SECTION IV

BACKGROUND PAPERS

THE GLOBAL INITIATIVE FOR MOTHER SUPPORT
GIMS for Breastfeeding

I. *GIMS explained*

The Global Initiative for Mother Support (GIMS) aims to create the appropriate environment of awareness and support for a mother to initiate and sustain breastfeeding. As defined by GIMS, mother support is any support provided to mothers for the purpose of improving breastfeeding practices for both mother and baby. The support needed varies from woman to woman but generally includes encouragement, accurate and timely information, humane care during childbirth, advice, reassurance, affirmation, hands-on assistance, and practical tips.

Moral and social support is needed from many persons in different places. Women need the support of professional health providers, employers, friends, family and the community. Conditions need to be created during pregnancy, birth and lactation so that women can safely carry healthy babies to term and give birth in the company of those they select to share this experience. Employed women should receive support for practicing exclusive breastfeeding for the first six months and continued breastfeeding after the introduction of complementary foods.

GIMS is based on an approach that respects human rights and women's reproductive rights. It emphasises gender-sensitive support services, women's right to good prenatal education and care, and respectful and women-centred birthing practices that give an appropriate and adequate measure of control to women. GIMS recognises the role of experienced women in the community who can share their wisdom on health, food and medicine. Men’s participation and community involvement is also fundamental to create the support needed by breastfeeding women.

The Global Initiative for Mother Support for Breastfeeding is further defined by networks of individuals and organizations concerned with breastfeeding support. While broad in scope, each organisation may decide to focus on implementing one element of the initiative. Some groups may focus on strengthening community support systems, others on mother-to-mother support, support groups, or health services.

Background Information

In 1990, policy makers from 31 governments, representatives of ten UN agencies, and other participants at a WHO/UNICEF meeting adopted the Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding. During the decade of the 90's, the Innocenti Declaration provided momentum for the global breastfeeding movement, particularly in launching the Baby-Friendly Hospital Initiative and strengthening implementation of the International Code of Marketing of Breastmilk Substitutes. The Innocenti Declaration also served as the driving force for setting international targets (particularly for policy issues and health services), increasing support for working women and establishing national breastfeeding committees.

In reviewing the current state of breastfeeding, WABA identified areas that need reinforcing. The Baby-Friendly Hospital Initiative (BFHI), focused on the infant, does not sufficiently address the needs of women. It is time to make BFHI more “mother friendly” by ensuring that antenatal, labor, delivery and postnatal care for the mother supports a woman's health and well being, recognising that such care also supports optimal breastfeeding. Pregnant women and those who have just given birth are often in a precarious situation due to fragmented services and lack of supportive policies, procedures, and practices in health facilities.

Gaps occur in the community as well as in health facilities. In traditional societies, relatives and close friends provided women with the support and practical advice needed to successfully initiate and maintain breastfeeding. In some places this traditional support structure still exists, but in other settings it has broken down.

Aware of these needs at both the health facility and community levels, WABA resolved to develop an initiative that gives heightened attention to the “support” component of the Innocenti Declaration and calls for strategic thinking around support for mothers at all levels.

II. Supporting evidence

Given the nutritional, immunological, and psychological benefits breastfeeding brings to mothers and babies, breastfeeding rates around the world continue to be distinctively low. Furthermore, a great majority of women who do start with breastfeeding, do not continue for more than two or three months. In 1997, 59.7% of US mothers breastfed upon hospital discharge, and only 21.6% were breastfeeding at 6 months.[1] Numerous studies have been undertaken to better understand what factors contribute to a woman's decision to initiate or persist in breastfeeding. Consistently, these studies have determined that although the reasons are complex, lack of support and assistance once a woman leaves the hospital have been key.[2] Successful breastfeeding is not innate in human beings and, hence it is imperative for the mother to gain knowledge through observation and support from the people around her. Confidence in breastfeeding is generated by people around the mother who provide information, and emotional and physical support. Support is an ideal method for the mother to obtain the knowledge and confidence needed to experience successful breastfeeding.[3]

In a study to identify the needs of 1520 Australian mothers, it was demonstrated that community-based breastfeeding support can be an effective way to increase rates of breastfeeding initiation, exclusivity and duration. It was found that most mothers need reassurance, and therefore seek support through support group meetings. "Breastfeeding Counsellors fulfil a vital role in the lives of those who come to them for help. They not only provide encouragement and information for those who wish to breastfeed, but as mothers themselves, are also able to provide much needed reassurance and support in relation to managing motherhood." [4]

VISION

Every woman irrespective of her circumstance of residence will have lay, professional and social support for breastfeeding and will receive the necessary information, education and encouragement enabling her to have the breastfeeding experience she and her child want.

PURPOSE

To put optimal outcomes for the mother and her baby at the core of steps taken in providing breastfeeding information, education, support and care.

FOCUS

On practices that specifically affect breastfeeding outcomes for women during their reproductive cycle (pregnancy, childbirth, post-partum and breastfeeding). This does not preclude reaching out with education or support before or after this period or to their support network (partner, relatives, friends etc).

GOALS

- To broaden the support for mothers beyond the breastfeeding period, to include support during pregnancy, birth and post-natal;
- To develop guidelines and tools for transforming birthing practices (that specifically affect breastfeeding) into a more humane and gender sensitive health care practice;
- To promote a global understanding of mother support that values and gives credibility to the role of mother support groups to strengthen both community mother support systems and national breastfeeding mothers' support groups;
- To promote step 10 of the BFHI, and develop guidelines for putting it into effect by broadening the understanding of breastfeeding support groups;
- To link and collaborate with other issue movements such as those working on natural/humane childbirth practices, family support, midwifery, women's health and rights, etc. in order to facilitate a holistic view on mother support; and
- To provide the impetus for changes in employment, health facility, and marketplace policies and practices so that women experience optimal pregnancy, birthing and breastfeeding outcomes.

It has also been found that breastfeeding needs to be addressed during prenatal visits. Most women make a decision about breastfeeding early in their pregnancy. It is important for the family doctor, midwife, or health care facility to be aware of this need and to repeatedly educate the parents on breastfeeding. The more information and support the mother receives before she makes a decision, can have a significant influence on breastfeeding outcomes. "Prenatal support, hospital management and subsequent pediatric and maternal visits are all important components of breastfeeding promotion. Prenatal encouragement increases breastfeeding rates and identifies potential problem areas." [5] In another study among women of different social and ethnic backgrounds in the United States, "women who were encouraged to breastfeed were more than four times as likely to initiate breastfeeding as women who did not receive encouragement." It was also found that "in populations traditionally less likely to breastfeed, provider encouragement significantly increased breastfeeding initiation, by more than threefold among low-income, young, and less-educated women; by nearly fivefold among black women; and by nearly 11-fold among single women." [6]

Mothers need more than a simple advice or instruction when breastfeeding. It is more likely that they will have a successful breastfeeding experience if they receive support from a wide range of people. It has also been shown that the most beneficial sources of support may vary depending on the women's age, social class, or culture; and the stage at which the mother is. In some cases it has been reported that the baby's father is an important source of social support. In another study on adolescent mothers, the results showed that for them it is more important for their friends to support breastfeeding. [7]

The importance of specific sources and types of support is affected by the stage at which the mother is. The need for early contact and support from health professionals may be important. Women have stated an increased need for advice and assistance during the first week of lactation, however many women prefer to rely on themselves than to seek advice from their doctor. Health professionals have to be aware of the needs of the mother and seek an active role as a support person helping women to feel comfortable in asking for their advice. [8] There may be important stages during pregnancy or after the baby is born for health professionals to effectively demonstrate their support.

Sociologists, anthropologists, and other experts on human behavior state that human beings need social interaction and are dependent on one another in many ways. This is even more important for those mothers who are expecting or taking care of their children. Mothers need other, more experienced women who have gone through motherhood, to guide them through the early days and weeks of breastfeeding. New mothers will also need the support and encouragement from more experienced mothers to sustain their breastfeeding relationship, ideally until the baby outgrows the need.[9]

It has been proven that the more support a mother receives from the people and services around her, the more successful and rewarding her breastfeeding experience. Furthermore, "interventions to promote breastfeeding must occur simultaneously on many levels and at multiple intervention points."[10] Although individual programs may focus on one of the elements important in mother support, they all need to come together in one overarching coordinated initiative.

III. Core issues

In the past, most societies had traditions where women helped and supported each other during pregnancy, childbirth and child rearing. There have also been strong social systems to protect and support the mother and the newborn baby, including breastfeeding support. Increasing urbanisation and dislocation of the extended family, however, have weakened these mechanisms of social support, while bottle-feeding has become one of the symbols of modernisation. The rising number of hospital deliveries have also changed birthing practices, from a very natural and women-centred practice to a very medicalised practice, alienating women from their reproductive powers. As a response, women in some societies lacking traditional support systems have formed their own support groups to cope with change.

The new millennium poses many challenges for mothers whose multi-faceted lives require different forms of support in different environments. The Global Initiative for Mother Support is aware of these challenges, and is therefore addressing the following issues to strengthen existing strategies and develop new ones to create the appropriate supportive environment for mothers around the world.

Supportive birthing practices, maternity care, and lactation:

- Issues surrounding a mother's experience of pregnancy and birthing may greatly enhance or negatively affect her breastfeeding experience. Mothers need to have the appropriate information and support.
- Create conditions in which women can safely carry healthy babies to term, give birth in the company of those people with whom they select to share this experience; and be together with their babies enough to ensure that 6 months exclusive breastfeeding and on-going breastfeeding after the introduction of complementary foods is possible.
- Nutritional support during pregnancy and lactation where and when there is household food insecurity.
- Appropriate care for women from those involved with her before and after her baby's birth-full communication, accurate and relevant information, and a respectful treatment and support in the choices she makes.

Breastfeeding support through reproductive health care and services:

- Breastfeeding has always been a part of the reproductive cycle. Support for breastfeeding must be placed in the context of greater support for women during pregnancy and childbirth.

Support from health services and health system within the community:

- A necessary range of professional health services for mothers, infants and young children, as well as on-going peer support in the community. Mothers need to have the tools necessary to have a rewarding breastfeeding experience.
- Healthcare service support is a significant factor in mother support. This includes not just improving health care workers' knowledge and skills in breastfeeding and childbirth management, but striving to assure a caring "bedside manner" that is the norm by everyone who comes in contact with a mother giving birth and after the birth.

Support for the working mother:

- There needs to be support for working women to be with the newborn for at least six months through paid leave, paid preferably through public funds.
- Support for working women can come through paid breastfeeding breaks and hygienic facilities for feeding or expressing/pumping milk up to one year after birth.

Support from national and international entities and organisations:

- Concrete government support and implementation of activities which would provide the optimal environment for breastfeeding – implementation of the International Code of Marketing of Breastmilk Substitutes, implementation of the Baby-Friendly Hospital Initiative with all 10 steps carried out, especially Steps 5 and 10, the implementation of relevant International Labour Organization conventions, and legislation to protect the rights of women who are breastfeeding.

Mother support from every aspect of society:

- Explore the different needs for mother support in changing societies – more women entering the formal employment sector, increase in a woman's earning power, breakdown of the extended family.
- Moral support from friends and family and the community can be achieved through positive and supportive social norms – involve family, friends, fathers, religious institutions, the public, media, etc.

IV. Recent Developments

GIMS Asia-Pacific Conference 2002
"Linking & Nurturing Mother Support and Strengthening Maternity Protection"
April 21-25, 2002; Kuala Lumpur, Malaysia

The goals of the conference were to highlight good practices that already exist, explore new support measures, share experiences across different cultural contexts and launch the GIMS network in the region, that will support mothers during pregnancy, birthing, breastfeeding and child care. The meeting was held with support from and in collaboration with the Norwegian Agency for Development Cooperation (NORAD), the Malaysian Ministry of Health and Ministry of Women & Family Development, World Health Organization (WHO), United Nation Children's Fund (UNICEF), and the Malaysian Trade Union Congress (MTUC). You can find the Conference Report at WABA website: www.waba.org.my.

During the conference particular attention was given to birthing practices, bringing to light the risk of disruption to breastfeeding that comes with many technological birth interventions, while prioritising access to basic maternity care and extending Safe Motherhood to all women. For the final two days the organizers placed special emphasis on women at work

and turned the attention to maternity protection. Representatives from trade unions, government, and women's reproductive health and rights groups met with breastfeeding advocates to discuss national laws, the chances for ratifying the ILO's new (2002) Maternity Protection Convention 183 and Recommendation 191, how to set up a worksite crèche, and ways to change the workplace from an obstacle to a supportive environment for breastfeeding.

From the GIMS meeting came a list of recommendations for different sectors-mother-to-mother support groups, employers, health care workers and community – as well as a list of people who will act as national focal points for GIMS activities. The Maternity Protection Seminar developed a regional plan for assessing and strengthening maternity protection at the national level.

New Zealand

- The Public Health Association of New Zealand adopted a Breastfeeding Policy at their Annual General Meeting (AGM) and Conference in late June, and are now starting to speak out on breastfeeding issues. The draft policy was written by Anne Heritage and Rosemary Gordon, LLL Leaders, with later minor amendments overseen by Anne Devereux, LLL Leader, and Julie Stufkens of the New Zealand Breastfeeding Authority, who together steered it through a Policy Roundtable and the AGM.
- LLL New Zealand continues to work on establishing a Peer Counselor Program; is networking with other organizations in New Zealand in childbirth, breastfeeding and parenting; and continues to lead the way in promoting World Breastfeeding Week in New Zealand.
- As a member of the New Zealand Breastfeeding Authority, LLL New Zealand is working on setting up BFHI in maternity facilities.
- Parents Centre has encouraged the formation of support groups after Childbirth Education classes and Postnatal courses finish.

Australia

- The Royal Women's Hospital has started changing their models of care to team care in response to community concern. They have also started looking at ways to facilitate best practice in their care of mothers and babies.

Peru

- Coordinated and implemented a conference with Soup Kitchens on the importance of supporting mothers. At the end of the Conference, the participants came up with a written declaration on how GIMS can be implemented.

V. Future developments

GIMS Latin American Conference 2002
"Strengthening Cooperation for Mother Support"
August 26-31, 2002; Lima, Peru

As an activity for GIMS and to celebrate World Breastfeeding Week in Peru, CEPREN/Red Peruana de Lactancia Materna y La Leche League Peru have organized the First 2002 Latin American Conference. The purpose of this Conference is to revise, share and discuss experiences significant to providing support to mothers within the GIMS framework. The meeting will bring together mothers, leaders, and professionals representing many Latin American countries, to discuss experiences and lessons learnt relevant to the focus and methodology of mother support for breastfeeding.

During the Conference the following topics will be covered:

- Mother support in every aspect of society
- A mother's right to practices that support birth and prenatal care
- Supporting breastfeeding through the reproductive cycle
- Human rights and women rights, reproductive health care and services, that include support for breastfeeding.

VI. Recommendations for action:

- Extend the Baby-Friendly Hospital Initiative (BFHI) to include good birthing practices in order to transform the BFHI into a Mother-Baby Friendly Initiative; with special emphasis on promoting Step 3 (antenatal), Step "3 ½" (nursing), Step 4 (early initiation), and Step 10 (mother support).
- Share models of community support programs to assist organizations to successfully reach out to the mothers they are helping.
- Link actively with UNICEF CARE initiatives and Global Movement for Children, and WHO Global Strategy on Infant and Young Child Feeding.

- Educate and influence attitudes toward breastfeeding in the community.
- Recognize and strengthen mother support groups and other community based support systems.
- Create working environments suitable for a working breastfeeding mother.
- Work with government agencies and NGOs to develop new guidelines for maternity care.
- Encourage creative means to teach reproductive health at schools.
- Link GIMS with the WHO global strategy and show that GIMS is taking care of the Mother Support component.
- Reflect on lessons learnt from the BFHI-effective coordination, good justification, focused/specific, getting government support.
- Promote the involvement of men and boys in maternal support and to form Mother Support Groups with traditional old people, family members, housemaids and NGO and others.
- Strengthen networking and an exchange of information, ideas and experiences among participants and across cultures and regions.

VII. Conclusion:

Many women benefit from some kind of support as they are thinking about breastfeeding during their pregnancy, through to the ending of their breastfeeding experience. The kind of support that is needed will vary from woman to woman and should cover things such as: encouragement, accurate information, timely information, hands-on assistance, practical tips, a visit, skilled lactation assistance, humane care during childbirth, a person to hear what she is thinking and feeling, etc.

GIMS emphasises the importance of promoting a wider perspective on mother support that recognises:

- that women need support throughout their reproductive cycle;
- that mother support includes and goes beyond mother-to-mother support;
- that every sector of the community has a clear role and responsibility to play in supporting mothers; and
- that useful traditional practices which support mothers should continue to be highlighted and strengthened, such as special foods, healing remedies, massage techniques, and holistic treatments of the mother and baby; and that new ones might be developed where there is a need.

References

1. Lawrence, Ruth. Peer support: making a difference in breast-feeding duration. *JAMC* 2002; 166(1):42-43
2. Lawrence, Ruth. Peer support: making a difference in breast-feeding duration. *JAMC* 2002; 166(1):42-43
3. Matich JR et al. A comparison of social support variables between women who intend to breast or bottle feed. *Soc Sci Med* 1992; 34(8):919-21
4. Grieve, V. and Howarth, T. The counselling needs of Breastfeeding Women. *Breastfeeding Review* 2000; 8(2):9-15
5. Moreland, Jay and Coombs, Jennifer. Promoting and Supporting Breastfeeding. *American Family Physician* April 1, 2000
6. Lu, Michael et al. Provider encouragement of breastfeeding: evidence from a national survey. *Obstetrics and Gynecology* 1997;(2):290-295
7. Matich JR et al. A comparison of social support variables between women who intend to breast or bottle feed. *Soc Sci Med* 1992; 34(8):919-21
8. Matich JR et al. A comparison of social support variables between women who intend to breast or bottle feed. *Soc Sci Med* 1992; 34(8):919-21
9. Betsy Liotus, 1996
10. Tiedje LB, Schoffman R, Omar M, et al. An ecological approach to breastfeeding. *Maternal and Child Nursing* 2002; 27(3):154-160

PREPARED BY:

Paulina Smith, WABA Mother Support Task Force Coordinator

Rebecca Magalhães, Director, External Relations and Advocacy, LLLI, and WABA Mother Support Task Force Co-coordinator

Natalia Smith, Special Projects Assistant, External Relations and Advocacy, LLLI.

July 2002.

Birth, Initiation of Breastfeeding, and the Early Days after Birth

by Mary Kroeger

Mother and Baby: A Partnership

The partnership of mother and baby is genetically programmed to support the physical, hormonal, and emotional events of pregnancy, labor, birth, and initiation of breastfeeding. The new mother is immediately ready to care for her newborn – to provide warmth, nourishment, and to protect her baby from harm and infection, just as occurred inside her womb. Initiating breastfeeding is easiest and most successful when a mother is physically and psychologically prepared for birth and breastfeeding, when she has information and support in moving through these events, and when she maintains a sense of her own empowerment in mothering.

Birth Events and Breastfeeding

In 1989, the UNICEF and WHO issued the Joint Statement – Promoting, Protecting, and Supporting Breastfeeding: The Special Role of Maternity Services, in which maternity hospitals are targeted for strengthening breastfeeding in the prenatal and early postnatal periods. While it is recognised that in many settings, birth still occurs at home, the rationale for targeting maternity facilities is that if the formal health sector establishes breastfeeding policy and improved practices based on sound evidence, this will ripple out to the community as well. The Joint Statement recommends ten principles, applicable in any setting, which are known internationally as the "Ten Steps to Successful Breastfeeding" (See Box 1). The WHO/ UNICEF **Baby Friendly Hospital Initiative (BFHI)** puts forth the "Ten Steps" as best practices for promotion and support of breastfeeding globally. Step Three addresses the prenatal period and the need for health education and Step Four addresses the importance of early initiation of breastfeeding. While the Joint Statement document itself discusses the importance of care for the mother during and immediately after delivery, this important period is not included in the "Ten Steps." Research is showing that some interventions in labour can support breastfeeding and others can have a detrimental effect on establishing breastfeeding. The "best practices," recommended in this Facts For Feeding are aimed at the essentially healthy mother, foetus, and newborn.

BOX 1

The Ten Steps to Successful Breastfeeding

Every facility providing maternity services and care for newborns infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to carry out this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.
7. Practice rooming-in – allow mothers and infants to remain together -24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.

Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Continuous Support in Labour

Continuous support to the mother during labour and birth can positively influence the ease of her delivery, reduce the need for medical interventions and increase her confidence in mothering and breastfeeding. Many hospitals still do not allow labour support companions in the maternity wards, but just as outdated routines were changed in the BFHI, this practice can be changed as well. Based on the convincing evidence of the importance of labour support to the well-being of mother and baby, it is recommended that maternity care include:

- COMPANION FOR LABOUR SUPPORT – Allow a mother to have continuous support during labour and delivery of a companion of her own choosing. Often this companion is a female relative, but it may be her partner, or a friend or neighbour.

- Training for Labour Support – When possible, provide some training for these companions (sometimes trained labour companions are called *doulas*) so that they can work with maternity staff to keep labour as normal as possible.
- "Normal" Labour Assistance – Include the labor companion in the role of helping to keep labor progress normal, by encouraging the mother to walk and move around in labour, by offering or "breastfeed on-cue") light nourishment and adequate hydration, by providing encouragement and telling her how well she is doing, and by suggesting ways to keep pain and anxiety from overpowering her.
- Training for Maternity Staff – Train maternity care staff (or home birth attendant) to include these companions as part of the birth team. Often when maternity facilities are understaffed, these labour companions provide essential one-to-one care to the mother in labour.

Pain Relief in Labour and Birth

Most mothers experience some level of discomfort and pain during labour and delivery, and pain management measures are important. In some settings, medication is offered to a mother in labour to reduce pain from contractions and to help her relax. All of the common labour pain medications have some impact on the newborn, and in some cases breastfeeding and early bonding with the mother may be negatively affected (see box 2). Alternative ways of managing the pain and anxiety of labour and delivery should be encouraged, or at least tried first, before offering labour pain medicines. These methods all serve to reduce mother's anxiety and fear, thus reducing adrenaline, which when secreted by the mother serves as an antagonist to oxytocin and slows her labor. Specific suggestions for alternatives to pain medicines include:

- Education – Encourage the mother during her pregnancy to learn about the stages of labour, what to expect as contractions get stronger, and to learn some drug-free ways to cope with labour pain. Mothers also need to be informed about the side effects of labour medications on themselves, their newborn and on early breastfeeding success.
- Position changes – Encourage the laboring mother to not stay in bed, but rather to stand, walk, sit, squat, use hands and knees, and other positions both to assist with coping with contractions and to speed the course of labour naturally.
- Touch and Massage – Offer massage of her back, face, legs, feet, or other areas if the mother welcomes such touch. Locally available oils such as olive or coconut oil are useful for this. Touching the mother actually increases her own body's oxytocin secretion (the hormone that stimulates labor contractions) and may both reduce the stress of labour and encourage oxytocin secretion. Just holding a mother's hand provides comfort and decreases anxiety.
- Water – Where possible and culturally appropriate, offer a warm shower or bath during labour. Water (sometimes called "hydrotherapy") is associated with greater relaxation and pain relief for many mothers in labour. Immersion in a tub of water during

BOX 2 Medication for Labour Pain

Narcotics used to relieve labour pain, like pethidine (Demerol) and morphine, are given by injection or in the intravenous drip, are rapidly absorbed by the foetal bloodstream through the placenta and may result in a baby with respiratory depression at delivery and persistent lethargy and inability to attach at the breast well for several hours. These medicines are still widely used in some countries and are included in recently published WHO / IMPAC Guide for Midwives and Doctors (WHO, 2000) as appropriate analgesics. Newer "synthetic" narcotics, while clearing the mother's system faster than the earlier narcotics, still have some impact on newborn's reflexes, alertness and this can persist for several days.

Epidural anesthesia, medicine injected into the space above the mother's spine thus numbing her lower body, has been associated with increased instrumental and cesarean deliveries, increased need for augmentation of labour, maternal fever, and a negative impact on certain newborn motor skills and orientation behaviour. The jury is still out about how "safe" for baby the epidural anesthesia is and mothers must be informed about the added risk of epidurals causing labour complications, including maternal fever, and the increased risk of separation from her newborn after delivery. Mothers and maternity care staff need to be fully informed about the risks versus benefits of any pain medication given in labour.

labor is best done with the help of a birth attendant who is knowledgeable in this technique.

- CONTINUOUS LABOUR SUPPORT – Encourage continuous support in labor by someone with whom the mother feels comfortable. As mentioned, this can decreases both the mother's perception of pain and also her need for pain medication. When such a person is not available from the mother's own family or circle of friends, the health care worker, a nursing or medical student should provide close support and care.

Caesarean Section

Sometimes, even with optimal care and support, labor progress is not normal, complications arise, and a cesarean section (CS) or instrumental delivery (with forceps or vacuum extraction) is necessary to ensure a healthy mother, baby, or both. A mother delivering by caesarean must recover from major abdominal surgery, must cope with incision pain and possible side effects of anesthesia, she may have hypertension, infection, or other medical complications. If the mother or baby is ill, they may be separated at birth. She may have to emotionally adjust to the fact that she was unable to deliver normally, possibly after a long, difficult labour. Thus CS, particularly an emergency CS, may interfere with early mother-baby bonding and initiation of breastfeeding. If the mother has had a caesarean she will need special support and care. This care should include:

- EARLY CONTACT WITH HER BABY (WITH SKIN-TO-SKIN OR AT LEAST CHEEK-TO-CHEEK) – Offer the opportunity for the mother to see, touch, and hold her baby as soon as she has regained consciousness from anesthesia. Babies born by CS can be held close to the mother's cheek right after delivery. Also involve the woman's partner or other relatives in the early care and holding of the newborn while the mother is in the postoperative recovery area.
- EARLY INITIATION OF BREASTFEEDING – Offer early initiation of breastfeeding, if possible within the first 1-2 hours while the newborn is still alert from the delivery. A knowledgeable health care provider will need to help the mother with optimal positioning and attachment.
- TEACH EXPRESSION OF COLOSTRUM – If the mother and infant have to be separated for medical reasons, help the mother to learn hand expression of breastmilk and to save her colostrum for the baby. Teaching the mother to effectively express her colostrum, either by hand or with a pump, will help avoid engorgement on the second to third day after delivery when the milk "comes in." For a mother recovering from a difficult or surgical delivery, it is very important that she not have to contend the added difficulties of overly full breasts.

First Six Hours after Birth

The first few hours after delivery are a very critical time for both mother and her newborn, even when both are perfectly normal and healthy. The mother is recovering from the sudden dramatic physical and hormonal changes that came about with labour, birth and the expulsion of the placenta. The drop in placental hormones "signals" to her body that she should begin making breastmilk in sufficient quantities to feed her baby. Those who attended the mother at birth must keep a watchful eye on her to ensure that her bleeding is within normal amounts, that her nutrition and fluids needs are met, and that she remains comfortable, supported and protected. The newborn baby likewise is undergoing the dramatic shift to life in the world outside the womb. The baby needs to stay dry and warm, to feel secure and safe from harm, and to initiate breastfeeding. These needs are most successfully achieved if the baby stays right in the arms of the mother from birth.

Early Initiation of Breastfeeding

A healthy newborn is delivered awake, alert, and "programmed" with many behaviors and reflexes to help with finding the breast, finding the nipple and latching on to start the first feed. A healthy newborn, left alone on his mother's stomach, will scoot upwards pushing with the feet, pulling with his arms, and bobbing his head until he finds and latches on the nipple. A newborn's sense of smell is highly developed which also helps with the task of finding the nipple. At the same time, the mother produces high levels of oxytocin as the baby is in contact with her skin. This oxytocin will help keep her uterus firm, thus keeping bleeding to a minimum, and prepares her breasts to eject colostrum when the baby finds her nipple. All of this suggests that leaving a baby quietly on its mother's chest right after delivery is the very best practice. Other routines need to wait while this special bonding period is allowed to take its course. Most newborns are ready to find the nipple and latch onto the breast within the first hour of birth. Some are ready to latch on much sooner and a few take somewhat longer. Recommended best practices for early optimal initiation of breastfeeding include:

- Immediate skin-to-skin contact – Right after delivery, dry the baby well and place skin- to-skin next to the mother with a second dry cloth on top. It is not necessary to wait until the cord is cut to put the baby up on its mother's abdomen. Early skin-to-skin contact stabilises the newborn's temperature, respiratory rate and blood sugar levels more effectively than if the infant is in a separate cot in the first 90 minutes of life.
- Minimise suctioning – Suction the baby's mouth and nose only if necessary to clear secretions that are preventing the baby from breathing well. A baby, who is crying, does not need suctioning. If suctioning is necessary do so gently as the suctioning may cause micro trauma to the delicate skin of baby's throat, which can interfere with breastfeeding.
- Delay routine newborn procedures – Weighing, measuring, cord care, eye care and other procedures are not critical and should be delayed until the baby has breastfed for the first time. Bathing in the early hours after birth is not recommended as the baby's ability to regulate its body temperature is still immature.
- Monitor the mother and baby together – During the first few hours after delivery, the mother's temperature, pulse, blood pressure (often called 'vital signs') and bleeding can all be checked while the baby is on her abdomen. The baby's temperature, breathing and heart rate can be checked this way as well, even if s/he has already begun to breastfeed.
- Stitches – If mother needs stitches in her birth canal, ask her labour companion, a family member, or another maternity staff to help her hold and position the baby as the stitching is being done. Sometimes when the mother is involved with looking at and getting to know her baby, the stitching is less uncomfortable.
- Positioning and attachment – Provide assistance with positioning the mother and baby so the latch-on is effective and does not hurt the mother. Pillows or a folded blanket under her head may help if she is on a delivery bed. She can also roll to one side and tuck the baby next to her. The best time to take advantage of the baby's inborn rooting and suck reflexes is during that awake, alert time right after birth. Healthy babies, born by normal vaginal birth, have large concentrations of the hormone adrenaline in their blood stream, making their pupils dilated and their level of alertness very sharp. Waiting to give the baby to the mother, as was done in times past, until after newborn procedures and after the "mother has rested," meant that the first feed was tried too late, when the baby had become sleepy.

Family Centred Care

If birth occurred at home, the family members are nearby to meet and greet the new baby. In a maternity facility, the immediate family should be encouraged to see mother and baby in this time. If there was a labour support companion, often this person stays with the mother during the early hours postpartum to provide support for early breastfeeding as well. Other suggestions:

- Partner Involvement – Encourage the father of the baby to be involved in this early postpartum period. Cultures vary as to how involved men are in birth, but almost ALL fathers are proud and eager to have bonding time with their newborn.
- Special Foods – encourage the mother to eat nourishing foods and drink plenty of water and other nourishing fluids. In many cultures, an animal is slaughtered to feed the mother or special ginger/ chicken soups or "hot" foods are offered to ensure fast healing and breastmilk production.
- Rest – Family members are the BEST people to make sure that mother rests with baby and not too many non-family visitors. When the baby sleeps, the mother should also be encouraged to sleep.

Postpartum Days 1-3

The first three days after a normal delivery, the mother and baby continue to need warmth, support, and a quiet supportive environment that encourages the two to get to know one another. Mother and baby both continue to need to have their "vital signs" monitored to make sure all remains healthy. If the baby is breastfeeding frequently and effectively, this will help to keep the mother's womb firm and will keep the bleeding to normal amounts. The help of an experienced family member or a knowledgeable health care worker is so important at this time. In many traditional cultures mothers are kept sequestered in a quiet, safe, private place so that neither she nor her newborn is exposed to people who are not in the immediate family. In hospitals this is not as easily the case, yet by the mother rooming-in or bedding-in with her baby, she still can keep the exposure to outside infections to a minimum.

Baby Friendly Hospital Initiative

Several of the "Ten Steps" are very important during this period. Even if the birth has occurred at home, these principles are the best practices to ensure the establishment of early, optimal breastfeeding.

- BFHI STEP 5 – SHOW MOTHERS HOW TO BREASTFEED AND HOW TO MAINTAIN LACTATION, EVEN IF THEY SHOULD BE SEPARATED FROM THEIR INFANTS – Mothers, especially first time mothers, need help and support in getting breastfeeding off to a good start. They need to be shown correct positioning and attachment (sometimes called latch-on). A mother needs to known how often to feed the baby, if breastfeeding is going well, and if baby is getting enough (See LINKAGES: Facts for Feeding Recommended Practices to Improve Infant Nutrition during the First Six Months). Signs of effective breastfeeding include: rhythmical sucking, visible jaw movement of baby drawing the milk out, hearing the baby swallow, no drawing in or "dimpling" of the baby's checks, and absence of pain for the mother. As mentioned above, mothers who must be separated from their baby need special help to begin expressing milk from their breasts to avoid engorgement and the establish a good milk supply.
- CUP FEEDING – If a baby cannot suckle at the breast, an excellent way to give expressed colostrum and breastmilk is with a small cup. A mother can easily be taught how to cup feed her baby and this will avoid the problems that might arise with an artificial teat (see Step 9). Even premature babies can safely learn how to take breastmilk from a cup. Cups are easier than feeding bottles to keep very clean, and the feeding behavior baby learns with 'lapping' the milk from the edge of the cup does not interfere with latch-on when the baby is ready to feed at the breast.
- BFHI STEP 7 – PRACTISE ROOMING-IN – ALLOW MOTHERS AND INFANTS TO REMAIN TOGETHER – 24 hours a day. All routine care for a healthy newborn can be done at the bedside, even the first physical exam of the baby by the doctor. This way the mother becomes familiar with all the specials characteristics of her baby. She learns the sounds and gestures the baby makes for different needs, such as wanting to be fed (sometimes called feeding cues), needing to be held and cuddled, or needing dry, clean clothing. In many settings, there is not a separate cot or crib for the baby, but rather the baby and mother "bed-in" together. This closeness to the mother's body to works well to ensure warmth, comfort and ease of breastfeeding.
- BFHI STEP 8 – ENCOURAGE BREASTFEEDING ON DEMAND – Newborn babies need to suck often and as a guideline they should nurse at least 8-12 times in 24 hours. The length of the feeding will vary from feed to feed and from baby to baby and this is why each baby needs to "demand" (some prefer the term "request" or "breastfeed on-cue") when s/he is hungry. The first 1-3 days after birth the mother will have colostrum, sticky yellow-white early milk, which is high in protein, immune factors, and is JUST what the baby needs for the first few days of life. Mother needs to be reassured that her colostrum is enough for her baby and that the more the baby suckles, the sooner mature breastmilk is produced.
- BFHI STEP 9 – GIVE NO ARTIFICIAL TEATS OR PACIFIERS (ALSO CALLED DUMMIES OR SOOTHERS) TO BREASTFEEDING INFANTS – This step speaks of the problem of some newborns becoming accustomed to an artificial nipple. Hard rubber or plastic nipples do not conform to the baby's mouth the same way as mother's nipple and thus a baby can rapidly become accustomed to a way of sucking the artificial nipple, which, when applied to the mother can cause pain, trauma and may not remove breastmilk effectively. It is a best practice to avoid artificial teats altogether in the early weeks of breastfeeding.

The Breastmilk "Comes in"

Mothers vary as to when the colostrum turns into the more mature breastmilk. If the baby initiated breastfeeding right after delivery and has fed frequently and effectively from birth, this occurs usually by the second or third day after delivery. If mother and baby have been separated, or if there has been less effective breastfeeding, this may occur somewhat later and the breast may become over full or engorged. These are suggestions for the mother on the day her milk comes in:

- CONTINUE WITH EXCELLENT POSITIONING AND ATTACHMENT. This is even more important when the breasts are very full. Help mother with pillows and alternative positions if she has difficulty. If the breasts are very full, help the mother hand express some of the first milk out of her breasts to soften the nipple and the area around the nipple (areola) so the baby can get a good latch on.

- ENCOURAGEMENT – Encourage the mother that her body is doing a great job making milk for her baby and that this extra fullness will pass in a few days.
- MILK FEVER – Occasionally a mother will run a low-grade fever on the day her milk comes in. This 'milk' fever should not be above 37.6 C or 100 F and should last no more than 24 hours. An analgesic like paracetamol (Tylenol) can be taken if the fever causes the mother distress. Plenty of fluids and extra rest are very important for mother at this time.
- ANXIETY, FATIGUE, AND DEPRESSION – Let mother know that it is not unusual to feel a little "blue" on about day three after birth. The accumulated events of the labor, birth, sleep interruption, and all the changes in her body tend to catch up with her on about the third day. Rest is very important, as is the caring support of her partner and family.

Postpartum Days 4-7

The first week after delivery is a unique in a woman's life. The new mother is totally involved with caring for her baby, with breastfeeding, and recovering from profound physical and hormonal changes. As discussed, a new mother needs support, comfort, good nutrition, and rest. She needs the encouragement and self-confidence that she is a good mother and that breastfeeding is providing the very best nourishment, comfort and warmth.

Risky time for Abandonment of Breastfeeding

This is a time that a mother lacking in confidence, or with some difficulties like sore nipples, may be influenced to give breastmilk substitutes. In settings where breastfeeding is not the norm, breastmilk substitutes are common and readily available (and may have even been sent home from the hospital) the risks are greater. There may also be family or friends who are not encouraging breastfeeding or a well-meaning partner, grandmother or health care provider will offer some formula "just in case" the baby is still hungry, or "so the mother can rest." If the mother is on the fence about whether or not she can breastfeed, giving breastmilk substitutes and seeing that the baby takes it and seems satisfied, is enough to convince her that she should stop breastfeeding. Here are some suggestions:

- 'SUPPLY AND DEMAND' MECHANISM OF BREASTFEEDING – Mother and family must understand that during the first few days and weeks of breastfeeding, ANY breastmilk substitute may interfere with mother's milk production, may confuse the baby if given by a feeding bottle, and may begin a cycle whereby less frequent breastfeeding leads to less breastmilk production.
- EFFECTIVE BREASTFEEDING – Make sure mother knows the signs of effective breastfeeding mentioned above and how to know baby is getting enough (baby is passing urine at least 6 times in 24 hours, having at least four stools per day, is swallowing so mother can hear, and mother's breasts feel softer after a feed).
- HELP MOTHER WITH THE COMMON DIFFICULTIES IN EARLY BREASTFEEDING – If sore, cracked nipples and/or engorgement occur refer mother to a knowledgeable person who can help solve these difficulties.
- SPECIAL NEEDS BABIES – Breastfeeding is possible even when baby is very small or sick. A method of caring for very small or premature babies, called "Kangaroo Care" can encourage stable vital signs for the infant, mother-baby bonding, and establishment of successful breastfeeding once a baby is mature enough to suck (See Box 3).

BOX 3. WHAT IS KANGAROO CARE?

Kangaroo Care (KC) is defined as: "Early prolonged, continuous skin-to-skin care in a kangaroo position between the mother and the newborn." Over twenty years ago, this technique was developed in Columbia, South America, out of a necessity to care for small infants in settings with limited technical resources. Since that time research and clinical experience have demonstrated that KC has a positive effect on newborn health, particularly for low-birth weight and healthy premature infants. KC has been shown to achieve effective and prolonged body temperature regulation, stable heart rate and respiratory rate in the low birth weight newborn. The skin-to-skin care with KC encourages pre-feeding behavior, latch-on and suckling and excellent breastfeeding practices can be established. Infants cared for by mothers using KC exhibit far less crying than comparable infants placed in infant cots. Mothers assisting in KC have a great sense of satisfaction that they are helping their premature or very small infant to gain weight and thrive while being held close to their own body.

Beyond the First Week

The partnership of mother and her baby, through the shared experience of pregnancy, birth and breastfeeding is a relationship based on a rhythm of give and take and of mutual love and caring. The help and support given to the new family in the first week after birth is of utmost importance for the success of breastfeeding. There is no dispute that the best nourishment for her baby comes from a mother's own breasts, yet a mother who decides that breastfeeding is not for her can still provide plenty of love for her baby. Support for the mother beyond the first week will help her continue to recover from pregnancy and birth and will help her feed her baby exclusively with breastmilk for six full months. Ways to assist in this ongoing support include:

- SUPPORTIVE HEALTH CARE – Choose a health care provider who supports exclusive breastfeeding for the first six months of life and who knows how to advise mothers with breastfeeding difficulties
- BFHI STEP 10: FOSTER THE DEVELOPMENT OF MOTHER SUPPORT GROUPS AND REFER MOTHERS TO THEM ON DISCHARGE FROM HOSPITAL OR CLINIC. The tenth step to successful breastfeeding speaks to the time after the mother has left the maternity facility and is back at home. Home visits by a breastfeeding counselor or participation in a breastfeeding support group can extend the period of exclusive breastfeeding up to six months. Especially in settings where not all mothers are breastfeeding, mother-to-mother breastfeeding support groups are very important to ensure the ongoing success of breastfeeding.
- POLICY ENVIRONMENT OF MOTHER SUPPORT – Establish a national policy environment that acknowledges the importance of pregnancy, birth, and breastfeeding as a valuable natural resource. The *WABA Global Initiative on Mother Support* speaks to many of the important components of such a policy.

References

Belizan JM. Althabe F. Barros FC. et al. 1999. Rates and implications of caesarean sections in Latin America: Ecological study. *BMJ* 319 (7222): 1397-1400.

Caldeyro-Barcia R. 1979. The influence of maternal position during second stage of labor *Birth and Family Journal* 6:1, 31-42.

Cattaneo A. Davanzo R. Bergman N. et al. 1998. Kangaroo mother care in low-income countries. International Network in Kangaroo Mother Care. *J Trop Pediatr* 44 (5) 279-282

Chen DC. Nommsen-Rivers L. Dewey K. et al.1998.Stress during labor and delivery and early lactation performance. *Am J Clin Nutr* 68: 335-344.
Dewey.KG 2001. Maternal and Fetal Stress are Associated with Impaired Lactogenesis. *J. Nutri*. 131:3012S-3015S.

Hofmeyr GJ. Nikodem VC. Wolman W. et al.1991. Companionship to modify the clinical birth environment: effects on progress and perception of labour, and breastfeeding. *Brit J of Obstet Gynecol* 98: 756-764

Kennell J. Klaus M. McGrath S. et al. 1991. Continuous Emotional Support During Labour in a US Hospital. *JAMA* 265 (17): 2197-2201.

Langer A. Campero L. Garcia C. et al. 1998. Effects of Psychosocial support during labour and childbirth on breastfeeding, medical interventions, and mothers' well-being in a Mexican public hospital: a randomised clinical trail. *Brit J of Obstet Gynecol* 105:1056-1063.

Madi BC. Sandall J. Bennett R. et al.1999. Effects of Female Relative Support in Labour: A Randomised Controlled Trail. BIRTH 26 (1): 4-8.

Newton N. 1971. Trebly Sensuous Women. *Psychology Today* July 68-71.

Rajan L.1994. The impact of obstetric procedures and analgesia/anesthesia during labour and delivery on breast feeding. *Midwifery* 10: 87-103.

Righard L. and Alade MO. 1990. Effect of delivery room routines on success of first breast-feed. *Lancet* 336: 1105-1107.

Riordan J. 2000. The effect of labor epidurals on breastfeeding. La Leche League International Lactation Consultant Series Two, Unit 4 (No 298-4).

Rowe-Murray H. and Fisher J. 2001. Operative intervention in delivery is associated with compromised early mother-infant interaction *Br J Obstet Gynecol* 108: 1068-1075.

Sepkoski C. Lester B. Ostheimer G. and Brazelton TB (1992) The effects of maternal epidural anesthesia on neonatal behavior during the first month *Developmental Medicine and Child Neurology* 34:1072-1080.

Wagner M.1993. An epidemic of unnecessary cesareans. *Mothering* Fall: 71-73

Sosa J. Kennel JH. Klaus M. et al. 1980. The effect of a supportive companion on perinatal problems, length if labor and mother-infant interaction. *N Eng J Med* 303: 597-600.

Varendi H. and Porter R. 2001. Breast odour as the only maternal stimulus elicits crawling toward the odour source. *Acta Paediatr* 90 (4) 372-375.

Walker M. 1997. Do labor medications affect breastfeeding? *J of Human Lact* 13: 131-137.

WHO 2000 *Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors.* WHO, UNFPA, UNICEF World Bank Integrated Management of Pregnancy and Childbirth WHO/RHR/00.7

WHO 1997.*Thermal Protection of the Newborn*. WHO/INT/RH MSM.97.2 www.who.org

WHO 1985. Appropriate technology for birth. *Lancet* ii (August 24): 436-437.

WHO/UNICEF (Joint Statement). 1989. Protecting, Promoting, and Supporting Breast-Feeding: The special role of maternity services. Geneva: WHO.
World Alliance for Breastfeeding Action (WABA) 2002. Pamphlet: The Global Initiative for Mother Support (GIMS) www.waba.org.br

Other Resources

Better Births Initiative: A collaborative project between the Effective Care Research Unit and the Reproductive Health Research Unit University of Witwatersrand and Liverpool School of tropical Medicine. www.liv.ac.uk/lstm/bbimainpage.ht

Chalmers B. Mangiaterra V. and Porter R.2001. WHO Principles of Perinatal Care: The Essential Antenatal, Perinatal, and Postnatal Care Course. *BIRTH* 28 (3).

Chalmers B. and Porter R. 2001. Assessing Effective Care in Normal Labor: The Bologna Score. *BIRTH* 28:2 June 2001

Coalition to Improve Maternity Services. Includes the Mother Friendly Childbirth Initiative Website: www.motherfriendly.org

Kroeger M. 1993. *Labor and delivery practices: The eleventh step to successful breastfeeding?* Presentation at 23rd Triennial International Congress of Midwives, Vancouver. Available on request from MaryKroeger@aol.com

LINKAGES Project website www.linkagesproject.org

Paciornik M.1979 Video: *Birth in the Squatting Position* Revised version, 2001. Academy Communications, Sherman Oaks, CA.

Righard L and Frantz K.1992 Video: *Delivery Self Attachment* Geddes Productions 10546 McVine, Sunland CA 91040

WHO 1998. Evidence for the ten steps to successful breastfeeding. WHO/CHD/98.9.

Need to Address Women's Health Issues to Promote Breastfeeding

by Lakshmi Menon

Introduction

The world breastfeeding movement has a long history of successful advocacy. Early in the 1970s, diverse groups and concerned individuals came together to counter the large-scale unscrupulous marketing of baby milk formula products to "developing countries" by transnational companies (TNCs). Around the mid-1970s, the movement gained organisational strength when it became increasingly important and urgent to highlight and promote the health and economic benefits of breastmilk. The 'baby killer' scandal which came to light showed how the widescale sales of baby milk substitutes by TNCs, cost enormously in terms of children's health and lives worldwide as the sale of milk formula rapidly replaced breastmilk as the "best food for babies". The breastfeeding movement had to act swiftly in promoting the health and economic benefits of breastfeeding and exposing the unsafe and nutritionally inadequate baby milk substitutes. Gaining further support, the movement soon led to a range of concerted global actions against unethical baby milk sales, by health and nutrition personnel, consumer rights groups, women's groups, development and donor agencies and also some governments.

The rationale behind the breastfeeding movement is that breastmilk, as a natural and wholesome food, provides children with the foundation to good health particularly after the appalling effects of malnutrition and deaths of children fed on artificial baby milk were reported from many developing countries. The TNCs' unconscionable marketing practices of artificial baby milk included pushing the infant formula into the poorest communities. As a result, there was a discernable change in infant feeding patterns, with a gradual decline in breastfeeding practice the world over.

So the breastfeeding movement sought to ensure that women breastfeed their children by:

- informing women and communities on the benefits of breastfeeding
- battling the aggressive and unethical marketing practices of the baby milk industry
- ensuring that the WHO International Code of Marketing of Breastmilk Substitutes is implemented
- prompting governments to enact legislation to promote breastfeeding and,
- focusing on provision of sufficient maternity protection, childcare facilities and other support for working mothers by governments.

Addressing Women's Issues

Over the past ten years, WABA has felt the need to collaborate more closely with the women's movement in its efforts to address women's health issues to promote breastfeeding. At the Second WABA Global Forum at Arusha, Tanzania during 23-27 September 2002, WABA is now seriously paying attention to the general health, social and economic situation of women that is hindering breastfeeding especially in the current context of globalisation. It allotted two workshop themes: # 4 – "Women and Work" and theme # 7 – "Outreach to Women's Groups" to address these concerns. Workshop theme # 7 will discuss these issues and develop an advocacy strategy that will reflect a wider social and economic perspective.

This paper examines some of these key issues like the prevailing health situation of women, the economic and social impact of globalisation on women, the impact of globalisation on women's health and the need to collaborate with women's groups to promote breastfeeding.

Economic Impact of Globalisation on Women

The globalisation process involved the opening up of financial markets, free flow of commodities and capital, and the unchecked power of transnational corporations which has resulted in uneven economic relations (Sen, 1998). It has also contributed to reinforcing already existing imbalances because poorer countries and people have fewer opportunities to participate in the expanding global economy, global technology, the global spread of cultures and global governance (National Council of Applied Economic Research, 2000:30). This has caused wide gaps in incomes, economic growth and disparities in the distribution of economic resources and opportunities. Under such circumstances the poor and the under privileged groups tend to suffer most. Furthermore, the dominance of rich nations, multinational corporations and international capital over markets, resources and labour in the developing countries through aid and technology transfer has greatly weakened the capacity of nation states and governments to promote human development and offer

protection to their people (Pande, 2001). The World Bank and the International Monetary Fund (IMF) have prevailed upon governments to adopt the structural adjustment programme which has resulted in reduction of subsidies for development programmes such as health and even doing away with some welfare schemes. This has contributed to further impoverishing people, especially women, in the developing world.

According to Jayati Ghosh of the Centre of Economic Studies and Planning at the Jawaharlal Nehru University in New Delhi, India, "there is need for designing macro-economic policies in Asia that are sensitive to the needs of women and which do not put the main burden of adjustment on this already disadvantaged group". The poor women in any part of the world are the ones who suffer most from globalisation. Women have to bear the brunt of the economic crisis directly or indirectly having to cope with inflation, job loss or working at lower salary, which demand drastic cuts in family budget. The liberalisation of trade and investments, especially the financial investments which led to the Asian financial crisis in 1998-1999, has exacerbated unemployment, underemployment and dislocation from traditional sources of livelihood. Ghosh's paper delivered at a UNESCAP forum in Bangkok, Thailand in 1997 on the impact of globalisation on women, points out that easy dismissal is one of the reasons why women found jobs in large numbers during the boom years of the 1980s and 1990s. They are employed as women workers are widely perceived as or are "more tractable and subservient, less prone to organise into unions, more willing to accept lower wages, less likely to expect upward mobility and easier to dismiss using life-cycle criteria like marriage and childbirth" (Sakanond, 1999).

The Asian financial crisis has shown how fragile are the jobs which women hold. Women are always the first to be fired in times of crisis or job redundancy. Despite their many difficulties, women have a deep sense of responsibility towards their families. They somehow manage to keep the family together, taking on themselves the burden of housework and childcare, undertaking jobs in the informal sector, such as contract or seasonal work, or working as domestic help to augment their family income. They have also shown great ingenuity in managing the family budget despite increasing prices, mostly through personal sacrifice and foregoing their own needs for clothes, entertainment, healthcare or even by skipping meals.

Globalisation has also caused shifts in production patterns which has led to dislocation of rural women from their traditional sources of livelihood. In their race towards international competition, several governments are promoting commercial land and crop conversion schemes for the production of 'high-value' (or globally competitive) crops like asparagus, bananas, eucalyptus, and cut flowers like orchids. Even commercial rice and corn growing are discouraged. As a result women engaged in subsistence farming are left high and dry, robbed of their traditional sources of livelihood.

Fertile agricultural lands, forests and rural communities in general have been transformed into enclaves to attract foreign investors to set up industries, real estate and tourism projects and mining operations (e.g. in the Philippines). According to Oliveras, "the new world trade regime has intensified demand for agricultural products according to the changing tastes, preferences and lifestyles of people in the Northern countries and the need for raw materials by multinational corporations" (Oliveras, 1997). Peasant women who are deprived of their agricultural activities end up in irregular work with very low pay and exploitative work conditions. Many peasant women are also forced to migrate to nearby towns or cities to work as domestic helpers, service workers in restaurants and hospitality centres or entertainment establishments. In sheer desperation, many of them may also succumb to prostitution and sex tourism.

Apart from being subject to landlessness and threat to food insecurity, peasant women face additional health problems due to intensive use of pesticides. For instance, in the banana and pineapple plantation belonging to DOLEFIL-STANFILCO in Mindanao in the Philippines, women agricultural workers are exposed to pesticides and agro-chemicals. Women are hired as ground sprayers because "women do not smoke" and are "easier to handle"(Oliveros, 1997).

In India, agricultural workers and fisher people have lost their livelihood on account of private and foreign companies who have converted traditional paddy growing lands to prawn fisheries in the coastal areas of Orissa, Andhra Pradesh and Tamil Nadu in eastern India. It has caused environmental problems, such as salination of soil, depletion of groundwater resources, and diseases by effluents. In addition, privatisation of coastline and beaches has deprived local fisher people of their traditional access (Patnaik, 1996).

Effects of the IMF-World Bank conditionalities on rural agriculture in Sri Lanka

All Governments of Sri Lanka until 1977 were supportive of small farmers. Subsidies, liberal credit, free irrigation and extension services and the provision of land to the landless peasants were some of the support given. However, when Sri Lanka came under International Monetary Fund (IMF) and World Bank (WB) policies, most of these support systems were removed. The rupee was devaluated from Rs 8 in 1977 to Rs 60 to a US $ in 1998. Rural poverty increased from 13 percent in 1965 to 46 percent in 1988 (IFAD Study on State of Rural Poverty, 1992). A 1996 World Bank proposal on Rural Agriculture states that 1.8 million small farmer families should be moved out of the land they are tilling.

Source: Presentation by Sumika Perera, a peasant woman from Sri Lanka, at the "Rural and Indigenous Women Speak Out on the Impact of Globalisation" held in Chiangmai, Thailand on 22-25 May 1998 and cited in Tauli-Corpuz 1998.

Following economic liberalisation, preference for non-food crops has resulted in marked decline of the land scale for food grains production as well as the annual growth rate of food grains production in India (Iigai, 2001).

A Declaration made by sixty participants, comprising of peasant women, fisher folk and indigenous groups, at the Asian Peasant Women's Workshop made on 13 August 1999 at Bangkok, Thailand states:

> "Trade liberalisation in agriculture results in the dumping of subsidised imported produce from the capitalist countries such as USA and the European Union causing the collapse of peasant incomes and the loss of their own source of livelihood. Structural shifts towards the production of export crops due to the import-dependent nature of Asian domestic economies, TNC contract-growing arrangements and conversion of agricultural lands for non-productive uses and giving unrestricted play to "market forces" have had tremendous impact on Asian peasants.
>
> "It is clear that there is a connection between the plight of Asian women and our governments' thrust for globalisation.
>
> "Asian governments' desire for "globalisation" has further pushed Asian peasant women into far worse structures of exploitation and oppression thus making them poorer and powerless than ever." The declaration also proposed alternative solutions."

The **indigenous women** too have a similar tale to tell. Liberalisation and privatisation have seriously undermined the rights of indigenous women to their ancestral territories and resources. Subsistence economies, which have been developed and nurtured by indigenous women over the centuries have been eroded because globalisation supports the development of economies of large-scale mechanised farms which use agro-chemicals intensively (Tauli-Corpuz, 1998).

Social Impact of Globalisation on Women

The new growth-oriented policies have taken away whatever control women had over traditional occupations. The shift from welfare development to economic development has meant increasing marginalisation and pauperisation for women. Globalisation has only widened gender disparities and increased the feminisation of poverty (Pande, 2001).

Rajani X. Desai in her paper (Desai, 2001) points out that under India's New Economic Policy, the per capita food grains production fell during the structural adjustment period. This, together with rupee devaluation and reduction of subsidies in public distribution system brought about a steep increase in food prices which caused further constraints on women's food intake. Thus, "structural adjustment has meant for the toiling women, a downward adjustment in their already inadequate consumption".

Increased retrenchment of women workers from the formal sector has forced women to seek jobs in the informal sector where they suffer job insecurity, long hours of work at low salaries, working under appalling conditions with little or no protection against labour or sexual abuses. Maternity protection even in countries where it exists is hardly implemented, and women dare not protest for fear of losing their jobs. In Bombay, women contract workers commonly work 10 to 12 hour shifts for monthly salaries as low as Rs 800 (US $20).

This is "less than their minimum living expenditure and is a measure of their desperation to add to their family's sinking real incomes" (Desai, 2001).

Impact on Women's Health

Globally male-female differences are evident in the health risks, health-seeking behaviour, access to and utilisation of health services and health outcomes. For example, in South Asia, women are more vulnerable to chronic respiratory disorders through inhaling cooking fuels due to the gender division of labour. Women are known to delay seeking medical help due to under-valuation of self and less belief in their entitlement to good health compared to men. The healthcare system discriminates against women. The traditional emphasis focuses on women's reproductive health matters such as pregnancy, childbirth and contraception (ARROW, 2000a)

The health sector reform in Asia is weakening the ability of public health systems to deliver the promises made by governments when they ratified the ICPD and Beijing Platform for Actions (ARROW, 2000b). The forced liberalisation of economies has badly affected sexual and global reproductive health worldwide. It has caused reduction in government health budget resulting in the decline in health education services necessary for good reproductive health practices; increase in more expensive private practice in reproductive health; and the unregulated prescription of ineffective or overpriced drugs. The rise in health cost is forcing more women to try self-treatment of reproductive tract infections, which is mostly ineffective. Public health systems are being restructured so health services charge fees to cover operating costs since the government health subsidies have decreased due to pressure of international debt repayments. In many Asian countries, women themselves undervalue their own and their daughters' health; women avoid seeking gynecological care from male doctors; and women feel discouraged from seeking care due to demeaning treatment and trivialisation of their health complaints by the health system (ARROW, 2001).

Maternal Mortality

Even to this day, women continue to die from some of the most common complications of pregnancy and childbirth – haemorrhage, infections, unsafe abortion, obstructed labour and the hypertensive disorders of pregnancy. In 1995 the latest estimated number of maternal deaths globally was 515,000. Of these deaths,

- 53 percent (272,000) occurred in Africa,
- 42 percent (217,000) in Asia,
- 4 percent (22,000) in Latin America and the Caribbean, and
- less than one percent (2,900) in the world's more developed regions

(Source: AbouZhar, Warlaw, 2001).

Addressing the Problem of Maternal Mortality: Experiences of some countries in tackling the problem of maternal mortality and also morbidity show that that three fundamental measures are necessary to prevent maternal mortality. These are:

- Emergency obstetric care
- A functioning health referral system
- Availability of skilled and competent birth attendants.

According to Marilen J. Danguilan, governments are duty bound to provide a health system which ensures that pregnant women can access quality health care, especially life-saving emergency obstetric care (ARROW, 2001).

Quality health services are very necessary for women during pregnancy, childbirth and post-partum periods. A study conducted by the Population Council (in the Indian states of Andhra Pradesh, Madhya Pradesh and Orissa) with local NGOs, found that the post-partum period is the riskiest period with 62 percent of all deaths occurring at that time. Of those who died, 72 percent had been poor, 82 percent had been illiterate while 88 percent had been jobless. The families of the deceased reported massive bleeding and high fever as the main complication and 73 percent of the deaths occurred at home. While 95 per cent of survivors of complications had sought treatment, 73 percent had not sought treatment because they did not realise the need for it (ARROW, 2001). Lack of awareness, poverty and lack of facilities to reach distant hospitals were some of the causes for maternal deaths.

Breastfeeding Campaign and Women's Health

For the breastfeeding movement to be really successful it needs to urgently address the worsening health problems that women face. Only when women enjoy a reasonably good health status with adequate nutrition and well-being are they in a better position to take care of their family's well-being. Breastfeeding will be easier to establish as women are relieved of multiple

burdens with equal social relations. Maternity provisions can be better implemented in such an environment. Hence breastfeeding promotion planning must also work towards achieving women's social and economic empowerment.

Vanessa Griffen, Coordinator of the Gender and Development Programme of the Asian and Pacific Development Centre, confirms that because of the limited focus of the breastfeeding campaign "women tend to be seen as producers of breastmilk rather than persons with their own health status and needs…and this makes demands on women tied to their reproductive function" (Griffen, 1999:348). She therefore cautions the breastfeeding movement from becoming another means of defining women by their biological function and emphasises the need to ensure that women's other reproductive and health needs are not ignored.

For women's groups globally, the key issues regarding health care and reproductive rights are women's right to control decisions over their bodies and to have easy access to comprehensive, holistic health care, which takes into account all aspects of women's lives.

One of the most important aspects is the status of women's health. Malnutrition and anaemia are common causes of ill health and even deaths among women. The nutritional status of women needs to be given priority if women are expected to continue their productive and reproductive roles. In 1992, the World

Two Case Studies of Efforts at Preventing Maternal Deaths

MALAYSIA: Malaysia's maternal mortality rate was reduced from 570 per 100,000 live births in 1957 to 30 in 1999. Maternal and child health care is now easily accessible and more than 95 percent of deliveries are safe. Malaysia's experience in combating maternal mortality spans three and a half decades of initiating, field-testing, implementing, modifying and reviewing strategies. It adopted a multi-strategy approach that focused on: 1) improving quality of care by making basic health services more accessible; 2) upgrading the quality of essential obstetric care in district hospitals; 3) streamlining and improving the efficiency of referral and feedback systems; 4) increasing the capacity and skills of professionals and paramedical staff in managing pregnancy and delivery complications; 5) reviewing the system of investigation periodically; and 6) reporting maternal deaths.

The success in preventing maternal deaths was mainly due to the hard work, dedication, commitment and perseverance of the health workers in the Ministry of Health. The Ministry's implementation of innovative strategies and giving priority to understanding and responding to the needs of women, families, community are indicators of the government's commitment to reducing maternal mortality.

SRI LANKA: Though about a third of Sri Lankans live below the national poverty line, the maternal mortality ratio at 60 per 100,000 live births, is amongst the lowest in the developing world. The number of maternal deaths fell from 520 in 1990 to 250 in 1998. Now over 96 percent of deliveries are attended to by a skilled birth attendant and over 90 percent take place in a health facility with a referral system. All the high-risk pregnancies are referred to health facilities with obstetricians. Community midwives provide antenatal care for about 75 percent of the women. Sri Lanka's success in reducing maternal deaths is due to the government's commitment to improving education and healthcare. Maternal and child health services are provided as part of the integrated reproductive health services at the community level. Over 60 percent of the married women use contraception, allowing them to space births and limit family size. Other factors are education (adult literacy rate is 88 percent and girls can have free education up to university) and relatively high status of women.

Source: Extracted from ARROWS for Change, vol.7 (1), 2001.
For more information contact Asian-Pacific Resource & Research Centre for Women (ARROW), Ground Floor, Block G, Anjung Felda, Jalan Maktab, 54000 Kuala Lumpur, Malaysia. Tel. (60-3) 26929912, Fax: (60-3) 26929958. Email: <arrow@arrow.po.my> Homepage: www.arrow.org.my

Health Organization reported that more than 50 per cent of pregnant women are anaemic. A majority of women around the world do not have access to pre-natal care. Contraception is often women's responsibility. Pregnancy and childbirth-related complications and deaths, particularly where nutritional status is low, are quite prevalent in the developing world.

It is also important to take into account several factors that inhibit women from breastfeeding. For the majority of the world's women, life is a painful struggle to meet basic needs.

Thus, a programme of action that seeks to promote breastfeeding and protect the rights of both women and children should ensure that women live and work in conditions of gender equity and equal human rights. This includes reproductive health, sexuality, choices in family planning services, access to community resources, food distribution, and adequate, non-discriminatory nutrition for women. In order for women to breastfeed and to provide the best possible food and care for their infants, they need to be in control of their lives and well being. In addition, their health needs have to be addressed.

And breastfeeding must be seen as part of a wider health perspective of the woman rather than as a separate issue. The global breastfeeding movement must therefore align itself with women groups working on women's health issues. It is only through that, that women and their children can hope for a better and healthier future.

References

AbouZhar, Carla and Warlaw, Tessa (2001). Maternal Morbidity in 1995: Estimate Developed by WHO, UNICEF, UNFPA. Geneva: WHO, p.2 cited in *ARROWS for Change*, 2001.

ARROW (2000a). "Gender-Sensitive Health Care", *ARROWs for Change*, May, vol. 6 (1).

ARROW (2000b) "The Impact of Health Sector Reform on Reproductive Health", *ARROWs for Change*, vol. 6 (3).

ARROW (2001). "Maternal Mortality – Why Women Need to Die", *ARROWs for Change*, vol. 7 (1).

Desai, Rajani. X. "Structural Adjustment and the Role of the Family – Note for the Conference of the Progressive Organisation of Women, June 3-4 1997, at Elaru, Guntur District, Andhra Pradesh (India)" in Controversies on the Women's Question and Women and Globalisation. Bombay: Research Unit for Political Economy, 2001. pp.43-48.

Griffen, Vanessa. (1999) "Reproductive Rights and Health Issues in the Women's Health Movement and Breastfeeding Campaigns" In Griffen, Vanessa and Lakshmi Menon (eds). Asia-Pacific Post-Beijing Implementation Monitor 1999 – Health. Kuala Lumpur: Asian and Pacific Development Centre, 1999. pp.346-360.

Iigai, Yuka (2001). Rural Women under Indian Liberalization: Economic Exploitation and Political Empowerment, *Journal of Asian Women's Studies*, vol.10, Dec: 37-42.

Oliveros, Teresita (1997). "Impact of New World Trade Regime on Peasant Women in the Philippines", *Third World Resurgence*, No,86, Oct:36-38.

National Council of Applied Economic Research (2000). India: Human Development Report: a Profile of Indian States in the 1990s, New York: Oxford University Press, cited in Pande, 2001.

Pande, Rekha. (2001). "The Social Costs of Globalisation: Restructuring Developing World Economies", *Journal of Asian Women's Studies*, vol.10, December 2001.pp.1-14.

Patnaik, Usha (1996). "Export-oriented Agriculture and Food Security in Developing Countries and India", *Economic and Political Weekly*, Special number, Sept. 1996: 2429-49 cited in Iigai, 2001.

Sakanond, Boonthan.(1999). "Double Wammy for Women", *Third World Resurgence*, No. 100-101, Dec.1998- Jan: 62-63.

Sen, Gita and Anita Gurumurthy (1998). "The Impact of Globalisation on Women's Health", *ARROWs for Change*, vol. 4(1) May.

Tauli-Corpuz, Victoria (1998). "Asia-Pacific Women Grapple with Financial Crisis and Globalisation", *Third World Resurgence*, No. 94, Jun:15-20.

HUMAN RIGHTS AND INFANT NUTRITION

by George Kent

Infant Feeding Issues

The feeding of infants generally goes smoothly, particularly with the advice of appropriately trained health workers. Many problems are solved with improved feeding techniques. However, there are times when the difficulties are so serious and so extensive that they must be viewed as problems of society. The most widespread and sustained of these issues to catch the public consciousness has been the improper marketing of breastmilk substitutes. There also have been problems in finding ways to accommodate mothers doing income-generating work so that they can feed their infants. In some countries there have been controversies over whether breastfeeding in public is permissible. In several countries, there have been court cases on the question of whether a mother diagnosed as HIV-positive should be permitted to breastfeed her infant. All of these are political issues, issues that can raise serious concerns about human rights.

The parties to infant feeding are, most obviously, the mother and the child. But there are others with some interest and some influence in the situation. There is the father, and siblings. There is the extended family. There are friends. There is the local community. There are also doctors and nurses, and other health professionals. Employers are affected. The local government may be concerned in some way, and possibly the national government, and even some international organisations. And there are also a variety of commercial interests.

Each of these parties has some interest in the infant feeding relationship. All of them may feel or claim that they have a common interest in the health and well being of the infant, but they have other interests as well. The mother is, and should be, concerned with her own health and comfort. Siblings may be jealous because of the attention paid to the newcomer. Some fathers may feel jealous as well. Both father and mother may be concerned about the mother's being drawn away from work in the field or the factory, or from the work of caring for other family members. Older female relatives may try to influence the feeding process. Employers may be concerned with the ways in which breastfeeding takes the mother away from work, whether for minutes, hours, days, or months. They may be concerned that publicly visible breastfeeding will distract other workers.

Healthcare workers may be concerned with the well being of the infant and the mother, but they also have other concerns. They may have only limited time and other resources for preparing and for assisting and enabling the new mother for breastfeeding. Their incomes may be affected by the new mother's choice as to whether to breastfeed or not. Commercial interests may want to sell products, either to support breastfeeding (such as breast pumps or special clothing) or for alternatives to breastfeeding (such as formula, sterilisation equipment). Government officials may be swayed in different directions, depending on which of these parties has the greatest influence on them.

The idea of "breastfeeding as a human right" is ambiguous; it can refer to the rights of the infant or of the mother. We may normally think of them as bonded so closely that they are one, with no imaginable conflict between them. Perhaps that is usually the case, but we must acknowledge that sometimes there can be differences between them. Certainly they do not always "agree" on when to start or when to stop feeding. The infant may be insensitive to the inconvenience or even pain he or she may sometimes cause. The mother may also be unhappy about being drawn away from work, or from her husband, or from other children, or from rest. There sometimes can be real differences in interests between mother and child.

These parties can influence one another's decisions in many different ways, through education, persuasion, money, affection. The infant may not appear to be influential, but its birth and its behavior affect the mother's hormones, and provide a positive stimulus for breastfeeding. The hormones of pregnancy also cause proliferation of the ducts and alveoli of the mother's breasts, in preparation for production of colostrum and mature milk. As a result of the delivery of the placenta after the birth of the infant, the drop in progesterone causes production of breastmilk within three to six days of the birth. Thus, lactation is the natural and direct result of pregnancy and delivery.
Beyond that, the interests of the infant may have an impact if he or she is represented by surrogates, others who have some capacity in the situation and who choose to speak and act in the infant's behalf.

Nevertheless, the infant has little direct power in the relationship. It is particularly because of this extreme asymmetry in the power relationships that it is important to articulate the rights of the infant.

The Human Right to Adequate Food

The human rights of infants with regard to their nutrition must be located within the broader context of the human right to adequate food in modern international human rights law and principles. The foundation lies in the Universal Declaration of Human Rights (UDHR 1948), which asserts, in article 25(1), that "everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food . . ."

The right was reaffirmed in two major binding international agreements. In the International Covenant on Economic, Social and Cultural Rights, which came into force in 1976, article 11 says that "The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing, and housing . . ." and also recognizes "the fundamental right of everyone to be free from hunger . . . (ICESCR 1976)."

In the Convention on the Rights of the Child, which came into force in 1990, two articles address the issue of nutrition (CRC 1990). Article 24 says that "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health . . . (paragraph 1)" and shall take appropriate measures "to combat disease and malnutrition . . . . through the provision of adequate nutritious foods, clean drinking water, and healthcare (paragraph 2c)." Article 24 says that States Parties shall take appropriate measures . . . "To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition [and] the advantages of breastfeeding . . . ." Article 27 says in paragraph 3 that States Parties "shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing, and housing."

Thus, the human right to adequate food is well established in international law. Even if the right had not been stated directly, it would be strongly implied in other provisions such as those asserting the right to life and health, or the Convention on the Rights of the Child's requirement (in article 24, paragraph 2a) that States Parties shall "take appropriate measures to diminish infant and child mortality". The human right to adequate food is reaffirmed or implied in other binding international human rights agreements such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW 1981).

Several non-binding international declarations and resolutions help to shape the emerging international consensus on the meaning of the human right to adequate food as it applies to infants:

- In response to concerns about inappropriate marketing and promotion, the World Health Assembly adopted the International Code of Marketing of Breastmilk Substitutes in 1981 (WHO 1997). The WHA approved a series of resolutions in subsequent years to further clarify and strengthen the Code.
- The World Summit for Children held in 1990 called for "Empowerment of all women to breast-feed their children exclusively for four to six months and to continue breastfeeding, with complementary food, well into the second year."
- On August 1, 1990 the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding was adopted by participants at a meeting on Breastfeeding in the 1990s held at the Innocenti International Child Development Centre in Florence, Italy. The declaration stated a variety of specific global goals, including the goal that "all women should be enabled to practice exclusive breastfeeding and all infants should be fed exclusively on breastmilk from birth to 4-6 months of age. Thereafter children should continue to be breastfed, while receiving appropriate and adequate complementary foods, for up to two years of age or beyond (Innocenti 1990)". In 1991 the UNICEF Executive Board passed a resolution (1991/22) saying that the Innocenti Declaration would serve as the "basis for UNICEF policies and actions in support of infant and young child feeding". In May 1996 the World Health Assembly passed a resolution on Infant and Young Child Nutrition (WHA49.15) in which it confirmed its support for the Innocenti Declaration.
- In 1992 the World Declaration and Plan of Action for Nutrition, agreed upon at the conclusion of the International Conference on Nutrition in Rome, pledged "to reduce substantially within this decade . . social and other impediments to optimal breastfeeding". The Plan of Action asserted, in article 30, "Breastfeeding is the most secure means

of assuring the food security of infants and should be promoted and protected through appropriate policies and programmes." Article 33 stated that "Governments, in cooperation with all concerned parties, should . . . prevent food-borne and water-borne diseases and other infections in infants and young children by encouraging and enabling women to breast-feed exclusively during the first four to six months of their children's lives." Article 34 provided a detailed call for action on promoting breastfeeding.

- In 1995 the Platform for Action that came out of the Fourth World Conference on Women in Beijing called for promoting public information on the benefits of breastfeeding, implementing the International Code of Marketing of Breastmilk Substitutes, and facilitating breastfeeding by working women.

On May 12, 1999 the UN's Committee on Economic, Social and Cultural Rights released its General Comment 12 (Twentieth session, 1999): The Right to Adequate Food (Art. 11) (General Comment 12, 1999). This statement by the committee constitutes an authoritative contribution to international jurisprudence.

There is increasing recognition at the international level that good nutritional status is an outcome that depends not only on good food but also on good health services and good care (Engle 1997; Longhurst 1995). Health services consist of a broad range of measures for the prevention and control of disease, including the maintenance of a healthy environment. Thus, infant feeding is not simply a matter of the physical transmission of nutrients. There should be a strong component of caring in it, through the closeness and contact that can be provided during feeding. Breastfeeding protects the infant against a broad variety of diseases and encourages optimal caring.

Because of their immediate and direct dependence on their mothers, the nutritional status of infants is determined not only by the quality of the food, health services, and care they receive directly, but also by the food, health service, and care received by the mother herself. The infant's nutritional status at birth depends on the quality of the mother's health status and prenatal care, and whether she has had a good diet in general and has been protected from iron deficiency anemia in particular.

Mothers, and fathers as well, should be entitled to particular services not only because of their own rights but also because of their obligations to provide for their children. Mothers should receive good pre-pregnancy and prenatal care, and parents should be well informed about the risks and benefits of all alternative means for feeding their infants because, like everyone else, their infants have a human right to adequate nutrition.

Principles

What does the human right to food and nutrition mean for infants in particular? At a conference of the World Alliance for Breastfeeding Action (WABA) in Thailand in 1996, a number of specialists formulated a statement on infant feeding and human rights. That statement said, in part:

> A major principle in international law is that the best interest of the child must govern all matters relating to children. All children have the right, as have their mothers, to enjoy the highest attainable standard of health, through access to appropriate helaths services and to adequate food . . .
>
> In view of the fact that breastfeeding is almost without exception in the best interest of children and mothers, WABA interprets these provisions of international law as implying that children have a right to mother's milk as the only fully adequate form of child nutrition for the first half year of life, and an important supplement to the diet for the first two years of life. And that mothers and childen have a right to enjoy conditions that facilitate breastfeeding.
>
> States that are parties to the ICESCR, CRC and related international human rights agreements have an obligation to respect, protect, facilitate and fulfill these rights relating to child nutrition. They are obligated to remove obstacles to breastfeeding and to appropriate complementary feeding, and they are obligated to create supportive social and economic environments for both parents and children that will assure good nutrition.
>
> This shall not be understood to imply that the mother has a duty to breastfeed. It is the conditions that exceptionally lead to a choice

> not to breastfeed that must be altered. Thus there is an obligation on the States Parties to these international human rights agreements to alter those conditions that lead a mother to choose not to breastfeed. . . .

Following further discussion, in 1998, WABA took the following position on breastfeeding and human rights in its Quezón City Declaration (WABA 1998):

> Breastfeeding is a right of mothers and is a fundamental component in assuring a child's right to food, health and care. Governments and civil society should pursue full implementation of these as human rights. The protection, respect and fulfillment of these rights requires universal recognition of the importance of maternity as a social function supported by public funds. "Maternity protection is a precondition of genuine equality of opportunity and treatment for men and women." (International Labour Organization [ILO], Maternity Protection at Work, pg. 51, 1997).
>
> All babies and mothers have the right to an environment that protects, promotes and supports breastfeeding. This includes informing all members of society of the benefits of breastfeeding, protecting parents and health workers from commercial pressures and misinformation through the implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent WHA resolutions, implementing the Baby-Friendly Hospital Initiative, and protecting the breastfeeding rights of women at work. Measures should also be taken to recognize the shared responsibility of women, men and society in child-rearing.

While there was broad consensus on this view, some individuals expressed reservations about the statement, and called for a reexamination of the positions that had been taken. The major question was whether the infant should be regarded as having a right to be breastfed. This was seen as problematic, since such a right would limit the mother's freedom of choice.

The 1996 statement was reaffirmed at the October 1999 WABA Steering Committee meeting held in Penang, Malaysia.

A number of interested individuals agreed to discuss the issues through email, over the Internet. The discussion was launched on May 1, 1999. The group focused on articulating a list of agreed principles relating to human rights and infant nutrition. After long hard discussion, the group formulated the following Consensus Statement Regarding the Nutrition Rights of Infants, based on their understanding of international human rights law and principles. Personal preferences had their influence, of course, but the main objective was to make sensible interpretations of currently established human rights law and principles.

1. Infants have a right to be free from hunger, and to enjoy the highest attainable standard of health.

2. Infants have a right to adequate food, health services, and care.

3. The state and others are obligated to respect, protect, and facilitate the nurturing relationship between mother and child.

4. Women have the right to social, economic, health, and other conditions that are favorable for them to breastfeed or to deliver breastmilk to their infants in other ways. This means that women have the right to:
   a. Good prenatal care.
   b. Basic information on child health and nutrition and the advantages of breastfeeding, and on principles of good breastfeeding and alternative ways of providing breastmilk.
   c. Protection from misinformation on infant feeding.
   d. Family and community support in the practice of breastfeeding.
   e. Maternity protection legislation that enables women to combine income-generating work with nurturing their infants.
   f. Baby-friendly health facilities.

5. Women and infants have a right to protection from factors that can hinder or constrain breastfeeding, in accordance with:
   a. The Convention on the Rights of the Child,
   b. The International Code of Marketing of Breastmilk Substitutes and related World Health Assembly resolutions,
   c. The International Labor Organization's Maternity Protection Convention Number 103 and its subsequent revisions, and

d. The Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding.

6. States, represented by their governments, have an obligation to:
   a. Protect, maintain, and promote breastfeeding through public educational activities,
   b. Facilitate the conditions of breastfeeding, and
   c. Otherwise assure that infants have safe access to breastmilk.

7. No woman should be prevented from breastfeeding.

This statement, finalised on January 19, 2000, concluded what is retrospectively described as Phase I of the "Consultation on Human Rights and Infant Nutrition (CHRIN)." A presentation was made on this consultation process at the meeting of the UN's Sub-Committee on Nutrition in Washington, D.C. in April 2000.

Contentious Issues

There are major issues on which consensus has not yet been reached, such as the question of whether and how these principles should apply when mothers are diagnosed as HIV-positive. However, rather than addressing application of the principles in specific settings, here we will review some of the major difficulties with the general principles.

Women's Rights to Breastfeed vs. Infants' Rights to be Breastfed

A fundamental question remains unresolved: *do infants have a right to be breastfed?* On July 23, 2000, in an early phase of the Consultation on Human Rights and Infant Nutrition, Pamela Morrison argued that children should be viewed as having an unconditional right to be breastfed:

> Since lactation is the biological continuum of pregnancy and birth, the breasts producing milk which is perfectly suited to the needs of the human infant, since the lactogenesis occurs, regardless of what the mother "chooses" to do, and in fact even if the baby is not viable, and since the physiological requirement of the baby is to receive such breastmilk (all commercially manufactured substitutes and the milks of other mammals failing to duplicate the nutritional/ immunological components of human milk, thus in effect mal-nourishing the infant who receives such breastmilk substitutes) – how can a mother's right to exercise "freedom of choice" about how she feeds her infant (which presumably means the freedom *not* to breastfeed) be seen as equal to or, in fact, take precedence over the baby's right to his mother's milk? It seems to me that the mother's right to make choices (a social convenience) should be placed lower down on the hierarchy of needs than the baby's right to the food that nature provides (a biological necessity, without which he will either die or become ill).

Morrison's view is that the mother should not be viewed as having a choice in the matter, but is obligated to breastfeed.

This view warrants close examination. What is the relationship between the mother's interest in breastfeeding and the infant's interest in being breastfed? How do the mother's rights relate to the infant's rights?

At times the mother and the infant may have conflicting interests in relation to feeding. The conflict is raised in clear relief when it is argued that the infant has a right not only to be well nourished but, more specifically, that the infant has a right to be breastfed. Such a right could clash with the woman's right to choose how to feed her infant.

Article 3 of the Convention on the Rights of the Child says, "In all actions concerning children . . . the best interests of the child shall be a primary consideration". Combining this with the observation that breastfeeding is better than alternative methods of feeding, some argue that infants have a right to be breastfed.

In human rights law and principles, it is true that decisions must be based on consideration of the best interests of the child, but that is not the only consideration. Moreover, it is assumed that normally the parents judge what is in the child's best interests. The state should interfere in the parent-child relationship only in extraordinary situations, when there is extremely compelling evidence that the parents are acting contrary to the best interests of the child.

Those who press the view that the infant should be viewed as having the right to be breastfed center their argument on the point that breastfeeding is almost always best for the health of the infant. While that may be true, it does not necessarily follow that breastfeeding

must be mandated under human rights law. The task of human rights, and governance generally, is not to prescribe optimal behavior. Rather, their function is to establish outer limits, saying that people's behavior should not go beyond certain extremes. Thus, people are allowed to smoke and eat unhealthy food, even though it is not best for them.

By definition, *human rights* are universal; they do not vary from country to country, from place to place. However, national and local legislatures are free to formulate legal requirements appropriate to their particular local circumstances, provided they do not conflict with general human right rights law and principles.

The infant has great interests at stake, but few resources to be used to press for preferred outcomes. Given the infant's powerlessness, it is sensible to use the law to help assure that the best interests of the infant are served. However, while it is surely appropriate to use the law to protect the infant from outsiders with conflicting interests, the position proposed here is that it is not reasonable to use the law to compel an unwilling mother to breastfeed, or to prevent a willing mother from breastfeeding. Thus, for the purposes of framing appropriate law, the woman and infant can be viewed as generally having a shared interest in the infant's well being. From the human rights perspective, the major concern is with protecting the woman-infant unit from outside interference.

In many countries, the dominant view is that mothers should remain free to feed their infants as they wish, in consultation with other family members. Outsiders are obligated to refrain from doing anything that might interfere with a mother's freely made, informed decision. Mothers should have appropriate and accurate information available to them so that they can make informed decisions. This is the approach taken in the International Code of Marketing of Breastmilk Substitutes. The code is not designed to prevent the marketing or use of formula, but to assure that parents can make a fully and fairly informed choice on how to feed their infants. The main task is not to prescribe to women what they should do, but to remove all the obstacles to feeding their infants in accordance with their own well informed choices.

Thus, the solution suggested here is that the mother and child together should be understood as having a type of group rights. Breastfeeding is the right of the mother and the infant together. This could be expressed as the following principle:

- Infants have the right to be breastfed, in the sense that no one may interfere with their mothers' right to breastfeed them.

If this were to be accepted, it could replace principle 7, listed earlier: "No woman should be prevented from breastfeeding."

This proposed formulation means that the mother-infant pair, taken together, have certain rights in relation to outside parties, such as rights to certain kinds of information and services, and the rights to be protected from undue influences from outside interests. It does not say that women are obligated to breastfeed their infants. It does not invite the state to intervene in the relationships between mothers and their infants.

My personal view is that the principles proposed here (with the revised number 7) do not give priority to the mother or to the child, but instead try to forge a sensible balance between their interests. The principles are based on the concept that mothers should not be legally obligated to breastfeed, but rather they should be supported in making their own informed choices as to how to feed their infants.

There is widespread concern that mothers might make unwise choices with regard to feeding their infants. We then have two basic options: either have society override the mother's choice, or find ways to support the mother so that she makes wise choices. In my view, the first approach is disempowering, while the second is empowering for women. If women are given good information, and have all the obstacles to breastfeeding eliminated, they are likely to make good choices. Women should be enabled to make their choices with good information, and with the elimination of obstacles to carrying out their choices.

Rather than have the state make decisions for them, citizens in a democracy prefer assurances that nothing impedes them from making their own decisions. To the extent possible we should be free to choose, and that includes being free to some extent to make what others might regard as unwise or sub-optimal decisions.

Coercion

The debate about whether infants should be viewed as having the right to be breastfed is closely related to the question of when the state may reasonably force a mother either to breastfeed or not breastfeed. The issue comes up, for example, when there is fear that the infant might suffer from contaminants or infectious agents in the breastmilk. The fears that arise in relation to these situations are comparable to the fears from concern that illness or death might result from the use of breastmilk substitutes.

The view advanced here is that under normal conditions the state should not interfere in the nurturing relationship between mother and child. The mother, in consultation with other family members, gets to decide how the child is to be fed. The mother has a range of choices, and is not to be limited to what some governmental agencies decide is the optimal diet.

This formulation applies in normal situations. However, it is recognized and accepted that the state may sometimes be justified in intervening in that relationship in extreme situations. These are situations in which there is clear evidence that the diet (or other treatment) intended by the mother is highly likely to lead to extremely bad health outcomes for the infant. If a mother wanted to treat her infant's stomachache with a harmful dose of cyanide, we would want the state to block her. In all such cases where it is claimed that the situation is so extreme as to warrant state intervention, that would have to be based on clear and strong evidence of the danger.

There is clear and strong evidence that in some circumstances the use of breastmilk substitutes leads to substantially higher infant mortality rates. In those situations, we could accept a national government's prohibiting the use of breastmilk substitutes, or limiting their use to cases in which a physician prescribes substitutes. However, in places where the health outcomes of infants fed with breastmilk substitutes are only slightly inferior to those of breastfed infants, we would not want to have the government force the choice. Where the differences in health outcomes are somewhere in between these extremes, the appropriate action on the part of government may be to support educational campaigns and to assure that mothers do not make their decisions on the basis of misleading information. The argument here is that it is only in extremis that the judgments of governments should override those of mothers, and then only when there is solid scientific evidence to support the government's judgment.

On this basis, I would propose as a principle:

- Mothers have the right to use breastmilk substitutes when national governments determine that they can be used safely.

The idea here is that national governments would have the authority to determine whether, in their particular national circumstances, it would be possible for women to use breastmilk substitutes safely.

Governments would be obligated to do what they could to assure that safety. This would include informing women about the the risks involved. Thus I would add the principle that:

- Mothers have the right to good information about the benefits and risks involved in using different feeding methods.

Safety

What is the meaning of "safely"? Two aspects of the question need to be considered. First, what should be the appropriate standards of safety? Second, who decides?

Regarding appropriate standards of safety, there would be a need to assess the actual risks of breastmilk substitutes in different circumstances. If adequate data could be obtained, the risks associated with using breastmilk substitutes could be compared with the risks of doing other kinds of things. Some ideologues might feel that infants should not be exposed to any sort of risk under any conditions, but most people understand that all sorts of activities entail some amount of risk. One doesn't want to keep infants in bed under guard all day long. The task is to find reasonable ways to balance different sorts of risk and different sorts of interests. In developed countries, the risk to the infant of using formula may not be much different from, say, taking the infant around in a car, in an infant seat, or exposing the infant to second-hand smoke. If one of these is to be banned, serious consideration should be given to banning the other as well.

We can generally define normal risks as those in the moderate range, where some people are likely to judge one way and others are likely to judge another way. These different perceptions of risk result in different preferences. In these cases, decisions should be left to people's own judgments.

Extreme risks, in contrast, can be demonstrated on the basis of clear scientific evidence, and thus there is little public dispute over them. For example, it has been shown that in some developing countries the mortality rates for infants who are fed with breastmilk substitutes are far higher than they are for breastfed infants (WHO 2000). I would have no quarrel with national legislatures in such countries requiring that breastmilk substitutes may be obtained only with a prescription from a physician. However, where a government wishes to force women either to breastfeed or not breastfeed, there is a heavy burden of proof. Coercion should not be accepted except where there is strong scientific evidence to support its use.

Adequacy

Adequacy is an important concept in any discussion of nutrition rights. The UN Committee on Economic, Social and Cultural Rights' General Comment 12, on the right to food, discusses the adequacy issue as it applies to food, but does not define it explicitly (General Comment 12 1999). However, paragraph 9 is especially relevant.

> Dietary needs implies that the diet as a whole contains a mix of nutrients for physical and mental growth, development and maintenance, and physical activity that are in compliance with human physiological needs at all stages throughout the life cycle and according to gender and occupation. Measures may therefore need to be taken to maintain, adapt or strengthen dietary diversity and appropriate consumption and feeding patterns, including breastfeeding, while ensuring that changes in availability and access to food supply as a minimum do not negatively affect dietary composition and intake.

On this basis, "adequate food" could be understood as meaning a food supply that contains a mix of nutrients sufficient for "normal" physical and mental growth, development and maintenance, and physical activity. The word "normal" is not in paragraph 9. However, if we take this sensible course, we would still be left with the question of whether "normal" in this context means bare life or optimum health or something in between. In my view, the answer should be guided by the concepts on safety suggested in the preceding section. Governments should protect us from extreme risks, but not try to prescribe optimum diets.

As indicated earlier, the legal foundation for the human right to adequate food lies in the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights. Both speak of the right to an "adequate" standard of living. Also, article 12 of the covenant speaks of "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". What do these terms – "adequate" and "highest attainable standard" – mean?

The UN's Committee on Economic, Social and Cultural Rights has prepared a General Comment on the right to health (General Comment 14 2000). Its paragraph 9 explains:

> The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health."

This implies that in current human rights law the right to "the highest attainable standard of health" depends in part on the level of resources available to the state. The "safety net" with regard to health services should be higher in richer countries. Governments of countries with more abundant resources should commit themselves to higher standards with regard to their people's health.

In contrast, "adequacy" in relation to the right to an adequate livelihood appears to mean that people should be assured of at least some minimum quality of life everywhere, even in very poor countries. All people everywhere should get what they need in order to live in dignity. I take this to mean that "safety nets" must not be allowed to go below a certain level, no matter

how poor the country may be. "Adequacy" does not depend on the level of state resources.

The Role of Human Rights

Human rights law is generally based on consensus. It is not an instrument for resolving deep differences among people with regard to their moral outlooks. Consider the example of capital punishment. Because many people feel that it is morally wrong for any state to execute people for their crimes, a Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty, was adopted by the United Nations General Assembly on December 15, 1989. However, as of July 2002, only 47 countries have ratified it. The instrument is binding on those countries that have ratified it, but it must be acknowledged that the protocol has failed the test of consensus. Thus, we cannot say that capital punishment is a violation of universal human rights under international human rights law.

A great deal of work remains to be done to clarify the ways in which human rights law and principles should apply in relation to the feeding of infants. The meaning and implications of terms such as "the best interests of the child", "safety", "adequacy", and "the highest attainable standard of health" need to be worked out.

The core of the debate lies in differences in views on the merits of breastmilk substitutes. Some people view infant formula as a sensible modern convenience while others view it as being close to poison. Others are arrayed somewhere in between. In localities where there is strong evidence and a clear consensus that the use of formula would be seriously dangerous, it would be sensible to adopt rules limiting its use. However, the position proposed here is that until there is broad consensus on this point, the best universal rule would be to rely on informed choice, with mothers having a clearly recognized right to good information on the risks of using different feeding methods in their particular local circumstances.

Bibliography

(CEDAW 1981). *Convention on the Elimination of All Forms of Discrimination against Women*. 1981. www.unhchr.ch/html/menu3/b/e1cedaw.htm

(CRC 1990). *Convention on the Rights of the Child*. http://www.unhchr.ch/html/menu3/b/k2crc.htm

(General Comment 12 1999). United Nations. Economic and Social Council. Committee on Economic, Social and Cultural Rights. *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment 12* (Twentieth Session, 1999) *The Right to Adequate Food* (art. 11) (Geneva: ECOSOC E/C.12/1999/5). http://www.unhchr.ch/tbs/doc.nsf

(General Comment 14 2000). United Nations. Economic and Social Council. Committee on Economic, Social and Cultural Rights. *The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)* (Geneva: ECOSOC E/C.12/2000/4) http://www.unhchr.ch/tbs/doc.nsf

(ICESCR 1976). *International Covenant on Economic, Social and Cultural Rights*. 1976 http://www.unhchr.ch/html/menu3/b/a_cescr.htm

(Innocenti 1990). *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding*. 1990. http://www.elogica.com.br/waba/inno.htm

(Kent 2001). Kent, George, "Breastfeeding: A Human Rights Issue?" *Development*, Vol. 44, No. 2 (June 2001), pp. 93-98. http://www2.hawaii.edu/~kent/breastfeedingrights.pdf

(UDHR 1948). *Universal Declaration of Human Rights*. 1948. http://www.unhchr.ch/udhr/index.htm

(WABA 1998). World Alliance on Breastfeeding Action, *Quezón City Declaration: World Alliance for Breastfeeding Action International Workshop, June 1-5, 1998, Philippines*. (Penang, Malaysia: WABA, 1998). http://www.waba.org.br/planacti.htm

(WHO 1997). World Health Organization, *The International Code of Marketing of Breast-milk Substitutes: A Common Review and Evaluation Framework* (Geneva: Nutrition Unit, Division of Food and Nutrition, WHO-WHO/NUT96.2, 1997).

(WHO 2000). WHO Collaborative Study Team on the Role of Breastfeeding on the Prevention of Infant Mortality, "Effect of Breastfeeding on Infant and Child Mortality due to Infectious Disease in Less Developed Countries: A Pooled Analysis," *The Lancet*, Vol. 355, No. 9202 (5 February 2000).