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"Proposed film to encourage breast-feeding in hospitals", outline (second version) prepared by John Balcomb, UNICEF, describing the technical educational film on breastfeeding prepared by UNICEF.

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Notes

20 pp

The outline describes the film, shot at the Baguio General Hospital in the Philippines. It details changes made to the hospital routine at the Maternity Centre, and explains in medical terms the greatly improved survival rate and health of babies and their mothers. Dr. Clavano became convinced of the merits of breastfeeding while doing post-graduat work in medicine in London, and on her return to the Philippines set about to put her ideas into practice. The document also discusses how the film should be edited and presented for maximum impact of the points being made. Testimonials by well-known obstetricians and doctors reinforce the message.

Print Name of Person Submit Image	*Signature of Person Submit*	*Number of images without cover*
Saroja Dewgun	Saroj. Dewgun.	20

UNICEF Information Division
Radio-TV-Film Services

= Medical Schools ?
= Trainni of hostesses ?
= Hospital administrators ?
= Hospital designers ?
= architects ?

? General consumption.
? Specified audience.

PROPOSED FILM TO ENCOURAGE BREAST-FEEDING IN HOSPITALS

Outline* (second version)

Opening sequence shows baby being born in Baguio General Hospital and put to breast immediately.

Dr. Clavano introduces herself and explains. It wasn't like this seven years ago, she adds. Then she tells her story... her story, in effect, illustrating, in the span of a few years, the story of the decline and subsequent resurgence of breast feeding in the most forward-looking hospitals around the world.

Documentary
60 minutes
people

Interspersed in Dr. Clavano's story will be testimony by prestigious "witnesses" in the medical profession. (She can, for example, pick up a document and say: "Here's what Dr. Catherine Lobach, of Albert Einstein Medical College in New York says..." Then cut to filmed statement by Dr. Lobach).

Switzerland

What it was like seven years ago in Baguio will be shown by footage taken in a hospital where the old practice of isolating neonates is still the norm. (One could probably be found in Philippines).

Brazil

How did this come about? Principally fear of cross infection. After all, this was a terrifying threat in the old days, particularly before the discovery of penicillin and other modern drugs. Introduce Dr. Keithley T. Santos, who was head of obstetrics at Baguio to discuss this.

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*Prepared by John Balcomb - June 1982

How do Routine hospital procedures discourage breastfeeding.

Separation of mother and neonate led to a decline in mothers breastfeeding on discharge from hospital... and increase in use of artificial feeds... but this was, somehow, considered a normal concommitant of urbanization and economic development. It was what had been taking place in the industrialized countries when leading medical people from developing countries had studied there... and, of course, the very low infant mortality rates achieved in the industrialized countries were "what we all hoped to realize in our own countries."

Dr. Clavano briefly points up problems that they didn't seem to be able to cope with: continued incidence of diarrhea, thrush and respiratory disorders in hospital nursery; unsanitary and inadequate bottle feeding when mothers returned home; and large numbers of babies readmitted with malnutrition and other disorders in first few months. (All these can be shown on film).

Then Clavano (1974) went to London to do post-graduage work with Dr. David Morley and his associates. He converted her to breastfeeding beginning with change of hospital procedures to facilitate it in every way. She has described this experience as an "epiphany" -- and we bring in, very strongly, the discoveries then being made (and still being made) about the remarkable anti-infective, immunogical and anti-allergic properties of human milk. (These had been suspected for quite some time, but aside from a few nutritionists, nobody had paid much attention to them. Beginning about 25 years ago, however, researchers began to identify the specific agents responsible for these properties-- the current WHO/UNICEF "Infant and Young Child Feeding: Current Issues" described them in detail on 10 pages. pp 103-112).

This section has to be strong--backed up by authoritative opinion, even if it interrupts the main story line somewhat. Dr. Clavano also learns that after declining for many years breastfeeding is making a strong comeback in some of the leading industrialized countries, notably the U.S. and Scandinavia. And, contrary to the situation in the developing countries, breastfeeding in the West is now more common among better educated middle class women than among the poor. In short, "It's the coming thing."

In 1975 Dr. Clavano returns to Philippines, determined to try to change hospital practice at Baguio. The nursery is shown decorated with

posters from the infant formula companies. Nurses regularly pop bottles in babies mouths. Before she can do anything, she must enlist co-operation of the head obstetrics, Dr. Keithley Santos-- and she obtains this. Santos should make another statement on camera at this point. We show the two of them discussing their strategy.

Clavano describes how they proceeded step by step-- and we illustrate these steps on camera.

Quote from Clavano: (Assignment Children, 55/56, p. 145) "How does one break the strong hold that milk companies have on doctors, nurses and hospital staff?

Step 1. Convince hospital administrators that breastfeeding is practical and economic.

Step 2. Reorienting hospital staff, including residents and nurses. Some, for example, regarded breast-fed infants' normal stool as alarming, since it's not as well-formed and bulky as bottle-fed infants' stool. Reorienting nursery staff to the mechanics of breastfeeding and rooming in. Distributed educational materials to staff and held weekly discussion meetings. A restaging of a weekly discussion meeting gives opportunity to introduce misgivings of some staff members, particularly concerning cross infection.

Step 3. Introduce early post-partum breastfeeding and rooming in among women who wanted to.

Step 4. (Not necessarily in this order). Tear down milk company posters in nursery and bar salesmen from premises, putting up "bottle is baby-killer" posters.

Step 5. Education work among mothers who at first didn't want to nurse by medical and nursing staff. Owing to extensive promotion by formula companies, many women feel breastfeeding a mark of poverty -- implies they can't afford the best for their babies.

Step 6. Education work and special measures among problem cases... training mothers to look after their at risk children -- reassuring them that adequate milk will come in -- setting up mother and child room in part of the former nursery where mothers stay and help look after preemies and fragile babies.

Step 7. As early results came in, the virtual disappearance of diarrhea and clinical sepsis convinced any members of staff who still had

doubts -- including the hardest cases of all, nurses and women physicians who gave birth in the hospital and wanted to bottle feed.

Results Dramatic ... after first two years of new programme. Dr. Clavano describes with aid of charts: fig. 1 (maybe simplified into bar charts), fig. 2, fig. 5, and fig. 6 from Clavano's article in Assignment Children 55/56.

In May 1978 Clavano testifies before the US Senate Subcommittee on Health and Scientific Research, which was investigating the infant formula thing in developing countries. On her return she resolves that bottle feeding (still continued at 5.88% -- bottle and mixed) should be completely eliminated at Baguio General Hospital.

This is the final step. Step 8, I guess. ~~ff~~ mothers who can't breastfeed at first, baby given to a woman who has plenty of milk. For preemies who can't suckle, b-milk expressed manually; kept in refrigerator; given to baby by eyedropper. Never bottle, which discourages proper sucking reflex. These can all be shown, of course.

Here we need clinching arguments that "it's feasible." Some more testimony by prominent witnesses.

Dr. Allan Cunningham (Imogene Bassett Hospital, Cooperstown). Mixed rural, small town clientele, including both poor and middle class. Very modern hospital-- well endowed, complete medical care with doctors organized along lines of group medicine. Rooming in presented no real problem-- once it was started, it actually reduced work load of nursing staff. Results very good. (Head nurse: Mrs. Jean Thompson. Some difficulty with the State of New York-- but last year--April 81 April 82-- 70% breastfeeding. On demand-- no longer four hour cycle. "They didn't have to convince me; I've had five children myself and breastfed all of them.") Cunningham did a study: in first two months of life, illness is 16 times more frequent in bottlefed than breastfed babies. Five times more respiratory infections. Two to three times more otitis media. Twice as many gastro-intestinal disturbances. In the case of Imogene Bassett, bottle-fed infants have more than fifteen times as much chance of being rehospitalized during the first four months of life as breast fed, with a cost of $892.-in medical costs for each!

Even more convincing testimony could come from the University of Colorado Medical Centre in Denver, Los Angeles County Hospital, or San Diego--where up to 90% breastfeeding now attained.

- breast feeding failure processes
- infections
- savings on staff

+ Mother educ.
+ T/orientation of staff
+ Cost & medication

Convincing testimony could also come from the University of Colorado Medical Centre in Denver; Los Angeles County Hospital, where 90% rate of breastfeeding has now been attained among a largely Hispanic clientele, or San Diego's University Hospital.

The case of San Juan de Dios Hospital, in Costa Rica, could also be brought in here. Here Leonardo Mata and his colleagues managed to introduce universal breastfeeding, as opposed to the old pattern of separation and artificial feeding, with results as dramatic as those reported by Clavano in terms of infant morbidity and mortality.

Catherine Lobach could testify here as to unjustified footdragging she's encountered among hospital administrators in New York (to suggest that being out-of-date in this regard is not exclusively a problem related to developing countries) and to emphasize that in-hospital breastfeeding on demand and rooming in do not disrupt hospital routines if everyone is properly motivated. Here, too, Lobach could make the statement she herself suggested to me:

"Administrators and gynaecologists: If you heard of a new procedure that could cut morbidity among neonates and young infants by more than 50%, wouldn't you move heaven and earth to get it for your hospital, even if it involved the expenditure of many thousands of dollars? Here's one that won't cost you anything-- just a change in routines and reeducation of staff."

Shots of happy parents taking healty babies home in both developed and developing country settings.

Back to Clavano. Repeat shot of newborn baby being put to breast.

"You can't overlook social implications, either," she says. The bond established between mother and infant when the child begins to nurse immediately after delivery is one of the strongest bonds in the world. In the old days, many unmarried mothers simply abandoned their babies after giving birth at Baguio General. Today--when babies are brought to their mothers within 30 minutes for normal deliveries and within four to six hours for caesarians--this problem has disappeared. This experience has been duplicated in hospitals following these procedures in Costa Rica, Brazil, and Nicaragua. In the U.S. studies have shown that an unusually high percentage of infants hospitalized on account of physical maltreatment by their parents (the "battered baby syndrome") were separated from their mothers at or near birth.

Most of these were prematures or other low birth-weight babies, and at Baguio General we involve the mothers in the care of such infants from the beginning.

Move to wrap-up with Clavano. "It is as a practicing pediatrician, though, that I find the most gratifying results of our rediscovery of breastfeeding at Baguio General. At our hospital, babies come back to us when they get sick, so when we make mistakes, we have to live with the consequences. This is our infant malnutrition ward"-- points to empty beds-- "In 1975 this used to be full. Today, we concentrate on teaching better supplementary food practices to mothers since the incidence of malnutrition and associated infection among children up to the age of four months has dropped so sharply with increased breastfeeding." Nurses who used to be preoccupied with giving bottles to babies in the well-infants nursery, now freed to concentrate on health and nutrition and education in well-babies clinics. (Show such a session).

Benefits

"It took a little trouble to change hospital routines...is there any doubt it was worth it?"

Costs

Quick montage of shots: neonate nursing in birthing room, rooming in, mothers' room in former nursery, and healthy kids at well-babies clinic.

CREDITS

Annex I

Identify Specific areas on which they have strongest testimony - detail them to Clavano's story.

A note on possible "witnesses"

Experts to testify as "talking Heads"

Any of the persons I interviewed would be happy to testify on film. These were:

Ed Baer, Associate Director Infant Formula Programme,
Interfaith Centre for Corporate Responsibility,
475 Riverside Drive, NYC 870-2295

Leah Margulies, the Co-Director of the programme

Joe Wray, Centre for Population and Family Health,
Columbia University, 60 Haven Ave. (Columbia switchboard)

Dr. Deborah Hales, ditto

Dr. Catherine Lobach, Director Pediatric Services,
Comprehensive Family Care Centre, Albert Einstein
College of Medicine, 1175 Morris Ave., Bronx.

Lobach, for one, said: "What I'd like to tell hospital administrators is-- if you knew of a new procedure that would cut morbidity in neonates by at least 50%, wouldn't you move heaven and earth to get it? Well, here it is." She said she'd love to say it on film.

These people suggested a number of other experts we might use as witnesses. Ed Baer noted that obstetricians control the routine in hospitals, so we had better get some prominent obstetricians to testify.

Possibilities:

1. Pierre Mandl has apparently persuaded the head of the World Federation of Obstetricians and Gynaecologists to write a statement in favour of breastfeeding. This person (whose name no-one here seems to know) would be excellent for an on-camera statement if we can arrange.

2. Dr. Leonardo Mata, Director
Institución de Investigaciones en Salud (INISA)
University of Costa Rica, Ciudad Universitaria
"Rodrigo Facio"
Costa Rica -- telephone office 243-668
home 357-165

3. Dr. Caldyero-Barcia, professor of obstetrics and gynaecology, University of Uruguay, Montevideo. He is the author of the major textbooks in this field used in Latin America and his statement would carry a lot of weight. He is for breastfeeding, of course.

4. Dr. David Morley in England, of course, "converted" Clavano. He'd be a good witness.

5. Dr. Fred Sai of Ghana (now associated with UN University), P. O. Box 197, Accra.

6. Jelliffe, at School of Public Health, University of California at Los Angeles, would be glad to testify of course.

7. Best work in U.S. so far as hospital-scene goes being done in the West. Following are names:

   a. Marianne Neifer, Dept. of Pediatrics
   University of Colorado Medical Centre
   Denver 80602. (The University Hospital is said to be just about the best from breastfeeding point of view).

   b. Kittie Frantz, Director, Breastfeeding Infant Clinic Los Angeles County USC medical Centre
   Los Angeles 90033-- telephone (213) 226-3644

   c. Audrey Naylor, Director Lactation Programme
   University of California Medical Centre,
   University Hospital, 225 Dickinson St.,
   San Diego, CA 92103

8. In New York, Dr. Michael Katz, Head of Pediatrics Department, Columbia and Director of Babies' Hospital.

Dr. Irwin Merkatz, Chairman of Obstetrics, Albert Einstein Medical College, would make a strong statement.

9. Marshall H. Klaus, Chairman Department Pediatrics Michigan State University--East Lansing, Michigan 48823

Klaus "put bonding on the map", so they say--is quite famous.

10. In Brazil, Ed Baer recommends:

Dr. Marina Rea, Dept. Nutricao FSPUSP

Ave. Dr. Apinaldo 715, Sao Paulo SP 01255

But no doubt our people in Brazilia will have other strong candidates.

Cunningham
607-547-3456

Annex II

Background notes on hospital practices and breastfeeding

Hospital practices which are current in most of the world inhibit breastfeeding. As more and more birthings in the developing countries take place in hospitals, breastfeeding can be expected to decline unless these practices are changed.

Winikoff and Baer put it nicely: "Technological progress has permitted enormous advances in the care of sick and abnormal infants, but routine hospital procedures for healthy infants in many cases, appear to interfere with normal physical and psychologycal processes... Anything that restricts feeding contact during the first ten days of life is associated with less successful breastfeeding. Included are separation of mother and baby after birth, introduction of prelacteal feeds and/or supplementary feeds, feeding on a rigid schedule, and drugs administered in labor."

Manufacturers of infant formulas are well aware of the importance of hospital practices in establishing infant feeding patterns. In the United States they supply hospitals with their products free and give free samples to mothers leaving the hospitals. Free samples are routinely passed out in the developing countries as well, and often mothers in the obstretric wards are visited by company representatives disguised as "milk nurses" who advise them on artificial feeding. Indeed, gaining access to maternity units, by hook or crook, is regarded as a "must" by the sales managers of these companies.

How did hospitals come to adopt routines that inhibited breastfeeding? Fear of infection seems to have been a very important factor. As Klaus and Kennell point out, in the early 1900's in the industrialized countries the high rate of morbidity and mortality among hospitalized patients with communicable diseases led to strict isolation techniques for diseased patients and separate wards with protective isolation for those free of infection. "In children's hospitals concern about protecting patients from contagious disorders led to what today appear to be bizarre policies of isolation and separation... Not only was diarrhea epidemic but respiratory infections were a scourge of children's hospitals and maternity and infant units."

In fairness, it must be noted that until the discovery of antibiotics, isolation was about the only way large hospitals could cope with cross-infection. Separation of the neonate from its mother during their stay in the hospital thus became routine. In Charity Hospital in New Orleans an epidemic among babies so terrified the staff that the nursery was moved to a separate building from the obstetrical ward and mothers were not allowed to touch their babies until they were discharged. This is still the basic practice at Charity, though a few rocking chairs have now been placed in a small room off the nursery for mothers who insist on holding their babies in their laps. Martin Cooney, an early pioneer in caring for premature babies in incubators used to exhibit them at World Fairs. Mothers were not allowed to take care of their infants at Cooney's exhibits but were given free passes. On some occasions he had great difficulty getting mothers to take their babies back when they had grown to 5 lbs.

Then, too, as better infant formulas were developed, the idea seems to have taken hold that bottle feeding was somehow more "scientific" as well as being a mark of progress and modernization. Pediatricians believed that the neonate needed artificial feeds to prevent weight loss before the mother's milk came in. In the case of low birth weight or at-risk infants, artificial feeding was almost always prescribed--among other reasons, because the amount taken by the child could be accurately measured (again, more "scientific"). The formula companies naturally encouraged these beliefs, and as Joe Wray of Columbia puts it, developed a "very cozy relation" with pediatricians. Breastfeeding was, of course, permitted. There was lipservice on the part of most professionals to the value of breastmilk. But rooming in was almost unknown. The child would not be brought to its mother to nurse until at least 24 hours had passed, and then only on a regular 4-hour schedule. Under such circumstances, failure of lactation became common.

In the developed countries it seemed, until 20 years ago, that breastfeeding was on the way out. In the United States the percentage of mothers nursing their infants on discharge from hospital fell from 65% in 1946 to 14% in 1971. (Lobach). Comparable declines took place in Scandinavia. (See graphs in Helsing, "Infant Feeding Practices in Northern Europe," Assignment Children 55/56, pp 78-79). Since then, there has been a sharp reversal in these countries--the rate has bounced back to 50% in the U.S.

Comparable statistics are difficult to obtain for the developing countries, but it seems to be the case that the decline in breast feeding set in later in these countries and is still continuing, especially in urban areas. (WHO/UNICEF- "Infant and Young Child Feeding").

There are interesting differences. In the U.S. and Scandinavia, the return to breastfeeding has been most marked among middle-class women, least marked among the poor. For instance (Lobach) in the U.S. incidence of breastfeeding at discharge from hospital in 1978-79 was 41% for clinic patients, 47% for private patients. In New York City the discrepancy was even greater: 21% as against 47%. Helsing reports similar discrepancies in Scandinavia, where, she feels, the recent overall resurgence of breastfeeding was initiated by the better educated mothers themselves, with the medical profession following. In the U.S., also, indications are that the greater use of rooming in etc., in private hospitals was initiated by "public demand."

The poorest groups in countries like the U.S. are not in a position to demand changes in hospital procedures, and among recent immigrant groups from the Caribbean and the deep South there is still a feeling that breastfeeding carries with it a stigma of a deep poverty--that mothers who can afford to, should buy formula for their babies.

In the developing countries, so far as can be ascertained, the decline in breastfeeding is most marked among the more economically advantaged classes. In the Philippines (1975-77) it was found that in the urban community a third of the economically advantaged mothers had never tried to initiate breastfeeding, while only a sixth of the mothers from the urban poor community had never been breastfed. (Clavano). In Guatemala (WHO study) the corresponding percentages were 23% among the urban well-to-do and 9% among the urban poor.

Worldwide, therefore, it appears that it is among the more affluent, better educated mothers that the trend has been set: first away from breastfeeding (up to 1971) and then back to breastfeeding in the developed countries; away from breastfeeding in the developing countries, with the countertrend still to come, or just beginning to.

Breastfeeding and Health

Wray has cited a great deal of historical evidence showing dramatically lower morbidity and mortality figures among breastfed infants over "artificially-fed" infants in the late 19th and early 20th centuries in Europe and the U.S. However, as better artificial feeds were developed and as standards of sanitation generally improved, infant morbidity and mortality rates dropped sharply in these ~~centuries.~~ countries. By the 1960's, when only a minority of mothers were breastfeeding in the developed countries, and when infant mortality rates had fallen to less than 20 in these countries, it might have seemed to health officials from the developing world, anxious to reduce their own infant mortality rates to these levels, that other things being equal, breastfeeding was not very important from a health point of view.

Other things were not equal, of course. Few mothers in the developing world were in a position to use the necessary sterile procedures in bottle feeding, and because powdered formulas were expensive they often overdiluted them. Opponents of bottle feeding in the 1950's and 1960's concentrated chiefly on these arguments-- which are as valid today as they were then. To pediatricians and public health personnel, these were convincing reasons to fight the decline in breastfeeding; but hospital administrators, concerned primarily with what happened on their own premises, were inclined to go along with the isolation techniques they had observed in hospitals in the West where they had studied. The fact that keeping mothers and neonates apart as much as possible in the hospital led to a great deal of lactation failure did not concern them a great deal, so far as can be judged.

As recently as 25 years ago, Bo Valquist, the distinguished Swedish nutritionist, reported that there was no solid evidence that breast milk in itself prevents infection. According to Teply, this is not strictly true: Paul Gyorgi in the early 60's reported on the bifidus factor in human milk which promotes the growth of favourable gut bacteria; Lars Hansen of Sweden later identified immunogobulin A in breast milk. But it took pediatricians 10 years to accept these findings; and the real wealth of evidence as to anti-infective properties of breast milk has come in the past 15 years. Today there is a "hell of a lot of evidence" for the anti-infective properties of

human milk, as Wray says. These are summarized in technical language in pp. 103-111 of Infant and Young Child Feeding, WHO/UNICEF 1981. These include various types of white cells (white cell content of breast milk is higher than that of blood!) which destroy harmful bacteria; the above-mentioned immunoglobulin A which protects mucous membranes from many different viruses and bacteria; an anti-staphyloccus factor; and specific antibodies against diseases to which the mother has been exposed. By avoiding foreign proteins, breastfeeding also diminishes the risk of allergic reactions in infants.

A great deal of epidemiological evidence has been accumulated confirming the anti-infective properties of breast milk-- which are particularly pronounced in colostrum, it should be noted. These factors are essential to protect the newborn arriving from a sterile environment into one full of pathogenic organisms. A number of studies in both developed and developing countries show that breastfed babies have lower rates of diarrhea, respiratory infections and otitis media (middle ear infection) than bottle fed babies. The WHO/UNICEF report states, for example, that "pathogens like Shigella, which cause severe diarrhea in artificially-fed infants, cause only insignificant symptoms in those who are breastfed."

Dr. Clavano's epidemiological findings in Baguio are very much to the point, of course. Also see Mata et al on experience in Costa Rica. In San Juan de Dios Hospital between 1976 and 1980 the old pattern of separation of formula feeding was replaced progressively by rooming-in, a colostrum bank plan with universal breastfeeding and skin-to-skin contact at birth. Morbidity due to diarrheal disease fell by 91%, lower respiratory disease 43%, and meningitis 92%. Cunningham's findings at Imogene Bassett Hospital in Cooperstown NY confirm this experience even in small-town/rural setting of modern conveniences, good hygiene, etc. Here in the first 2 months of life illness was 16 times more frequent in bottlefed babies -- twice as much for gastrointestinal disturbances, 5 times more for respiratory infections, 2-3 times more for otitis media.

Besides all this, of course, the nutritional qualities of human milk are unique-- and the "formula" of mothers' milk changes as the child grows. But babies can be successfully nourished on artificial feeds-- whereas the anti-infective qualities of human milk cannot be duplicated.

Bonding has also emerged in recent research as important concommitant of breastfeeding, particularly in the very earliest stages. Klaus and Kennell in the United States found that a high proportion of "battered babies" -- babies hospitalized because of physical abuse by their parents-- were babies separated from their mothers at birth for prolonged periods. In Philippines, Brazil, Costa Rica and Nicaragua the rate of abandonment declined sharply when early breastfeeding and rooming-in were initiated in various hospitals.

Implications for Hospital Practice

The recommendations of the 1980 Caribbean Workshop on Obstetric Management, Breastfeeding, etc. are worth noting: (pp. 14 et seq of report). Among other things:

> "A normal baby should be given to the mother immediately after birth and should be put to the breast (even before the completion of the third stage of labor).
> "The baby and mother should be together for at least twenty minutes and preferably they should not be separated at any time during the stay in hospital...
> "Routine formula feeding to newborn babies should be completely prohibited."

The recommendations also note that "breastfeeding is the method of choice for feeding low birth-weight babies." If the baby is unable to suckle, freshly expressed breastmilk, preferably from the mother, should be used. If the baby is in a special care unit, the mother should be encouraged to have as much contact with the baby as possible-- handling, nursing, changing, fondling, etc.

The trend is definitely toward these practices in the more progressive hospitals in the developed world, though it has been difficult to change old habits and routines. New York City's municipal hospitals do poorly in this regards. The best records in regard to breastfeeding for large hospitals serving poor communities are found in the Western U.S. Los Angeles County Hospital, with a largely Hispanic clientele, has a 90% rate of breastfeeding.

In the developing countries, these recommendations seem to have been completely realized in Baguio General Hospital in the Philippines, San Juan de Dios Hospital in Costa Rica and (perhaps) in Recife. In Nicaragua, the situation is more typical: progress is being made by a women's group dedicated to breastfeeding, but considerable resistance is being encountered by hospital staff.

Annex III

Notes on "Maternal-infant Bonding" by Klaus & Kennell

Russian proverb; "You can't pay anyone to do what a mother will do for free."

Refers to P. Budin's book, The Nursling, (London, 1907). Budin designed a glassed-walled incubator for preemies, which allowed mother to look at infant easily and permitted them to visit and care for their infants. Recommended mothers be encouraged to breastfeed their premature infants.

A pupil of his, Martin Cooney, went to the Berlin Exposition of 1896 where his Kinderbrutanstalt (child hatchery) for preemies was successful commercially. Since preemies were not expected to live, German doctors gave'em to Cooney. Cooney exhibited preemies at fairs in England and came to the U.S. where he exhibited them at expositions and settled on Coney Island. Last exhibited at N.Y. World's Fair of 1940. There's a picture of Cooney's exhibit at San Francisco, 1915-- big sign "Infant Incubators with Living Infants." Mothers were not allowed to take care of their infants at Cooney's exhibits, but got free passes. On some occassions he had great difficulty getting mothers to take their babies back when they had grown to 5 lbs.

In the early 1900's the high rate of morbidity and mortality of hospitalized patients with comm. diseases led to strict isolation techniques for diseased patients and separate wards with protective isolation for those free of infection. "In children's hospitals concern about protecting patients from contagious disorders led to what today appear to be bizarre policies of isolation and separation."

Visiting hours in major children's hospitals no more than 30-60 minutes/week. "The fear of spread of infection also accounts for the physical barriers often observed between individual beds in the older children's hospitals and the actual spacing between the obstetrical and pediatric divisions in the large general hospitals. Not only was diarrhea epidemic but respiratory infections were a scourge of children's hospitals and maternity and infant units."

Maternal-infant bonding, Marshall H. Klaus & John H. Kennell, C.V. Mosby Co, St. Louis, 1976.

Annex IV

Selected Bibliography

WHO/UNICEF. Infant and Young Child Feeding: Current Issues. Geneva, 1981. Covers the field of breastfeeding thoroughly. Especially useful to the researcher is Part II, Background Information, which includes up-to-date summaries of what is known about nutritional and anti-infective qualities of human milk. A technical description of the anti-infective factors alone takes up ten pages.

Caribbean Food and Nutrition Institute/Pan American Health Organization. Obstetric Management, Breastfeeding, Bonding and Subsequent Child Development: Guidelines for the Caribbean. Kingston, Jamaica, 1980. This report, developed in an international workshop on obstetric management and its effect on subsequent child development, reviews the latest findings on the various advantages -- nutritional, anti-infective, psychological -- of breastfeeding and recommends ante-natal, obstetrical and post-partum procedures to encourage it. A tightly written summary.

Kolasa, Kathryn M. Promotion and Protection of Breastfeeding Worldwide: Report of a Meeting of Journalists and Concerned Scientists. University Field Service International, Hanover N.H., 1981. Good review of information presented by Heyward (UNICEF), Prof. Joe Wray (Columbia); Dr. Deborah Hales (Columbia), Dr. Allan Cuningham (Imogene Bassett Hospital, Cooperstown, N.Y.), Dr. Doris Calloway (Berkeley) and others. Hales' discussion of hospital practices is of particular interest.

Wray, Joe D. Feeding and Survival: Historical and Contemporary Studies of Infant Morbidity and Mortality, 1979, mimeographed. Wray reviews extensive 19th century and early 20th century evidence dramatizing lower mortality rates among breastfed infants and moves up to the contemporary scene, reviewing recent statistical evidence and scientific discoveries confirming the benefits of breastfeeding. He also discusses the counterclaims put forward by the infant formula companies.

Winikoff, Beverly and Baer, Edward C. "The Obstetrician's Opportunity: Translating 'Breast is Best' from Theory to Practice." American Journal of Obstetrics and Gynecology, Vol. 138, No. 1, pp 105-117, Sept. 1, 1980. Reviews changes in hospital procedures that encourage breastfeeding, especially putting the child to the breast immediately on delivery and skin-to-skin contact. The authors note that "even minimal expression of interest by physicians" helps.

O'Leary de Macias, Geraldine. Promotion of Breastfeeding--How and Why. Genesis II, Managua, Nicaragua, 1981. Typed document. Genesis II, "a second beginning for children and women," is a Nicaraguan NGO working closely with the ministries of health, education and social welfare. This is an interesting account of Genesis II's effort to counter the apparent decline of breastfeeding in the country. "Even women who do breastfeed because of economic pressure," the author reports, "feel it would be better if only they could afford to buy the canned product." Hospital practices add to the problem, since in the urban centres babies are generally taken away from their mothers immediately after birth and there is no contact until the mother leaves the hospital. Some progress is being made in changing this.

UNICEF, "Breast Feeding and Health," special issue of Assignment Children, No. 55/56, 1981, Geneva. In this special issue, the following articles are particularly pertinent to the issue of breast-feeding and hospital practices.

Relucio-Clavano, Natividad. "The results of a Change in Hospital Practices--a Pediatrician's Campaign for Breastfeeding in the Philippines."

Anand, R.K. "The Management of Breastfeeding in a Bombay Hospital."

O'Leary de Macias, Geraldine. "A Woman's Movement in Nicaragua: an Advocate of Breastfeeding."

Helsing, Elisabet. "Infant Feeding Practices in Northern Europe."

Apple, Rima D. "To be Used Only Under the Direction of a Physician: Commercial Infant Feeding and Medical Practice, 1870-1940." Bulletin of

History of Medicine, 54, 1980, pp 402-417. How the "cozy relationship" between infant formula companies and pediatricians developed. The companies' advertising, at first directed to the general public, was later confined to medical journals; and pediatricians were encouraged to prescribe various proprietary products as a way of "building up a good practice." A fascinating story, wittily presented.

Cunningham, Allan S. "Morbidity in Breastfed and Artificially Fed Infants." Journal of Pediatrics, St. Louis. Part I, May 1977; Part II, November 1979. Cunningham reports on the significantly lower morbidity rates for breastfed as against bottle fed infants among those born in the Imogene Bassett Hospital, Cooperstown, N.Y. (Because Imogene Bassett functions as a community hospital, providing all medical services in Cooperstown through its clinics, the opportunity to follow up the progress of infants born in the hospital is exceptionally good).

Mata, Leonardo et al. "Promotion of Breastfeeding, Health and Growth in a Rural Area of Costa Rica." Position Paper presented at a Workshop in Bellagio in 1981. University of Costa Rica. About 84% of the mothers in Puriscal, a rural area not far from San José, the capital of Costa Rica, are delivered in the San Juan de Dios Hospital. The authors document the markedly lower rates of early infancy morbidity and mortality that accompanied implementation of universal breastfeeding in this hospital.

Lobach, Katherine S. "Effectiveness of a Breastfeeding Initiative at a Community Health Centre," paper presented at the 11th Annual Meeting of the Nation Association of Community Health Centres, 1980. Describes Dr. Lobach's experience is trying to encourage breastfeeding in a municipal hospital in Bronx, N.Y., and at the all-private hospital of the Albert Einstein College of Medicine. Not exactly a "success story," but includes valuable background material and pinpoints a number of problems.