks meaningful breastfeeding support and is heavily shaped by historical vulnerabilities. Contrarily, citizen mothers are shielded from formula milk advertising, as a result of a blanket ban on advertising and promotion, as a direct result of state endeavours to uphold their obligations under IHRL to educate, support and promote breastfeeding, to which the article now turns.

#### 4. THE NEXUS BETWEEN THE RIGHT TO HEALTH AND THE RIGHT TO ADEQUATE FOOD: NUTRITION AND HEALTH: IS THE CHOICE TO BREASTFEED A HUMAN RIGHT UNDER IHRL?

The right to breastfeeding education and support is contained within various IHRL instruments. This section will consider the right to support the choice to breastfeed, after which Section 5 of the article will assess the applicability of such a right within emergency situations.

109 Interview C.

110 Interview D.

111 Bauer, 'Breastfeeding: how one group fought the spread of formula milk in refugee camps', *Guardian*, 30 November 2016, available at: [www.theguardian.com/global-development-professionals-network/2016/nov/30/baby-bottles-camps-dangerous-refugee-mothers-breastfeed-greece](http://www.theguardian.com/global-development-professionals-network/2016/nov/30/baby-bottles-camps-dangerous-refugee-mothers-breastfeed-greece) [last accessed: 25 September 2020].

112 Interview D.

113 Ibid.

114 Bentley, Aubrey and Bentley, supra n 42 at 38.

### A. The International Code of Marketing of Breastmilk Substitutes 1981 and the Innocenti Declaration 1990

Aggressive marketing campaigns and approaches used by formula milk companies in the 1930s and throughout the 1970s exaggerated and, in instances, fabricated the benefits of formula milk,<sup>115</sup> significantly contributing to the global decline in breastfeeding. The success of formula milk companies, generating billions of dollars for formula milk companies,<sup>116</sup> as a direct result of this marketing approach, has been described as the 'catalyst' for a decline in breastfeeding.<sup>117</sup>

Unpalatable formula milk selling tactics directed at women from economically developing countries included saleswomen dressing as nurses in maternity wards and advising the use of formula milk over breastfeeding.<sup>118</sup> The presence of formula milk in maternity hospitals and the endorsement of salespeople purporting to hold medical knowledge implied the hospital and healthcare providers favoured formula feeding over breastfeeding.<sup>119</sup> Formula milk companies were accused of an irresponsible approach to child feeding which attributed to the deaths of infants from malnutrition as a direct consequence of intentionally disseminating deceptive information.<sup>120</sup> It was against this backdrop that the International Code of Marketing of Breastmilk Substitutes 1981 ('the Code')<sup>121</sup> was passed as an international health policy framework for the regulation of formula milk marketing. The overarching objective was established as protecting breastfeeding as the optimum method of infant and child feeding.<sup>122</sup> The decline in breastfeeding was determined by the WHA in 1974 to be attributed, at least in part, to 'sales promotion activities on baby foods' and urged states to 'introduce appropriate remedial measures, including advertisement codes and legislation where necessary' in order to counter the detrimental shift away from breastfeeding.<sup>123</sup> In 1978, the WHA revisited the issue and gave priority to preventing malnutrition in infants and young children by both supporting and promoting breastfeeding in parallel with efforts to 'regulat[e] inappropriate sales promotion of infant foods . . . used to replace breastmilk.'<sup>124</sup>

The WHA adopted the Code in May 1981 and it prohibited all forms of 'advertising [and] other form[s] of promotion to the general public' of breastmilk substitutes.<sup>125</sup> It is crucial to note that the Code and its subsequent resolution ban the promotion of breastmilk substitutes, although breastmilk substitutes can be legally marketed, sold

115 Brady, supra n 108 at 529.

116 Stevens, Patrick and Pickler, 'A History of Infant Feeding' (2009) 18 *The Journal of Perinatal Education* 32 at 35–6.

117 McCollough, 'A Perspective on the Impact of Formula Milk in Developing Nations: Future Goals and Policies' in Raphael (ed.), *Breast Feeding and Food Policy in a Hungry World* (1979) 129 at 132.

118 Ibid.

119 Rosenberg et al, 'Marketing Infant Formula Through Hospitals: The Impact of Commercial Hospital Discharge Packs on Breastfeeding' 98 (2008) 290 at 290, 292 and 294.

120 Coutsoudis, Coovadia and King, 'The Breastmilk Brand: Promotion of Child Survival in the Face of Formula-Milk Marketing' 374 (2009) *The Lancet* 423 at 423.

121 World Health Organization, International Code of Marketing of Breast-milk Substitutes 1981, supra n 13.

122 Ibid.

123 World Health Organization, Handbook of Resolutions and Decisions of the World Health Assembly and the Executive Board 1981 at 58.

124 Ibid. at 62.

125 Article 5.1 International Code of Marketing of Breast-milk Substitutes 1981, supra n 13.

and used.<sup>126</sup> The Code specifically affirms breastfeeding as a way to ‘improve the health and nutrition of infants and young children’ and endeavours to ‘overcome problems that might discourage [breastfeeding].’<sup>127</sup> In referencing breastmilk substitutes as a barrier, and therefore an ‘obstacle’, to breastfeeding, the Code takes a strong position on misleading formula milk marketing campaigns which gained huge amounts of traction in the twentieth century.<sup>128</sup>

The Code affirms ‘the right of every child and every pregnant and lactating woman to be adequately nourished, as a means of attaining and maintaining health’<sup>129</sup> and recognises breastfeeding as ‘an unequalled way of providing ideal food for the healthy growth and development of infants.’<sup>130</sup> In order to ensure the health of children by protecting breastfeeding, formula milk marketing is strictly regulated and governments are responsible for ensuring that there is clear and reliable information on infant feeding available to pregnant women, mothers and carers of children; furthermore, pictures and texts which ‘idealise the use of breastmilk substitutes’ are strictly prohibited.<sup>131</sup>

Article 5.2 of the Code prohibits ‘manufacturers and distributors [of formula milk] to provide, directly or indirectly, to pregnant women, mothers or members of their families, with samples of products.’<sup>132</sup> Building further on this, Article 5.4 of the Code expressly prohibits the distribution of ‘any gifts of articles or utensils which may promote the use of breast-milk substitutes or bottle feeding’ and Article 5.5 prohibits ‘marketing personal, in their business capacity . . . direct or indirect contact of *any* kind with pregnant women or mothers of infants and young children.’<sup>133</sup> The clear prohibition on freely-distributing formula milk in hospitals, by company employees wearing nursing uniforms, was a direct attack on business tactics and effectively disrupted formula milk companies’ methods and profits.<sup>134</sup> Significantly, soft law provisions explicitly assign governments the duty of controlling corporations,<sup>135</sup> meaning responsibility is held at a state level.

Further, governments are obliged to ensure health authorities promote breastfeeding,<sup>136</sup> and crucially, manufacturers and distributors are only permitted to rely on scientific and factual matters and ‘should not imply or create a belief that bottle-feeding [formula feeding] is equivalent or superior to breastfeeding.’<sup>137</sup> As a whole, the Code unequivocally chastised the aggressive formula milk marketing campaigns led by formula milk providers and distributors, clearly indicating that formula milk promotion tactics were not in the best interests of child health. Responsibility is clearly assigned at

126 Article 5.3 International Code of Marketing of Breast-milk Substitutes 1981, supra n 13.

127 Brooks, *Legal and Ethical Issues for the IBCLC* (2012) at 347.

128 Stevens, Patrick and Pickler, supra 116 at 35–6.

129 Preamble International Code of Marketing of Breast-milk Substitutes 1981, supra n 13.

130 Introduction International Code of Marketing of Breast-milk Substitutes 1981, supra n 13.

131 Article 9.2(d) International Code of Marketing of Breast-milk Substitutes 1981, supra n 13.

132 Article 5.2 International Code of Marketing of Breast-milk Substitutes 1981, supra n 13.

133 Articles 5.4 and 5.5 International Code of Marketing of Breast-milk Substitutes 1981 (emphasis added), supra n 13.

134 Black, *Children First: The Story of UNICEF, Past and Present* (1996) at 75.

135 Article 11(2) International Code of Marketing of Breast-milk Substitutes 1981, supra n 13.

136 Article 6.1 International Code of Marketing of Breast-milk Substitutes 1981, supra n 13.

137 Article 7.2 International Code of Marketing of Breast-milk Substitutes 1981, supra n 13.

national levels and governments are unambiguously accountable for upholding formula milk companies' responsibilities towards women and children's health.<sup>138</sup>

Furthermore, the Code makes evident the need for support when establishing and continuing breastfeeding within the multiple references to the duties of health workers who, at the outset of the Code, are broadly defined as '... person[s] working in a component of such a health care system' to assist natural feeding, which in turn, acknowledges that breastfeeding requires support in a multifaceted manner.<sup>139</sup>

Reinforcing these provisions, the Innocenti Declaration 1990 committed governments: to ensure maternity services uniformly provided breastfeeding services; to take action to effect the Code's provisions; and crucially, to enact legislation to protect breastfeeding rights of women and to establish means for its enforcement with an independent body providing oversight.<sup>140</sup> The holistic approach to dismantling the damaging legacy of aggressive marketing campaigns and affirmative actions required of states to protect and promote breastfeeding all indicate the complexity and deep-rooted trauma caused by devastating formula milk marketing campaigns, the effect of which economically developing countries and/or countries with poor governance have continued to endure for generations.

Whilst the Code and Innocenti Declaration are non-binding, it is noteworthy that the majority of countries have enacted legislation or other legal measures in efforts to incorporate the Code's provisions (to varying degrees of integration and success) into national law<sup>141</sup> and these soft law provisions have been strongly persuasive.<sup>142</sup>

## **B. The International Covenant on Economic, Social and Cultural Rights 1976: Articles 11 and 12**

The International Covenant on Economic, Social and Cultural Rights 1976 (ICESCR)<sup>143</sup> provides for a range of rights. Its implementation is monitored by the United Nations Committee on Economic, Social and Cultural Rights (CESCR) and the treaty is legally binding on all state parties.

### *(i) Article 11: Right to an Adequate Standard of Living (Right to Food)*

Article 11 recognises the right to adequate food as a prerequisite to realising an adequate standard of living.<sup>144</sup> In 1999, the CESCR affirmed the 'right to food' as 'the availability of food in a quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances, and acceptable within a given culture.'<sup>145</sup> Further, food is required to be 'sustainable' in a way which does not 'interfere with the enjoyment of

138 Article 11.1 International Code of Marketing of Breast-milk Substitutes 1981, supra n 13.

139 Article 3 International Code of Marketing of Breast-milk Substitutes 1981 defines both 'Health care system' and 'Health worker' providing a broad range of individuals who may engage with a mother; and Article 7 directs '[H]ealth workers should ... encourage and protect breast-feeding', supra n 13.

140 UNICEF, Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding 1990.

141 UNICEF, National Implementation of the International Code of Marketing of Breastmilk Substitutes 2011.

142 Interview A.

143 International Covenant on Economic, Social and Cultural Rights 1966, 993 UNTS 3.

144 Article 11 International Covenant on Economic, Social and Cultural Rights 1966, supra n 143.

145 Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 12: The Right to Adequate Food (Art.11), 12 May 1999 at para 8.



other human rights.’<sup>146</sup> Elaboration was also given to the term ‘dietary’, clearly stating: ‘measures may therefore need to be taken to maintain, adapt or strengthen dietary diversity and appropriate consumption and feeding patterns, including breastfeeding.’<sup>147</sup>

(ii) *Article 12: Right to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*  
Article 12 ICESCR seeks to safeguard the highest attainable standard of physical health and makes particular reference to the ‘reduction . . . of infant mortality . . . for the healthy development of the child.’<sup>148</sup> Given that formula milk seeks to mimic breastmilk and replicate its health benefits as closely as possible,<sup>149</sup> it can clearly be reasoned that the physical health protection of breastmilk is unparalleled to any other form of infant feeding,<sup>150</sup> and is subsequently a means of realising Article 12 with relation to children.

The CESCR’s General Comment 14<sup>151</sup> sought to counter misconceptions that Article 12 indicated a right to be ‘healthy’, by affirming the Article sought to secure appropriate health support and included ‘the right to be free from interference’, as well as entailing ‘the participation of the population in all health-related decision-making at community, national and international levels.’<sup>152</sup> Crucially, General Comment 14 affirms the need for states to uphold ‘international obligation[s]’ and reinforces Article 2(1) of the ICESCR which obliges state parties to take steps ‘individually and through international assistance and cooperation, especially economic and technical’, meaning resources from outside state party territories should be maximised to fulfil and achieve provisions.<sup>153</sup> The same General Comment also affirms the fundamental concept of non-discrimination and the duty of economically developed states towards economically developing states is emphasised.<sup>154</sup> The precise nature of the duty is not stipulated but this can reasonably be regarded as a duty to ensure non-discrimination within sovereign boundaries as well as with respect to international development aid.

### (iii) *Reading Articles 11 and 12 together*

The combined reading of these rights is a rational interpretation of the Articles and indeed, of IHRL as a whole, which seeks to establish a framework where human rights intersect and give rise to a multitude of protections in order to provide the maximum amount of security for the individual. Within the context of infant feeding, not only should Articles 11 and 12 be read together legally, they must logically be read together, given the inseparable nature of successful breastfeeding and optimal nutrition.<sup>155</sup> Articles 11 and 12, when read together in an intersectional manner—as they were

146 Ibid.

147 Ibid. at para 9.

148 Article 12(2)(a) International Covenant on Economic, Social and Cultural Rights 1966, supra n 143.

149 Martin, Ling and Blackburn, ‘Review of Infant Feeding: Key Features of Breast Milk and Infant Formula’ (2016) 8 *Nutrients* 279 at 282.

150 Ibid. at 279.

151 Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), 11 August 2000 at para 1(8).

152 Murphy, *Health and Human Rights* (2013) at 42–5.

153 Ibid. at 42–3.

154 Ibid. at 44–5.

155 World Health Organization, ‘Country implementation of the International Code of Marketing of Breast-milk Substitutes: Status report 2011’ (2011) at Executive Summary.

intended to be, given the inextricability of rights—or even as independent rights, produce an overall right not simply to the food needed in terms of calorie quantity for survival, but rather as a right to nutrition, and as such, a right to nutritious food which focuses on the outcome of consumption: health promotion. This is compelling and underpinned when considering ‘globally, breastfeeding has the potential to prevent 800,000 under-five deaths per year if all children 0–23 months were optimally breastfed.’<sup>156</sup>

As stated in the introduction of this article, there is no right to be breastfed or to breastfeed but rather there is a right to receive support for the choice to breastfeed and states cannot negatively influence or encroach on this symbiotic aspect of the mother–child dyad. States are clearly responsible for ensuring clarity and factual accuracy on the health benefits of infant and child feeding. It is noteworthy that the ICESCR does not list non-derogable rights but as per General Comment 14, there is a ‘core obligation’ for all state parties ‘to ensure access to a minimum amount of essential food which is both safe and nutritionally adequate in order to ensure freedom from hunger’, in addition to this, state parties are required ‘to ensure reproduction (prenatal as well as post-natal) and child health care’, stating the two are of ‘comparable priority’.<sup>157</sup> The CESCR’s General Comment 15 also affirms the right to ‘ensure access to the minimum essential amount of water, that is sufficient and safe for personal and domestic uses to prevent diseases’.<sup>158</sup>

### C. The Convention on The Rights of the Child 1989

The preamble to the CRC firmly establishes that ‘childhood is entitled to special care and assistance.’<sup>159</sup> The CRC provides for the principles of non-discrimination;<sup>160</sup> the best interests of the child;<sup>161</sup> and the right to life, survival and development.<sup>162</sup> Article 3 of the CRC stipulates the central need for an approach that is in keeping with the best interests of the child. As such, Article 3 has been regarded as a ‘mediating principle to assist in resolving conflicts between rights where they arise within the overall framework of the CRC, and to evaluate laws, policies and practices concerning children which are not covered by express obligations in the CRC.’<sup>163</sup>

The CRC is unique as a legally binding human rights treaty that protects the full range of rights encompassed within the Universal Declaration of Human Rights in relation to children,<sup>164</sup> extending to and including social and cultural rights, and does not allow for derogation. Consequently, children are, in effect, afforded a wider range of rights than adults under the adult ‘equivalent’ treaties. Illustratively, the International

156 Ibid.

157 Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), 11 August 2000 at paras 43(b) and 44(a) respectively.

158 Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 15: The Right to Water (Arts. 11 and 12 of the Covenant), 20 January 2002 at para 37(a).

159 The Convention on the Rights of the Child recalls the wording of the Universal Declaration of Human Rights at this point in the preamble.

160 Article 2 Convention on the Rights of the Child 1989, *supra* n 15.

161 Article 3(1) Convention on the Rights of the Child 1989, *supra* n 15.

162 Article 6 Convention on the Rights of the Child 1989, *supra* n 15.

163 Alston and Gilmour-Walsh, ‘The Best Interests of the Child: Towards a synthesis of children’s rights and cultural values’ (1996) at 1.

164 Freeman, *supra* n 14 at 176.

Covenant on Civil and Political Rights permits for state parties to 'take measures derogating from their obligations' under the Covenant 'to the extent strictly required by the exigencies of the situation',<sup>165</sup> and requires strict justification given international discouragement to derogate from international human right instruments.<sup>166</sup> The non-derogable nature of the CRC reflects the vulnerability of children and the extent to which this is recognised in IHRL.<sup>167</sup>

(i) *General Provisions*

Crucially, Article 3(1) requires decision-makers and legislators to go beyond considering the best interests of the child but, rather, to make those interests 'a primary consideration.' The use of the word 'interests', as opposed to 'rights', indicates a broader concept of protection.<sup>168</sup> The consideration of interests reinforces the necessity to regard children's needs and well-being as a framework to work within.<sup>169</sup> This approach was reflected in the Australian High Court case, *Teoh*, which regarded 'concerning' as a 'wide-ranging application' and affirmed it was applicable in all action impacting children, including indirect effect.<sup>170</sup> In this approach, even if not the direct subject, should a child be affected, the best interests must be actively investigated and considered.<sup>171</sup> The main provisions of the CRC affirm the inherent rights to life and survival.<sup>172</sup> The primary responsibility for ensuring child survival and development is recognised as being with the family, with the pivotal role of a child's family emphasised in Article 5. Article 24(2) of the CRC sets out a comprehensive spectrum of duties with regard to 'appropriate measures' state parties are obliged to 'pursue' with Article 24(2)(f), specifically recognising the central function of the family in realising the good health of children.<sup>173</sup> Building on this, governments have a duty to create conditions that enable

165 Article 4 International Covenant on Civil and Political Rights 1966, 999 UNTS 171.

166 Müllerson, *Human Rights Diplomacy* (1997) at 81.

167 McAdam, *Complementary Protection in International Refugee Law* (2007) at 176.

168 Freeman, *supra* n 14 at 178.

169 *Ibid.*

170 A Deportation Order was made with respect to a Malaysian father of three Australian children. The Malaysian father was convicted of serious drug importation charges in November 1990, at which point his resident status application was pending. During his imprisonment term, Mr Teoh's resident status application was refused, and he applied for a review of the decision. Whilst the decision was upheld by the Federal Court, the High Court ruled that insufficient enquiry had been made into the effect of Mr Teoh's deportation on his children. The CRC, which Australia ratified in December 1990, required Australia to make 'active investigation into the impact on children' in order to give genuine meaning to CRC provisions. See *Minister of State for Immigration and Ethnic Affairs v. Ah Hin Teoh* (7 April 1995) 128 ALR 353 High Court of Australia, paras 442–3.

171 *Minister of State for Immigration and Ethnic Affairs v. Ah Hin Teoh* (7 April 1995) 128 ALR 353 High Court of Australia, para 30.

172 Article 6 Convention on the Rights of the Child 1989, *supra* n 15.

173 Article 24(2) Convention on the Rights of the Child 1989, *supra* n 15. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (a) To diminish infant and child mortality; (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution; (d) To ensure appropriate pre-natal and post-natal health care for mothers; (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

parents, extended families or communities to provide for their children and to avail themselves of the protection established within the CRC.<sup>174</sup> The CRC does not offer a clear definition of ‘appropriate assistance to parents and legal guardians’ but different Articles provide insight into the kind of services that are required from member states. Article 18(2) obliges state parties to ‘render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of the children.’<sup>175</sup>

Further, similarly to the CESCR, the Working Group of the CRC Committee has framed ‘resources’ in an expansive manner, encompassing ‘human, technical, organisational, natural and information resources.’<sup>176</sup>

(ii) *Breastfeeding Specific Provisions*

Article 24(2)(b) of the CRC directs for support and education on breastfeeding, as a matter of child health and nutrition, and has been described as ‘ground-breaking’, as it makes explicit the implied link between health and food in the ICESCR.<sup>177</sup> Article 24 of the CRC, as a whole, seeks to combat malnutrition and disease,<sup>178</sup> diminish infant mortality<sup>179</sup> and ensure appropriate post-natal care for mothers.<sup>180</sup> Specifically, the provision of nutritious food is made with a clear reference to an obligation to educate on the benefits of breastfeeding as a means of achieving this.<sup>181</sup> States are therefore required to educate families on the importance of infant and child nutrition as well as being responsible for enabling families to undertake safely their informed and preferred choice of feeding.<sup>182</sup>

The CRC aligns with UNICEF objectives and adds legitimacy to the organisation’s mandate when broaching matters of difficulty with governments, extending to and including children at risk or ‘in especially difficult circumstances’—ultimately, as one author states, the ‘convention [has] transform[ed] charity-orientated approaches to providing services for children into national obligations to give meaning to their

child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents; (f) To develop preventive health care, guidance for parents and family planning education and services.

174 Namazi and Sicola, ‘Kenya: the Convention as a framework for cooperation’ in Newman-Black and Light (eds), *The Convention and UNICEF experience at the country level* (1991) 24 at 26.

175 Article 18(2) Convention on the Rights of the Child 1989, supra n 15.

176 Committee on the Rights of the Child, Background document for working group 3: States Parties’ obligations: realizing economic, social and cultural rights. Are child rights a luxury during an economic crisis? 2009.

177 Bellows and Burbano de Lara, ‘Gender, Nutrition, and the Human Right to Adequate Food: Introducing Two Structural Disconnects and the Human Rights Processes Necessary to Address Them’ in Anne Bellows et al (eds), *Gender, Nutrition, and the Human Right to Adequate Food* (2015) at 76.

178 Article 24(2)(c) Convention on the Rights of the Child 1989, supra n 15.

179 Article 24(2)(a) Convention on the Rights of the Child 1989, supra n 15.

180 Article 24(2)(d) Convention on the Rights of the Child 1989, supra n 15.

181 Article 22(2)(e) Convention on the Rights of the Child 1989, supra n 15.

182 van den Boom, ‘Advancing Children’s rights through Parent Support Services’ in Liefwaard and Sloth-Nielson (eds), *The United Nations Convention on the Rights of the Child: taking stock after 25 years and looking ahead* (2006) 801 at 805.

rights'<sup>183</sup> and the recognition of the need to protect, promote and support breastfeeding is evident.

#### D. Convention on the Elimination of All Forms of Discrimination Against Women

The Convention on the Elimination of All Forms of Discrimination Against Women 1979 (CEDAW)<sup>184</sup> is a binding and non-derogable treaty with reservations permitted. Reservations amount to signatory states rejecting specific provision(s) of a treaty and can be made upon ratification, acceptance, accession or succession. CEDAW state parties are responsible for their own actions in addition to those perpetuated by private individuals and organisations. Article 12 of CEDAW outlines the IHRL provisions on health and requires States Parties to 'ensure to women appropriate services in connection with pregnancy . . . and the post-natal period . . . as well as adequate nutrition during pregnancy and lactation.' Whilst CEDAW does not specifically touch on breastfeeding beyond this reference, the Article clearly recognises differing needs for breastfeeding support which remain relevant in the context of refugee camps and where 'the health needs of female refugees in camps are the most frequently neglected.'<sup>185</sup>

The article now turns to evaluate the role and suitability of breastfeeding in refugee camps.

#### 5. GENERAL APPLICABILITY OF IHRL IN REFUGEE

##### CAMPS—CONSIDERING 'EMERGENCY' AND DEROGATION ARGUMENTS

Distinct and exceptional circumstances have historically led to special forms of protection.<sup>186</sup> The particular protection of the parent–child dyad has been recognised by the European Convention of Human Rights and has been reinforced by the CRC.<sup>187</sup> The latter affords special protection for refugees' specific needs given their precarious and vulnerable situation.<sup>188</sup> The right for states to derogate from protecting, promoting and supporting the choice to breastfeed is central within this examination, as: formula milk is largely supplied to refugee camps by states who are both bound by the IHRL provisions, as scrutinised in the section above; refugee camps are commonly within countries bound by the same provisions; and the same states customarily follow soft law provisions. Given IHRL duties to facilitate a mother should she choose to 'opt in' to breastfeeding are established in non-derogable treaties, in the absence of reservations which are arguably inherently incompatible with IHRL and further discussed below—a shift from this on a mass scale would legally be very challenging to justify.<sup>189</sup>

183 Black, 'Intro' in Newman-Black and Light (eds), *The Convention: Child Rights and UNICEF experience at the country level* (1991) 5 at 8.

184 Article 12 Convention on the Elimination of All Forms of Discrimination against Women 1249 UNTS 13.

185 Govindjee and Taiwo, 'The Protection of Women Refugees under the International Refugee Convention' in Islam and Bhuiyan (eds), *An Introduction to International Refugee Law* (2013) 379 at 393.

186 McAdam, *supra* n 167 at 175.

187 Preamble and Article 24(2) Convention on the Rights of the Child 1989, *supra* n 15.

188 Plender and Mole, 'Beyond the Geneva Convention: Constructing a *de facto* Right of Asylum From International Human Rights Instruments' in Nicholson and Twomey (eds), *Refugee Rights and Realities: Evolving International Concepts and Regimes* (1999) 81 at 100.

189 Interview A.

The unscrutinised delivery and distribution of formula milk in refugee camps is clearly at conflict with IHRL, yet, there is little dialogue as to why an established breach of norms has evolved to the point of established practice; indeed, formula milk is distributed by countries with strong track records of prohibiting formula milk promotion and affording rights to refugees in line with humanitarian commitments and obligations.

In broad terms, derogations are 'permissible' actions that would usually amount to non-compliance.<sup>190</sup> Derogations may be utilised during emergency situations, often in an 'attempt to reconcile individual and public interests'; permitting derogations allows for parameters of international supervision and often protects more human rights than non-derogable implementation.<sup>191</sup> However, given rights are most at risk during times of emergency, the need to promote health provisions is, in itself, a strong, moral and ethical argument reinforcing legal obligations.

States have historically regarded and therefore approached refugee camps as emergency settings thus rendering the use of special measures appropriate. This extends to and includes infant feeding. Whilst the emergency nature of a camp is inherent in its character, the temporal argument which sees states approach refugee camps as transient settings are undermined when new generations are born and raised in camps, as outlined in Section 3A. The time frame to return and resettle refugees extends beyond the non-existent timespan where neglecting infant feeding would lack impact on vulnerable newborns and infants. Any delay in establishing best practice would affect children's nutrition. There is an unavoidable need to equip refugee camps from the outset to render them fit for purpose with respect to child feeding. However noble the vision to disband refugee camps, to mitigate any detriment to children, breastfeeding support requires integrating into the make-up of the setting.

The application of IHRL provisions, particularly to children, on the distinguishing basis of nationality or immigration status, clearly amounts to discrimination, as foreign national mothers and children have no less health needs than citizens. Human rights scholars have argued that such discrimination amounts to inhumane and degrading treatment.<sup>192</sup> A 'reduced' legal status does not warrant the deprivation of rights as reflected by the absolute non-derogable nature of the CRC, the IHRL instrument which provides the strongest level of protection for choosing to breastfeed as a human right. Notwithstanding the CRC permitting reservations, these cannot be 'incompatible with the object and purpose' of the Convention.<sup>193</sup> To suggest inferior infant feeding for refugee children is consistent with the objectives of the CRC is fundamentally flawed and wholly unsustainable given Article 2 expressly prohibits 'discrimination of any kind'. Additionally, married with the inherent need to protect the health of vulnerable infants in refugee camps, it is problematic to justify reasonably, ethically and morally.

190 Higgins, 'Derogations under Human Rights Treaties' (1977) 48 *British Yearbook of International Law* 281 at 281–2.

191 Nystuen, *Achieving peace or Protecting Human Rights?: Conflicts Between Norms Regarding Discrimination in the Dayton Peace Agreement* (2005) at 184–5.

192 Dembour, *When Humans Become Migrants: Study of the European Court of Human Rights with an Inter-American Counterpoint* (2015) 270–1.

193 Article 51(2) Convention on the Rights of the Child 1989, supra n 15.

## A. General Breastfeeding Obstacles: Lacking Access to Information and Support

There are a number of common obstacles to breastfeeding, with a high proportion of women experiencing one or a combination during the early stages of establishing breastfeeding.<sup>194</sup> The ability to access relevant and needed information is a huge factor in breastfeeding.<sup>195</sup> A woman with access to the internet may search for common symptoms and be reassured that they are routine in the breastfeeding process; conversely, a woman in a refugee camp may lose confidence in breastfeeding and, without reassurance, may herself conclude that she is unable to continue and consequently stop breastfeeding despite wishing to continue.<sup>196</sup> Access to knowledge and expertise have been recognised in the Innocenti Declaration, which advocates access to specialist support, particularly in the earlier stages of initiating and establishing breastfeeding.<sup>197</sup> Underpinning this established provision is the broadly agreed notion that healthcare professionals who are poorly educated on breastfeeding constitute a significant barrier to breastfeeding.<sup>198</sup> The lack of reliable and available information and support is compounded by the fragmented nature of health services which intensifies the issue.<sup>199</sup>

## B. Refugee Camp and Migration Specific Breastfeeding Obstacles

Exacerbating the issue of limited assistance, which almost all women face, healthcare professionals, and those with expertise in lactation support, are rare within refugee camps despite the fundamental role they play in facilitating breastfeeding. The gap is often filled by NGO volunteers.<sup>200</sup>

A significant refugee camp specific issue manifests when women in camps need to queue for hours at a time to obtain aid packages, conflicting with the need to be with their infants in order to breastfeed frequently, as needed to establish breastfeeding in the first months of life. Owing to the length of time, extreme temperatures and the possibility of conflict arising between residents, which are cited as frequent with respect to aid, mothers prefer to queue without their children. A mother who needs to queue for aid is likely to turn to formula so that her infant can be fed in her absence.<sup>201</sup>

Additionally, women in refugee camps and on irregular migratory journeys are often tasked with sourcing water and fuel for the family.<sup>202</sup> Within the refugee and migration setting, collecting firewood or water to boil for the purposes of formula

194 Interview D.

195 Ibid.

196 Interviews B and C[\*]—Illustratively, women experience issues with a baby latching incorrectly, soreness and/or bleeding of nipples and milk ducts becoming blocked leading to mastitis: a serious infection and inflammation of the breasts. Women also need advice on how to safely take medication without affecting the baby through breastmilk consumption, quantum concerns, that is, how often and how long to breastfeed for. A range of services can be utilised with peer support primarily for encouragement and lactation consultants who are the most skilled and are able to diagnose tongue and lip tie in an infant which may hinder their ability to latch and feed effectively.

197 UNICEF, Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding 1990, *supra* n 140.

198 Biancuzzo, *Breastfeeding the Newborn: Clinical Strategies for Nurses*, 2nd edn (2002) at 8.

199 Helsing and King, *Breast Feeding in Practice: A Manual for Health Workers* (1982).

200 Interview B.

201 Ibid.

202 Forbes Martin, *supra* n 84 at 37.

milk preparation exposes women to risks, particularly if long or arduous journeys need to be made alone; women may find themselves vulnerable to gender-based violence (GBV), especially sexual, during the course of these activities.<sup>203</sup> Women who embark on irregular migratory journeys often prefer to wear incontinence pads overnight than risk travelling to toilets, as it is unsafe to do so at night.<sup>204</sup>

Similarly, beyond the physical parameters of the refugee camp, and whilst looking at the entity of a migrant mother as a whole, breastfeeding a child allows for feeding continuation in the event of continued migration, should a woman be forced to relocate quickly. During empirical interviews, an interviewee recalled a Yazidi woman who fled from her home village following an attack by the jihadist military group, Daesh. After 10 days of hiding in a mountainous area with her 2-year-old child and without food, she arrived in a refugee camp in Iraq. The refugee mother simply stated: ‘if I was not breastfeeding him, he [the child] would have died.’<sup>205</sup>

### C. Cultural Factors

The cramped nature of refugee camps leads to a lack of privacy which is of relevance as refugee women frequently originate from countries with potentially conservative social/cultural norms. Breastfeeding in front of an unrelated man is likely to be culturally inappropriate and, as such, prohibits a mother from breastfeeding freely and in comfort.<sup>206</sup> Lack of privacy and space to initiate and continue breastfeeding may ultimately undermine a mother’s confidence, which has been cited as a key component to successful natural feeding.<sup>207</sup> Embarrassment has also been reported as a reason for preferring formula feeding in societies where publicly exposed breasts do not align with social and/or religious customs.<sup>208</sup> Formula milk companies are also able to capitalise on this cultural sensitivity and impress on women the preservation of modesty and demureness which formula feeding allows, compounding the preference for formula milk in a manner that is clearly both targeted and discriminatory.<sup>209</sup>

### D. Discriminatory Advertising of Formula Milk in Economically Developing Countries

The formula milk industry received huge criticism for its approach to economically developing countries<sup>210</sup> in the 20th century, particularly those previously colonised by European states.<sup>211</sup> Marketing tactics deployed by formula companies utilised almost all means of the then modern methods of consumer promotion: billboards, loud-speakers and widespread advertisements.<sup>212</sup> Women were bombarded with positive slogans and imagery of formula feeding and women were compelled to resort to formula

203 Ibid.

204 Interview C.

205 Interview B.

206 Interview B [\*].

207 Goode et al., ‘Breastfeeding in Today’s Culture’ in Black, Jarman and Simpson (eds), *The Support of Breastfeeding* (1998) 3 at 28.

208 Interview C.

209 Interview B.

210 McCollough, *supra* n 117 at 129.

211 Ibid. at 131–2.

212 Ibid. at 132.



feeding, in order to provide their babies with nutrients they were falsely told their bodies would not provide. These notions were often passed on to women hours after birth, when they were incredibly vulnerable and the aggressive marketing tactics were, rightly, condemned for being exploitive.<sup>213</sup>

Illustratively, underpinning the Code and Innocenti Declaration are the mass number of African women who succumbed to targeted campaigns of formula milk fuelled by the advertising of plump white babies on tins—narratives which were dangerous in times of famine.<sup>214</sup> Aggressive sales tactics used these images to portray to mothers that wealthier women in more economically stable countries formula-fed their babies as they could afford to. Formula milk became a status symbol for those who could afford it.<sup>215</sup> The presence of formula milk in affluent urban neighbourhoods, in economically developing countries, indicated that formula feeding was an aspirational middle-class undertaking to which many aspired.<sup>216</sup> Labels stating ‘made in Europe’ also implied advancement in the design and manufacture of the product and introduced a racialised dynamic which exacerbated the issue.<sup>217</sup>

The western culture viewed and, to some extent, continues to view a ‘good’ baby as one who gains weight predictably and sleeps for long periods.<sup>218</sup> Formula-fed babies often sleep for longer as formula milk is not as easily digested as breastmilk, owing to curds forming in an infant’s stomach. A formula-fed infant appears satisfied for longer as she feeds less frequently than a breastfed baby. The association between sleeping for longer and needing to feed less often has been, and is still, misunderstood as normal and desirable infant behaviour. When breastfed infants indicate a need to feed frequently, mothers and families question the ability of a mother’s breastmilk to satisfy an infant which can be confidence damaging.<sup>219</sup>

As the Code initially addressed, and as the Innocenti Declaration reaffirmed, the deployed marketing tactics played, and continue to play, a significant role in undermining breastfeeding in countries of poor governance, which are highly represented in refugee camps. The distorted approach towards breastfeeding and formula feeding is the culmination of years of marketing tactics and the entrenched views on formula feeding require addressing directly.

### E. Continued Promotion of Formula Milk

Whilst international soft law standards directly state, and IHRL can consequently be interpreted to direct: formula milk advertising and promotion are to be contained within strict parameters in order to genuinely protect, promote and support breastfeeding. However, there is a general lack of compliance in countries with poor governance owing to a number of reasons, the most prominent being monetary gain.<sup>220</sup> Formula milk representatives in countries that do not adhere to the Code exploit the lack of

213 Interview B.

214 Interview A.

215 Biancuzzo, *supra* n 198 at 4.

216 Interview A.

217 *Ibid.*

218 Interview D[\*].

219 *Ibid.*

220 Interview B.

regulation and accountability in maternity hospitals and continue to directly approach women in clear breach of international standards.<sup>221</sup> Overt advertising on television is prohibited as a result of the Code and so the ‘battleground’ has recalibrated itself, taking on a more oblique form, and has shifted from the advertising world to maternity and infant wards.<sup>222</sup> Corruption is a significant factor in countries with poor governance and healthcare professionals can be exposed and vulnerable to bribery and incentives. Illustratively, formula milk representatives in economically developing countries are encouraged by all expenses paid trips to Europe if they sell more formula milk than their regional competitors.<sup>223</sup> Better oversight, accountability and tougher sanctions are needed in combination to remove the financial driving forces which create an economic cocoon protecting salespeople who work in breach of international standards.

Many refugee women who arrive in refugee camps have already been discriminated against in that they may well have been victims of inaccurate and unlawful marketing and their compromised position within the above context must be taken into account when states seek to uphold their IHRL commitments. The promotion of formula milk is further compounded when women are offered formula milk in refugee camps—cultural and historical vulnerabilities are engaged with and states have a duty to holistically assess and evaluate the impression which is created on refugee mothers when distributing formula milk.

As established in the previous sub-section of this article, formula milk campaigns rely on the medically questionable attributes of formula milk that babies sleep for longer and cry less; both are attractive qualities in cramped quarters where there is no sound barrier between families in tents.<sup>224</sup> Furthermore, within the specific refugee context, women are keen to avoid their babies crying on journeys so as not to alert law enforcement to further irregular migratory journeys that routinely take place at night.<sup>225</sup> The culmination of social pressure can burden a mother in a refugee camp who may conclude formula feeding is the most appropriate environment-specific means of feeding.

The ever-present and indiscriminate distribution of formula milk in refugee camps is, therefore, an impediment to successful and exclusive breastfeeding given its capacity and inherent ability to interfere with successful breastfeeding. In order to mitigate this hazard, in instances when a mother wishes to breastfeed, a two-prong approach is needed: meaningful support to maximise the chances of successful breastfeeding and restrictions on blanket formula milk distribution in order to circumvent the undesirable effects of formula milk on effective feeding. Overall, better support for breastfeeding is needed in parallel with controlled distribution of formula milk.

221 Ibid. [\*]

222 Black, *supra* n 134 at 77.

223 Interview B.

224 Ibid.

225 Interview C.

## 6. HOW BREASTFEEDING SHOULD BE PROTECTED

### A. Supporting Breastfeeding: What are State Duties?

As the article has established in Section 4, states are the primary addressees of the treaties relating to breastfeeding and they must undertake their obligations irrespective of the legal status of women and their children. As analysed in the same section, in order to meaningfully realise the rights contained within IHRL provisions, such as the CRC, soft law directions must be reflected in a state's approach to child feeding and nutrition. Protecting breastfeeding, by not promoting formula feeding over it, is a correlative obligation that a state holds in order to respect non-interference and can be achieved by both banning the advertising of formula milk and stopping formula companies providing formula in hospitals. The presence and provision of formula milk in maternity wards is predatory and opportunistic in character, given the perception that formula milk supply could be interpreted as a medical endorsement. The potentially vulnerable state of a woman postpartum, particularly true of women on migratory journeys, also lends to a stark image of clear exploitation. The historical misinformation which was disseminated will require systematic reversal, which is logistically challenging given the remoteness of some of the locations in question. Without an adequate system to reverse the damage done, the effects of intentional misinformation will remain entrenched within countries unable to govern corruption or educate on a systematic scale—something which would require considerable political will.<sup>226</sup>

### B. Mapping Obligations: Ensuring Responsibilities are Assigned

Turning to refugee camps, states are directly and indirectly responsible for refugee camps within their borders. This is particularly salient given the historical and continual presence of NGOs and aid workers within refugee camps. In order to clearly assign duties, so as to maximise compliance with soft law provisions, states ought to designate a body, with the required expertise, both with respect to lactation and the refugee context, to have oversight of the intersection between women's and children's rights. The focus of such a delegated entity should be both the postpartum period and parental duties related to the nutrition of young children. Such an entity could comprise of a holistic maternal team that extends to and includes lactation consultants. Further, a clear channel of communication is needed between the state and those implementing and overseeing practice on the ground in the absence of direct government presence.

Additionally, government guidelines applicable to a camp setting and a designated entity must be clear, compliant with soft law and made known to those with decision-making capacity within the refugee camp. Donations of formula milk should be overseen: expired or inappropriate donations should be screened and prohibited from arriving in a camp. Government responsibility, if not taken on directly, must be consigned to an entity with an active presence in a refugee camp. As with refugee camps in Mosul, Iraq—which saw breastfeeding rates and child health increase exponentially, formula milk supplies should only be offered by those who are aware of their responsibilities with relation to soft law, who have the approval to do so at a camp level and who have

226 Black, *supra* n 183 at 12.

informed and educated refugee mothers of the health and practical implications of both formula feeding and breastfeeding.

During the operational stages of establishing a refugee camp, the onus is on a state to provide adequate resources in order to establish an engaged entity on the ground with overall oversight of children's nutrition. Such an entity must be appointed to hold authority that permits them to stimulate identified needed changes, in relation to aspects of a camp, to the benefit of refugee mothers and children.

Lactation consultants require training on the nuances of refugee situations and their obligations under international law to achieve comparable compliance between refugee and citizen mothers, which extends to and includes training on the impact of aggressive formula milk campaigns. The distribution of formula milk, by such consultants or entities, should be solely conferred to an appropriate delegated entity in the absence of direct governmental presence and oversight.

### **C. Identifying the Non-Economic Arguments for Uncontrolled Distribution Formula Milk: The Genuine Need for Controlled, Appropriate and Adequate Distribution**

An argument for unfettered formula milk distribution can be traced to biological origins, as a plausible position which could be taken against supporting breastfeeding in refugee camps, or other emergency situations, is likely to be entrenched in a mother's ability to: (a) produce breastmilk; or (b) breastfeed as a joint-undertaking with her newborn or infant. This is owing to a widespread consensus that a woman who is stressed—as a woman in a refugee camp would likely be—would be rendered physiologically unable to breastfeed as a consequence.<sup>227</sup> However, this rationalisation is deep-rooted in misinformation and has been proven to be false for the majority of refugee mothers, as the inhibition of breastmilk production would require 'acute stress' which is 'sustained', and women in camps would not routinely experience this level of continued heightened anxiety.<sup>228</sup> Further, arguments against the suitability of breastfeeding in refugee camps stem from mothers being unable to produce the milk of adequate quality and quantity on the basis of an inadequate diet themselves. Biologically, a mother preserves weight during pregnancy for the purposes of having fat reserves which she then depletes through breastfeeding.<sup>229</sup> Furthermore, whilst additional calories are recommended, a mother is able to produce satisfactory milk on minimal additional calorific input,<sup>230</sup> and moreover, arguments founded in concern over the accessibility of food in refugee camps ironically acknowledge and indirectly recognise the risks in relying on aid—which is precisely one of the pertinent risks of formula milk. It is necessary to bear in mind that the optimum setting for breastfeeding is one free of pressure—physical and mental—and with unconstrained access to nutritional food.

227 Biancuzzo, *supra* n 198 at 32.

228 Pantelia, 'Why we're helping mothers to breastfeed in refugee camps', (2016) *Save the Children*, available at: [www.blogs.savethechildren.org.uk/2016/04/why-were-helping-mothers-to-breastfeed-in-refugee-camps/](http://www.blogs.savethechildren.org.uk/2016/04/why-were-helping-mothers-to-breastfeed-in-refugee-camps/) [last accessed 6 June 2020.]

229 Hall Moran, 'Nutritional Needs for Lactation' in Davies and Deery (eds), *Nutrition in Pregnancy and Childbirth: Food for Thought* (2014) 35 at 36.

230 Wambach and Spencer, *supra* n 3 at 472 and Dudek, *Nutrition Essentials for Nursing Practice*, 7th edn (2013) at 274.

Whilst controlled distribution as a concept should adapt to a setting on a camp-by-camp basis, as a basic measure, formula milk should not be freely distributed but, rather, allocated to mothers who wish to formula feed at any stage of feeding. For formula milk supply to be beneficial to mothers and babies, it must be effective. Formula milk must therefore be provided in adequate quantities, be of adequate quality and be supplied with the necessary apparatus for safe consumption. Further, appropriate guidance, ideally in the form of training must be delivered with comprehensible instructions on how to prepare formula milk.

Finally, registering formula-fed babies permits those running camps to identify the specific needs of families and to discern children reliant on formula milk facilitates ease of supply in both stable and unstable times. Dispensing formula milk in a more controlled manner would therefore be more beneficial to the health of mothers and children in refugee camps.<sup>231</sup>

(i) *At the root of the global issue: the historical hangover*

At a social level, work is needed to move away from bottle association with newborns and infants. The term ‘formula’ itself implies a scientific concoction and it begins the presentation of formula milk as scientific advancement.<sup>232</sup> The notion of its superiority is shown to be embedded in contemporary culture: birth congratulations cards feature images of feeding bottles which reinforce this association<sup>233</sup> and signs in hospitals, airports and other public spaces in economically developing countries still use bottles as images to indicate mother and baby rooms.<sup>234</sup> The social impact of formula milk advertising can be seen in East Africa where relatives give tinned formula powder as gifts to a mother following childbirth.<sup>235</sup> Brazil, as an initiative to encourage breastfeeding, instigated a campaign both to normalise and promote breastfeeding by conveying positive messages and imagery in a systematic way through soap operas, on lottery tickets, and on bank statements, with considerable success.<sup>236</sup> Nothing less than a holistic, strategic and consolatory approach is needed, where governments and civil society collaborate together to advance children’s rights, including health and well-being, through the provision of parent support services.<sup>237</sup>

(ii) *Within refugee camps*

Within refugee camps, the indiscriminate supply of formula milk must be addressed as a priority and governments, IOs and NGOs must scrutinise the perceptions created by the distribution of formula milk to refugee mothers from economically developing states, as outlined in section 3B(iii) of this article.

It is mocking that in the worst emergency situations, when the health risks are highest to the most vulnerable subjects, the international community has defaulted to the poorest and pre-code standard of practice. The logical and IHRL compliant approach

231 Interview D.

232 Biancuzzo, *supra* n 198 at 3.

233 Renfrew, Fisher and Arms, *supra* n 54 at 222.

234 *Ibid.* at 221.

235 Interview A.

236 Black, *supra* n 134 at 76.

237 Forbes Martin, *supra* n 84 at 37.

would be for states to have emergency infant and child feeding protocols in place, which would be applicable to refugee camps and other emergency situations. Initiating and organising pre-planned support services to begin when people flee and cross borders to take up residence in refugee camps would allow infant and child feeding to be effectively addressed at the outset of an emergency situation.

#### **D. Educating the Carers of Infants and Children on the Benefits of Breastfeeding and the Risks of Formula Milk**

In order to comprehensively support and therefore, promote breastfeeding, there needs to be access to information which is a crucial component of establishing and sustaining breastfeeding. Women need access to the internet, information through reading material and/or healthcare practitioners in addition to support networks. Education cannot be limited to breastfeeding as women who choose to formula feed need to be informed on how to safely prepare formula milk for their infants and children. In order to educate and equip mothers in refugee camps, existing norms and instruments should be utilised and adapted, an approach advocated by Pacheco Pacifico and Pires Ramos.<sup>238</sup> This should entail education through the usual channels: access to material and expert support in appropriate ways. The use of adapting existing mechanisms at an implementation level, known as ‘regime stretching’, is optimum in impact within emergency situations.<sup>239</sup> Simple reading material, with imagery and in languages understood by refugees, would allow for information dissemination which could realistically be understood and acted upon by literate and illiterate mothers. Equally, the provision of healthcare professionals, who are well-versed and up-to-date on breastfeeding support and practices, would assist women and children. This is further reinforced and proven relevant when consider that ‘breastfeeding, perhaps more than other topics in health-care, is strongly affected by the personal attitudes, beliefs, and values of the healthcare provider.’<sup>240</sup>

#### **E. Support Breastfeeding**

On a practical level, women in refugee camps require access to support services and expertise in the same manner citizen women do. Support services should be free and those providing support and expertise should be trained appropriately and be aware of their obligations under IHRL and relevant soft law provisions. This is particularly fitting given that health workers still rely on out-dated books that contain inaccurate advice.<sup>241</sup> Furthermore, support should be provided at the outset, as the likelihood of successful breastfeeding increases with early establishment,<sup>242</sup> and should be readily available in refugee camps and continue on to temporary accommodation when mothers and children are housed.

238 Pacheco Pacifico and Pires Ramos, ‘Humanitarian Asylum for Forces Migrants: The Case of Haitians’ Arrival in Brazil’ in Gauci, Giuffrè and Tsourdi (eds), *Exploring the Boundaries of Refugee Law* (2015) 218 at 239.

239 Ibid.

240 Biancuzzo, *supra* n 198 at 8.

241 Renfrew, Fisher and Arms, *supra* n 54 at 223.

242 Bentley, Aubrey and Bentley, *supra* n 42 at 12.

Whilst support groups providing medical assistance are vital, compassion and emotional support are also much needed by postpartum mothers and are even more necessary for refugee mothers.<sup>243</sup> Peer-group support is of considerable benefit to refugee mothers,<sup>244</sup> as they often lack the family networks who would have assisted with their breastfeeding efforts had they not been forced to flee their country of origin and/or residence. Further, safe spaces are needed to allow for breastfeeding in an environment that is conducive to feeding: temperature regulated, safe and with adequate privacy.<sup>245</sup> The threat of GBV means that women need an environment where they can comfortably undress/expose their breasts, without risk of privacy intrusion and violence. It is here that the need for mother/child tents in refugee camps is evident.

### F. Practical and Logistical Measures

Further, queues for aid, services—including medical—and administrative obligations, should be tailored to women who have infants, given the frequent amount of breastfeeding which is needed at the outset. This may mean separate queues for breastfeeding mothers or the setting up of appropriate spaces next to queues so that women with infants can leave and return to fulfil their tasks.<sup>246</sup> These adjusted approaches to queuing are, of course, second to breastfeeding mothers not having to queue for food/aid at all, and instead having aid delivered to them. Finally, pregnant and breastfeeding mothers should receive extra culturally appropriate food quotas to supplement their diets.<sup>247</sup>

## 7. CONCLUSION

Be it intentionally or negligently, the dispersal of formula milk during emergency situations, in the knowledge that it affords lesser health benefits and reduced immunity to vulnerable children, arguably creates life-threatening situations that could otherwise be avoided.<sup>248</sup>

Refugee women are a ‘doubly disadvantaged’ category of women<sup>249</sup> and when infants and children depend on them, they are exposed to an inherently weaker position. When the best interests of the child absolutely rely on the provision of welfare by a caregiver,<sup>250</sup> to address refugee women and children distinctly in the remit of child health is nothing less than illogical and will immediately contravene with IHRL. Furthermore, children have increased vulnerability by virtue of their unprecedented mobility and the existence of international borders should not facilitate the victimisation of children who cross them, as the global community has a responsibility towards children caught in international situations.<sup>251</sup> Asylum-seekers and refugees must, in actuality and practice,

243 Dykes, *Breastfeeding in Hospital: Mothers, Midwives and the Production Line* (2006) 121–2.

244 Interview C.

245 Interview B.

246 Ibid.

247 Interview C.

248 Freeman and Veerman (eds), *The Ideologies of Children's Rights* (1992) at 206–7.

249 Govindjee and Taiwo, *supra* n 185 at 395.

250 Fottrell (ed), *Revisiting Children's Rights: 10 Years of the UN Convention on the Rights of the Child* (2001) at 152.

251 Higgins, ‘Interim Measures for the Protection of Human Rights’ in de Detrick and Vlaardingerbroek (eds), *Globalization of Child Law: The Role of the Hague Conventions* (1999) 87 at 89.

be firmly situated within a human rights framework which actively acknowledges and approaches the multiple dimensions of their situation. Much work is needed to make the children of refugee women equal subjects of the law.

As this article has analysed, the need to strengthen the application of IHRL and soft law provisions pertinent to women in order to realise children's rights is evident. Parenting has been recognised as being particularly challenging in 'low-income communities when circumstances, such as poverty, exposure to violence and health issues are rife,' and the struggle is undoubtedly intensified for parents to act as primary duty-bearers in the implementation of children's rights' in refugee camps.<sup>252</sup> Consequently, 'parental support must be viewed as an intervention for parents or carers aimed at reducing risks and/or promoting protective factors for their children in relation to their social, physical and emotional well-being.'<sup>253</sup> Given that children depend on their parents and other adults to safeguard their rights and as the family forms the 'basic protective unit for children,'<sup>254</sup> it is logical to deduce that parenting—the process of promoting and supporting the developmental needs of a child—is fundamental for upholding children's rights; as such, parents and family units must be empowered and enabled to do so.<sup>255</sup>

Whilst a commodity like a tin of formula may appear a suitable, and certainly more straightforward, an option to a state, IO or NGO looking to undertake their relevant actions towards refugees, it is a diffuse range of services needed both to (a) support and enable refugee mothers; and (b) comply with IHRL. Given the strict parameters of IHRL provisions applicable to protecting refugee children, the unfettered and ill-informed material on formula feeding in refugee camps, reinforced by the indiscriminate supply of formula milk against the backdrop of misguided cultural mind-sets, means states are failing to comply with IHRL, contravening soft law provisions and acting in a discriminatory and unethical manner. The protection of young life is a matter of human rights concerning the most vulnerable and to act in any way other than in strict conformity with the law, and in a manner which maximises all protections available, is a clear breach of and disregard for IHRL instruments. By virtue of nationality (and underlying socio-economic constraints), infants are being discriminated against and their health gambled with. Pre-code practices of formula milk marketing and provision in camps appear to be applicable and even deemed necessary without actual reasoning or due process.

In political terms, the duty to plan requires states and agencies to stretch time, to decompress and think in longer timeframes with consideration as to the wider interests of the child. In order to do so, temporal compression associated with emergency situations, which routinely sets norms and planning to one side, putting the camp beyond the law and beyond orderly public health, must be resisted. Planning is needed to respect the most vulnerable refugee camp residents as legal subjects, rather than

252 van den Boom, *supra* n 182 at 802–3.

253 *Ibid.* at 804.

254 *Ibid.* at 802.

255 *Ibid.*



the present approach of treating each as bare life.<sup>256</sup> The standard deviation from this position is a clear breach of IHRL and soft law as well as being unsustainable, both legally and morally.

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256 Agamben's political philosophy portrays refugees as the 'ultimate biopolitical subject' or 'bare life', regulated in a state of exception outside of the normal legal framework. See Agamben, *Homo Sacer: Sovereign Power and Bare Life* (1998) at 119–80.