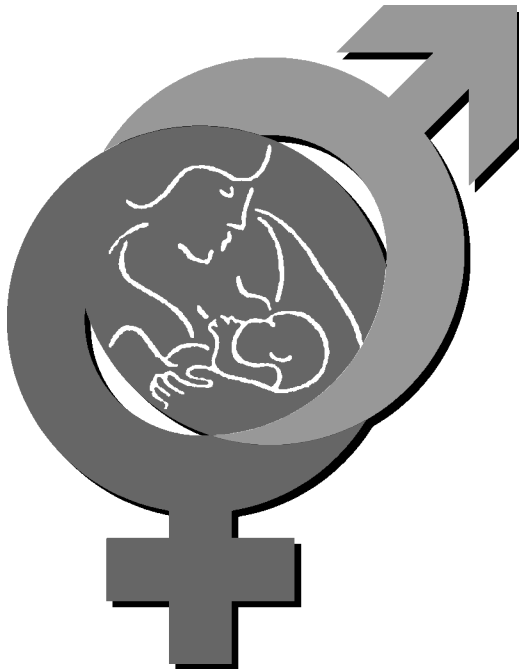


DISCUSSION PAPER

Towards Healthy Mothers and Children

**A GENDER AND RIGHTS APPROACH
TO BREASTFEEDING PROMOTION**

Lakshmi Menon and Radha Holla



TOWARDS HEALTHY MOTHERS AND CHILDREN: A GENDER AND RIGHTS APPROACH TO BREASTFEEDING PROMOTION*

Lakshmi Menon and Radha Holla

I. GENERAL BACKGROUND

A. Introduction

Breastfeeding plays a crucial role in reducing child mortality especially in developing countries where the health status is poor without adequate access to water, sanitation, essential drugs and healthcare facilities. Breastfeeding saves babies from diarrhoea, malnutrition and respiratory infections. Breastfeeding also plays an important role in mother's health by inhibiting pregnancy, preventing after-birth bleeding and reducing the risk of breast cancer and ovarian cancer. Breastfeeding also reduces household expenditure, and the money saved in buying expensive formula milk can be spent on better food and nutrition for the family.

Despite the several advantages, the age-old practice of breastfeeding continues to be under threat by various factors, some new and some old. Infant formula companies with their aggressive marketing tactics, for example, are convincing mothers of the so-called superiority of their fortified artificial milks. As more and more women join the workforce, they think it more convenient to bottle feed their babies with formula milk, especially where maternity protection is weak and not implemented. The situation in the informal and agricultural sectors is simply appalling. Moreover women are

* This paper was prepared for discussion at WABA's Gender Strategy Meeting held on 2-3 December 2004 in Penang, Malaysia.

further burdened with back-breaking household work, care of children and other family members. Women's condition is often made worse with their low nutritional status and poor health, compounded by too many and too close pregnancies. HIV/AIDS poses a new challenge. Furthermore, breastfeeding support is often lacking from the family, the community and in the public domain. Healthcare systems, while improved due to the Baby-Friendly Hospital Initiative (BFHI), need sustained efforts to be sensitive to women's health needs and to support breastfeeding.

Breastfeeding is crucial for child and maternal health especially in poor countries riddled by poverty, maternal and child morbidity and mortality, as well as inadequate access to health resources for majority of the population. In this context it is useful to examine the breastfeeding patterns in developing countries.

While a high percentage (over 90 per cent) of the children are breastfed in most of the developing countries of the world, only a few are exclusively breastfed for six months in one to five per cent in Algeria, Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire (Ivory Coast), Haiti, Malawi, Niger, Nigeria, Paraguay, Sudan, Swaziland, Thailand and Uzbekistan. (Breastfeeding Patterns, 1999).

The median duration of breastfeeding ranges from five months in Kazakhstan, 7 months in Brazil and Lebanon, and 8 months in Dominican Republic to as high as 33 months in Bangladesh. Children are breastfed up to 20 months and over in the following countries: Benin, Burkina Faso, Central African Republic, Chad, Cote d'Ivoire, Eritrea, Guatemala, India, Indonesia, Kenya, Lebanon, Mali, Malawi, Mozambique, Nepal, Nigeria, Pakistan, Peru, Rwanda, Uganda and Zambia. (Breastfeeding Patterns, 1999).

The median age of introducing complementary foods is as low as 2 to 3 months in Cameroon, Columbia, Dominican Republic, Jordon, Malawi, Philippines and Turkey. (Breastfeeding Patterns, 1999).

The worldwide total number of baby-friendly hospitals and maternities by April 2004 is 19,284 (UNICEF, 2004). However, in many countries, they are few in number and inadequate to protect breastfeeding. In many other

countries they do not even exist; for instance, Cameroon, Equatorial Guinea, Guinea-Bissau, Senegal and Zaire in West and Central Africa; Ethiopia, Sao Tome and Principe and Uganda in Eastern and Southern Africa; Djibouti Libya, Yemen in Middle East and Northern Africa, Cambodia in East Asia. Most countries of the South Pacific do not have any baby-friendly health facilities such as Cook Islands, F.S. Micronesia, Kiribati, Marshall Islands, Niue, Palau, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, and Vanuatu. Among the industrialised countries Belgium, Israel, Malta and Portugal are without baby-friendly health facilities (UNICEF, 2004).

Even where the number of baby-friendly health facilities is high, they are sorely inadequate. For example, the 1,250 baby-friendly health facilities in India make up only 25% of the country's overall health facilities; Nigeria with its 1660 baby-friendly hospitals and maternities make up only 26 % of its total hospitals and maternities, and China's 7329 BFHs account for only 55%, a little over half its total hospitals and maternities (UNICEF, 2004).

However it is clear that even if the proportion of baby friendly hospitals is high when compared to the number of total hospitals/maternities, the actual number of BFHs remains low. For example, in Vietnam only 51 baby-friendly health facilities make up 81% of the total health facilities, or the 376 baby-friendly hospitals in Iran form 94% of its total health facilities. Eritrea boasts of 100 per cent BFHs with only 46 hospitals, or El Salvador has 88 per cent BFHs with only 23 baby-friendly hospitals (UNICEF, 2004).

In Comoros Islands, Eritrea, Myanmar, Oman and Rwanda, 100% of hospitals and maternities are baby friendly. The countries with high proportion of BFHs are Macedonia (97%), Sweden (97%), Cuba (96%), South Africa (94%), Tunisia (93%), Thailand (87%), Mexico (84%), Swaziland (83%), Vietnam (81%), Philippines (79%), Nicaragua and Peru (70%) (UNICEF, 2004).

USA has the lowest baby-friendly hospitals with only 1% along with Italy, Uzbekistan, Papua New Guinea, and Niger. (UNICEF, 2004).

The status of implementation of the International Code of Marketing of Breast milk Substitutes is also an important indicator for breastfeeding promotion. Of the 192 countries monitored, only 27 countries have enacted

legislation encompassing all the provisions of the International Code while another 33 countries have most provisions as law. The United States of America is among the countries that have not taken any steps to implement the Code, others include Afghanistan, Solomon Islands, Antigua & Bermuda, St Kitts & Nevis, Surinam, Chad, Somalia, Iceland, Malta and Monaco. In 35 countries, a final draft of a law or other measure has been recommended to implement all or most of the provisions of the International Code and related Resolutions and final approval is pending (IBFAN/ICDC, 2004).

The UN Millennium Declaration, states:

“We recognise that, in addition to our separate responsibilities to our individual societies, we have collective responsibility to uphold the principles of human dignity, equality and equity at the global level. As leaders, we have a duty therefore to all the world’s people, especially the most vulnerable and in particular, the children of the world, to whom the future belongs.”

Yet, the number of deaths of children under-5 is appalling with 4.5 million deaths in Sub-Saharan Africa; 3.6 million deaths in South Asia, 1.4 million in East Asia and the Pacific. The mortality rate of children under 5 years is relatively less in Arab states at 0.6 million, 0.4 million deaths in Latin America and the Caribbean and only 0.2 million deaths of children under 5 years of age in Central and Eastern Europe and CIS. (UNDP 2003)

The Maternity Protection Convention C 183, adopted by the International Labour Organization in 2000, has been ratified by only nine countries: viz, Austria, Belarus, Bulgaria, Cuba, Hungary, Italy, Lithuania, Romania and Slovakia.

B. Children’s rights: basis for breastfeeding

The 1990s unto the 21st Century saw more of the breastfeeding promotion carried out from a rights perspective, particularly after 1995-96, when human rights discourse became popular within many social movements. The following is a selection of articles from various international instruments that support the rights of women and children to food and health. These articles provide a rationale for the breastfeeding movement.

As early as 1948, the *Universal Declaration of Human Rights* (UDHR) asserted in article 25(1), that “everyone has the right to a standard of living adequate for health and well-being of himself and his family, including food...” It was further reaffirmed in the 1976 International Covenant on Economic, Social and Cultural Rights; article 11 states “The States Parties to the present Covenant recognise the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing...”

In the *Convention on the Rights of the Child*, 1989, paragraph 1 of Article 24 states:

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

Paragraph 2 of CRC says “State Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures

- (a) To ensure appropriate pre-natal health care for mothers;
- (b) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution.”

These provisions can be interpreted as implying that children have a right to mother’s milk as the only fully adequate form of child nutrition and that the mothers and children have a right to enjoy conditions that facilitate breastfeeding (Kent, 2002). Breastmilk has elements that will provide for the highest attainable standard of health for the child in the first six months as laid down in CRC.

The World Health Assembly adopted the *International Code of Marketing of Breastmilk Substitutes* in 1981 and approved a series of resolutions in subsequent years to clarify and strengthen the Code which aims to check aggressive marketing of artificial milks and to promote breastfeeding.

The *World Summit for Children* held in 1990 called for “Empowerment of all women to breastfeed their children exclusively for four to six months and continue breastfeeding with complementary food, well into the second year.”

The 1990 *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding* stated a variety of goals to promote breastfeeding. 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 1992, 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 for Nutrition includes the following provisions on breastfeeding:

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: “Governments, in co-operation 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 breastfeed exclusively during the first four to six months of their children’s lives.”

Article 34 provides a detailed call for action on promoting breastfeeding with seven sub clauses.

And in 2002, the World Health Assembly adopted the Global Strategy on Infant and Young Child Feeding.

C. The real world of the world’s women

Women are at the centre of breastfeeding. It is a truism to say that the situation of the woman determines her ability to breastfeed successfully. Women have, through millennia, breastfed successfully. Even today, in most parts of the world, women continue to breastfeed their babies. And yet, breastfeeding continues to be a challenge. In most cases, it is neither adequate nor exclusive in the first six months of life. To address these challenges, we need to

look at the reality of women's lives, to identify what makes breastfeeding a difficult choice, and to create a world where women can successfully breastfeed their babies adequately for as long as is needed.

Women constitute 70 per cent of the world's 1.3 billion people living in absolute poverty (UN, 1996). They earn only 10 per cent of the world's income, own less than 1 per cent of the world's property, but they work two-thirds of the world's working hours. The number of rural women living in poverty has nearly doubled in the past 20 years. Women constitute 60 per cent of the 1 billion adults who have no access to basic education. Because women constitute the core of biological reproduction, over centuries and millennia, claims have been made on their lives by the society, by the community and by the family. As a result of this process of disempowerment, women have multiple burdens, including financial contributions through their work, resource management, household responsibilities, as well as the care of children and the elderly (Government of India) In many societies, few women are able to exercise their social and economic rights including rights over basic necessities as food, health care and education.

a) Health issues

Despite several international instruments calling for women's right to food and healthcare, the situation of women's maternal health is a cause for grave concern. Malnutrition and anaemia are common causes of ill health, and even death 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 Health Organization reported more than 50 percent of pregnant women are anaemic and this condition continues even today. A majority of women around the world do not have easy access to pre-natal care. Contraception is often women's responsibility and women are further subjected to risks of unsafe contraceptives and needless abortions. Pregnancy and childbirth related complications and deaths, particularly where nutritional status is low, are quite prevalent in the developing world.

Consider for instance the following facts and figures:

In 1995, Sub-Saharan Africa accounted for 1,098 maternal deaths per 100,000 live births. In the same year there were 509 deaths per 100,000 live births in Arab States, 427 in South Asia, 188 in Latin America and the Caribbean, 144 in East Asia and the Pacific, and 55 maternal deaths occurring in Central and Eastern Europe and CIS. Countries with high maternal deaths were Ethiopia with 1,800, Sudan with 1,500 deaths, Nepal with 830, Lao PDR with 650 and Bangladesh with 600 maternal deaths per 100,000 live births (*UNDP Human Development Report 2003*).

Consider also that, during the period 1975-91, an appalling 88% of pregnant women in India were anaemic, 64% in Indonesia and Ghana, and over 50% in Bangladesh, Lao PDR, Malawi, Nepal, Nigeria, Tanzania, Thailand, and Trinidad and Tobago (*UNDP Human Development Report 2000*).

The percentage of births attended by health personnel is also an important indicator of women's health status. Regions with high number of births attended by trained health personnel during 1995-2001 are East Asia and Pacific with 80 per cent, Latin America and the Caribbean accounted for 82 per cent and Central and Eastern Europe and CIS accounted for 96 per cent of births attended by trained health personnel. South Asia and Sub-Saharan Africa accounted for only 36 per cent and 38 per cent of births attended by trained health personnel respectively. The situation is appalling in Yemen with 22 per cent, Bangladesh -12 per cent, Nepal -11 per cent, and Ethiopia with as little as 6 per cent of births being attended by trained health personnel (*UNDP Human Development Report 2003*).

An increasing number of women living with HIV/AIDS has compounded the problem. For instance in 2001, there were 15 million women between the ages of 15 to 49 years with HIV/AIDS in Sub-Saharan Africa. South Asia accounted for 1.5 million women with HIV/AIDS, Latin America and the Caribbean had 640,000 women with HIV/AIDS. In East Asia and Pacific there were 600,000 HIV/AIDS-afflicted women, while the number of women with HIV/AIDS in Central and Eastern Europe and CIS was 270,000 and the Arab states accounted for 260,000 women with HIV/AIDS. (*UNDP Human Development Report 2003*). Imagine the scale of the problem with the majority of women with HIV/AIDS being in reproductive age.

b) Social and economic issues

Poverty, women's ill health, migration of women for work, increasing violence against women, lack of access to productive resources (e.g. land) all have a negative impact on women's health and overall well-being. For the majority of the world's women, life is a painful struggle to meet basic needs. The reality of the situation for women's breastfeeding therefore involves many complexities of their lives, especially for women in developing countries - from their economic situation to cultural practices, discrimination against women, limited choices of employment, poor child support and little legal protection of women's rights.

Even in developed countries where women enjoy better health and economic conditions and their social status is generally better, women still face gender inequality. For example, unemployment is higher among women than men, and women constitute three-quarters of unpaid family workers (UNDP Human Development Report 1997). Women's workload is disproportionate as compared to men's; women have to take on more domestic and childcare responsibilities. They do not always receive the legal/institutional and social support necessary to combine productive and reproductive roles/work adequately. In many instances too, women get lower pay.

D. Women's issues relating directly to breastfeeding

1. *Breastfeeding and maternal nutrition*

WHO/UNICEF recommend that a baby be exclusively breastfed for the first six months of life. After this, appropriate and adequate complementary foods need to be given in addition to breastmilk, which should continue being given till the child is at least two years old (WHO/UNICEF).

A breastfeeding woman produces 700 ml of milk per day during the first six months and a little less as time goes by. She stops producing milk once the baby is fully weaned off the breast. While breastfeeding, she needs an additional 500 kcal per day for the first six months; after that, this requirement is reduced to 400kcal per day (Manual of Clinical Nutrition Management, 2003; Picciano, 2003).

Studies have shown even the most undernourished woman can breastfeed her baby adequately. How do women who get barely enough calories to maintain their bodily system, get the extra calories required to produce breastmilk? They use up essential body fat and tissue, to the further detriment of their already compromised health, to make the milk for their babies.

Even in order to carry out their daily tasks, women's nutritional and health status can be compromised. Data from 32 studies examining PEM among women in developing countries established that women generally consumed only about two-thirds of the WHO recommended daily allowance for energy, and that their average weight-for-height was well below the average for small-frame women in the US. Women in many cultures around the world, particularly in South Asia, eat last and least. They suffer from malnutrition and anaemia in the best of times. When they become pregnant or breastfeed, the demand on their already weakened bodies is even greater, especially as they rarely get extra nutrition during this period. Other studies have established that the energy-intakes of pregnant and lactating women only marginally exceed those of non-pregnant, non-lactating women.

2. *Breastfeeding and work*

The problem that women face at their work place with regard to breastfeeding is often extremely complex and not given to easy solutions. Across the world, the situations of women at work vary. In some countries, there are laws that provide maternity entitlements; women have adequate transportation to carry the baby to work or to a nearby crèche. These women, however, are few in number. Though given the facilities to breastfeed successfully, many of these women have often chosen artificial feeding because they are both ignorant about the benefits of breastfeeding and they have the capacity to provide safe, affordable artificial feeding. In many cases, these women have been the main targets of breastfeeding promotions and campaigns.

According to a United Nations Report (World's Women, 2000), "In 1990, labour force participation rates were high for women in their 20s, rose through their 30s and 40s, and declined only after age 50. Increasingly women remain in the labour force during their childbearing and child rearing years." It also pointed out that while women's participation increased highly their working conditions did not improve much. It is crucial to remember that the majority of the world's women work in the unorganised sector, as agricultural labour, as contract labour in construction sites, as domestic workers, as itinerant vendors in streets and public transport. The UN Report further points out that women's participation in non-agricultural labour force in the informal sector during 1991/97 was very high. In Benin and Chad 97 per cent of the female, non-agricultural labour force is in the informal sector. In Mali, the figure is 96 per cent, India -91 per cent Indonesia - 88 per cent, Guinea - 83 per cent, Kenya - 82 per cent, Bolivia - 74 per cent, El Salvador -69 per cent, Brazil - 67 per cent (World's Women, 2000). Women workers are forced to travel long hours in overcrowded public transport to reach their places of work. Mostly, no affordable crèche facilities are available; they have to rely on expensive private crèches and often, unhygienic public crèches. In addition, the creches are not close enough to allow the woman to breastfeed when babies demand. For these women, the risks of carrying the baby to work may appear to pose far more hazards than not breastfeeding.

For the majority of the world's women, particularly women who work in low paid, itinerant jobs like domestic work, vending on the streets, there is no option but to continue to work in such distressing circumstances: their incomes are vital to the survival of their family.

A particular mention must be made of women's burden of work. A United Nations study (UNDP 2004) reported that in urban areas, women work as much as 10 hours or 600 minutes a day, with 590 minutes per day in Kenya, 579 minutes per day in Nepal, 545 minutes per day in Mongolia and about 12 hours per day in rural areas; 678 minutes per day in Guatemala, 546 minutes in the Philippines and 692 minutes per day in the

highlands of Nepal. Even in developed countries, women work up to 470 minutes per day, 435 minutes in Australia and 453 minutes in the United States of America. The study showed that time spent on non-market activities ranges from 60 per cent and 69% as compared to men for whom it ranges between only 21 per cent and 31 per cent. The majority of this time is spent on household chores, which is mostly unappreciated and undervalued.

The problem of combining breastfeeding with working is deepened by the fact that in an increasing number of cases, the woman is the single earner in the family. In the organised sector particularly, women are the first to lose their jobs in the case of retrenchment of workers. Thus women are often forced into a situation where they have to choose between breastfeeding a baby and earning to keep the family alive.

Maternity leave

For women who are working in the organised sector, often the problem is getting paid maternity leave. While over 120 countries have laws providing some amount of maternity leave, hardly any country gives paid leave for six months. However, even in the presence of legal infrastructures providing maternity benefits, going on leave for an extended period means that her job may be taken over by someone else.

The problem becomes even more complex due to the dictates of globalisation, labour laws, especially in developing countries, are being changed, and workers protections are being dismantled to allow investors to hire cheap contract labour. In such situations, even the existence of strong maternity protection laws does not help the woman to successfully breastfeed, if the survival of her entire family is at stake.

In the case of the unorganised or informal sector, the situation is worse. No government has yet found ways to translate existing maternity benefits in such ways as to make them accessible and meaningful to the women working in the informal sector.

3. *Violence against women*

Women, across all ages, caste, race, and economic status, are victims of violence. The violence may be obvious - beatings, rapes, torture, and so on.

However, women are also victims of hidden violence perpetuated by society - their low status especially in health and nutrition, multiple burdens, low social value and low economic status.

Women's multiple burdens contribute to their low health status, and to long working hours. In many cases, women are forced to work outside the home as well as inside the home. However, women's work inside the house is rarely looked upon as additional work for her. Despite of the fact that they are often important income earners, women are seldom given help with the house work, and are often also reprimanded for not doing it properly. As they are so busy caring for the rest of the family, they tend to neglect their own health needs.

In many cultures, society places women at the bottom. Thus girl children are viewed as burdens rather than being welcomed, and social conditioning as well as social pressures cause women to neglect themselves and their girl children. For example, in many parts of North India, girl babies are breastfed for shorter periods than boys, so that women can get pregnant again quickly in the hope that their next child would be a boy.

Yet another kind of violence against women is perpetuated when companies producing breastmilk substitutes, aided by the health professionals and workers, convince mothers that their own milk is valueless or inferior to artificial milks.

Women have no say in any major decisions, including how many children to have, and when, as well as what to feed them. Maternal and child health workers, often including those promoting breastfeeding, ignore this, and target women with breastfeeding messages. Such targeting worsens the situation by causing the women to feel guilty and more helpless, and is another form of violence against women.

Violence against women in any form - both overt and hidden - causes stress. Stress affects milk production and secretion, as the hormones controlling these functions are affected by the brain. The let down reflex is a very sensitive reflex and can be easily inhibited by psychological factors, and can be turned off by anxiety, tension and stress (Van Esterik and Menon 2003).

E. Women's rights

Recognising the reality of women's lives, their multiple burdens and the dire health situation of women especially in developing countries, the violence engendered against them, their lack of access to productive resources, and in particular, their lack of power to take decisions affecting themselves and their children, it becomes imperative to address women's conditions.

George Kent of the Joint WANHR^a-WABA Child Rights Task Force, points out that women too have the right to good nutrition and health care:

“Because of their [children's] 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 good diet in general and has been protected from iron deficiency anaemia in particular” (Kent, 2002).

Women's rights to health are specifically enshrined in various international instruments. The *Universal Declaration on Human Rights* of 1948 and the 1976 *International Covenant on Economic, Social and Cultural Rights* assert the right to health and well being for every one.

The *Convention on the Elimination of all Forms of Discrimination Against Women* (CEDAW) adopted in 1979 calls for right to protection of health and safeguarding of the function of reproduction. Article 11 and 12 provides against

^a World Alliance for Nutrition and Human Rights based in Hawaii, Honolulu.

discrimination on grounds of pregnancy or maternity leave, to introduce maternity leave with pay, for protection during pregnancy in types of work harmful to women. It states that “State Parties shall ensure to women appropriate services in connection with pregnancy, confinement and post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.”

In its statement, CEDAW also brings up the issue of men’s involvement and shared responsibility:

“Bearing in mind the great contribution of women to the welfare of the family and to the development of society, so far not fully recognised, the social significance of maternity and the role of both parents in the family and in the upbringing of children, and aware that the role of women in procreation should not be the basis for discrimination but that the upbringing of children requires a sharing of responsibility between men and women in society as a whole.

Aware that a change in the traditional role of men as well as role of women in society and in the family is needed to achieve full equality between men and women.”

Paragraph 2 of Article 24 of the *Convention on the Rights of the Child*, 1989 states, “To ensure appropriate pre-natal health care for mothers”

The *Beijing Platform for Action*, 1995 in its Strategic Objective C.1 states: “Increased women’s access throughout the lifecycle to appropriate, affordable and quality healthcare, information and related services” and Strategic Objective C.3 states, “Undertake gender-sensitive initiatives that address sexually transmitted disease, HIV/AIDS, and sexual and reproductive health issues”.

In addition the Strategic Objective F.6 states “Promote harmonisation of work and family responsibilities for women and men”.

The Platform for Action also called for promoting public information on the benefits of breastfeeding, implementing the International Code of Marketing of Breastmilk Substitutes (108-i of Strategic Objective C.3).

The *International Conference on Population and Development (ICPD)*, Cairo, Egypt, 1994 has several references on breastfeeding in its Programme of Action to support the rights of mothers and children. They include the following:

Chapter IV on Gender Equality, Equity and Empowerment of Women

A. Empowerment and Status of Women,

B. Actions: 4.4 (g): Making it possible, through laws, regulations and other appropriate measures, for women to combine the roles of child-bearing, breastfeeding and child-rearing with participation in the workforce.

Actions: 4.13: Countries are strongly urged to enact laws and to implement programmes and policies which will enable employees of both sexes to organise their family and work responsibilities through flexible work-hours, parental leave, day-care facilities, maternity leave, policies that enable working mothers to breastfeed their children, health insurance and other such measures. Similar rights should be ensured to those working in the informal sector.

Chapter V: The Family, its Roles, Rights, Composition and Structure, section A Diversity of Family Structure and Composition,

Actions: 5.3: Governments, in cooperation with employers, should provide and promote means to facilitate compatibility between labour force participation and parental responsibilities, especially for single parent households with young children. Such means should include health insurance and social security, day-care centres and facilities for breastfeeding mothers within the work premises, kindergardens, part-time jobs, paid paternity leave, paid maternity leave, flexible work schedules, and reproductive and child services.

Chapter VII on Reproductive Rights and Reproductive Health, section B on Family Planning,

Objectives: 7.14 (f): To promote breastfeeding to enhance birth spacing.

Actions: 7.23 (h): Family Planning and reproductive health programmes should emphasise breastfeeding education and support services, which can simultaneously contribute to birth spacing, better maternal and child health and higher child survival.

Chapter VIII: Health, Morbidity and Mortality

Section B on Child Survival and Health,

Objectives: 8.15 (c) To promote breastfeeding as a child survival strategy.

Actions: 8.18 For infants and children to receive the best nutrition and for specific protection against a range of diseases, breastfeeding should be protected, promoted and supported. By means of legal, economic, practical and emotional support, mothers should be enabled to breastfeed their infants exclusively for four to six months, without food or drink supplementation and to continue breastfeeding infants with appropriate and adequate complementary food up to the age of two years and beyond. To achieve these goals, Governments should promote public information on the benefits of breastfeeding; health personnel should receive training on the management of breastfeeding and countries should examine ways and means to implement fully the WHO International Code of Marketing of Breast Milk Substitutes.

Section C on Women's Health and Safe Motherhood

Objectives: 8.20 (b) To improve the health and nutritional status of women, especially of pregnant and nursing women.

Actions: 8.24 All countries should design and implement special programmes to address the nutritional needs of women of child-bearing age, especially those who are pregnant or breastfeeding, and should give particular attention to the prevention and management of nutritional anaemia and iodine-deficiency disorders....

II. WHY A GENDER PERSPECTIVE?

It is increasingly being recognised that a gender perspective on social issues helps refine action strategies to bring about desired results for social change and equity. The Platform for Action resulting from the Fourth World Conference on Women in Beijing (1995), and the Programme of Action of the International Conference for Population and Development (Cairo 1994) legitimised the concerns of women's movements world-over that a women's perspective as well as a gender perspective is essential in social sector policies and programmes. (WABA and some of its core members participated in both these events.)

A gender perspective provides the basis for understanding the dynamics of why women do what they do. Though it may seem that they choose to do what they do, in reality, they can exercise very little choice. Society-engendered gender roles and demands are the driving force behind women's apparent "free" choice.

Applying a gender perspective to health policy and programmes requires attention in not only to the different needs of women and men based on the biology, but taking account of the broader socio-economic and cultural context that shapes possibilities and actions of different groups of women and men. (Sida, 1997)

Without a gender-based understanding that sees women and their lives in completeness, health care and child care approaches will be fragmented, will have a very narrow focus, seeing women as mere childbearers and nurturers, and will not bring about social transformation, or even the desired change. Thus if breastfeeding is to become a woman's reproductive health right^b, meeting her other rights that ensure her survival with dignity and health is the first step. As a corollary, it is equally important to recognise that other members of the family, particularly men, have duties and responsibilities to create the circumstances where a woman can safely and satisfactorily breastfeed.

^b The gender workshop at the WABA Global Forum II, Arusha (September 2002) came up with a suggestion that breastfeeding be recognised as a Women's reproductive health right in order to find common ground with women's groups. This suggestion needs to be taken further.

Recognising men's duties and responsibilities becomes especially important in the context of unequal relationships between men and women. Men should share equal responsibility not only in housework and childcare, but also in fertility control, in safe sex (particularly with HIV/AIDS being on the rise) and to treat women with the respect due to an equal partner. This means violence against women in all its forms must be recognised and addressed. It must be acknowledged that patriarchy is at the root of violence and discrimination against women - within the home, at the workplace, by society, including corporate pushing of breastmilk substitutes. The solution to improving breastfeeding practices is thus to address the problems caused by patriarchy, by weaving gender justice into all aspects of breastfeeding promotion programmes.

III. GENDER PERSPECTIVE STRATEGIES FOR PROMOTING BREASTFEEDING

Framework

The broad framework for analyzing the political, economic, social, cultural and gendered contexts at national and international levels must be based on:

- Level of women's nutritional status
- Level of women's health status
- Level of women's status in law
- Women's access to economic independence
- Women's access to independent political participation
- Women's power to take decisions
- Involvement of men in shared responsibilities and roles
- Focus on health and development messages
- Level of women's social status (irrespective of relationship to men)

Initial concepts and thinking are outlined in Link #3 - Women's Empowerment. (See WABA Gender Training Workshop Handout # E - 6)

The following section provides a list of recommended actions for WABA, WABA's partners, network participants and others who are interested in the gender issue specific to breastfeeding.

Participants

- Within WABA, there needs to be close co-ordination among WABA's task forces and working groups: the Mother Support Task Force, Women and Work Task Force, HIV/AIDS Task Force, the Global Initiative for Father Support, the Health Care Practices Task Force and the Gender Working Group. Special concerted efforts should also be made to work more closely with women's groups, community organisations and trade unions.
- WABA's strategy should be to reach out to community women, service

providers (viz doctors, nurses, midwives, and health care personnel), the legal profession, employers, activist groups, government officials, media, NGOs, trade unions, religious groups and the private sector. It is also necessary to bring in new partners work more closely with WABA in promoting breastfeeding

- To conceptualise strategies according to levels:

Global: WABA & Core Partners, Task Forces and Working Groups and International Advisory Council

Regional: Regional Focal Points and regional partners, such as ARROW; and

National: WABA endorsers and National Contact Points

Suggested strategies and action ideas

It is important to protect, promote and support breastfeeding keeping in view both children's and women's health needs. A gender and rights-based approach to breastfeeding promotion requires multi-pronged strategies, which include

1. Information dissemination
2. Networking
3. Advocacy
4. Training
5. Research and Monitoring
6. Documentation and Publications
7. Social Mobilisations.

Some of the specific activities that taskforces and groups could allocate amongst themselves include:

1. Information dissemination

- Raise awareness on benefits of breastfeeding.
- Raise awareness on women's nutritional and health needs, especially during pregnancy and lactation.
- Undertake surveys/studies to understand problems that working

women/homemakers face combining breastfeeding and work in different environments, e.g. homes, public places, offices, market places, health facilities, public transport, etc.

- Increase public awareness on maternity protection rights and need for appropriate childcare facilities.
- Raise awareness of employers and policy makers.
- Raise awareness of family and community for support for breastfeeding

2. Networking - involve collaborative efforts with other groups, such as women's health groups, children's groups, health groups, men's groups, trade unions, etc., on issues of common concern. Networks help to pool resources, skills, expertise, knowledge in order to build capacity, generate strength and solidarity

- Work with like-minded organisations for collaborative action plans to promote breastfeeding.
- Start and sustain information exchange with them.
- to maximise networking, ensure participation in local, regional and international conferences and events such as
 - AP NGO Forum (Beijing + 10)
 - ICPD +10
 - XV International AIDS Conference Access for All
 - 10th International Women's Health Meeting
 - Fourth International Congress on Women, Work and Health - WWH 2005.

3. Advocacy - Advocacy is an important strategy if we want to change policies, laws and practices. It requires skills, patience and networking efforts.

- Lobby with governments to ratify the ILO Maternity Protection 2000 Convention C183 (and R 191).
- Work towards enactment of maternity protection laws and make them applicable to women workers in the informal and rural sectors as well.
- Engage in policy dialogue with key decision-makers to fulfill the provisions of the international instruments (specified earlier) especially in those countries that have ratified them.

- Monitor the implementation of national maternity protection laws.
 - Undertake advocacy campaigns for gender-sensitive and baby-friendly policies, laws and practices.
 - Advocate for increased human and financial resources and logistics for provision of creches at workplaces as well as at places convenient to women in the unorganised sector.
 - Ensure that the method, timing and message of advocacy are appropriate to the environment and circumstances.
- 4. Training:** should include problem identification, problem analysis, research, policy papers, situation analysis, negotiation and lobbying (with governments policy makers, with employers), audience targeting, communications materials, interventions and organisational capacity.

In addition to technical training on breastfeeding management,

- Undertake gender training for breastfeeding advocates, particularly WABA's core partners.
- Promote gender training of lactation counsellors to reassure and help new mothers breastfeed
- Advocacy training in ratifying and legislating ILO183 and R191
- Training in popular mobilisation with gender perspective.

5. Research and monitoring

- Undertake gender sensitive research studies/surveys on breastfeeding patterns to understand the decline in breastfeeding if any, and to enable strategies for BF promotion.
- Develop suitable gender sensitive indicators relevant to breastfeeding, such as women's nutritional and health status, reproductive health status (such as number of living children, number of pregnancies, contraceptive use, incidence of STD and HIV/AIDS), status of maternity benefit systems and law, baby friendly hospitals, International Code, laws related to violence against women, domestic violence, rape, women's access to health care.
- Coordinate with women's health groups to include breastfeeding indicators in their monitoring projects in women's health.

- Conduct literature search of studies on the conditions of women workers in informal sectors
- Compile bibliography on breastfeeding literature.

6. Documentation and publications

- Document successful campaigns of breastfeeding promotion at workplace
- Share experiences of success stories to inspire and to serve as models
- Document and publish good frameworks, useful campaign tools and lessons learned
- Bring out joint publications with other groups.

7. Popular mobilisation

Some tools for popular mobilisation that could be used for gender sensitization include:

- World Breastfeeding Week
- World Breastfeeding Charter
- International Women's Day
- International Day for Eliminating Violence Against Women
- People's Health Charter.

Gender mainstreaming is about assimilating a gender perspective in every aspect of life, of being, i.e. in thinking, personal relationships or interactions at work, etc. (Sida) This should be the context of developing a framework for strategies and planning activities to effectively promote successful breastfeeding. It is necessary to include gender equity in the agenda of all WABA's work

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The World Alliance for Breastfeeding Action (WABA) is a global network of individuals and organisations worldwide concerned with the protection, promotion and support of breastfeeding based on the Innocenti Declaration, the Ten Links for Nurturing the Future and the WHO/UNICEF Global Strategy for Infant and Young Child Feeding. Its core partners are International Baby Food Action Network (IBFAN), La Leche League International (LLL), International Lactation Consultant Association (ILCA), Wellstart International, Academy of Breastfeeding Medicine (ABM) and LINKAGES. WABA is in consultative status with UNICEF and an NGO in Special Consultative Status with the Economic and Social Council of the United Nations (ECOSOC).

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