Need to Address Women's Issues to Promote Breastfeeding*

by
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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 aggressive marketing 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 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 has allotted two workshop themes: # 4 - "Women

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and Work" and Workshop # 7 - "Collaborating with 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, "The Impact of Globalisation on Women" delivered at a UNESCAP forum in Bangkok, Thailand in 1997, 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, health care 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 company 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).

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).

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 a peasant woman from Sri Lanka, Sumika Perera 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.

A Declaration made by sixty participants, comprising of peasant women, fisher folk and indigenous groups, of 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. Sructural 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.
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> "It is clear that there is a connection between the plight of Asian women and our governments' thrust for globalisation.
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> "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 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[1] and Beijing[2] 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.

[1] International Conference on Population and Development, Cairo, Egypt in 1994
[2] Fourth World Conference on Women, Beijing, China in 1995

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.

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.

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

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. Breastfeeding will be easier to establish when women are relieved of their multiple burdens and enjoy equal social relations. Maternity provisions can be better implemented in such an environment. Hence breastfeeding promotion must also work towards achieving women's social and economic empowerment.

Dr. Vanessa Griffen, Coordinator of the Gender and Development Programme of the Asian and Pacific Development Centre in Malaysia 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 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 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.

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