

Dialogue on Diarrhoea



The international newsletter on the control of diarrhoeal diseases

Breastfeeding is best feeding



Sean Sprague/Panos Pictures

Nutritious and natural: exclusive breastfeeding provides the best start in life.

It is tempting to look to new scientific discoveries such as the latest vaccines and medicines to reduce child deaths. However, the very best way to ensure babies grow up healthy is a traditional practice and costs nothing – breastfeeding.

Breastmilk is nutritious and contains antibodies and other substances which protect against disease. Breastfeeding also reduces the risk of infection associated with poor food hygiene and inadequate water and sanitation. In developing countries artificially fed infants are at least 14 times more likely to die from diarrhoea than infants who are breastfed.

Although breastfeeding is promoted in

most traditional cultures, urbanisation and promotion of infant formula are undermining breastfeeding. Exclusive breastfeeding – feeding infants breastmilk only, with no other foods or fluids – is recommended until infants are 4–6 months of age. However, breastmilk is often supplemented with other milks or gruels before infants are ready to be weaned.

Health workers' presence at birth and their contact with mothers and infants afterwards provides them with ideal opportunities to support mothers to establish and continue breastfeeding. Research has shown that if health workers give skilled support, mothers are more likely to breast-

feed successfully and for longer.

This issue of *DD* looks at the skills health workers need to counsel mothers on breastfeeding. As well as understanding the techniques of breastfeeding and how to overcome common difficulties, communication skills such as listening and confidence building are important.

Many women who are in paid employment outside the home think that they will have to stop breastfeeding once they return to work. However, with good family and workplace support, this does not need to be the case. Inside, *DD* suggests several ways in which women working away from the home can continue to breastfeed.

In emergency situations such as refugee camps where access to water, sanitation, food and health care is very limited, breastfeeding is critical to protecting infant health. In such settings it is very important to recognise women's ability to breastfeed even in difficult circumstances and to support mothers to provide the best food for their infants.

Finally, this issue looks at what advice to give women in areas where HIV infection is common. The HIV virus has been found in the breastmilk of women who are HIV-positive, and there is a small risk that HIV infection can be passed on to infants through breastfeeding. However, this risk needs to be balanced against the danger of infants contracting other serious illnesses such as diarrhoeal diseases through alternative infant feeding, especially if families do not have access to clean water and sanitation.

William Cutting

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AHRTAG

Appropriate Health Resources
& Technologies Action Group

Training health care workers to counsel breastfeeding mothers

Felicity Savage and Bernadette Daelmans describe a new WHO training course.

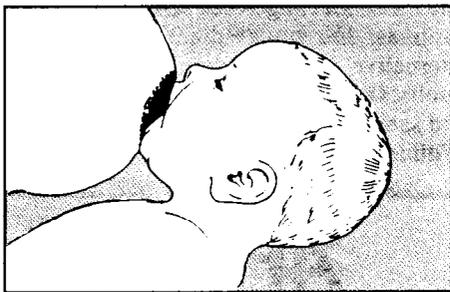
Health workers can play a key role in promoting breastfeeding. Research has shown that if they give appropriate and skilled support, it is more likely that mothers will breastfeed successfully and for longer.

In the last 20 years knowledge of the scientific basis of lactation and suckling and about how to prevent and overcome breastfeeding difficulties has increased enormously. But this new information has not been included in the training of most health workers, leaving an important gap in their knowledge and skills. To address this, WHO and UNICEF have developed a 40-hour breastfeeding counselling course designed for health workers who care for mothers and young children. The course emphasises the development of counselling and clinical skills to support good breastfeeding practices and to help mothers overcome difficulties according to the new understanding of breastfeeding.

Counselling

For breastfeeding support to be effective, a health worker needs to communicate well with a mother. Asking too many questions, giving a lot of instructions, or being critical can make a mother doubt her ability to breastfeed. Instead a health worker needs to listen to a mother and learn how she feels. Course participants learn the following listening and learning skills:

- using helpful non-verbal communication (showing your attitude through your posture, facial expression and gestures)
- asking open questions (questions that require more than just a 'yes' or 'no' answer)



Good positioning: the baby takes a mouthful of breast tissue.

- making responses or gestures that show interest (e.g. nodding or saying 'Aha')
- reflecting back (repeating in different words) what a mother says
- empathising (showing that you understand how she feels)
- avoiding words that sound judging.

Health workers also need to be able to build a mother's confidence and give her support. Course participants learn six confidence and support skills:

- accepting what a mother thinks and feels
- recognising and praising what a mother and baby are doing right
- giving practical help
- giving a little, relevant information (for example, explaining what has happened or what to expect)
- using simple language
- making one or two suggestions, not commands.

Clinical skills

Correct attachment of the baby to the breast is important to establish breastfeeding and to prevent and overcome most common difficulties. Participants learn how to assess breastfeeding by looking for the following signs of good attachment:

- the baby's chin is touching the breast (or is very close to it)
- the mouth is wide open
- the lower lip is turned outwards
- more areola (the circle of dark skin around the nipple) is showing above the baby's mouth than below it
- the baby takes slow, deep sucks, sometimes pausing.

Next, participants learn how to help a mother to position her baby at her breast so that the baby attaches well and suckles effectively. There are four key signs of good positioning:

- the baby's head and body should be in a straight line, not twisted
- the baby should face the breast with his or her nose opposite the nipple

- the mother should hold her baby close to her body
- if the baby is newborn, the mother should support his or her whole body, not just the head and shoulders.

The same principles apply whether a mother is sitting, standing or lying down to breastfeed. In the training course, participants help a mother to hold her baby in a good position and to touch the baby's mouth with her nipple. When the baby opens its mouth wide, the mother quickly moves the baby onto her breast, aiming the baby's lower lip well below the nipple. This helps the baby to take a big mouthful of breast tissue including the milk-collecting ducts under the areola which enables the baby to remove the milk effectively. Participants also learn how to express milk by hand (see DD37) and how to feed a baby by cup (see DD41).

Participants study and practise the skills in the classroom, then practise applying them with mothers and babies in maternity wards and outpatients facilities. They learn how to use these skills to help mothers with common difficulties such as worries that they cannot produce enough milk, sore nipples, a baby's refusal to breastfeed, engorgement, breast infections and when a baby is sick or is low birthweight.

Dr Felicity Savage, Dr Bernadette Daelmans, CDR, WHO, CH-1211 Geneva 27, Switzerland.

For more information about 'Breastfeeding counselling: A training course' (Ref. WHO/CDR/93.3-6) contact CDR Division, WHO.



Poor positioning: the baby is sucking the nipple only.

Counselling in a hospital setting

Khwaja Ahmad Abbas reports on a lactation management clinic in a children's hospital which is helping to increase exclusive breastfeeding.

In Pakistan, as in many traditional cultures, nearly all mothers wish to breastfeed their babies. But exclusive breastfeeding is not common. Mothers' first milk, colostrum, is usually thrown away, and other liquids such as water, *ghutti* (a herbal drink), tea and honey are given to the baby from birth. Giving other fluids makes a baby suckle less which leads to a decrease in a mother's milk supply.

In order to promote exclusive breastfeeding until 4–6 months of age and to try to solve mothers' breastfeeding difficulties, a lactation management clinic was started five years ago at the Children's Hospital in Islamabad.

The clinic is run by two specially trained public health nurses who are supervised by a woman doctor. Infants up to the age of four months and their mothers are referred to the clinic from other parts of the hospital when they have breastfeeding difficulties.

At the clinic, a nurse asks each mother a standard set of questions to try to find the cause of the difficulty. As well as a mother's own beliefs, the ideas and the influence of the child's father and grandmother are taken into account. This is followed by a medical examination of the mother and baby separately, and observation of the mother and baby breastfeeding. Close attention is paid to how the baby is positioned and attached, and how the milk flows. The baby is weighed to check its growth, mostly to reassure the mother that her breastfed baby is growing well.

As well as giving specific advice (e.g. on solving problems such as sore nipples, engorgement, mastitis or poor milk production), the nurse encourages mothers to breastfeed exclusively for 4–6 months and to continue breastfeeding in addition to giving adequate complementary foods until two years of age. She explains why bottle feeding and the use of pacifiers (dummies) are harmful. Each counselling session lasts about 35 minutes. Visual aids such as flip charts and a life-sized baby doll are used to reinforce the messages. Mothers are given a pamphlet in the local language to take home.

Mothers of young babies who have stopped breastfeeding are assisted with re-lactation (see *DD50* for more explanation).

So far, over 4,000 mothers have been counselled at the clinic. More than half of their breastfeeding difficulties have been caused by poor techniques such as incorrect positioning. Other important factors have included social attitudes (such as the belief that if a previous child has died, the mother's milk was to blame), mothers'

anxieties or lack of confidence, incorrect advice from health workers, and low birth-weight babies.

A sample of 273 mothers are being followed up at home three months after their first visit to the clinic. Preliminary results show that 67 per cent of mothers had solved their breastfeeding difficulties. More than 60 per cent were exclusively breastfeeding, while a further 25 per cent were breastfeeding and still giving other fluids. Only 9 per cent of those followed up were no longer breastfeeding.

These results suggest that lactation management clinics are a useful way of helping mothers to solve breastfeeding difficulties. Wherever possible similar clinics should be established in hospitals with maternity and paediatric services.

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Hilda Saeed/Imajics

It is important to ask about the father's and grandmother's views on breastfeeding, as well as the mother's beliefs, in order to find out the root cause of a breastfeeding difficulty.

Steps in lactation counselling

- take the baby's and mother's history, including how the baby is being fed
- examine the baby and mother
- weigh the baby
- observe the mother and baby breastfeeding
- praise the mother for helpful things she is doing
- assess and diagnose the difficulty
- if necessary, help the mother to improve her baby's positioning and attachment at the breast
- suggest what she can do to overcome her difficulties
- give relevant information, and correct any misinformation
- inform, encourage and motivate the mother and family
- follow up

Congratulations to the mothers

Mary Fukumoto and Hilary Creed Kanashiro report on a project where increasing mothers' knowledge about exclusive breastfeeding was found to be important.



WHO/J Littlewood

Breastmilk is good for satisfying thirst; other liquids are not needed until a baby is between four and six months old.

In the shanty towns of Peru's capital, Lima, almost all mothers breastfeed their children, but exclusive breastfeeding is rare. Most mothers supplement breastmilk with herbal teas and many also give other milks.

We wanted to know what influences mothers in making decisions about how they feed their infants. First, we found out local views about early feeding practices and what advice health workers were giving. We then followed the progress of a group of pregnant women. We interviewed

them in their homes on several occasions: before delivery, as soon as possible after the birth of their babies, and twice a week until their babies were one month old.

We found that decision making about infant feeding is a complex process. A key factor is mothers' previous experience of feeding infants. Advice from relatives, neighbours and health personnel is also important.

Lack of information about exclusive breastfeeding was common. Nearly all the mothers believed breastmilk was good for their babies, but they did not know that exclusive breastfeeding was best. Health workers' understanding was also incomplete. They advised mothers not to give other milks, but they did not always advise against giving other fluids such as sweetened water and herbal teas.

Mothers commonly believed that they could not produce enough milk for their babies because

they felt they themselves were undernourished. Some believed that although breastfeeding was good for babies, it could make their own health worse. Other mothers experienced difficulties with sore nipples when starting breastfeeding.

These beliefs led many mothers to introduce other milks to supplement breastfeeding. Herbal teas were also given because they were thought to prevent and cure colic and flatulence, and to quench infants' thirst.

Based on these findings, the project

decided to focus on providing better information in order to help mothers to produce enough milk, overcome breastfeeding difficulties, and build their confidence that giving other milks was not necessary.

In addition, the project also stressed that breastmilk is good for satisfying thirst and has benefits similar to herbal teas. Since mothers commonly believe that everything they eat or drink is transmitted to their babies through breastmilk, they were advised to drink herbal teas themselves, instead of giving them to their infants.

Because breastfeeding practices were so closely linked to mothers' beliefs about their own needs, the project paid particular attention to mothers, recognising them as valued people who deserve care and promoting the benefits of breastfeeding for mothers as well as infants. The slogan for the education – '*Congratulations to the mothers, and happy breastfeeding*' – reflected this.

Education was done mainly through showing locally produced videos to small groups of mothers. Other channels for information included posters, loud-speaker broadcasts from a mobile van, and the distribution of booklets describing breastfeeding techniques.

The educational activities continued for 12 months, so that some women were involved from when they were first pregnant until the first few months of breastfeeding.

The evaluation showed that there was a significant increase in the number of children aged 0–4 months being exclusively breastfed. However, the improvement had occurred in the second, third and fourth months. The number of children being exclusively breastfed in the first month of life had not increased.

The increase in exclusive breastfeeding seemed to be a direct result of a decrease in the use of sweetened herbal teas and waters. The number of women supplementing breastmilk with other milks did not decrease significantly.

This indicates that the intervention was successful in persuading mothers that herbal teas and waters were not necessary. However, it was more difficult to convince mothers that they could produce enough breastmilk without needing to supplement it. It suggests that we need to explore other ways of increasing mothers' confidence.

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The project was supported by WHO's CDD programme.

Women, work and breastfeeding

Women who work outside the home often assume that they have to stop breastfeeding when they return to work. *Nomajoni Ntombela* discusses ways in which working mothers can continue breastfeeding.

Every mother is a working mother, whether in formal or informal employment, self-employed or working in the home. The UN Economic Commission for Africa calculates that women carry out up to 75 per cent of all agricultural work in addition to doing 95 per cent of domestic work.

As a result of increasing industrialisation, more women are working away from home in large workplaces such as offices, factories, shops and hospitals, while continuing to take the main responsibility for child care. Often women working away from home believe that they cannot continue breastfeeding, although this does not have to be the case.

The following are some suggestions about how women can combine paid employment with breastfeeding.

1 Plan your pregnancy so that you can combine maternity leave with annual leave and spend more time at home with your baby.

2 Prepare yourself during pregnancy by learning about breastfeeding and how to continue breastfeeding when you return to work.

3 Ask advice from a friend or relative who has breastfed; join a breastfeeding support group; talk with a health worker; or read about breastfeeding.

4 Exclusively breastfeed your baby during your maternity leave.

5 When you return to work, continue to breastfeed your baby whenever you are at home, at night and on days off. If the baby sleeps in your bed, you can breastfeed more than usual during the night with less disturbance. Many babies need less milk during the day if they are fed well during the night.

6 If possible take your baby to your workplace so that you can breastfeed when he or she is hungry.

7 Alternatively, ask a helper to bring the baby to you at work to be breastfed. Or, if your home is not far away, you may be able to go home during breaks to breastfeed.

8 If the suggestions in 6 and 7 are not possible, it is best to leave expressed breastmilk for a helper to feed your baby while you are away.

Expressing milk

Learn to express your breastmilk soon after the baby is born (see *DD37*). In the week before you return to work, start feeding your baby expressed breastmilk by cup during the day.

Express your breastmilk early in the morning, so that you are relaxed and not rushed.

Most babies need to be fed about every three hours. If possible, express ½ cup of breastmilk for each feed. Many mothers find they can express a total of 2 cups or more. However, do not worry if this is not possible. If you can only express enough milk for one feed, then that is still helpful. If necessary, give the baby other milk later in the day.

After you have expressed your milk into a clean container, breastfeed your baby. Even though you have expressed as much milk as you can, your baby will still be able to get milk from your breast because suckling is more effective than expressing.



Cover the container with a cloth and store it in a cool place. Even at room temperature, expressed breastmilk can be kept for at least eight hours. Teach your helper how to feed the expressed breastmilk to your baby using a cup.

While you are at work, express your breastmilk two or three times during the day. This will help ensure that your milk production is maintained. If you have access to a refrigerator at work, the expressed breastmilk can be stored and taken home to feed to the baby the next day.

Household and workplace support

Make sure other household members share the workload so that you have more time with your baby in the morning and when you return from work.

Employers have an important role to play in promoting breastfeeding. Supportive policies should include:

- adequate maternity leave (women should not have to return to work until the baby is at least four months old and can be given complementary foods in addition to breastmilk)
- providing a room at the workplace for child care and breastfeeding
- allowing women to have two half-hour breastfeeding breaks
- arranging working hours which enable breastfeeding.

Workers need to negotiate with employers for these conditions. Women should seek support from their colleagues and workplace organisations such as trade unions to improve conditions at their workplaces.

Nomajoni Ntombela, IBFAN Africa Co-ordinator, PO Box 781, Mbabane, Swaziland.

Neli's success story

Neli, a secretary in Swaziland's capital Mbabane, is the mother of three children: aged 10 years, 3 years and 5 months. The youngest, Muziwandile, was born prematurely and weighed 2kg. Neli received counselling on breastfeeding during pregnancy and after delivery, and breastfed exclusively for four months. She negotiated two months paid maternity leave with her employer and continued to exclusively breastfeed for two months after she returned to work. Her employer allowed her breaks to express milk at work which a relative collected and took home to feed to Muziwandile. At four months old Muziwandile weighed 5.5kg. Neli has since received promotion at work.

HIV and infant feeding

In countries where HIV infection is widespread, some health workers are concerned about the risks of HIV transmission through breastfeeding. *DD* discusses the issues.

The HIV virus can be passed from a mother to an infant. This can happen at three stages: during pregnancy, childbirth or breastfeeding. However, most infants born to mothers who are HIV-positive do not become infected with HIV.

The HIV virus is found in breastmilk, and some infants are known to have been infected through breastfeeding. However, it is difficult to assess exactly how much of a risk breastfeeding is. Few studies have been done, and testing a baby's HIV status is complicated. Available research suggests that about one in every seven breastfed infants whose mothers are HIV-positive may become infected by HIV from their mother's breastmilk.

Recent HIV infection or advanced HIV infection mean that a woman has more of the HIV virus in her body fluids, including breastmilk. Therefore a baby is more likely to be infected if his or her mother was infected with HIV during pregnancy, childbirth or breastfeeding, or if she is ill with AIDS related illnesses.

Despite this risk, it is important to remember that most women are not infected with HIV, and that most babies breastfed by HIV-positive mothers do not become infected through breastmilk. Also, if the baby is already HIV-positive (having been infected in the womb or during childbirth), breastfeeding will help him or her to stay healthier longer.

If a woman knows she is HIV-positive, it is important to help her decide whether the chance of passing HIV to her baby via breastfeeding is greater than the risks associated with artificial feeding. For many

HIV-positive women, the risk of their babies dying if not breastfed will be much greater than the risk of passing on HIV.

Advice to all women (whether or not they know their HIV status)

- Health workers should discuss the benefits of breastfeeding with all pregnant women.

It is also important to give information about how HIV and other sexually transmitted diseases (STDs) are spread. The best way to prevent transmission of HIV and other STDs is by supporting women to protect themselves from unsafe sex, and by encouraging men to take more sexual responsibility.

Women need to know that having safer sex (using condoms or abstaining from intercourse) is especially important during pregnancy and breastfeeding.

If a woman's HIV status is not known

- The vast majority of women do not know their HIV status, and are probably not infected with HIV. They should be encouraged to breastfeed.

In most communities HIV counselling and testing services are not available, so many women do not have the choice of finding out their HIV status. However, if a reliable testing and counselling service is available, a woman may want to discuss whether to have an HIV test.

Counselling helps a woman to prepare for the possibility of knowing that she is HIV-positive, and means that she can agree freely to a test. The risk of infection through breastfeeding should *never* be used as a reason to put pressure on a woman to take an HIV test.

Knowing her HIV status may help her make the decision about whether or not to breastfeed, and will, of course, affect other choices about her life.

If a woman knows she is HIV-positive

- If a woman is HIV-positive, in some situations (especially if she herself is ill) it may be better for her not to breastfeed, but to find alternatives. However, alternatives may not be easily available or a woman may decide that the benefits of breastfeeding outweigh the

possible risk of transmission of HIV.

Health workers should help a woman to discuss the implications of being HIV-positive, and to make an informed choice. Find out what the woman already knows about HIV infection and breastfeeding, clarify any misunderstandings, and explain the possible risks and benefits. Reassure her that, whatever choice she makes, she is not to blame if her baby becomes ill.

Issues to consider include:

- Does she have access to clean water? Can she afford fuel or electricity for sterilising feeding utensils?
- Does she have support from family or friends to help her prepare and give alternative feeds?
- Does she have access to animal milk? Is there a nearby shop which regularly stocks formula milk?
- Can she afford to feed her infant with animal or formula milk?

In many situations it will be safer and more feasible to breastfeed.

Alternatives to breastfeeding

Infant formula is the most common alternative. However it is expensive, and hygienic preparation and feeding can be difficult in many households. To feed an infant for six months, at least 44 tins of 500g are needed.

Animal milk, such as cow or buffalo milk, can also be given. Animal milk should be diluted and sweetened (one cup of water, three cups of milk, four teaspoonfuls of sugar). It also needs to be brought to the boil to reduce the amount of curd and kill potentially harmful germs.

Giving expressed sterilised breastmilk is another option. Bringing breastmilk to the boil or pasteurising it (heating to 62.5 degrees centigrade for 30 minutes) kills HIV as well as other organisms.

In some places, it is usual for another woman, often a relative, to breastfeed a baby if the mother is unable to do so. This option can be considered, but is not advised in areas where HIV is common since there is a possibility that this other woman may be HIV-positive.

This article is a shorter version of one in AIDS Action 27. For readers who want more information write to AHRTAG for a copy of the AA article.

What is HIV?

The human immunodeficiency virus (HIV) attacks the body's immune (defence) system, weakening the body's ability to fight off illness. Many people with HIV stay well for some time, but eventually their bodies become unable to fight off illness. In the later stages of HIV infection, people usually develop a group of infections called acquired immune deficiency syndrome (AIDS).

Breastfeeding in emergencies

Marion Kelly proposes a strategy to support breastfeeding in emergency situations where good infant feeding is crucial to survival.



Jasper Young/Panos Pictures

Unrestricted distribution of infant formula could undermine breastfeeding.

People affected by wars or natural disasters often have to live in crowded and insanitary conditions. Their access to food and health care services may also be restricted. In these settings, the danger of diarrhoea and other infections is great. This means that during emergencies breastfeeding becomes even more important in protecting infant health.

Experience of relief operations in a range of countries has shown that anxieties about breastfeeding were most common in countries where artificial feeding was widespread *before* the emergency began. Even during war and famine in Ethiopia and Sudan, inability to breastfeed was much less commonly reported than in recent emergencies in Iraq, Eastern Europe and the former Soviet Union.

This difference suggests that cultural factors are more important in influencing breastfeeding than the emergency itself. As countries become more industrialised, artificial infant feeding is often introduced and breastfeeding skills tend to be lost. In many cases, inaccurate and out-of-date information about breastfeeding replaces traditional knowledge.

For example, it is often said that poor diet or psychological stress can make a mother's milk 'dry up'. However, this is not supported by evidence. Although a good diet is important for the health of mothers

themselves, even women who are quite undernourished are capable of producing enough milk to breastfeed their babies. Psychological stress can temporarily prevent the release of milk from the breast, but it does not affect milk production. If suckling continues and a mother's confidence in her ability to breastfeed is not undermined, then breastmilk will soon flow normally again.

Failure to understand this has led to a mistaken belief that during emergencies large supplies of infant formula are needed to save lives. However, unrestricted distribution of breastmilk substitutes can undermine breastfeeding and increase the risk of disease and death.

Although almost all mothers are physically capable of breastfeeding, some mothers may give up or never start breastfeeding if they do not receive encouragement, support and appropriate advice. Also, all pregnant and breastfeeding women need extra food in order to protect their own health.

Those who provide health care and relief assistance during emergencies should take the following measures to support breastfeeding and protect the health of mothers.

- Work to get agreement between outside agencies and local health workers on breastfeeding policy and practice. Share up-to-date information on breastfeeding with those who do not have all the facts. Establish mechanisms to

ensure that all of the following actions are implemented in a co-ordinated way.

- Make sure that maternity care practices follow the WHO/UNICEF guidelines.¹
- Do not condemn or criticise women who are not breastfeeding. Instead, take a positive approach by encouraging mothers to choose breastfeeding and reassuring them of their ability to do so.
- Educate the whole community about the benefits of breastfeeding. Highlight the importance of family and social support for breastfeeding.
- Offer one-to-one assistance for mothers who experience difficulties with breastfeeding. This can be done by helping local women to set up a network through which new mothers can get practical advice and moral support from other mothers who have successfully breastfed. Another option is to train women to work as breastfeeding counsellors. In either case, those who provide support must be sensitive to the culture, health beliefs and circumstances of the mothers they assist.
- Provide assistance with relactation to mothers of infants who have stopped breastfeeding early (see DD50).
- Supply adequate basic food rations to every family. Target supplementary food to pregnant and breastfeeding women and to children of weaning age, not to young infants.
- Only provide infant formula to infants who do not have access to breastmilk. Remember that such infants are usually few in number, and take care to identify them correctly. Make sure that their caregivers have the knowledge, skills and resources to prepare and give feeds hygienically, using cups rather than bottles.

Marion Kelly, Lecturer in Public Health, Centre for International Health, University of Wales College of Medicine, Heath Park, Cardiff CF4 4XN, UK.

1. 'Protecting, promoting and supporting breastfeeding: the special role of maternity services' is available free from local offices of WHO and UNICEF or by writing to WHO publications, CH-1211 Geneva 27, Switzerland.

Further reading: Write to AHRTAG for a copy of Kelly, M, 1993. Infant feeding in emergencies, Disasters 17 (2): 110-121.



Misleading promotion of breastmilk substitutes

For many years health organisations have been campaigning to stop the baby food industry undermining breastfeeding. In 1981 the World Health Assembly adopted the International Code of Marketing of Breastmilk Substitutes, which aims to regulate marketing practices for artificial infant foods. It covers artificial milks for babies, other artificial infant food, and feeding bottles and teats. The code specifies:

- **no advertising** of these products to the public
- **no free samples** to mothers
- **no promotion of products in health care facilities**, including no distribution of free or low-cost supplies
- **no company sales representatives to advise mothers**
- **no gifts or samples to health workers**
- **no words or pictures promoting artificial feeding**
- **all information** on artificial infant feeding, including on labels, **should explain the benefits of breastfeeding and the dangers of artificial feeding**
- **unsuitable products** such as sweetened condensed milk **should not be promoted for babies**.

So far 11 countries have passed national laws to enforce the code and many more are in the process of drafting legislation. However despite this, free or low-cost supplies continue to be provided to hospitals, clinics and individual doctors in many countries.

It is crucial that health workers actively promote breastfeeding and do not allow the distribution of free or low-cost formula, other substitutes or bottles and teats in their workplaces. When breastmilk substitutes are distributed in health facilities, many mothers believe that health workers recommend these products and that they must be good for their infants.

For more information about the *International Code of Marketing of Breastmilk Substitutes*, please contact the *World Alliance for Breastfeeding Action (WABA), Code Compliance Task Force, PO Box 1200, 10850, Penang, Malaysia*.

Breastfeeding resource list

For information about publications and health education materials on breastfeeding and details of organisations in over 50 countries supporting breastfeeding, write to AHRTAG for a copy of *Breastfeeding Information Resources*. The resource list is free to people in developing countries; for readers elsewhere it costs £5.

**Obituary –
Dr Katherine Elliott**

DD and AHRTAG regret to announce the death from cancer on 11 November 1994 of Dr Katherine Elliott, *DD*'s Scientific Editor and AHRTAG's founder.

In 1979 Dr Elliott had been approached by Dr Halfdan Mahler, the then Director-General of WHO, to publish an international newsletter to spread the news about the effectiveness of ORT. *Dialogue on Diarrhoea* was born in 1980 and in the 14 years since has been widely acclaimed internationally, growing to a circulation of over a quarter of a million readers in nine languages. Dr Elliott set high standards for *DD* and made sure that the newsletter recognised the important role of the mother and the family in promoting child health. *DD*'s success in reaching health workers at district level with practical advice expressed in plain language was the spur to the publication of AHRTAG's other newsletters, *ARINews*, *AIDS Action*, *CBR News* and *Health Action*.

Twelve years ago, WHO estimated that 5 million children died every year as a result of diarrhoeal diseases. Recent studies suggest that deaths have decreased to 3.2 million a year. The information and enthusiasm of *DD* have played an important role, and this is an appropriate memorial to Katherine Elliott. But she would be reminding us about the remaining millions, and urging us to play our part!

Dr William Cutting, Co-founding Scientific Editor

New child health newsletter

As a result of feedback from readers about the need for information on a range of child health issues, AHRTAG is combining its two newsletters *Dialogue on Diarrhoea* and *ARI News* in mid 1995.

The new child health publication will continue to provide up-to-date information about diarrhoeal diseases and acute respiratory infections, and will broaden its focus to include other key child health topics such as malaria and measles.

The last issue of *Dialogue on Diarrhoea* will be in March 1995. Readers of *DD* will automatically be put on the mailing list to receive the new child health newsletter.

Readers' competition:

Help AHRTAG to find a name for its new child health newsletter. Send suggestions for new names to AHRTAG by 1 March 1995. **Prizes for the best entries!**

Dialogue on Diarrhoea is published four times a year in English, Bangla, Chinese, French, Portuguese, Spanish, Tamil, English/Urdu and Vietnamese and reaches more than a quarter of a million readers worldwide.

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