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QUESTIONNAIRE

Contact Details

Please provide your contact details in case we need to contact you in connection with this questionnaire. Note that this is optional.

Type of Stakeholder (please select one)	☐ Member State ☐ Observer State ☒ Other (please specify) Food systems, breastfeeding, health economics, and public health researchers and practitioners
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Can we attribute responses to this questionnaire to your State publicly*? *On OHCHR website, under the section of SR health	Yes Comments (if any):

Background

Within the framework of Human Rights Council resolution 51/21, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, has identified analyzing the progress and challenges to attaining the Sustainable Development Goals (SDGs) as one of the strategic priorities during her tenure, along with analysing the role of the underlying determinants of health, such as climate change and environment, water and sanitation, education and gender equality (See: A/HRC/47/28 para. 108). In compliance with her mandate and in line with these priorities, she has decided to devote her next thematic report to the General Assembly, to be held in October 2023, to the issue of "Food, nutrition and the right to health".

Objectives of the report

In the report, the Special Rapporteur will turn her attention to the underlying determinants of health, with a focus on how food and nutrition positively or negatively impact the right to health. In particular, she will rely on the frameworks of the social and commercial determinants of health to address how colonialism, racism, and other power asymmetries continue to build and maintain inequitable food systems and environments, influencing activities across the production, aggregation, processing, distribution, consumption, and disposal of food products,[1] and ultimately shaping the context in which consumers acquire, prepare, and consume food.[2] The Special Rapporteur's analysis will consider the double impact of malnutrition,[3] which refers to the co-existence of undernutrition with diet-related non-communicable diseases (NCDs) such as diabetes, cardiovascular diseases, and cancer. In this sense, she will emphasize that rights-based approaches to food and nutrition must reconcile and address both concerns, often misconstrued as competing. The Special Rapporteur will also report on new and emerging trends related to the impact of climate change, conflict, and COVID-19 on food and nutrition, as well as related responses.

Importantly, the Special Rapporteur will adopt an intersectional approach and consider the multiple forms of discrimination affecting persons in the context of food and nutrition. She will analyse the links between inequities in accessing adequate food and sex, gender, poverty, class, and the rural and urban divide, as well as related systems of oppression.

The Special Rapporteur intends to analyse the obligations and responsibilities of actors, such as States and corporations respectively, in relation to food and nutrition under the

[1] FAO, IFAD, UNICEF, WFP and WHO. 2020. The State of Food Security and Nutrition in the World 2020. Transforming food systems for affordable healthy diets. Rome, FAO, available at: https://doi.org/10.4060/ca9692en
[2] HLPE, Nutrition and food systems. A report by the High-Level Panel of Experts on Food Security and Nutrition of the Committee on World Food Security, 2017, Rome, available at: https://www.fao.org/3/i7846e/i7846e.pdf
[3] World Health Organization, The double burden of malnutrition: Policy brief, 2017, available at: WHO/NMH/NHD/17.3

framework of the right to health. The Special Rapporteur would therefore like to identify specific challenges and opportunities related to food and nutrition in countries and within communities around the world. She would also like to identify good practices that affirm the right to health in this context, as well as seek examples of how to combat discrimination in accessing adequate food.

Glossary of definitions for the purpose of this questionnaire:

- **Double burden of malnutrition**: refers to "the coexistence of undernutrition along with overweight, obesity or diet-related NCDs, within individuals, households and populations, and across the life-course."[4]
- **Food environments**: refer to "the physical, economic, political and socio-cultural context in which consumers engage with the food system to make their decisions about acquiring, preparing and consuming food."[5]
- **Food systems**: refer to "the entire range of actors and their interlinked value-adding activities involved in the production, aggregation, processing, distribution, consumption and disposal of food products. Food systems comprise all food products that originate from crop and livestock production, forestry, fisheries and aquaculture, as well as the broader economic, societal and natural environments in which these diverse production systems are embedded."[6]

Questionnaire

The questionnaire can be downloaded below in English (original language), French and Spanish (unofficial translations). Responses can address some of the questions or all of them, as feasible or preferred.

- Download the questionnaire (WORD): English | Français | Español

How and where to submit inputs

Inputs may be sent by e-mail by 24 March 2023.

E-mail address	ohchr-srhealth@un.org
E-mail subject line	Contribution to GA report - SR right to health
Word limit	750 words per question
File formats	Word, PDF (Please note that only word docs will be posted online)
Accepted languages	English, French, Spanish

Treatment of inputs/comments received

Please note that all responses will be published on the official webpage of the Special Rapporteur.

Key Questions

You can choose to answer all or some of the questions below. (750 words limit per question).

[4] *Ibid.*
[5] HLPE, Nutrition and food systems. A report by the High-Level Panel of Experts on Food Security and Nutrition of the Committee on World Food Security, 2017 Rome, available at: https://www.fao.org/3/i7846e/i7846e.pdf
[6] FAO, IFAD, UNICEF, WFP and WHO, The State of Food Security and Nutrition in the World 2020. Transforming food systems for affordable healthy diets Rome, 2020, available at: https://doi.org/10.4060/ca9692en

1. What are the major factors that challenge quantitatively and qualitatively adequate access to food and nutrition in your country and/or community (including external to your country)? Taking into consideration the underlying determinants of health, in what ways do they contribute to health inequities?

One major factor that challenges adequate access to food security and nutrition in many countries and globally, is the powerful influence of baby food corporations within 'first-food systems' – the food systems that provision foods for infants and young children (IYC) (1-3). Recent studies reveal how corporate and state practices associated with the marketing and promotion of commercial milk formulas, violate women's and children's rights, including the rights of the child to life, and to the best possible nutrition and health that breastfeeding enables (4). An enabling environment for breastfeeding, including adequate maternity protection, is also essential to realising the reproductive rights of women, their right to health, and their right to non-discrimination including in employment (5).

IYC diets are becoming increasingly ultra-processed (1). This is reflected in the rapid rise of commercial milk formulas in IYC diets nearly everywhere, coinciding with the displacement of breastfeeding (1, 6, 7), as well as extensive exposure to commercial complementary foods for young children, and ultra-processed foods that are not marketed specifically to children, but are now often consumed by them (8-10). These developments raise serious concerns for global health, given the lifelong importance of early nutrition, and the well-known harms to health associated with not breastfeeding (11), as well as evidence of the harms ultra-processed foods pose to both human health and the environment (12-15). The rapid growth of follow-up formulas and toddler milks is especially problematic from an environmental standpoint, given these foods are recognised as unnecessary for a healthy IYC diet, are unsuitable as breastmilk substitutes, and yet now comprise more than half of all milk formula market sales worldwide (3).

A major driver of this transition to more ultra-processed IYC diets, is the unconstrained globalization of the baby food industry, and the under-regulated spread of its aggressive marketing practices (2). The new 2023 Lancet Series on Breastfeeding describes this marketing as a sophisticated system 'designed to capture parents, communities, science and policy' (7). Companies are marketing directly to health professionals who have significant influence over parental decision-making, invest massively in direct-to-consumer advertising and promotion, and use product strategies such as 'cross-promotion' and packaging claims backed by little – or even no – supporting scientific evidence (7, 16). The power of these marketing techniques is further amplified through the use of digital technologies, that enable companies to conduct surveillance and precision targeting of women and parents, at a unique time of vulnerability (17). This system of influence undermines the rights of women and parents to fact-based information on IYC feeding, that is free from commercial influence (7).

The baby food industry's large dairy- and formula producing client nation states (US, EU, Australia and New Zealand), have also lobbied extensively to block the implementation of breastfeeding protection laws of other nation states through sub-arbitration processes in the World Trade Organization (WTO), and bilaterally, often claiming that breastfeeding protection measures are unscientific or exceed standards established by the Codex Alimentarius Commission, the lead UN food standard-setting body (2, 18). These same industry groups and nation states have strongly contested standards established in Codex, relating to the composition and labelling of milk formula products (19, 20). Lobby

groups established and coordinated by the baby food industry, have undertaken aggressive actions to block the implementation of the WHO's International Code of Marketing of Breastmilk Substitutes into national laws (2), described as a major commercial barrier to advancing global breastfeeding protection worldwide (3).

These behind-the-scenes activities of both industry lobbyists, and client nation states, violate or fail to uphold women's and children's rights. We call on United Nations human rights bodies to expand their monitoring activities to encompass WTO, Codex and other international organizations and settings, and to report on state activities that violate children's and women's rights (3). This may include the development of additional specific protocols to the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. States are obligated under relevant international human rights treaties to use maximum available resources to progressively fulfil human rights, including taking all necessary measures to support and protect the capabilities of women and IYC to breastfeed (4), and to protect and uphold children's rights in digital environments (21). This includes national and international collective actions to end the exploitative marketing practices of the baby food industry, including the promotion of commercial milk formulas and other ultra-processed foods, that undermine healthy and sustainable first-food systems.

2. What legislative or regulatory measures (such as those related to nutrition standards, labelling, marketing, procurement in institutional settings including – but not limited to – schools and prisons, and fiscal measures) have been considered or adopted in your country and/or community to improve food and nutrition, especially for persons in vulnerable situations? Where relevant, how are those measures being enforced?

Infants and young children are the most nutritionally vulnerable group and require special protection. To protect and support breastfeeding, multiple regulatory measures are required across ten key policy areas recommended by WHO/UNICEF in the Global Strategy for Infant and Young Child Feeding 2003 (22). Comparisons of progress in implementing these policies using the World Breastfeeding Trends Initiative show the gaps in regulation globally and for specific counties (23). These gaps, and a lack of national policy coordination, prevent equitable access to effective breastfeeding support and provide opportunities for misleading marketing and inappropriate use of products, which displace breastfeeding. The International Code of Marketing of Breastmilk Substitutes recognises the particular vulnerability of mothers and infants to marketing and promotion of formula. Forty years after WHO member states adopted the International Code of Marketing of Breastmilk Substitutes to end promotion of breastmilk substitutes, many have yet to fully implement its provisions, or those of subsequent World Health Assembly resolutions, into national law – a situation that reflects limited political commitment for breastfeeding, and actions by the baby food industry and client states to block its implementation (3). Another critical missing measure is national oversight and governance of IYF feeding policy free from commercial conflicts of interest, by governing bodies consisting of representatives with expertise in breastfeeding from government agencies, non-government organizations and breastfeeding mothers.

Australia provides examples of these gaps in policy and programs. Australia's National Breastfeeding Strategy (ANBS) and national Guidelines for Infant Feeding recommend that infants are breastfed exclusively to around six months, when complementary foods should be introduced while breastfeeding continues to 12 months and beyond. However, these guidelines fall short of the periods recommended by WHO, to breastfeed exclusively for six months and continue to 24 months and beyond. Four years after the

adoption of the ANBS, plans for strategy implementation are non-existent and the strategy itself remains largely unfunded. Regulatory measures that enable women's right to breastfeed in Australia, include The Sex Discrimination Act 1984; the Paid Parental Leave scheme which provides universal access to maternity leave for 18 weeks at minimum wage (to be extended to 26 weeks by 2025); and The Fair Work Act, which provides the right to unpaid breaks to breastfeed or express breastmilk, and for parents to request extended unpaid leave. However, for many women, workplaces do not make adequate provisions for breastfeeding employment, and it is costly and difficult to uphold these rights. For women in prisons or engaged in Family Law disputes, the rights of women to breastfeed are rarely upheld.

Australian food standards for infant formula products prohibit nutrition or health claims on infant formula products for children less than 12 months of age, have labelling requirements to include a statement that breastfeeding is best for infants, and prohibit the use of images of babies or words that imply equivalence with breastmilk. However, this regulation fails to protect breastfeeding from exploitative marketing and promotion, as it is inadequately monitored or enforced. Australia does not provide protection to parents and children from misleading marketing of commercial complementary foods for ages 4-36 months. Food regulation allows labelling of commercial complementary foods indicating from 4 months, the period of recommended exclusive breastfeeding. The Marketing in Australia of Infant Formula (MAIF) Agreement restricts marketing infant formula 0-12 months, but its scope and effectiveness are limited, and it does not prevent cross-promotion of follow-up formulas or growing up milks. The MAIF is an industry self-regulated code of practice that has no penalties and does not apply to the marketing of toddler milks for young children aged 12-36 months. Promotion of CMFs continues to be unregulated through digital marketing, and via the health system through unconstrained sponsorship of health professional education and training, journals, conferences and travel. The MAIF Agreement and its governance are currently under review.

3. In your context, have any legislative or regulatory measures attempted to simultaneously address undernutrition, on the one hand, and diet-related non-communicable diseases such as diabetes, cardiovascular diseases, and cancer, on the other hand? In doing so, have they been successful? Please provide concrete examples.

Breastfeeding women in all countries are effectively delivering a triple-duty action that simultaneously addresses undernutrition, diet-related non-communicable diseases, and climate change and other forms of environmental degradation (24). In this regard, breastfeeding women make vital – yet under-recognised and under-valued – contributions to sustainable food systems and human development, including through the prevention of multiple forms of malnutrition. Legislative and regulatory measures to protect, promote and support breastfeeding therefore enable the capabilities of women to deliver this foundational triple duty action. This is seen in countries such as India, that have fully legislated the WHO's International Code of Marketing of Breastmilk Substitutes into national law and sustained high levels of breastfeeding, contrary to comparable countries such as China, where absent or limited legislation has enabled the proliferation of milk formula markets, and the demise of breastfeeding for millions of women and children. Other examples of successful country-level actions and strategies are documented in the 2023 Lancet Series on Breastfeeding (25).

4. Beyond diet-related non-communicable diseases, food and nutrition are also relevant in relation to infectious diseases and other illnesses. For example, contaminated food can lead to foodborne illnesses, poor nutrition can make persons more susceptible to infectious diseases, and individuals living with infectious diseases and other chronic illnesses may have unique dietary requirements for health. Please describe any challenges and progress made in this regard in your country and/or within your community.

Commercial milk formula for infants is well known to be an unsterile product. Even when correctly prepared, there are intrinsic risks of contamination in the manufacturing process, yet few countries warn that this is not a sterile product, or that infection may occur even if prepared according to instructions. On the other hand, the unique immunological properties of breastmilk contribute to the reduced prevalence and of gastrointestinal, ear and respiratory infections in breastfed infants and young children in high income and low income countries (11). Despite this, the protection against infection and health gains and savings in health systems costs across all country settings have not attracted investment in breastfeeding in national budgets, particularly in high income countries (26). For very premature and low birthweight infants, the provision of donor human milk rather than infant formula halves the rate of a severe gastrointestinal tract disorder, necrotizing enterocolitis, if a mother is unable to breastfeed or provide her own milk (27). Expanding access to donor human milk banks is recognised as essential to reducing neonatal mortality associated with premature birth (28), and hence to realising children's rights to life, optimal nutrition and health.

5. Multi-stakeholder approaches to food and nutrition are often affected by power asymmetries that exclude persons and communities in situations of vulnerability.

    5.1. Please provide concrete examples of the barriers and opportunities for these persons or communities, such as Indigenous peoples, women, children, and migrants, to participate in national and/or international policymaking processes pertaining to food and nutrition, including the process of participation.

Barriers to breastfeeding by disadvantaged groups include a lack of access to health services with adequately trained health professionals to provide breastfeeding protection, promotion and support. This is pervasive in Australia with only a third of women and children being able to access maternity care which is accredited as practicing the WHO/UNICEF Ten Steps to Successful Breastfeeding under the Baby Friendly Hospital Initiative. Although women desire continuity of care through midwifery models, this is poorly funded and results in over-medicalised childbirth that disrupts optimal newborn care and nutrition. Indigenous women in Australia have a long tradition of exclusive and extended breastfeeding that has been badly disrupted by colonisation, and experience high rates of health disadvantage for acute (otitis media) and chronic conditions (diabetes) related to poor early nutrition as a direct result.

Aboriginal Controlled Women living in remote communities have sociocultural systems of breastfeeding support disrupted when they must access maternity services and give birth hundreds of kilometres away from where they live. In Australia, the 'Birthing On Country' program aims to provide local and culturally safe maternity services to Aboriginal and Torres Strait Islander communities. The development and delivery of this program is enabled through Aboriginal Community Controlled Health (ACCHO) primary health care services initiated and operated by local Aboriginal communities. Furthermore, Australian universities and medical education and training systems fail to adequately

prepare health workers to adequately support breastfeeding. Most health workers receive minimal or no preservice education on breastfeeding.

5.2. What proactive steps or good practices can you report on taken by the State to engage in activities to strengthen people's access to and utilization of resources for food security in this regard?

Infants and young children are uniquely vulnerable to food insecurity. Responsibility is too often implicitly devolved to their mothers, yet the key role of women in food provision and food security is poorly recognised and adequately resourced. Rapid and large-scale expansions in milk formula and other ultra-processed food markets, and the exploitative marketing that enables this proliferation, are commercial forces reducing breastfeeding. Such marketing places IYC at risk of food insecurity resulting from reliance on commercial supply chains vulnerable to disruption, contamination during production, natural and human caused disasters, and family financial stress. The ongoing formula contamination and shortage crisis in the United States, and the extreme food insecurity that has resulted for IYC and families, demonstrates the risk of dependence on expensive and fragile commercial supply chains, and baby food markets that are highly commercialised, and monopolistic in structure (3). Growing country dependence on milk formula and loss of breastfeeding capacity reduces first-food systems resilience, representing a crucial global food security, issue with large economic costs (29). Poor maternity protection, maternity services, and aggressive milk formula marketing are unaddressed causes of malnutrition and ill health. Investment in breastfeeding policy and national breastfeeding capacity builds national ‘first-food security’.

6. What is the impact of gentrification, development, technology, industry activity and deforestation on food security? Please share some concrete examples.

7. Please provide examples related to the impact of food production, on the right to health of the population living or the people working in or near the areas of production/cultivation?

The rise of ultra-processed foods in IYC diets creates environmental externalities, and exacerbates climate change risks to food security, by adding to high levels of land clearing, greenhouse gas emissions and high water use, packaging waste, and other environmental harms associated with dairy products (14, 30, 31). The proximity of a mother and her infant is essential for successful production of breastmilk and continued breastfeeding. Breastfeeding women have difficulty in sustaining their valuable productivity in care and nutrition if economic or other production systems require separation of mothers and children, for example, from ‘the areas of production’ (a breastfeeding mother’s body), by hospital or workplace policy, or disapproval of public breastfeeding. The Baby Friendly Health Initiative, which includes the proven effective ten-steps to successful breastfeeding, remains underfunded and therefore undersubscribed in many countries and worldwide (3). Breastfeeding friendly workplaces or childcare services are not widely available to breastfeeding women and children. Societies should re-structure their perceptions of production, work, and public spaces to welcome the presence of breastfeeding infants and mothers and their sociocultural systems of breastfeeding support, to provide food security for the most vulnerable.

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