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PAKISTAN BREASTFEEDING PROGRAM  
QUETTA, BALUCHISTAN, PAKISTAN

**PRITECH**

Technologies for Primary Health Care

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PN-ACN-505

PAKISTAN BREASTFEEDING PROGRAM  
QUETTA, BALUCHISTAN, PAKISTAN

A Report Prepared By PRITECH Consultants:  
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During The Period:  
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\*Available in pocket of folder

(1) BACKGROUND AND PURPOSE

In recent years, increased attention has been given to breastfeeding in Pakistan. This has been especially so since the 9th Pakistan International Paediatric Conference in Peshawar in 1988. This has been supported by USAID, UNICEF and PRITECH for whom the present writers have been consultants on several occasions. Activities have included Travelling Seminars to six centers in Fall 1989, publication of "30 Key Questions" in the Pakistan Paediatric Journal and presentation to the then Director-General of Health of suggested plans during a short visit to Islamabad in August 1989.

The purpose of the present visit by the three PRITECH consultants (Dr. Audrey Naylor, Director, Well-Start Lactation Program and the two present writers - Derrick B. Jelliffe and E.F. Patrice Jelliffe) was (a) to bring together pediatricians and obstetricians to emphasize the need for their collaborative and potentially mutually supportive roles, together with such important co-workers as midwives and nurses, in breastfeeding, as a method of improving both perinatal health and maternal mortality, (b) to reinforce and give continuity to the on-going Pakistan breastfeeding program and to meet with the National Breastfeeding Steering Committee to discuss problems and selection of future plans.

(2) PERINATAL NUTRITION CONFERENCE

This one-day Conference was unusual, if not unique, in that it was attended by over 40 physicians -- half pediatricians and half obstetricians. In the program (Appendix: A), the four consultants\* presentations were very much directed to obstetrical roles in promoting breastfeeding (prenatal examination and advice; intra-partum procedures) and to the advantages of early onset "biological" breastfeeding with regard to both decreasing maternal mortality (diminished hemorrhage; increased child spacing) and improving perinatal health.

Presentation by Pakistani colleagues included an account of problems encountered by one obstetrician (Dr. Altaf Bashir) in introducing modern breastfeeding management procedures into a maternity (600 deliveries), the development of a Lactation Clinic in Islamabad (Prof. Khwaja Abbas) (including mention of less appreciated problems related to male physicians not being allowed to examine the breasts) and the development of the first Breastfeeding Mothers Support Group (MAMTA<sup>6</sup> = "Mother Love" in the Urdu language) located in Lahore (Prof. Fehmida Jalil), especially as lectures and classroom conferences had been shown to have limited effect (for details, see Fig. 1).

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\*Three were from the USA, together with a fourth colleague, Dr. Hadi Promoto from PERINASIA (Perinatal Society), who presented developments in Indonesia, with special reference to the need for collaboration between disciplines.

<sup>6</sup>MAMTA is also an acronym for the Urdu words meaning "Mother and Breastmilk Promotion Society"

Reporting on the Formation of the First Breastfeeding Promotion Group Cassandra Baichin explains that as more women are employed in the Urban areas with a lack of day-care facilities and paid maternity leave has contributed to the decline of Breastfeeding in the cities.

It was against this background that 14 women gathered at Mayo Hospital's Department of Social and Preventive Paediatrics on Oct. 21 to set up Pakistan's first breastfeeding promotion group. The women included doctors specializing in nutrition, social psychology and epidemiology from all of Lahore's major hospitals, along with Prof. Dr. Fehmida Jallil of King Edward Medical College -- the country's sole Professor of Preventive Paediatrics. There was also a child care worker and a family planning worker with 13 years' experience in motivating mothers to breastfeed, a psychiatrist active in the International

Breastfeeding Woman's League, a senior representative of the Adult Basic Education Society NGO, and a journalist.

The group hopes to expand to include all those--professionals and non-professionals alike--interested in promoting breastfeeding. It is particularly keen to involve nurses and gynaecologists, who are in close contact with mothers during the prenatal and postnatal periods which are so vital to getting breastfeeding off to a good start.

The group's basic objective were tentatively outlined as:

- \* to promote breast-feeding.
- \* to provide follow-up support.
- \* to help solve problems relating to lactation.

It hopes to achieve aims by providing:

- \* prenatal guidance.
- \* skilled immediate postpartum assistance.
- \* a telephone consultation service.
- \* evaluation of lactation progress and problem solving in a unique lactation clinic.
- \* educational programmes for community doctors and nurses.

Ultimately, the idea is to establish a widespread network of community-level breast-feeding promotion groups providing mother-to-mother support. Pooling their professional resources and skills as mothers, the group's members also intend to publish informative material on breastfeeding using simple Urdu so as to reach the maximum possible audience.

Although Pakistan is still very much a traditional society, promoting breast-feeding as the best physical and psychological option for mothers and their babies is going to be an uphill task requiring the involvement of as wide a section of society as possible. The new group is an important first step.



*Note: The opinions expressed in this report are those of the authors and not necessarily those of the organizations represented on the National Steering Committee on Breastfeeding.*

Involvement by both obstetricians and pediatricians in discussion was lively and interactive. Special topics commented on repeatedly included: (a) difficulties in overcrowded maternity wards (sometimes with discharge after only six hours) and (b) emphasis on Cesarean Section (C.S.), especially with epidural anesthesia, being an indication for breastfeeding as soon as feasible, and the under-appreciated fact that the longer stay of C.S. mothers in the ward, after several days, could make the initiation of breastfeeding more secure.

A dramatic Australian-made video was shown on "Bottle feeding in Pakistan" demonstrating the very serious ill-effects in conditions of poor hygiene and poverty, with diarrhea, marasmus and death commonly occurring.

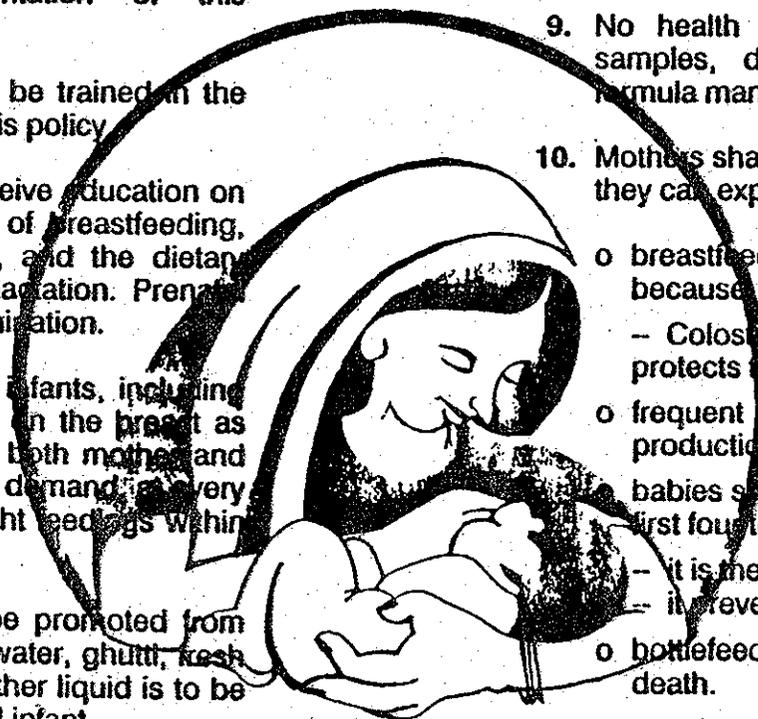
The last part of the day was taken up by Working Groups discussing the two Draft Policy outlines (Figs. 2 and 3) prepared by the National Breastfeeding Steering Committee and considering their use and interpretation in the differing circumstances in the delegates own hospitals and health facilities. Suggestions made by these Groups were collected and are reported on with a view to possible revision or modification of the Draft Policy statements. Results were not finalized, but the following points recurred: feasibility of immediate breastfeeding after delivery in all cases; need for an interdisciplinary hospital committee; usefulness of joint obstetrician-pediatrician ward rounds; expanded role of the obstetrician in breastfeeding (prenatal, intrapartum, follow-up). Final analysis will be undertaken by the Committee in the near future.

**FIG:2**

## **PROPOSED MODEL FOR HOSPITAL BREASTFEEDING POLICY**

**BREAST MILK IS THE IDEAL FOOD FOR BABIES. THE HEALTH FACILITY SHOULD DO THE FOLLOWING TO PROTECT, PROMOTE AND SUPPORT BREASTFEEDING.**

1. Hospital administrative, obstetric, paediatric, nursing and paramedical staff shall form a team that ensures the implementation of this breastfeeding policy.
2. Relevant health care staff shall be trained in the skills necessary to implement this policy.
3. All expectant mothers, shall receive education on the benefits and management of breastfeeding, the dangers of bottle feeding, and the dietary needs during pregnancy and lactation. Prenatal exams shall include breast examination.
4. In the delivery room, newborn infants, including premature infants, shall be put in the breast as soon after birth as feasible for both mother and infant. Babies should be fed on demand, every 2-3 hours for a minimum of eight feedings within 24 hours.
5. Exclusive breastfeeding shall be promoted from birth to four to six months. No water, ghutti, fresh animal milk, infant formula or other liquid is to be given to an exclusively breastfed infant.
6. Trained health care staff should help mothers having breastfeeding problems to enable them to exclusively breastfeed babies from birth to 4-6 months of age when semi-solids should be progressively introduced and breastfeeding continued up to 2 years.



7. No feeding bottles and pacifiers shall be allowed in the health facility.
8. No promotional materials about formula, feeding bottles and pacifiers, such as posters, free samples or gift items, shall be allowed in the facility nor shall they be given to the mother.
9. No health care staff shall receive gifts, free samples, donations, free training, etc. from formula manufacturers.
10. Mothers shall be given sufficient education so that they can explain that:
  - o breastfeeding should be started soon after birth because
    - Colostrum is important for babies and protects them from infection.
  - o frequent breastfeeding increases breastmilk production.
  - o babies should be fed only mother's milk for the first four to six months because:
    - it is the best food for babies.
    - it prevents infections.
  - o bottlefeeding can cause serious illness and death.
  - o supplementary foods should be started between four and six months.
  - o lactating mothers should eat more food and drink more liquids to maximize their milk supply.

### FIG:3. PROPOSED MODEL FOR HEALTH FACILITY BREASTFEEDING POLICY

BREAST MILK IS THE IDEAL FOOD FOR BABIES. THE HEALTH FACILITY SHOULD DO THE FOLLOWING TO PROTECT, PROMOTE AND SUPPORT BREASTFEEDING.

1. All health facility staff including doctors, health technicians, lady health visitors, vaccinators and community health workers shall work together to ensure the implementation of the breastfeeding policy.
2. All relevant health care staff shall be trained in the skills necessary to implement this policy.
3. Health facility staff shall ensure that all expectant mothers, at clinic visits or during outreach activities, receive education on the benefits and management of breastfeeding, the dangers of bottle feeding, and the dietary needs during pregnancy and lactation. Prenatal exams shall include breast examination.
4. At delivery, newborn infants, including premature infants, shall be put on the breast as soon after birth as feasible for both mother and infant. Babies should be fed on demand, at every 2-3 hours for a minimum of eight feedings within 24 hours.
5. Exclusive breastfeeding shall be promoted from birth to four to six months. No water, ghutti, fresh animal milk, infant formula or other liquid is to be given to an exclusively breastfed infant.
6. Trained health care staff should help mothers having breastfeeding problems to enable them to exclusively breastfeed babies from birth to 4-6 months of age when semi-solids should be progressively introduced and breastfeeding continued upto 2 years.
7. No feeding bottles and pacifiers shall be allowed in the health facility.
8. No promotional materials about formula, feeding bottles and pacifiers, such as posters, free samples or gift items, shall be allowed in the facility nor shall they be given to the mother.
9. No health care staff shall receive gifts, free samples, donations, free training, etc. from formula manufacturers.
10. Mothers shall be given sufficient education in group classes, individual counseling and/or home visits so that they will be able to explain that:
  - o breastfeeding should be started soon after birth because:
    - Colostrum is important for babies and protects them from infection.
  - o frequent breastfeeding increases breastmilk production.
  - o babies should be fed only mother's milk for the first four to six months because:
    - it is the best food for babies.
    - it prevents infections.
  - o bottlefeeding can cause serious illness and death.
  - o supplementary foods should be started between four and six months.
  - o lactating mothers should eat more food and drink more liquids to maximize their milk supply.



(3) 10th PAKISTAN INTERNATIONAL PAEDIATRIC CONFERENCE

The Conference was attended by over 200 Pakistani pediatricians and 10 foreign speakers (including the PRITECH consultants). The following are some comments based on relevant Conference papers, indicated in the attached Program (Appendix: B), and from informal discussions with participants.

(i) General. It was emphasized on several occasions that the Conference had the very unusual characteristic of not receiving any support from formula companies for organization and hospitality, and even for Conference bags and note-pads (Fig. 4). The latter were funded by UNICEF and USAID. This was a striking "first," although unfortunately the usual dubious, "mixed message" advertisements were included in the Conference Newspaper (Figs. 5&6).

Emphasis was also given by leading introductory speakers to recent advances in long sought after changes in emphasis given to pediatric education, notably its recognition as a distinct discipline, with a separate final examination for medical students. Such education has to emphasize knowledge of breastfeeding, nutrition of mothers and babies, immunization schedules and other preventive approaches.



R

# For All Cases of Diarrhoea ORS + Breastfeeding + Feeding

بچے کو دست کی بیماری ہے تو مندرجہ ذیل ہدایات پر عمل کریں

- ایک لیٹر پیرا پائڈ بھر کے چار لٹا س سات پانی میں اگلا۔ ایس کو پڑھائیے
- اچھو لہو صحت کریں
- بچے کو برسات کے بعد اور آج ایس والا پانی دن میں صرف سے پینا
- دو سال سے کم عمر کے بچے — کم از کم پانچ بار
- دو سال اور زیادہ عمر کے بچے — کم از کم ایک پیسہ
- اگر بچہ پیس ٹھوس کرے تو تیز اور آہستہ پلائیے
- اگلا ایس والا پانی جھجھ سے آہستہ پلائیے
- ماں اپنا دودھ سب سٹول بچے کو پلائیے
- اگر بچہ آڈ پرکا دودھ پیسٹا مورتا سے بھی جاری رکھیں

فراہم کیا جائے گی

- دو دن دست بچے کو نرم غذا یعنی کھانا، کچڑی، دہی، دلیہ، ذرا دار
- دلم، ذم، جھ سات، تیرہ، اور
- ایک برانا پوریا مندرجہ ذیل میں سے کوئی حالت بھی پھر پھر تیز اور تیز کر کے پاس پھانسی
- پھر بہت زیادہ دست کرے یا پھر جڑاؤ دے
- یا پیاسا
- یا دست میں خون آنے کے
- یا نڈھاڑا ہو جانے
- یا بچے کو آٹھیں، ناک، کوسٹھی، جازر
- یا بخیر نہ رہا

بالکل اور آہستہ اور آہستہ پانی مال کا دودھ نرم غذا دینا ضروری ہے

R

FOR Diarrhoea : ORS + Breastfeeding + Feeding

COURTESY OF USAID

Fig:4. Note - Pads supplied to Conference participants the National Committee, USAID and UNICEF(both sides shown).

# FOR CONTINUED GOOD NUTRITION DURING THE FIRST YEAR ...

*When breast feeding is not adopted or supplementation is required*

**NOW  
TAURINE  
FORTIFIED**

## SIMILAC®

### SIMILAC® WITH IRON

**Close Equivalent in Nutritional Composition  
and Quality of Performance**

- 1. PROTEIN (1.5%)**  
Amino acid profile inclusive of Taurine closest to human milk - supports normal growth.
- 2. FAT (3.6%)**  
Absorbed and digested as easily and as well as human milk.
- 3. CARBOHYDRATE (7.3%)**  
Lactose, exactly the same as breast milk - does not alienate baby from breast.
- 4. VITAMINS AND MINERALS**  
Help ensure balanced nutrition.

*From Generation to Generation*

Recommend **SIMILAC®**

### SIMILAC® WITH IRON

**An infant formula for all times**

Full prescribing information available on request



HEALTH CARE WORLD WIDE  
ABBOTT LABORATORIES (PAKISTAN) LTD  
P. O. Box 7229, Karachi-3.  
Manufacturers of Quality Pharmaceuticals

Breastfeeding is the best source of infant nutrition. Good maternal nutrition is important for preparation and maintenance of breastfeeding. When infant formula is to be used, a mother should be aware of the financial and social implications of formula feeding, the difficulty of reversing the decision not to breastfeed, and the care that must be taken to prevent partial formula feeding from interfering with lactation. Proper preparation of formula also requires the use of boiled water to mix the formula and clean the implements, as well as careful adherence to mixing instructions. Improper mixing or preparation may make the baby sick. A health care professional should be consulted before initiating formula feeding.

Fig:5. Deceptive Advertising. (i)no mention of other amino acids than taurine (ii) Fat absorbed: effect of breast milk lipase (iii) "Breastfeeding" box (bottom right): very small, difficult to read (type size 1/5 of similac)

The product you have preferred for generations!

# Time-Tested Ostermilk complete formula

A modified milk-food for babies of all ages

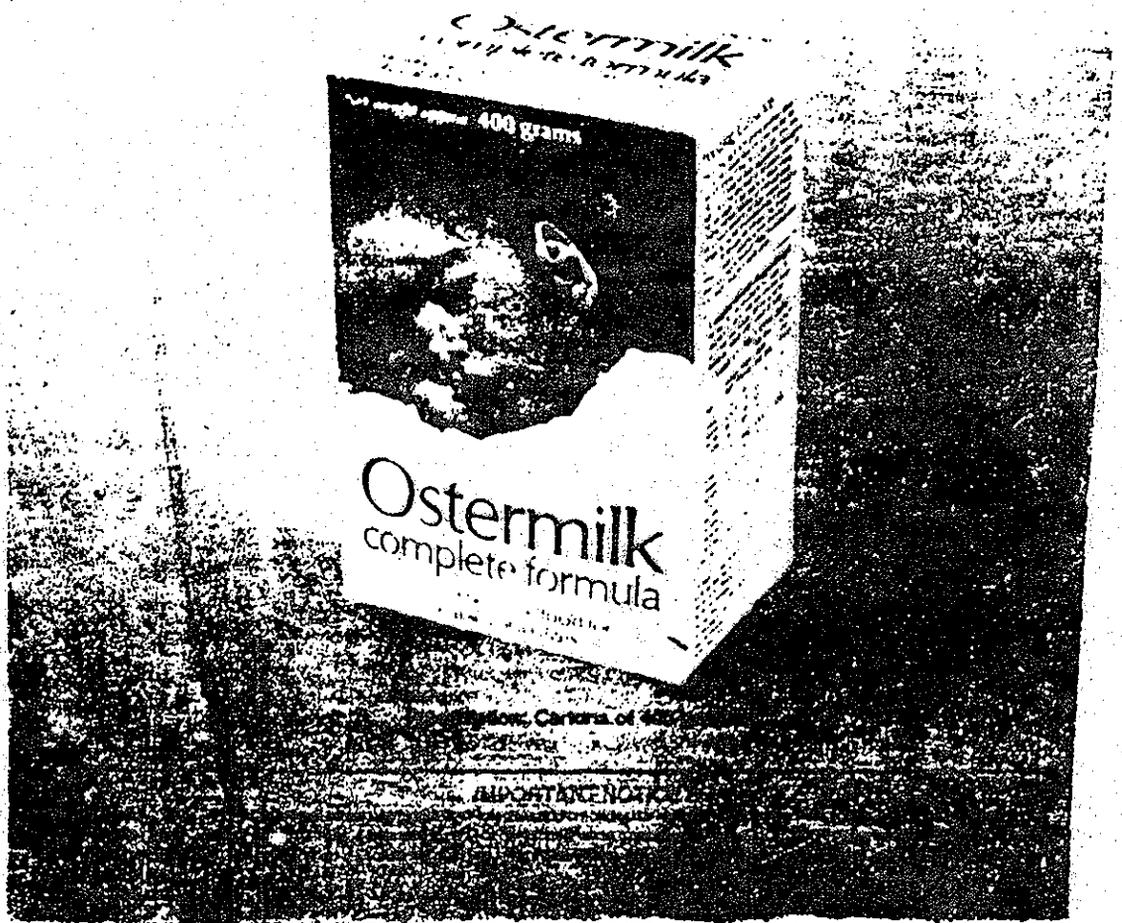


Fig:6. Deceptive advertising.  
Code violations  
Picture of body on box illegible, very small,  
blurred print on "Important notice"? concerning  
breastfeeding (situation the same in original  
advertisement - Medical Herald, p.14)

Also, it was noted that the P.P.A. now has a Code of Ethics Committee, mainly concerned with the widespread availability of unsafe drugs and harmful and inappropriate infant food advertisements to the public.

(ii) Breastfeeding. Awareness of the scientific information on breastfeeding and its public health importance seemed on the increase. However, it was apparent that many physicians, especially private practitioners, were not really promoting breastfeeding by their actual activities rather than their words. Their response to the ill-defined yet common complaint of "insufficient milk" was most often an immediate change to formula. Rather than realizing that anxiety and inadequate suckling ("dysreflexia") and faulty nursing techniques were usually responsible. The situation seems to be made more difficult by the cultural proscription of male pediatricians examining mothers' breasts, at least in some areas. The acknowledged role of maternal under-nutrition was also over-emphasized.

Other, cultural factors were also mentioned, including (a) various forms of colostrum rejection, (b) limitation of the diet in lactation owing to the traditional classification of foods (perhaiz) into "hot" and "cold," with some nutritious hot foods used by breastfeeding mothers as being believed to cause diarrhea in the baby, and (c) difficulties with male obstetricians and pediatricians not being permitted to examine some mothers' breasts.

(iii) Related conditions. Much attention was given to diarrheal disease in young children -- probably the commonest illness causing an estimated 200,000 deaths in Pakistani children annually. Emphasis was given to continuing breastfeeding during diarrhea, to the use of cereal-based ORS and to early feeding. The use of khichri: rice and lentil (60%) and yoghurt (40%) was shown to reduce stool numbers, improve nutrition and lead to obvious "well-being", in addition to being acceptable as "cold" foods culturally appropriate for a "hot" illness, diarrhea.

Delayed feeding in "invasive diarrhea" (mainly shigellosis) in already malnourished children was shown to be likely to cause coma, convulsions and death, which investigators had demonstrated to be due to hypoglycemia.

The need to differentiate AWD ("Acute Watery Diarrhea") (usually from Esch. coli and rotavirus) from "invasive diarrhea" (usually shigella dysentery with blood and mucus in the stools) was high-lighted by several speakers. The latter (bacillary dysentery) being the only indication for pharmaceutical treatment with antibiotics. Otherwise, it was repeatedly noted that unnecessary, expensive, potentially dangerous drugs, especially antimotility drugs in concentrated drop preparation, were widely advertised, freely available and unwisely prescribed. This was and remains a major issue.

Home rehabilitation of Grade III Gómez malnourished children (<60% weight-for-age) was reported, using locally available food mixtures cooked by mothers at

home, with frequent follow-up home visits. Assessment of improvement included both weight and the disappearance of classical signs of malnutrition, but (refreshingly) the always looked for, but never reported scientifically, "smiling" and "more active."

Evidence of unappreciated sub-clinical vitamin A deficiency was commented on, with potential impact on infant and young child mortality rather than the more classical eye changes.

Other public health issues discussed included acute respiratory infections (ARI) (diagnosis and management by paramedical staff), child abuse (more common than usually appreciated), neonatal sepsis etc.

Lastly, Mr. Kurio Waki (UNICEF County Representative) emphasized the prevalence of multiple diseases as causing morbidity and mortality in Pakistani children. This implied the need for multi-sectoral activities, including improved sanitation and water supply, education (especially for women) etc. The recent UNICEF publication "Facts for Life" covered the main areas of knowledge needed by populations for actions to improve the health of mothers and children. Breastfeeding was one of the ten areas included as a means of diminishing perinatal and maternal ill-health.

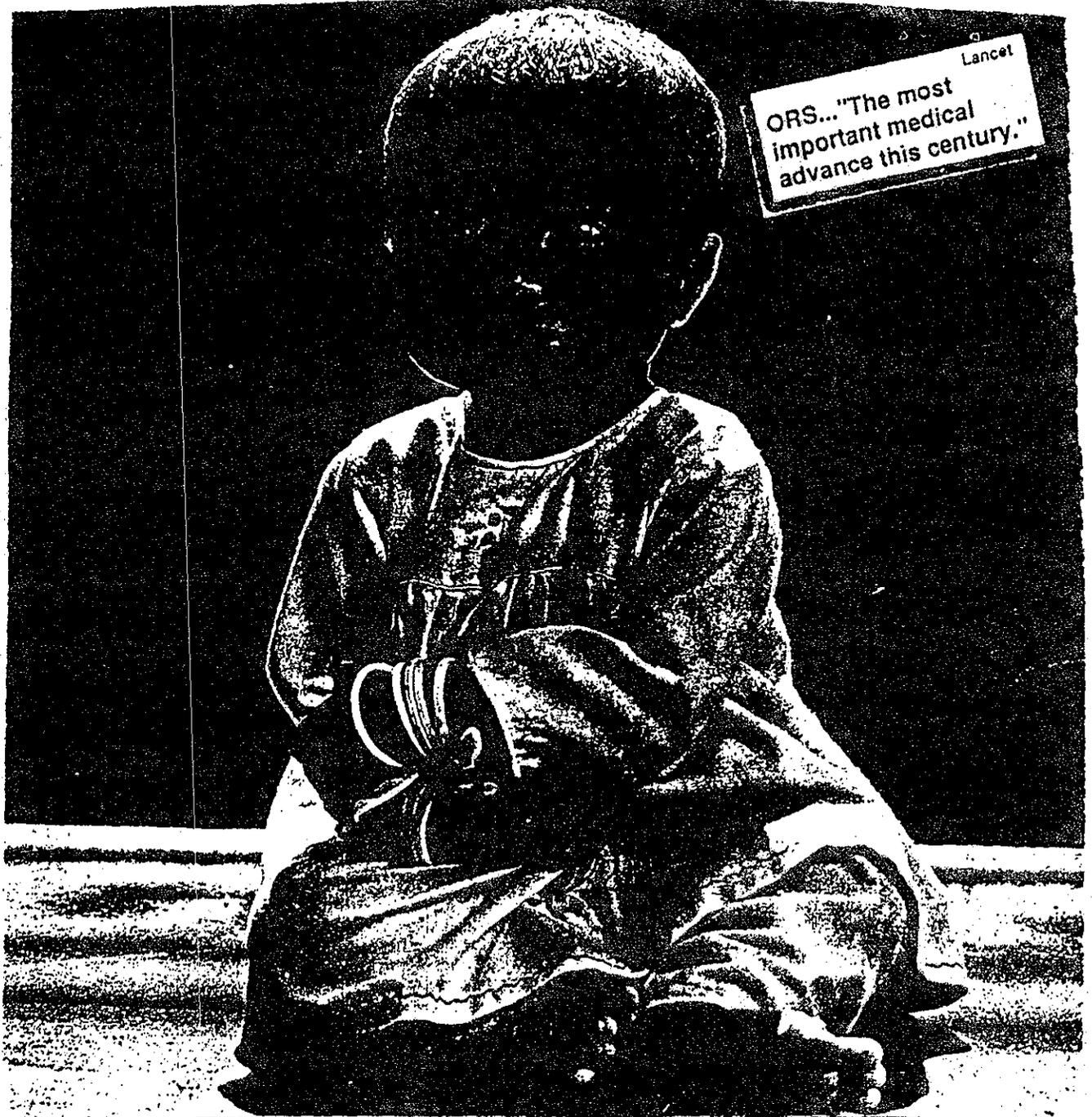
(3) NATIONAL STEERING COMMITTEE

(i) Activities. The Committee, whose composition is shown in Table 1, has undertaken a considerable number of activities since the writers last visit (August 1989). These include: (a) functional training linkage with the DTU (Diarrhea Training Units), including a widely distributed brochure (Fig. 7&8) and a note-pad for the Paediatric Conference (with slogan, logo and detailed advice on ORS and feeding on the reverse side (Fig. 4), (b) two Workshops earlier in 1990 ("Lactation and Fertility": Dr. J. Sheldon, USAID; "Breastfeeding for Mother and Child Health": Dr. A. Tompkins, London School of Tropical Medicine and Hygiene), and (c) the successful organization of the Perinatal Conference (with support from USAID and UNICEF for bags and note pads with slogan, and two Draft Policy Documents for Hospitals and for other Health Facilities (Figs. 2 and 3), and an innovative billboard poster on the road from the airport (Fig. 9), (c) distribution of the summary of the WHO/UNICEF Code (Fig. 10), and (d) input into a radio Question and Answer session "Ask the Doctor."

Unfortunately, no further developments have occurred with regard to Government action on the WHO/UNICEF "Code of Marketing of Breast-Milk Substitutes," which has been under consideration since 1982. Advertisements directly to the public are still widespread (Fig. 11). The question of taxing all imported formulas has been found not to be feasible in the past. Practical strategies for banning direct advertising were discussed inconclusively.

- Dr. Mushtaq A. Khan,  
Chief, Nutrition Cell,  
Planning Division, Islamabad
- Dr. Khawaja A. Abbas  
Professor Paediatrics  
Childrens' Hospital, Pakistan Institute of Medical Sciences,  
Islamabad
- Dr. Zafar Ahmad,  
Deputy Director General (Health) BHS Cell  
Islamabad
- Col. M. Akram Khan,  
National Project Manager, EPI/CDD  
National Institute of Health,  
Islamabad
- Dr. Samia Janjua,  
Visiting Obstetrician/Gynecologist  
Federal Government Sewices Hospital, Islamabad
- Dr. Sawat Ramaboot, WHO Advisor (CDD)  
National Institute of Health,  
Islamabad
- Ms. Lucia Ferraz-Tabor  
Representative, PRITECH/Pakistan  
Islamabad
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Office of Health, Population & Nutrition,  
USAID, Islamabad
- Dr. Pirkko Heinonen  
Programme Officer, Health and Nutrition  
UNICEF, Islamabad
- Ms. Naveeda Anjum,  
Asst. Project Officer Nutrition  
UNICEF, Islamabad

**Table 1: National Breastfeeding Steering Committee**



Lancet  
ORS... "The most  
important medical  
advance this century."

**ORS + BREASTMILK + FOOD**

**DOCTOR RECOMMENDED  
FIRST LINE OF TREATMENT  
IN DIARRHOEA**

Fig:7. Connect Treatment of Diarrhoea, Distributed widely in Porwstam and health professionals by EPILCDD, USAID, PRITECH

## PRESCRIBING INFORMATION FOR ORS:

### Composition:

— Sodium Chloride	3.5 g
— Potassium Chloride	1.5 g
— Trisodium Citrate Dihydrate	2.9 g
— Glucose Anhydrous	20.0 g
(to be dissolved in 1 litre of water)	

Lancet

**ORS... "The most important medical advance this century."**

### Indications:

1. All diarrhoea cases including dysentery and cholera.
2. Prevention and treatment of all types of dehydration.

### Dosage and Administration:

	1-5 Months	6-23 Months	2-10 Years
<b>MILD TO MODERATE DEHYDRATION</b>	First 4-6 hours ORS 200-600 ml or 1/4-1/2 seer	First 4-6 hours ORS 600-800 ml or 1/2-3/4 seer	First 4-6 hours ORS 1 to 2 litres or 1-2 seers
<b>MAINTENANCE HOME TREATMENT</b>	1 large cup (200 ml) ORS per stool	1 large cup (200 ml) ORS per stool	1 large cup (200 ml) ORS per stool

- Continue feeding the child often.
- If child wants more water, give it.
- Give ORS/Fluids with a cup and spoon.
- Offer 1 spoonful per minute.
- If child vomits, wait 10 minutes, then continue giving ORS more slowly, a spoonful every 2-3 minutes.

**Contraindications:** Diarrhoea cases with inability to drink.

**Remember...**  
You can help save the lives  
of 200,000 children each  
year by prescribing



# ORS/FLUIDS + BREASTMILK + FOOD

Developed and printed courtesy of USAID/PRITECH for Federal EP/CDO Cell, NIH, MOH, Government of Pakistan.

Designed and Produced by Trimina Graphics

Fig: 8. Connect Treatment of Diarrhoea (back page of brochure shown in fig:7)



Fig:9. Billboard Promoting Breastfeeding  
(Road from airport, Quette. Erected  
by the National Committee).

## INTERNATIONAL CODE OF MARKETING OF BREASTMILK SUBSTITUTES

The Code includes these 10 important provisions:

1. No advertising of these products to the public.
2. No free samples to mothers.
3. No promotion of products in health care facilities.
4. No company mothercraft nurses to advise mothers.
5. No gifts or personal samples to health workers.
6. No words or pictures idealising artificial feeding, including pictures of infants on the labels of the products.
7. Information to health workers should be scientific and factual.
8. All information on artificial infant feeding, including the labels, should explain the benefits of breast feeding, and the costs and hazards associated with artificial feeding.
9. Unsuitable products, such as sweetened condensed milk, should not be promoted for babies.
10. All products should be of a high quality and take account of the climatic and storage conditions of the country where they are used.



**Fig: 11.** *Unconscionable Advertising attitude of Multinationals*  
Photograph: Lytton Road, Quetta. by Fareeda Noshervani

(ii) Organization. Two meetings were held with the National Steering Committee. The following were the main areas discussed.

The need to obtain official Ministerial recognition for the Committee was emphasized, together with procedural difficulties in doing so, including its headquarters (Ministry of Health or Planning), and a National Program Coordinator, who could visit the Provinces. A major lack appeared to be with not having an universally agreed upon chairman, especially as members from UNICEF, USAID and PRITECH could not act in this capacity. The possibility of co-chairs -- from the Ministry of Health and of Planning -- was mentioned. Firm leadership is certainly required.

Also, the need for the selection of appropriate and motivated Province Coordinators was emphasized and some names were tentatively suggested by UNICEF. This would be expected to lead to the formation of Provincial Steering Committees, with general guidelines prepared by the National Committee for modification to varying Provincial needs.

A flow chart of National and Provincial Committee organizations and functions was suggested as an aid to action.

(4) SUGGESTED ACTIVITIES

In the limited time available for discussion with the National Steering Committee, suggestions for detailed plans were not possible. As far as the writers were concerned continuing the momentum, publicity, and priority of breastfeeding promotion as such, and within other active programs (e.g., CDD, EPI, etc.), were major concerns. This is emphasized by the lack of attention to breastfeeding in a recent analysis of Primary Health Care Project Activities (in US Dollars) in the country (Fig. 12).

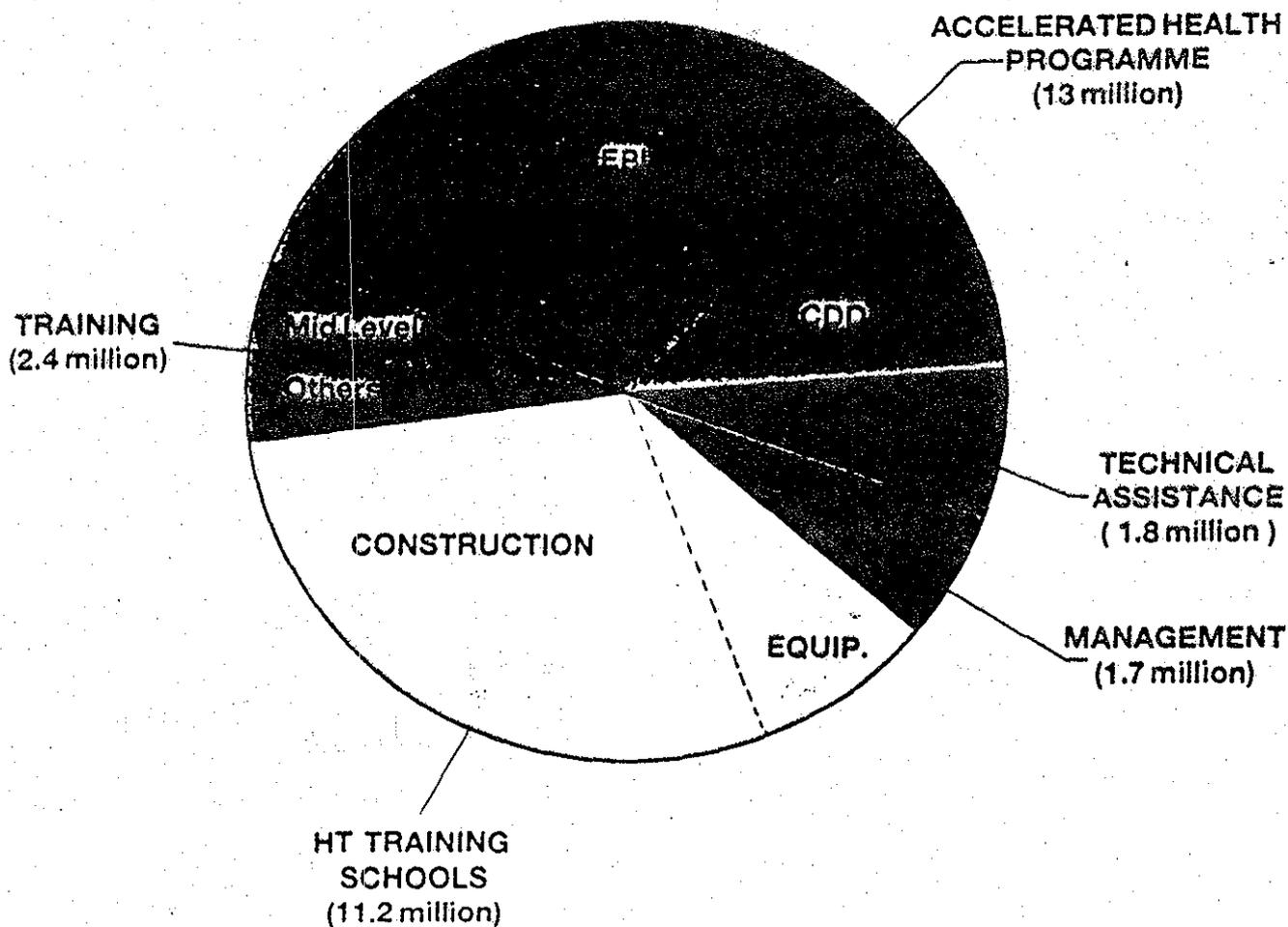
Some of the main suggested activities are summarized in Table: I. These can be further explained as follows:

(i) INFORMATION DISSEMINATION. THE NEED FOR PRESS RELEASES WAS NOTED, especially with more dramatic and underappreciated aspects of the subject (i.e., the cost in foreign currency to the country of importation of formula, etc.),, together with desirability of identifying supportive journalists.

The possibility of developing a syndicated column on child health was discussed. This could cover oral rehydration, immunization, weaning, breastfeeding and other key topics.

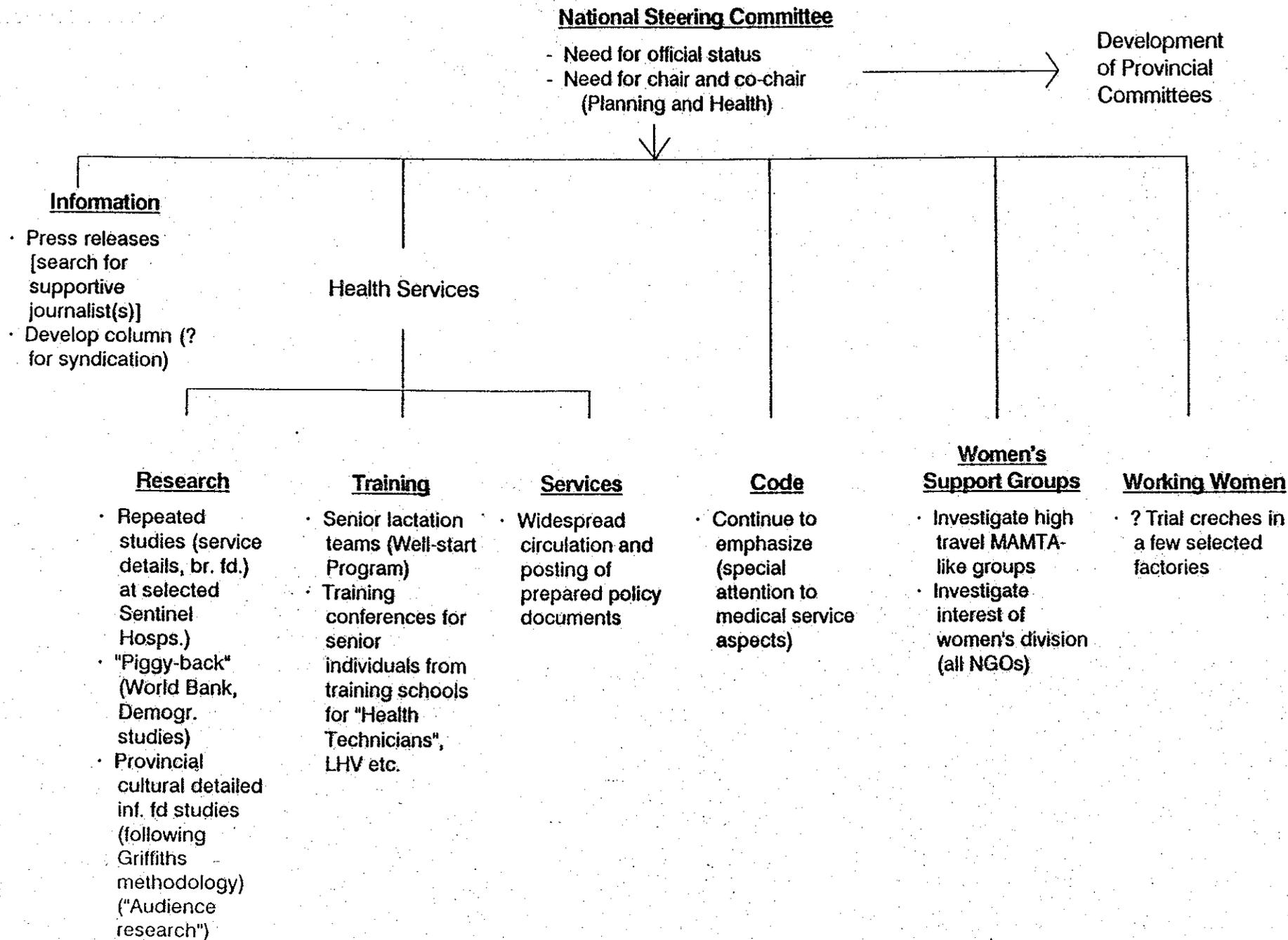
Fig: 12

# PRIMARY HEALTH CARE PROJECT ACTIVITIES (in U.S. dollars)



TOTAL : 30 million

**Table 2: Main Proposals for Future Actions**



25

Time did not permit the discussion of a short article entitled "Queries Concerning Breastfeeding and Diarrhoe" compiled by two writers, based on answers to questions collected by PRITECH, Islamabad which were most commonly asked in the DTU training courses (Appendix C). The final version will be sent to the Pakistan Paediatric Journal. Also, the previously written "30 Key Questions" asked in the course of the previous Travelling Seminars has been worded more simply by PRITECH, Islamabad for publication in appropriate Women's Magazines (Appendix D).

(ii) RESEARCH. The following research projects are forthcoming:

- Epidemiological data collected at intervals on hospital practices and breastfeeding on discharge at selected "sentinel hospitals" and basic health units.
- "Piggy-back" collection of data from on-going projects (such as made available by proposed review of the CDD case management register) and from forthcoming surveys (such as the World Bank Demographic Survey).
- Provincial studies into the detailed cultural practices in infant feeding ("audience research"), following Marcia Griffiths' training and methodology, including focus group interviews and anthropological techniques. These

would also be designed for partial replication as part of the assessment of the breastfeeding program's effectiveness.

(iii) HEALTH SERVICES TRAINING. Three senior lactation teams are to be selected to take the Well-Start Lactation course. This process was to have been initiated at a meeting being organized by the National Committee on May 14th, which would be attended by Dr. Audrey Naylor. The members of such teams will have to bear in mind the cultural difficulties that male physicians may experience in examining women's breasts.

Training seminars for senior individuals from schools for Health Technicians,\* Lady Health Visitors, etc. should be a priority in the writer's opinion. These are the cadres in direct contact with mothers and families, and tend to be most neglected in training activities. Such seminars could commence (a) before the projected cultural practices research (see above), or (b) after, or (c) both could be instituted. There is enough generic material for initial courses (a); thereafter the participants could collect data on possible problems that they have encountered, which could be incorporated into a second "reinforcement" training session, which would include information and curricular modifications based on the Griffiths surveys.

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\*The cadre of "Health Technicians" started in 1979. There is an 18 month training program for both female and male students having had 10 years schooling. The training objectives emphasize health promotion and work in basic health units in rural areas.

(iv) SERVICES. The widespread circulation and conspicuous posting of the policy summaries prepared by the National Steering Committee was to be undertaken to all hospitals and health facilities.

(v) CODE OF MARKETING. It was agreed that the Government should be reminded of the very long delay in action, but that this would be particularly related to medical service aspects.

(vi) WOMEN'S SUPPORT GROUPS. Difficulties with this type of activity were appreciated, but it was felt that two levels should be explored. The possibility of high level MAMTA-like groups (see earlier) being developed, and, secondly, inquiries be made into the interest of the Women's Division as regards NGOs being involved in such support activities or groups.

(vii) WORKING WOMEN. It was felt that legislation and action in this regard was a matter of great difficulty, but it was suggested that the possibility of developing trial creches in a few factories might be explored.

## CONCLUSION

The National Breastfeeding Committee had achieved a great deal. Apart from the initiatives suggested above, the prime needs seemed to the consultants to be continued visibility and momentum. This will be aided by the proposed team-

training in San Diego, and the earliest possible workshops for teachers of paramedical personnel.

PROGRAMME

Appendix: A

# PERINATAL NUTRITION WORKSHOP



May 8, 1990  
**Serena Hotel,  
Quetta, Balochistan  
Pakistan**

Sponsored by:  
The National Breastfeeding Steering  
Committee and USAID/Pakistan

## Objectives of the Workshop

1. To provide knowledge about the importance of breastfeeding and the role of the physician in lactation management.
2. To describe the role of the Obstetrician/Gynecologist in developing hospital policy on infant feeding, promoting breastfeeding with patients and advocating changes in the health facility.
3. To share pediatrician's and obstetrician's experiences in breastfeeding promotion and support.
4. To help establish a cooperative, team approach to breastfeeding.

## Guest Speakers

1. **Derrick Jelliffe, M.D.**  
Professor of Public Health and Paediatrics,  
Schools of Public Health & Medicine,  
University of California, Los Angeles, California, USA
2. **Patrice Jelliffe, M.P.H.**  
Lecturer and Researcher, Population & Family Health Division,  
School of Public Health,  
University of California, Los Angeles, California, USA
3. **Audrey Naylor, M.D.**  
Co-Director, Well-Start Lactation Program and Associate  
Professor of Pediatrics, School of Medicine,  
University of California, San Diego, California, USA
4. **Hadi Pratomo, M.P.H., Ph.D.**  
Project Director, Perinasia  
Jakarta, Indonesia
5. **Ataf Bashhir, M.D.**  
Professor of Obstetrics/Gynecology,  
Punjab Medical College/Allied Hospital Faisalabad
6. **Khwaja Abbas, M.D.**  
Professor of Paediatrics, Children's Hospital,  
PIMS, Islamabad
7. **Fehmida Jalli, M.D.**  
Professor of Preventative Paediatrics,  
King Edward Medical College, Lahore

# Agenda

- 09:00-9:10 Welcome Address: Dr. Mushtaq A. Khan,  
National Breastfeeding Steering Committee.
- 09:10-9:40 Recent Biomedical Advances in Breastfeeding  
Dr. D. Jelliffe
- 09:40-10:10 Breastfeeding and Perinatal Health: Guidance for  
Training, with Special Relevance to Nurses and  
Midwives  
Mrs. P. Jelliffe
- 10:10-10:30 Video Tape on Bottle Feeding in Pakistan
- 10:30-11:00 Tea
- 11:00-12:30 Successful Breastfeeding Promotion Activities
- Indonesia's Activities  
Dr. Hadi Pramoto
- An Obstetrician's Activities  
Dr. Altaf Bashir
- A Lactation Management Clinic  
Dr. Khwaja Abbas
- MANTA  
Dr. Fehmida Jalil
- 12:30-1:00 Additional Questions and Summing up.
- 01:00-2:00 Lunch
- 02:00-2:30 The role of the OB/GYN in Lactation Management  
Dr. A. Naylor
- 02:30-4:00 Provincial Group discussions: How to Promote  
Breastfeeding
- Discussion will revolve around the model hospital  
and health facility proposed policy. All  
participants will develop an individual and/or  
provincial action plan and policy statement.
- 04:00-5:00 Provincial Reports and Consensus Statement
- Summing up  
Dr. Mushtaq A. Khan
- Concluding comments  
Chief Guest - Chief Secretary, Balochistan

## **National Breastfeeding Steering Committee**

- Dr. Mushtaq A. Khan,  
Chief, Nutrition Cell,  
Planning Division, Islamabad
- Dr. Khawaja A. Abbas  
Professor of Paediatrics  
Childrens' Hospital, Pakistan Institute of Medical Sciences,  
Islamabad
- Dr. Zafar Ahmad,  
Deputy Director General (Health) BHS Cell  
Islamabad
- Col. M. Akram Khan,  
National Project Manager, EPI/CDD  
National Institute of Health, Islamabad
- Dr. Samia Janjua,  
Visiting Obstetrician/Gynecologist  
Federal Government Services Hospital,  
Islamabad
- Dr. Sawat Ramaboot,  
WHO Advisor (CDD)  
National Institute of Health, Islamabad
- Ms. Lucia Ferraz-Tabor  
Representative, PRITECH/Pakistan  
Islamabad
- Ms. Jill Randell  
Health and Nutrition Specialist  
Office of Health, Population & Nutrition,  
USAID, Islamabad
- Dr. Pirkko Heinonen  
Programme Officer, Health and Nutrition  
UNICEF, Islamabad
- Ms. Naveeda Anjum,  
Asst. Project Officer Nutrition  
UNICEF, Islamabad

PROGRAMME

10TH BIENNIAL INTERNATIONAL  
PAEDIATRIC CONFERENCE

QUETTA, 9th—11th MAY 1990



PAKISTAN PAEDIATRIC ASSOCIATION  
BALUCHISTAN.

## INAUGURAL CEREMONY

9TH MAY, 1990 (STAGE SECRETARY DR. LUTF ALI)

CHIEF GUEST: His Excellency, the Chief Minister of Balochistan,  
Nawab Muhammad Akbar Khan Bugti.

- 9.00 AM Guests to be seated.
- 9.00 AM Arrival of the Chief Guest.
- 9.35 AM Recitation from the Holy Quran.
- 9.40 AM Welcome Address by Dr. Muhammad Rafique, President P.P.A. Balochistan.
- 9.45 AM Report of Secretary General P.P.A.(Centre) Dr. Sala-ud-Din Sheikh.
- 9.55 AM Address by UNICEF Representative in Pakistan Mr. Kunio Waki.  
(Stratagies for Pakistani Children in 1990s).
- 10.05 AM Address outgoing President P.P.A.(Centre) Dr. Imran Khan.
- 10.15 AM Oath Taking Ceremony.
- 10.20 AM Keynote Address by President P.P.A. (Centre) Dr. A. Malik Kasi.
- 10.30 AM Award of Gold Medals.
- 10.35 AM Address of the Chief Guest.
- 10.50 AM Vote of Thanks Dr. S.M. Naeem, Secretary General P.P.A. Balochistan and Secretary Organising Committee.

### Visit to the Stalls

- 11.00 AM Tea
- 12.00 MD

PROGRAMME OF CONFERENCE  
9TH MAY, 1990.  
Killah Saifullah Hall  
(Razia Rahmatolla Memorial)

A. Scientific Session..... 12.00 AM to 1.45 PM.

ANTHROPOLOGY & COMMUNITY PAEDIATRIC:

Chief Guest Prof. G.J.Ebrahim, University of London.  
Chairman Prof. Hamid Ali Khan, Karachi.  
Co-Chairman Dr. Fouzia Qureshi "  
Secretary Dr. Afroz Ramzan "

- 1) Health Strategies used by literate Mothers to ensure the health of their children and themselves :

Prof. G. J. Ebrahim London.

- 2) National Neonatalanthropometry Study a Preliminary Report :

Dr. Zulfiqar A. Ehatta, Karachi.

- 3) Growth Patterns of Pakistani Children in mid 1990's:

Prof. Holger Hansen, U.S.A.

- 4) Lead levels in School Children at Peshawar:

Dr. Tasleem Akhtar, FMRC Peshawar.

- 5) Neonatal growth parameters from Civil Hospital Karachi:

Dr. D. S. Akram Karachi.  
Dr. Mubina Abgoatwala "  
Imtiaz Ali Khan "

- 6) Changes in disease pattern and out-come amongst admitted patients in the year 1989 compared with those admitted in 1979 in Paediatric Wards of Mayo Hospital, Lahore:

Abdul Tawab Khan Lahore.  
Shaheen M. A. Khan "

7) Health Profile of Children of Prisoner Mothers :

Prof. Ashfaq Peshawar  
Dr. Tufail M. Khan "

8) Paediatrician - Working in Katchi Abadies of Lahore:

Prof. S. M. Haneef  
Dr. Ghazanfar Ali  
Dr. Ghulam Sabir  
Miss Naheed

LUNCH (PRAYERS).....1.45 PM to 2.50 PM.

9TH MAY, 1990.  
ZIARAT HALL

B. Scientific Session..... 12.00 NOON to 1.45 PM.

Nutrition:

Chief Guest Prof. D. B. Jelliffe (U.S.A.)  
Chairman Dr. Mushtaq Khan (P&D Islamabad).  
Co-Chairman Dr. Barbara. Underwood (U.S.A.)  
Secretary Dr. Suleman Malik (Multan).

1) Rehabilitation of Grade III PCM in OPD :

Dr. Azra Jamal.  
Ghaffar Billo.  
Tajam-ul-Hussain.  
Munawar Sultan.

2) Bone Metabolism in Malnourished Children studies in Quetta :

M.B. Krawinkel A. Lund K. Kruse  
A. M. Kasi

3) The "P" in GMP - A major shift in high risk approach to the Management of Malnourished Children :

Dr. Inayat Karachi.  
H. Thaver. "  
Khatija Hussain "

4) ~~Effect of Supplementary feeding of pregnant women on B.W.T. of the New Born :~~ in

~~Dr. Tajam-ul-Hussain Peshawar.~~

5) ~~Malnutrition Brain and Child Development :~~

~~Prof. P.M. Udani Bombay, India.~~

6) Effect of Supplementary feeding of pregnant women on B.W.T. of the New Born :

Dr. Tajam-ul-Hussain Peshawar.

Nargis Begum "

Balqis Afridi "

A. Hamid "

7) ~~Malnutrition Brain and Child Development :~~

Prof. P.M. Udani Bombay, India.

8) The Principals and Strategic Steps of a simple Nutrition message :

Prof. Femida Jalil Lahore.

LUNCH (PRAYERS).....1.45 PM to 2.50 PM.

9TH MAY, 1990.

ZIARAT HALL

C. Scientific Session..... 2.50 PM to 4.30 PM.

PAEDIATRIC SURGERY:

Chief Guest Prof. Ibrahim Memon (Hyderabad)

Chairman Prof. Abdul Hamid (Lahore)

Co-Chairman Prof. Nilzam-ul-Hassan (Karachi)

Secretary Dr. M. Naeem Khan, PIMS, (Islamabad)

1) Neuro Fibro Matosis :

Dr. M. Zaheer Abbasi, P.I.M.S. Islamabad.

2) Malrotation a Maldiagnosed Condition :

Dr. Mohsin Ali Azhar, Karachi.

- 3) Black Hairy Naves, Surgical Management :  
Dr. Iftikhar Jan.  
M. Naeem Khan.
- 4) Diagnostic Dilema of Hip Joints. Application in Children:  
Dr. Naeem Khan.  
Dr. Iftikhar Jan.
- 5) Painless Rectal Bleeding in young child :  
Dr. Muhammad Azam Khalid, P.I.M.S. Islamabad.
- 6) Management of High Variety of Imperforated Anus:  
Prof. Abdul Hameed Lahore  
Dr. Afzal Sheikh "
- 7) Congenital Achalasia:  
Prof. Abdul Hameed Lahore  
Dr. Afzal Sheikh "
- 8) T.B. Lymphadenopathy:  
Prof. Nizamul Hassan Karachi

**9TH MAY, 1990  
KILLAH SAIFULLAH HALL**

D. Scientific Session..... 2.50 PM to 4.30 PM.

NEONATOLOGY:

Chief Guest Prof. Mubhariz Naqvi - U.S.A.  
Chairman Prof. A. Ghaffar Billoo, Karachi.  
Co-Chairman Prof. M. Arif, Karachi.  
Secretary Dr. Sajid Maqbool, Lahore.

- 1) Correlation of Neuro Sonographic finding with Clinical Features in L.B.W. :

Laeq Akmal and Najmudin.

- 2) The effect of minimal stimulation on the incidence of I.V.H. in V.L.B.W. neonates :

Dr. Mubriz Naqvi, Martha White Cotton,  
U.S.A.

- 3) Serum Ferritin/Gastrointestinal Age and B.W. on New Born :

Drs. Sajjad-ur-Rehman / Fazle Razaq and  
Prof. Imran, P.G.M.I. Peshawar.

- 4) Relation of creative protein (C.P.R) to prognosis in New Born septicemia :

Zulfiqar-B- Olavi-F - Ozman  
Istanbul Medical School, Turkey.

- 5) Skin to skin mother infant contact for body in L.B.W.I.:

Prof. G.J. Ebrahim London.

- 6) Caloric intake and growth of L.B.W. infants under Intensive Care :

Mubariz Naqvi - Terry Loughofer, U.S.A.

- 7) Intra Thecal Administration of Tetanus Immune globulin in Neonatal Tetanus :

Ghazanfar Ali Sheikh

- 8) Experience with I.R.D. S. :

Liaqat Ali, Lahore.  
Drs. Muntaz Lakhani Huttu, Karachi.

10TH MAY, 1990.  
KILLAH SAIFULLAH HALL

Expert Committee Meeting All Professors Requested  
Kindly to Attend.

E. Scientific Session..... 9.00 AM to 11.00 AM.

ARI/CARDIOLOGY:

Chief Guest Prof. Hamid Ali Khan  
Chairman Prof. S. Hameed (Lahore).  
Co-Chairman Prof. Mushtaq Khan (P.I.M.S.), Islamabad.  
Secretary Dr. Tasleem (P.M.R.C.), Peshawar.

- 1) Diagnostic value of respiratory rate and soft tissue recession in Lower Respiratory Infection in Children:  
Khan A. Tawab - A.J. Samadani,  
A. Qayum and S. R. Khan (Lahore).
- 2) Recurrent Pneumonia in Childhood :  
Dr. Suraj Gupte  
Government Medical College, Jammu.
- 3) A.R.I. in young children in Pakistan our experience:  
Prof. Mushtaq Khan, Islamabad.
- 4) Evaluation of clinical Signs of A.R.I. for diagnosis by Paramedical Staff :  
Dr. Alok Gupte - Sharma V.K. - Miss Taluja  
G.R. Medical College Gwalior (India).
- 5) Trial of Ketotifen in Asthma Prophylaxis in Lahore:  
Dr. Muhammad Iqbal Sheikh (Lahore).
- 6) Wheezing child an unusual presentation :  
Dr. Amir Hamza Gharsheen, Islamabad.
- 7) Long Term Comparative Observation of First Episode and Recurrent Rheumatic Fever :  
Liaqat Cheema / Kalim A. Aziz, Karachi.
- 8) Clinical Based Study of Acute ARI in children at Civil Hospital Quetta :  
Dr. Lutf Ali / Prof. Dr. Rafique

10TH MAY, 1990.  
ZIARAT HALL

F. Scientific Session..... 9.00 AM to 11.00 AM.

BREAST FEEDING:

Chief Guest Prof. Ashfaqe Ahmed (Peshawar).  
Chairman Dr. Audry Naylor (U.S.A.)  
Co-Chairman Dr. Khawaja Abbas (Islamabad).  
Secretary Dr. Attaullah Mazhar (Bahawalpur).

1) Attitude of mothers towards breast below two years:

Dr. Sardar Alam Sarwar/Attaullah Mazhar.  
Dr. Muhammad Azhar, Quaid-e-Azam  
Medical College,  
Bahawalpur.

2) Determinants of decline in Breast Feeding in Middle  
Class Mothers :

Dr. Inayat H. Thaver / Farayl Filkree  
Agha Khan University, Karachi.

3) Breast Feeding Practices in Karachi Katchi Abadies:

Shifin Ramzan Ali, Community Health Nurse,  
Agha Khan University,  
Karachi.

4) Nursing Bottle Syndrome Blamed for Serious Damage  
to Teeth and Gums :

Prof. Willi Reckhard Wetzel,  
Glessen University, West Germany.

5) Breast Feeding - Key to Survival :

Dr. Aziz-ur-Rehman, Karachi.

6) General Practitioners & Promotion of Breast Feeding:

Dr. Imran Iqbal, Multan.

7) Breast Feeding Protects against neonatal Sepsis :

Dr. Rifat N. Ashraf, Lahore.

TEA.....11.00 AM to 11.30 AM.

10TH MAY, 1990.

ZIARAT HALL

11.30 AM to 1.00 PM

STATE OF ART LECTURES:

Chief Guest Prof. Udani (India).  
Chairman Prof. G. J. Ebrahim(London).  
Co-chairman Prof. Haquani (Karachi).  
Secretary Prof. D. S. Akram (Karachi).

- 1) Prof. G. J. Ebrahim.
- 2) Prof. ~~Wasthi~~ ~~Jeff~~ ~~FE~~
- 3) Dr. Barbara Underwood (U.S.A.)
- 4) Dr. Mubariz Naqvi (U.S.A.)

LUNCH..... 1.00 PM to 2.00 PM.

10TH MAY, 1990

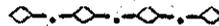
KILLAH SAIFULLAH HALL

G. Scientific Session..... 2.00 PM to 3.30 PM.

ONCOLOGY/NEPHROLOGY/HAEMATOLOGY:

Chief Guest Prof. Wasthi (Lahore).  
Chairman Prof. Abdul Waheed (Lahore).  
Co-Chairman Prof. Gul Rehman (Cenar).  
Secretary Prof. Faiz Muhammad Khan (Peshawar)

- 1) Acute Lymphoblastic Leukemia Ukall 10 in Leukemia:  
Taj Mary Munaza, Lahore.
- 2) Behaviour of parents of children with Leukemia and Solid Tumors on the subject of discretion :  
Gokturk. U. Zulfikar, Istanbul, Turkey.
- 3) The efficacy of Mezlocillin - Amikacin combination in Febrile Neutropenic Children with Oncology diseases:  
Gedikoglu G./Zulfikar, Istanbul, Turkey.
- 4) Childhood Acute Leukemias in Pakistan high incidence of CNS relapse in Acute Lymphoblastic Leukaemia :  
Dr. Shahina Qureshi, Islamabad.
- 5) Identification of source of Haematuria by automated measurement of M.C.R. of Urinary R.B.Cs. :  
Masood Akhtar, Lahore.
- 6) Hemolytic Uremic Syndrome in Children :  
Dr. Sajid Maqbool, Lahore.  
Dr. Akbar, "  
Dr. Tahir Shafi, "
- 7) Review of 1510 cases of Haemoglobinopathies:  
Dr. Bushra Rafique,  
Fathmid Foundation, Karachi.
- 8) Management of A. L. L. :  
Prof. Gul Rehman (Cenar Quetta).



10TH MAY 1990.  
ZIARAT HALL

H. Scientific Session..... 2.00 PM to 3.30 PM.

NEUROLOGY:

Chief Guest Prof. Shoukat Raza Khan (Lahore).  
Chairman Brigadiar Arwar (Rawalpindi).  
Co-Chairman Prof. Hassan Memon (Hyderabad).  
Secretary Prof. Ahjaz Arain (Nawabshah).

1) Pattern of Epilepsy and response to Drugs in 30 children:  
Nazir Malik, Lahore.

2) Value of C.S.F. Smear examination in Acute Bacterial  
Meningitis :  
Iqbal Sheikh, Lahore.  
Mary Taj, "

3) Etiological agents and outcome in 150 cases of Acute  
Bacterial Meningitis :  
Iqbal Sheikh, Lahore.  
Mary Taj, "

4) An out break of Group "A" Meningococcal Meningitis  
in Pakistan :  
Prof. Imran, Dr. Hamid Ali Aurakzai.

5) Meningitis in children at Nawabshah in 1989 :  
Dr. Ahjaz Arain, Nawabshah.

6) Diagnostic aspects of Neuro Tuberculosis in unusual  
presentation by C.T. Scan. :  
Dr. P.M. Udani, Bombay (India).

7) Guillain - Barre SYN Drome :  
Dr. Parvez Akbar Khan, Multan.  
Dr. Abid Hussain, "

8) Epilepsies in Children:  
Prof. Hassan Aziz, Karachi.

10TH MAY, 1990.

J.K. ....3.30 PM to 4.30 PM.

PLANNING AND DEVELOPMENT:

Chief Guest Prof. Fehmida Jaleel (Lahore).  
Chairman Prof. S. M. K. Wasti.  
Co-Chairman Prof. Imran Khan.  
Secretary Dr. Tufail M. Khan (Peshawar).

- 1) Undergraduate Medical Education :  
Prof. Ashfaq, Peshawar.
- 2) State of Children in Pakistan & Paediatrician's Role:  
Prof. Shoukath Raza Khan, Lahore.
- 3) Postgraduate Paediatric Medical Education:  
Prof. Zeenath (Issani).
- 4) National Health Intervention Programme (Child Survival)  
(ARI/CDD/EPI) :  
Prof. Mushtaq A. Khan (P.I.M.S.)

11TH MAY, 1990.

KILLAH SAIFULLAH HALL

Expert Committee Meeting All Professors Requested  
Kindly to Attend :

I. Scientific Session..... 9.00 AM to 11.30 AM.

C.D.D. A.D.D.R. SYMPOSIUM:

Chief Guest Prof. Barnish (U.S.A.)  
Chairman Prof. Majeed Mollah (Karachi).  
Co-Chairman Prof. Dr. Iqbal Memon (Nawabshah).  
Secretary Dr. Z. Hurta (Karachi).

- 1) Treatment of Diarrhoea History of Evaluation:  
Prof. A. Majaid Mollah, Karachi.
- 2) Honey in O.R.S. instead of glucose :  
Dr. Ghazanfar Ali sheikh, Lahore.
- 3) Perceptions of illness Home Care, and Health Seeking Behaviour in childhood Diarrhoea :  
Dr. Asma Fozia Qureshi, Karachi.  
Dr. M. Lobo, "  
Dr. Laila Hassan Ali "
- 4) Dietary Management of persistant Diarrhoea in children a comparison of Kitchri and Yogurt with Soya from ULA :  
Zulfikar A. Bhutta, Zeenath Isani.
- 5) Survey of Diarrhoeal disease in infants at Peshawar :  
Dr. Haqdad Khan, Peshawar.
- 6) Study of 344 cases of Diarrhoea in children at Peshawar:  
Prof. Imran, Peshawar.  
Faiz Mohammad, "  
Amin Jan, "
- 7) Personal Behaviour and Diarrhoea Infections :  
Fikree F. Thaver H. Naushabah.
- 8) Early Feeding in severe acute childhood Diarrhoea :  
Dr. Sala-ud-Din Sheikh Karachi.  
Majid Mollah "  
A. G. Billoo "
- 9) O.R.S. or O.D.S. :  
Dr. D. K. Tiwari, Sahranpur (India).
- 10) ~~Management of Refractory Diarrhoea in children based on its Etiopathogenesis Mechanisms :~~  
~~Dr. D. K. Tiwari (India).~~
- 11) Diarrhoea : Gen. Iftikhar Malik, Islamabad.

PICNIC..... 12.00 Noon MID-DAY

11TH MAY, 1990.

ZIARAT HALL

J. Scientific Session..... 9.00 AM to 11.30 AM.

INFECTION/ALLERGY/E.P.I.:

Chief Guest Prof. Mushtaq Khan (Islamabad).  
Chairman Prof. Zeenath Isani (Karachi).  
Co-Chairman Prof. Tariq Bhutta (Multan).  
Secretary Dr. I. Bangish (Islamabad).

1) Treatment of Malaria with Halofantrine:

Prof. Z. Isani, Karachi.

2) Liver Abscess in children not an uncommon problem :

Dr. Aysa Mahnaz,  
Dow Medical College, Karachi.

3) Use of Fosfomycin in treatment of Enteric Fever :

Dr. S.M. Inqisar Ali,  
Dow Medical College, Karachi.

4) Lung in Immunological Disease in children :

Prof. Ibrahim Memon.

5) Malaria in children :

Dr. Akram and Prof. Ashfaq.

6) Study of knowledge attitude and practice of parents  
to works immunisation of their children :

Dr. Ajay Kumar, India.

7) Analysis of Hospitalised Cases of Vaccine Preventable  
Diseases with reference to Immunisation Failure and  
Drop out Rates at A Gwalior :

Dr. Miss Taluja, India.

- 8) Immunological Studies in Polio Vaccination :  
Dr. Shakila Zaman, Lahore.
- 9) Cockroach Allergy in Pakistani Children :  
I. Bangash.
- 10) Present status on Vaccinal Association :  
Dr. Ajjan, Paris (France).

11TH MAY, 1990.

12.00 Noon

CONCLUDING SESSION

Chairman : Prof. M. Rafique

Co-Chairman: Prof. Mehr Taj Roghani

Secretary : Dr. Yunus Soomro

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QUERIES CONCERNING BREASTFEEDING AND DIARRHOEA\*

E.F. Patrice Jelliffe\*\*

Derrick B. Jelliffe\*\*

(1) How can breastfeeding help prevent diarrhoea?

Human milk is a clean, uncontaminated source of water and food, as opposed to other milks, formulas or semi-solids (especially using difficult to clean feeding bottles). All are likely to contain diarrhoea-causing bacteria or viruses. Breastmilk (especially colostrum) contains a wide range of anti-infective substances and white cells. These are particularly effective against organisms causing intestinal infections. After the early months, partial breastfeeding still has a limited protective effect against infective diarrhoea, even when other foods have been introduced.

(2) Is it true that babies up to 4-6 months do not need any food in addition to breastmilk?

X Yes. The vast majority of women can breastfeed. In successful "biological breastfeeding" given "on request" throughout <sup>the 24 hours a day,</sup> ~~the day,~~ the amount of milk produced is more than enough for "early infancy" -- that is for the first six months, with maintenance of satisfactory weight gain. The only exceptions are with mothers with the so-called "insufficient milk syndrome." This is usually due to faulty management and interference with maternal reflexes. Anxiety

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\*Over the past year the following questions were most frequently asked by doctors during the Diarrhoea Training Unit (DTU), programming and during visits in health facilities in the four provinces in Pakistan.

\*\*Population and Family Health Division, School of Public Health, University of California, Los Angeles

blocks the milk-ejection or let-down, and/or limited sucking reducing secretion of the milk-producing hormone, prolactin. Recent studies in many communities with moderately undernourished mothers have shown that they can produce sufficient milk, sometimes to their own detriment.

However, rarely in very severely malnourished impoverished mothers in some areas of the world, the breastmilk may be low in volume or in nutrients that are deficient in the local diet. These have included vitamin B12 in some poorer communities of South India vegetarians and thiamine in some Asian communities consuming diets mainly comprising white rice. For all of these circumstances, trying to improve the mother's diet is the essential approach.

(3) How about iron rich foods, don't they need <sup>them?</sup> it?

No. Iron is supplied to the young infant via liver stores acquired as a fetus and from the baby's diet. Human milk is not "rich" in iron, but has an exceptionally high bioavailability (absorption from the intestines). Also, medicinal iron is not necessary for breastfed babies, as it has the disadvantage of altering the composition of lactoferrin present and so decreasing one important anti-infective substance in breastmilk.

(4) Is it true that babies between 4-6 months do not need any drinks in addition to breastmilk? Not even water? Why?

This is true. Human milk has a high water content, so that breastfeeding is a demand and supply source of food and fluid. The lack of need for extra water has been proven scientifically by careful studies during the hot seasons in Jamaica, India, and, more recently, in Lahore, Pakistan. In all these

investigations, the concentration (specific gravity) of the infants' urines was normal despite extremely high ambient temperatures.

(5) We have heard that bottle feeding can cause diarrhoea. Is this true?

How?

This is correct. To use a feeding bottle without danger, there is a need for reasonable home hygiene (including adequate supplies of clean water and fuel to boil water and feeding utensils), several bottles and parental education concerning the need for careful cleaning, which presents a special problem in narrow, difficult to reach interiors of feeding bottles and teats. Without these, the feeding bottle easily becomes a "lethal weapon" -- highly contaminated with residual and infected milk clots, and then filled with very dilute animal milk or formula, made up with dirty, unboiled water. The result is often a potentially fatal downward spiral of diarrhoea and marasmus. The risk of serious diarrhoea has been estimated to be 25 times greater in bottle-fed compared with breastfed babies.

(6) Is the breastmilk a rehydrant during diarrhoea?

Yes. Breastfeeding should be continued during diarrhoea, as has been proven in many clinical studies. Breastmilk supplies clean water, nutrients and several substances, which facilitate absorption of water and the nutrients present. The presence of anti-infective substances combat enteropathogenic bacteria and thus help to decrease <sup>the</sup> duration and frequency of stools.

Also, if breastfeeding is discontinued for some days there is the risk the mother may believe that her milk has become insufficient and will introduce

bottle feedings. This is likely to decrease breastmilk secretion because of limited sucking stimulus --in effect, a "self-fulfilling prophecy."

- (7) If <sup>a</sup> ~~your~~ young baby is no longer breastfeeding, how should a mother feed the ~~baby~~ <sup>infant?</sup>

In less well-to-do circumstances, if young babies are not breastfed, they are in great danger of diarrhoea and marasmus. The risks can be reduced somewhat by using a cup or spoon, or a feeding cup. These are easier and more likely to be cleaned than the difficult-to-reach interior of a feeding bottle, *but are time-consuming to use.*

- (8) If the breast is not washed before a mother breastfeeds, could this cause diarrhoea?

Unless the breasts are especially dirty, washing prior to breastfeeding is not required. The special glands on the areola (Montgomery's glands) produce an antibacterial secretion and the milk produced contains anti-infective substances to most maternal bacteria.

- (9) Do children with diarrhoea digest foods they eat? Do they digest all foods equally well? Why?

Foods are digested much better than previously believed. This is understandable if considered in relation to the length of the intestines with thousands of villi giving a huge surface area for food to have contact with enzymes and subsequent absorption. Bland gruels, like rice, dalya, porridges or pastes are dealt with best. Their starches are hydrolyzed to glucose, which has a specific effect in assisting absorption of water and nutrients.

(10) Can't some foods decrease the purging rate? Why?

Yes. As previously mentioned, starches are hydrolyzed to glucose, which has a specific effect in assisting absorption of water and nutrients. Such foods decrease the stool output, which is what the mother (and health worker) are mostly concerned with. Again, these are starchy semi-solids -- like rice, dalva and kitchri.

(11) Can breastmilk cause diarrhoea? Is there a need for testing breastmilk?

No, breastmilk does not cause diarrhoea. There is absolutely no need to test breastmilk for this. One wonders what it is being tested for!

(12) Recently, we have been hearing about super ORS. What is it? Does it really reduce stool output? Does it have enough calories to be used as food during diarrhoea?

ORS from packets or from home-made sugar and salt can and do replace fluid and electrolytes in diarrhoea. The ORS packets are preferable as they contain potassium and "base" (sodium citrate) to neutralize the acidosis often present. What is usually referred to as "super ORS" has added glycine, an amino acid, to further increase the absorption of water, electrolytes and other nutrients made possible by the remarkable effect of glucose. However, no ORS, including the super version, is a food. It is an oral rehydration preparation to be used for a short period (preferably not more than 6 hours) to be followed speedily by appropriate foods as indicated earlier. Some newer ~~ORS~~ packets contain rice flour instead of glucose so that nutrients are included.

(13) Are there some foods which are "good" for diarrhoea?

Yes. Firstly, breastfeeding should be continued. Also, as previously mentioned, soft starchy preparations of the local staple (rice, wheat) are "good" for diarrhoea. For children over 4-6 months, depending on the stage of rehydration, soft boiled rice (as with rice-lentil kitchri) is valuable, as is ripe banana (especially rich in potassium) and yoghurt (low in lactose).

(14) Can foods cause diarrhoea? Which are they?

At any age, foods contaminated with enteropathogenic bacteria or viruses can cause diarrhoea, including undercooked eggs, and previously cooked items exposed to flies and dust. This means that foods should be freshly prepared and covered, as much as possible. Also, irritant foods (such as those highly spiced with chili) and poorly digested foods, such as some inadequately cooked, unsieved legumes, can lead to loose stools, as is well-known. It depends on the definition of diarrhoea -- a very variable condition. *end - result.*

(15) If children have lactose intolerance, should they be given lactose free formula?

Lactose intolerance is not common if diarrhoea is treated correctly -- that is with rapid oral rehydration, continued breastmilk and early feeding, as mentioned previously. If lactose intolerance occurs or is realistically suspected, a low-cost mixture of yoghurt and cow's milk can be used, as demonstrated by Karachi pediatricians, with excellent results. Alternatively, ~~milk~~ can be mixed with rice or other cereal preparations. Costly lactose-free formulas are not needed.

*yoghurt*

*1 or kitchri*

(17) When should foods be started during rehydration? What foods should be given at each stage of dehydration?

This depends on the age of the child, the previous diet, and the degree of dehydration. In general, for the breastfed infant aged over 4-6 months, a sequence should be (i) rapid oral rehydration with continuing breastmilk, (ii) use of soft rice or wheat preparations (porridge), (iii) kitchri, yoghurt, banana.

The 30 Key Questions on Breastfeeding in Pakistan with answers by the Jeliffes, has been adapted for the lay public, so that this important document can be widely circulated through newspapers and magazines.

Breastfeeding in Pakistan. Some of your questions answered by internationally renowned breastfeeding experts.

The experts from the University of California, USA :

Prof. Derrick Jeliffe, M.D., Professor of Public Health and Paediatrics.  
Patrice Jeliffe, M.P.H. Lecturer and Researcher.  
Audrey Naylor, M.D., Associate Professor of Paediatrics.

Some facts: Each year the lives of over 200,000 children are lost due to diarrhoea in Pakistan.  
Half the children in Pakistan are malnourished.  
One in ten Pakistani children are severely malnourished.  
Bottlefeeding is one of the main causes of malnutrition and leads to many of these deaths from diarrhoea.

1. Question.

Why should we worry about breastfeeding in Pakistan, because nearly all the children are breastfed ?

Answer.

This is true, but unfortunately the breastfeeding is started too late in Pakistan. It should start within half an hour of the delivery of the baby. Mothers also mix breastfeeding with bottlefeeding and this increases the risk of diarrhoea.

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2. Question.

What is the point of breastfeeding at, or as soon as possible after, birth ? Surely the mother is tired and needs to rest. She also has no milk for the baby at this time.

Answer.

This is the best time because the baby is wide awake and can suck the very nutritious "first milk", colostrum. It stops the mother bleeding too much by contracting the uterus and pushing out the placenta.

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3. Question.

Colostrum seems to be much discussed these days. Why is this ?

Answer.

Colostrum is the yellowish first milk, produced in late pregnancy and the first few days after birth. Modern scientific studies indicate increasingly that it is a "biological umbrella" to protect the vulnerable newborn, containing large amounts of protective substances active against the disease causing bacteria and virus microbes. Colostrum is also rich in nutrients like zinc and vitamins A and E. It also acts as a very mild laxative, helping to clean the newborns bowel

of the sticky green meconium stool. It is an unfortunate waste not to use this universally available "natural medicine."

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4. Question

What are the dangers of breastfeeding ?

Answer.

There are no dangers for mother or baby.

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5. Question.

The traditional practice of giving ghutti is very widespread in Pakistan. What would your advice be on this practice ?

Answer.

All cultures have beneficial and harmful practices. The giving of ghutti has to be considered as potentially dangerous. Anything that goes down the baby's throat apart from mother's milk has a high risk of causing diarrhoea. As the main function of ghutti, is as a laxative to clear out the first stool, perhaps colostrum could be advised as a natural ghutti.

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6. Question.

In a hot country like Pakistan, it seems reasonable to give extra water to the newborn in the summer months. Do you agree ?

Answer.

Nature has supplied a source of clean water through mother's milk. Breastfeeding is a supply and demand system for both hunger and thirst. The lack of need for extra water for young breastfed infants up to 4-6 months of age, even in the hot season, has been proven scientifically in many countries including Jamaica, Peru, India and recently in Lahore.

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7. Question.

Insufficient milk is the commonest reason given by mothers for early weaning in both well-to-do and poor sections of the community. What are the reasons for this ?

Answer.

Nearly all women can breastfeed. Some women may have problems with breastfeeding for 3 main reasons. These are: 1. Anxiety, reducing the "let-down" reflex which squeezes the milk out of the breast 2. The mother not offering the baby the breast frequently enough. The more frequently the baby sucks, the more milk will be produced. 3. Mother is sick or underfed. A lactating mother needs to eat more food than normal, an extra roti each day. She also needs to drink more fluids than normal, like milk.

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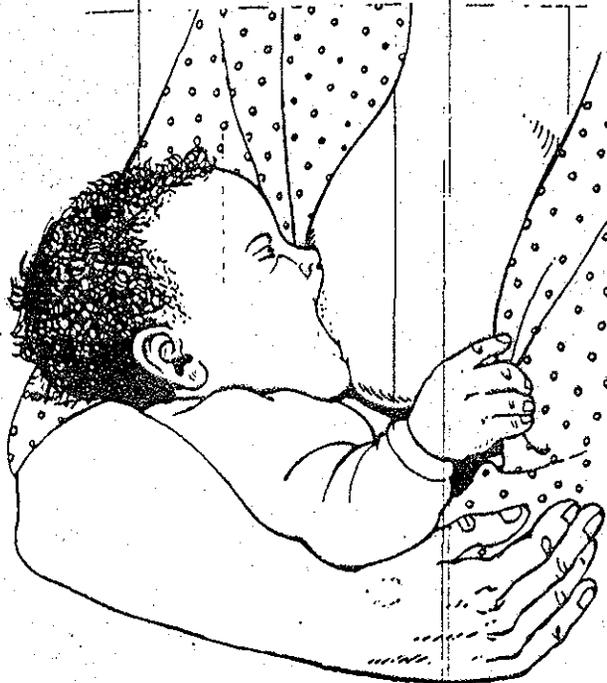
8. Question.

In those cases where the mother thinks she does not have sufficient milk, should she use formula milks ?

Answer.

No ! Formula milks if given will further reduce the mothers milk supply. The mother should build up her milk supply by breastfeeding more frequently. She and her family must look at ways of reducing her workload and improving her diet. Perhaps the baby's feeding position should be improved. The following are some signs that the baby has fixed to the breast in a good position:

- whole body is close to mother.
- mouth and chin are close to breast.
- baby's mouth is wide open.
- you cannot see much areola (dark skin around nipple) because most of it is in baby's mouth.



*Baby sucking in good position.*

9. Question.

Breastfeeding is said to have a contraceptive effect, yet one often sees women who have become pregnant whilst breastfeeding. Can you explain this ?

Answer.

This contraceptive effect will only work for the first few months, if the baby sucks frequently enough. With less frequent breastfeeding, as with the mixing of breastfeeding with bottlefeeding, commonly practiced in Pakistan, the contraceptive effect is shortened. Other contraceptives like condoms and pills or progestagen injections need to be used, which add to the contraceptive effect of breastfeeding, without interfering with milk production.

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Question.

10. Can foods eaten by the mother affect the breastfeeding baby ?

Answer.

Yes, but very uncommonly. Usually there is some other reason for a baby's colic or gas. If a definite food is found to cause the problem, it should be avoided by the mother.

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11.Question.

Can medicines, taken by the mother, harm the breastfeeding baby ?

Answer.

Yes they can. This is why it is better to take as few medicines as possible when breastfeeding. If you have to take medicines, check with your doctor first to ensure that they are safe.

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12.Question.

Has animal milk no place in the diet of children ?

Answer.

Not at all. Cow's milk, buffalo's milk and goat's milk are all excellent foods for older children and adults. The danger is if they are used instead of breastmilk for infants. Breastmilk is the best milk for infants.

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13.Question.

Two major problems reported by mothers are cracked, sore nipples and breast engorgement. Are these preventable ?

Answer.

Yes. Both can be prevented with the right technique. Cracked, sore nipples can be avoided by making sure that the whole nipple is in the baby's mouth, together with some of the areola (this is the dark skin round the nipple). Contrary to the advice in some textbooks, the baby does not suck directly on the nipple. No ointment or lanolin is needed, as a natural lubricant is produced by glands on the areola. If the nipple and areola are dry, just rub a little expressed milk gently into them. Breast engorgement is prevented in most cases by starting breastfeeding early, straight after birth, and breastfeeding frequently. If the mother is relaxed and confident, with a lot of reassurance and support from her family, this helps very much. If breast engorgement occurs, putting the baby more frequently to the breast and expressing the milk by hand will help.

14. Question.

Many mothers stop breastfeeding because they say that their baby refuses the breast. What is the reason for this strange behaviour?

Answer.

There is not one reason, but several which can be present singly or together. If the baby has been bottle-fed, the quite different mouth movements from breastfeeding can lead to "nipple confusion", together with a preference for the easier flow of milk from the bottle. Also, incorrect positioning of the baby against the breast and an anxious, uncomfortable mother can lead to the baby refusing the breast. A baby finds milk difficult to suck from an engorged swollen breast. To avoid all these problems a baby should be breastfed on demand from birth, and not bottlefed.

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15. Question.

Bottlefeeding is obviously dangerous for poor families with limited education and access to only contaminated water. Are there also real benefits from breastfeeding for the well-to-do?

Answer.

Definitely. Among the educated elite, breastfeeding reduces intestinal and respiratory illnesses in infants, almost eliminates cow's milk protein allergy and helps foster mother-child bonding. Breastfeeding also protects the infant partially against the "cot death syndrome," badly fitting teeth, diabetes (too much sugar in the blood) and atheroma (too much fat in the arteries) in later life.

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16. Question.

Should breastfeeding be stopped in children with diarrhoea?

Answer.

Definitely not! Breastmilk is a good supply of water and nutrition which is so important in treating diarrhoea to prevent dehydration and malnutrition. It must be continued.

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17. Question.

What are the economic considerations for Pakistan with regards to breastfeeding?

Answer.

On a family basis, formula feeding of a 3 month old baby will cost about 40% or more of the monthly earnings of less than 800 rupees found in 47% of Pakistani families, obviously an impossible situation for these families. On a national scale, the decline in exclusive breastfeeding is reflected by the increase in imports of "Formula Milk" from 75 million rupees in 1982-83 to 164 million rupees in 1985-86 (Federal Bureau of Statistics, Government of Pakistan.) This more than doubling of expenditure on milk imports not only indicates increased bottle-feeding, but also may be considered an inefficient use of foreign currency.

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18. Question.

The pacifier or comforter seems a harmless way to quiet a fractious, "fussy" baby. Is this so?

Answer.

Not at all. The pacifier has 3 main problems. It frequently falls on the dirty floor and therefore increases the number of bacteria microbes entering the infant's mouth. It means baby sucks less at the breast so milk production stimulated by this sucking reflex is reduced. Also a pacifier can cause "nipple confusion" because breastfeeding has a different "mouth feel" and mouth movements.

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19. Question.

Can legislation help in breastfeeding programmes?

Answer.

Yes, if the laws can be enforced they greatly help national breastfeeding programmes. An example of one law would be for Pakistan to enforce the WHO/UNICEF Code of Marketing of Breast Milk Substitutes, controlling unethical practices in the infant food industry, to which they are a signatory. The companies try to avoid these codes by calling their products "follow-on milks" when in fact they are used by the public as breastmilk substitutes. Another useful policy would be to limit imports of formula milks to selected brands which are economical, nutritious and not advertised. Working women who would like to breastfeed can be assisted by organising a flexible maternity leave. Establishing nurseries at their workplace would allow them to breastfeed at work. It is recommended they are allowed 2 half hour breaks each day, to breastfeed. This programme requires positive government support.

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20. Question.

What changes can you make to maternity units in hospitals to assist breastfeeding?

Answer.

The newborn should be put to the breast at delivery or as soon as possible after this. No extra foods like ghutti, formula milks or glucose water should be used. Breastmilk is enough. The baby should stay with the mother all the time and not be kept in a separate nursery. This will allow feeding on demand. There is a National Breastfeeding Policy in Pakistan to encourage these practices. For more information you should contact the National Breastfeeding Committee, Address:

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