# RIGHTS TO BOTTLE-FEEDING IN POOR COUNTRIES: WHAT IS REALLY AT STAKE? A RESPONSE TO DR. AGNÈS BINAGWAHO

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**Competing interests:** None declared.

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The article by Dr. Agnès Binagwaho in *Health and Human Rights*, Volume 10, Number 1, cannot go without a rebuttal, as the argument appears to rest on several fallacies. Recounting the skepticism that existed ten years ago about anti-retroviral (ARV) treatment in resource-poor settings and the success of activists in forcing the scale-up of access to treatment, Dr. Binagwaho argues that we should adopt a commensurate posture with respect to providing bottle-feeding for infants born to HIV-positive mothers. Although she does state that "[t]his is an area of great controversy, and experts deeply committed to children's well-being find themselves on different sides of the question," the rest of the article seems to assume that those who oppose her views on this: (1) are too willing to accept the failure to implement an effective distribution of breastmilk substitutes as a reason for not proceeding with such a distribution; and (2) fail to respect the human rights of African mothers to bottle-feed their children, as women in rich countries have the choice to do.

On the first point, Binagwaho wants to make us believe that shying away from supporting the feeding of infant formula to children born to HIV-positive mothers "is really an implementation failure that can be remedied through effective delivery strategies." She suggests that public health nutrition professionals who disagree with such a position are thereby implying that mothers in Africa "are not capable of preparing a baby bottle correctly." I am a public health nutritionist, and I am in no way implying that mothers in Africa cannot prepare a bottle correctly. Actually, that is totally beside the point.

Dr. Binagwaho challenges readers to think in terms of "practical implementation" options since "effective training combined with the appropriate technical *and* financial resources can ensure excellent delivery" of breastmilk substitutes to these infants. I do not doubt that this is true. *However*, the key here clearly lies in the "and" of her statement. Binagwaho bases her strong pro-formula argument on a study in Rwanda, which unfortunately is not available to the reader for scrutiny since it corresponds to an oral presentation in a meeting in Kampala. My contention is that the "and" is where the problem lies in her argument, as I assume (although I would be pleased to be corrected) that formula was provided free of charge to those mothers. That is *why* (to answer her question) effective training combined with the appropriate technical resources will *not* make breastfeeding substitution a workable solution.

Economic access to six or more months of infant formula supplies is not realistic for poor mothers in poor countries — nor, either, is access to clean water. Acknowledging this dire immediate reality is the real human

rights issue in this controversy, i.e., the economic discrimination against poor women. Failure to recognize this is, to me, an unacceptable oversight.

Of course we need to set the same human rights objectives for ourselves in the global South as those set in the North. However, as public health nutrition experts, it is our obligation to acknowledge the local reality of HIV and AIDS affecting important segments of the poor population in our respective milieus. That reality shows us that economic access to infant formula does not exist for vast numbers of affected women. It is overwhelmingly this reality that pushes us to aggressively promote exclusive breastfeeding for these infants given the current context — cognizant that this is not a risk-free alternative, but positively weighing it against the greater risks of bottle feeding.

There is an enormous difference between fatalistically accepting that ARVs cannot be made available in sub-Saharan Africa and selecting the best choice for mothers to feed their infants given the existing conditions. In short, as a matter of public policy, for the vast majority of public health nutritionists, promoting exclusive breastfeeding for infants born to HIV-positive mothers, when substitution remains an unrealistic goal, is still the right thing to do.

The morbidity and mortality data from numerous studies invariably support such a policy stance.[1] Binagwaho tells us that, in the study she cites, the rates of diarrhea and acute malnutrition in the "substituted children" were "not higher than those in the general population." However, the real questions are: (a) whether the rates were higher than in the exclusively breastfed children, as there is already an excess morbidity due to non-exclusive breastfeeding in the general population; and (b) whether the study group children were followed more closely with medical check-ups during the study.

The article implies that the extraordinary difference in outcomes between the study she cites and the literature supporting exclusive breastfeeding for infants with HIV-positive mothers lies in proper implementation and training. Binagwaho asserts that "when the means are available, what is criminal is to mismanage those means." But the problem is not that "when means are mismanaged they can be dangerous," although they can be. Nor are bad program managers the core problem, as Dr. Binagwaho at times seems to suggest.

The problem, as stated above, is fundamentally about access to economic resources, and a resulting lack of economic power. Binagwaho seems to believe that if activists would bring to bear the same political struggle around replacement feeding that they did in the issue of access to anti-retrovirals, the question would no longer be whether replacement feeding can be adopted, but rather how. Such a call would undoubtedly find its warmest reception in the milk industry which, of course, would use it in its own self-interest.

But the human rights framework requires us also to confront unfair economic power structures, and this leads to the second set of arguments that the article makes. Binagwaho writes, "universality is the very essence of human rights. It is, therefore, unacceptable to promote a two-tiered approach to . . . replacement feeding, because doing so implies that some people enjoy more human rights than others. It suggests that wealthy women's rights include being able to feed their children safely, while poor women's do not." The unfortunate reality is that "some people" *do* "enjoy more human rights than others" in practice, but not in theory. Our efforts to remedy that fact need to understand and proactively act upon the structural economic forces that keep women poor and deprive them and their children of their right to health, among other rights.

Binagwaho does mention, in passing, structural obstacles to expanding replacement feeding in low-income communities, citing "lack of infrastructure, unreliable access to water, lack of information, and many other factors." But the point is that these factors are not just obstacles to expanding bottle-feeding, but obstacles to women and children living lives of dignity and enjoying their inalienable human rights. Of course, all people are entitled to choices, as Binagwaho asserts. But the choice of whether to bottle-feed or not is not really at the forefront for a woman who cannot afford adequate food, has no adequate housing, nor access to safe water and sanitation, employment, and education, let alone a right to gender equality. To use a metaphor, arguing for the right to bottle-feed is at best like arguing for access to

a band-aid when faced with a hemorrhage. Poverty is the hemorrhage, and it is the dominant human rights violation endured by these women and children.

## Reference

1 . For two studies looking respectively at early weaning and prolonged breastfeeding, see, e.g., L. Kuhn, G. M. Aldrovandi, M. Sinkala, et al., "Zambia Exclusive Breastfeeding Study: Effects of Early, Abrupt Weaning on HIV-free Survival of Children in Zambia," New England Journal of Medicine 352/2 (2008), pp. 130–141; and L. Kuhn, P. Kasonde , M Sinkala, et al., "Prolonged Breast-feeding and Mortality up to Two Years Post-partum Among HIV-positive Women in Zambia," AIDS 19/15 (2005), pp. 1677–1681.