Issue No. 4 December 1995

Health Dialogue

A forum for the exchange of news and views on primary health care

Women, work and breastfeeding

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

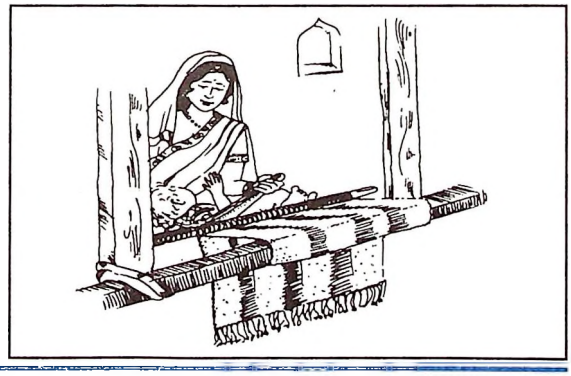
Every mother is a working mother, whether in formal or informal enjoyment, self-employed or working in the home. The UN Economic Commission for Africa calculates that women carry out up to 75 per cent of all agricultural work in addition to doing 95 per cent of domestic work.

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.



In this issue :

CMAI
Christian Medical Association of India

AHRTAG
Appropriate Health Resources & Technologies Action Group

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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 breast milk for a helper to feed your baby while you are away.

Expressing milk

Learn to express your breastmilk soon after the baby is born. 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 1/2 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 incluude:

- 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.

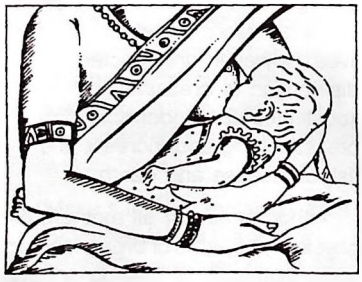
(Dialogue on Diarrhoea Issue No. 59)

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 breast-feeding practices and to help mothers overcome difficulties according to the new understanding of breastfeeding.



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

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)
- 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 :

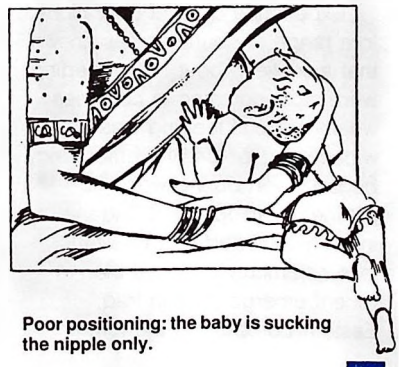
- accepting what a mother thinks and feels
- recognising and praising what a mother and baby are doing right
- giving practical help
- giving a little, relevant information (for example, explaining what has happened or what to expect)
- using simple language
- making one or two suggestions, not commands.

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



Poor positioning: the baby is sucking the nipple only.

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 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.

(From Dialogue on Diarrhoea Issue No. 59.)

Breastfeeding in emergencies

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

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

Unrestricted distribution of infant formula could undermine breastfeeding.

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 mechanism 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 breast fed. 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 care givers 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 CF 44XN, UK.

(From Dialogue on Diarrhoea Issue No. 59)

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.

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.

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.

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

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 breastmik without needing to supplement it. It suggests that we need to explore other ways of increasing mothers' confidence.

Dr Mary Fukumoto and Hilary Creed Kanashiro, Instituto de Investigation Nutricional, Apartado 18--0191, Lima 18, Peru.

(From Dialogue on Diarrhoie Issued No. 59.)

HIV Infection and Breastfeeding

HIV infection has no adverse effect on lactation and lactation has no adverse effect on the course and outcome of HIV infection. Both HIV and antibodies to HIV are present in breast milk; presence of antibodies to HIV may provide some protection against transmission of HIV infection through breast milk. Research studies indicate that transmission of HIV through breast milk accounts for 1-3 per cent of all mother to infant transmissions. Isolation of HIV from breast milk and the reported instances of HIV transmission through—breast milk have led to the public apprehension and debate about advantages of breast feeding in the era of the HIV pandemic. The concern has been heightened by the apparently conflicting recommendations of the advisory panels on breast feeding in seropositive women.

Breast feeding offers protection against a wide variety of infection and hence is crucial for survival for the high risk HIV infected neonates who might also be pre-term and have low birth weight. There are no tests by which HIV infected infants could be identified at birth. Unless all infants born to seropositive mothers are breast fed, HIV infected infants will be denied the benefit of breast feeding. The advantages of breast feeding by far out weigh the small potential risk of HIV infection through breast feeding. Therefore, in the Indian context, breast feeding by the biological mother is to be advocated in all infants born to seropositive women.

In India very few of the infected mothers can be detected because universal HIV testing is not possible. Breast teeding is essential for infant survival and growth especially among the poorer segments of the population, because infant food formulae are neither affordable nor safe. Hence breast feeding by the biological mother should continue irrespective of the HIV infection status of the mother or infant, known or unknown. Promotion of breast feeding by all mothers will therefore continue to be the national policy.

(Reprinted by permission from ICMR bulletin, Vol. 25, pages 78-79 written by Dr. P. Ramachandran, Advisor — Health Planning Commission, New Delhi.)

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).

The clinical challenge of the HIV epidemic

Charles Gilks argues that health systems in developing countries need to focus on treating common diseases such as pneumonia which are the main cause of illnesses in people with HIV.

Africa is bearing the brunt of the HIV epidemic, but the virus is now spreading most rapidly in Asia. It is clear that HIV infection will be a major problem in most developing countries for the foreseeable future.

However few comprehensive studies have been carried out to find out how HIV (which slowly, but progressively, weakens the body's immune defences) is affecting the pattern of illness and death in developing countries. Most research has focused on adults rather than children. Nevertheless, several facts are becoming clear.

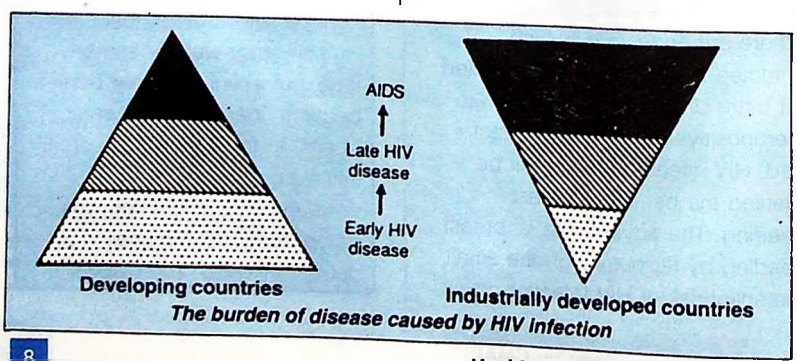
First, there are many differences between HIV infection in developing countries and AIDS in rich, industrialised countries. Unfortunately this means that much of the information and knowledge from the USA and Europe is of little practical relevance or use to health workers in developing countries.

Secondly, a different range of infections is found in HIV positive people in developing countries. In these communities ordinary infections such as *Streptococcus pneumoniae, Mycobacterium tuberculosis* and the salmonellae are common causes of illnesses in HIV-infected people because of intense exposure to these organisms in poor and overcrowded communities.

Thirdly, these infections occur relatively early in the course of HIV infection when the body is still able to respond well to standard treatment, so special drugs are not usually necessary. The bacteria that cause these infections are virulent and cause much illness and death even in adults and children with normal immune defences.

Fourthly, relatively few adults and children with HIV survive for long when they only have access to limited health care. Death occurs in the early stages of HIV caused by problems that are often treatable with standard drugs. Few people with HIV live long enough to develop unusual opportunistic infections such as pneumocystis pneumonia, atypical mycobacteria, disseminated viral infections or unusual lymphomas which are common in the USA and Europe. This is because these illnesses occur only with advanced HIV when the immune system is very badly damaged.

Finally, focusing on a clinical definition of AIDS will miss much of the disease burden caused directly by HIV in developing countries where ordinary illnesses early in the course of HIV are much more likely. The clinical definition of AIDS emphasises end-stage problems such as chronic diarrhoea and wasting, for which symptomatic relief is usually the only affordable option. Concentrating on this tends to divert attention away from the treatable illnesses that are common in early HIV infection



The burden of disease caused by HIV infection

such as pneumonia, tuberculosis and salmonellosis.

The most important lesson is that much early HIV disease is already being successfully treated, although it is usually not recognised as being HIV-related. The despair that health workers tend to feel when confronted with HIV/AIDS related illnesses should be balanced by the knowledge that effective treatment can often be given. A range of care needs to be available - from cure of early HIV-related infections, to giving symptomatic care for end-stage illness - with support and counselling at all stages.

The clearest implication is that there will be a large increase in the numbers of people with straight forward pneumonia, tuberculosis and salmonellosis - diseases which are already important public health problems.

The challenge is to provide more of the existing drugs and services with limited resources, staff and infrastructure. Much treatment will need to be hospital-based. There will also be large increase in specific HIV-related problems such as chronic diarrhoea and wasting, for which new solutions have to be developed. These chronic, incurable problems are often best dealt with in the home with active community involvement.

Internationally, more attention needs **to be given to the issue of care.** The consequences **of ignoring** the health care needs of millions of individuals with **HIV infection** are catastrophic. Much can be done to confront the clinical challenge of the HIV epidemic. Indeed much is already being done to great effect. In the words of a slogan I saw recently at The AIDS Support Organisation (TASO) in Uganda: 'No hope? Just cope.'

Dr Charles Gilks, Liverpool School of Tropical Medicine, Pembroke Place, Liverpool, L3 5aA, UK.

Editor's note: This article is based on the author's experience in Africa. We would welcome feedback from readers in India about how HIV is affecting child health care.

HIV Infection And Pregnancy

HIV Infection - Pregnancy Interactions

Contrary to the initial reports, pregnancy does not have any adverse impact on course of HIV infection. HIV infection, does not appear to have any adverse effect on health of the pregnant women, course of pregnancy, labour peurperium or lactation.

HIV readily crosses the placental barrier. The consequences of intrauterine infection on the foetus vary depending upon the period of gestation at the time of infection, degree and duration of viraemia. Increased abortion rates have been reported from Africa but it is not clear whether this is due to HIV infection or to other confounding factors. The available minimal data mainly from the European collaborative study indicate that use of AZT in early pregnancy is not associated with any increase in the abortion rates or congenital malformation rates. Data from collaborative studies in the USA indicate that use of AZT in the second and third trimesters of pregnancy is not associated with any adverse effect on the baby except for a higher prevalence of anaemia. Data, however, are insufficient to draw any firm conclusions regarding the absence of any adverse consequences on the foetus or beneficial effect in terms of reduction in the intrauterine transmission rate. Maternal HIV infection is associated with a higher rate of premature delivery, intrauterine growth retardation and higher perinatal mortality rates.

Screening for HIV in Pregnancy

Screening for HIV during pregnancy along the lines of screening for syphilis during pregnancy has many ardent advocates. The major reason for screening for STD like syphilis in pregnancy is to provide therapeutic intervention to prevent intrauterine infection. This justification does not exist for HIV. In many developed countries counseling women about STDs and HIV and, after obtaining informed consent screening them for STD including HIV has been included as a part of the "routine" antenatal care. In these situations there are adequate facilities for post test counseling and care of

women if any are found to be seropositive. In India such facilities are neither available nor affordable. Counseling for medical termination of pregnancy (MTP) in early pregnancy in parous seropositive pregnant women may provide the rationale for HIV screening in women who report early in pregnancy in our country. However,screening of all pregnant women is impossible because majority do not attend antenatal clinics; screening facilities are neither available nor affordable. So most HIV infected asymptomatic women will continue to remain undetected.

Management of Pregnancy in Seropositive Women

The fate of the unborn child is the major reason for concern regarding HIV infection in pregnancy. To prevent these potential calamities, MTP may be done in the first trimester, should the patients desire it. However, many of the known seropositive women may not opt for it especially if they do not have a living child.

Women who want to continue pregnancy should be provided with adequate, appropriate, antenatal care. In the USA in woman who opt to continue pregnancy, the prophylactic use of AZT is considered especially with falling CD4 count8; many obstetricians prescribe prophylactic chemotherapy against pnuemocystis pneumonia. In developing countries like India, seropositive women who opt to continue pregnancy are provided with antenatal care; specific efforts are made to promptly diagnose and treat any opportunistic or pathogenic infections in these women. Routine CD4 cell counts, prophylactic chemotherapy against infections in immunocompromised individuals and prophylactic therapy with AZT or similar virucidal drugs are not possible or affordable.

During labour specific efforts may be taken to reduce any invasive procedures such as scalp vein blood sampling, use of scalp electrodes to monitor foetal heart rate, to reduce the risk of transmission of infection to the foetus during labour. In the Indian context caesarean section is associated with maternal consequences not only in the present pregnancy but also in the subsequent conception. Hence normal vaginal delivery will continue to be the mode of delivery in HIV infected women who do not have any specific indications for caesarean section until such time as there is unequivocal proof that the risk of HIV transmission is lower with caesarean section. Stringent precautions should be taken to prevent accidental spread of HIV infection while providing health care especially during delivery. Specific efforts have to be made to keep appropriate provisions for looking after the low birth weight neonates.

HIV And Breast Feeding

HIV infection has no adverse effect on lactation and lactation has no adverse effect on the course and outcome of HIV infection. HIV has been isolated from breast milk. HIV antibodies are also present in breast milk and their presence may provide some protection against transmission of HIV infection through breast milk.Estimated risk of transmission of HIV infection through breast milk is between 1-3 per cent of all the perinatal infections.

Breast Feeding in Seropositive Women

All available data suggest that breast feeding will protect HIV infected infants from other infections and may prolong the survival period.There are no tests by which infected infants could be identified at birth. Unless all infants born to seropositive mothers are breast fed, HIV infected infants will be denied the benefit of breast feeding. In view of this it is essential to encourage all seropositive women to breast feed. In India, the advantage of breast feeding by far outweigh the small potential risk of HIV infection through breast feeding; this is especially important in seropositive mothers from low income groups among whom, breast feeding holds the key for infant nutrition, growth,relative freedom from infection and survival. Therefore, in the Indian context, breast feeding by the biological mother is to be advocated for all infants born to seropositive women.

Breast Feeding in the HIV Epidemic

In India breast feeding is essential for infant survival and growth especially among the poorer segments of the population. Hence breast feeding by the biological mothers should continue irrespective of the HIV infection status of the mother or infant, known or unknown. Promotion of breast feeding should continue to be the national policy.

HIV Infection And Immunisation

Increasing prevalence and awareness of HIV infection has led to concern about efficacy and safety of immunisation of the infants born to seropositive mothers and queries about the Universal Immunisation

Programme (UIP) in the absence of any information on the HIV status of the majority of infants.

Immunisation in Seropositive Infants

HIV infected infants are apparently healthy and do not have any immunodepression at birth. They usually remain asymptomatic during the first six months of life. They respond normally to immmunisation administered during the asymptomatic period. Experience with inactivated vaccines given to HIV infected children indicate that these immunisation are free from major short or long term side effects. Immunisation might offer some protection against the common infections during infancy in HIV infected children when immunodepression occurs. It is therefore essential that all infants born to seropositive mothers should receive all the vaccines on schedule. Special attention should be given to ensure that these infants receive BCG vaccination soon after birth, because (i) BCG vaccination cannot be given to infants once immunodepression sets in, and (ii) tuberculosis is one of the most common pathogenic infections in HIV infected infants in developing countries like India. If for any reason BCG vaccination was not administered at birth it should be administered as soon after birth as possible. **However, BCG vaccination should not be administered in seropositive infants if they have become symptomatic for AIDS.**

It is essential to ensure that all seropositive infants receive DPT, polio and measles vaccines on schedule. If given on schedule most of the infants would have completed their immunisation prior to onset of symptoms. If seropositive infants had not received immunisation on time and have become symptomatic, it is essential to give them DPT, polio and measles vaccine, because (i) all the available data indicate that in immunocompromised HIV infected infants risk of natural infections is greater than the risk of immunisation even with live attenuated vaccines (except BCG); and (ii) so far no major adverse effects of vaccination on HIV infected infants have been reported. Some paediatricians advocate that in symptomatic HIV seropositive infants killed polio vaccine may be used instead of OPV.

Universal Immunisation Programme and HIV Epidemic

The WHO Expert Group on Immunisation has recommended that there is no need to modify any of the existing guidelines for the Universal Immunisation Programme; all asymptomatic infants irrespective of the fact that HIV status of the mother or infant is not known, should receive all vaccines both live attenuated and killed as per the existing schedule. The advent of the HIV infection only calls for continued vigorous implementation of UIP even after the advent of the HIV epidemic. It is essential that the immunisations are administered on schedule so that all infants receive all the immunisations except measles before six months of age when almost all the HIV infected infants are in the asymptomatic phase.

HIV And Children

During the first six months of life, growth and morbidity of HIV infected infants is similar to uninfected infants from the same community; subsequently repeated infections and growth faltering appear. Paediatric AIDS is characterised by failure to thrive, poor weight gain/actual weight loss, hepatosplenomegaly, recurrent fever, respiratory infection, diarrhoeal diseases and bacterial or fungal infections of the skin.

Because of the limitations of the HIV screening programme in women, the majority of seropositive infants in India will remain undetected during infancy. Growth monitoring and investigation of infants showing growth retardation and repeated infections is likely to be the common method by which paediatric AIDS patients are detected in India.

Care of HIV Infected Infants

Physicians in developing countries advise admission only for treatment of life threatening infections and malignancies in children with AIDS. Monitoring of HIV infected children, providing appropriate care for repeated episodes of pathogenic/ opportunistic infection are best done at home with the help and cooperation of the family members. Children are certainly happier at home, than in the crowded hospital wards among strange, ill children. Hospital admission for only gravely ill children is a useful strategy to ensure that inpatient beds are not all taken up in the care of chronically ill children with AIDS and adequate beds are available for care of children suffering from other illnesses.

Reprinted by permission from ICMR bulletin, Vol. 24 Pages 122-124 written by Dr. P. Ramachandran Dy. Director General ICMR H.Q. New Delhi).

Breastfeeding and Reproductive Rights

Breastfeeding has been given global recognition for its contribution to child survival at international conferences and in international documents.

Less attention, however, is given to its significant role in empowering women. Breastfeeding empowers a woman by allowing her to control her own fertility and enhance her health as well as that of her children. The knowledge that a breastfeeding mother is less likely to become pregnant is part of the traditional wisdom of many cultures. *Breastfeeding is a woman's reproductive right which should be protected, supported and promoted.*

Current research confirms that as long as a woman is fully or nearly fully breastfeeding, and has not resumed menstruation, she has a less than 2% risk of becoming pregnant. Family planners know this method as Lactational Amenorrhea Method (LAM). In areas of the world where artificial contraception is unaffordable, unavailable or unacceptable, breastfeeding provides a woman with an effective means of family planning. A decline in breastfeeding rates contributes to the increase in birthrate where artificial means of family planning are not used.

Breastfeeding allows a woman to space births effectively, according to her own fertility, independently of any possible forces within her society which would hinder her right to control her own fertility.

HOW Breastfeeding Empowers Women

1. Breastfeeding confirms women's power to control their bodies, and challenges the bio-medical model and business interests that promote bottle-feeding.
2. Breastfeeding reduces women's dependence on medical professionals and validates the tried and trusted knowledge that mothers and midwives have about infant care and feeding.
3. Breastfeeding encourages women's self-reliance by increasing their confidence in their ability to meet the needs of their infants.
4. Breastfeeding helps child spacing, reduces the risks of anaemia and provides protection against ovarian and breast cancer, osteoporosis and multiple sclerosis.
5. Breastfeeding requires a new definition of women's work-one that more realistically integrates women's productive and reproductive activities, and which values both equally.
6. Breastfeeding requires structural changes in society to improve the position and condition of women.
7. Breastfeeding challenges the view of the breast as primarily a sex object.
8. Breastfeeding encourages solidarity and cooperation among women at the household, community, national and international level.

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