Breastfeeding Prevents Diarrhoea

Clare Blenkinsop

Diarrhoea and its fatal consequences are again making headlines in our daily newspapers. Certainly great improvements have been made in our understanding of how to treat diarrhoea quickly and effectively; over 90% of households know about ORT (Oral Rehydration Therapy) and its use is widespread. But unfortunately in another equally important area of understanding, we appear to be regressing rather than advancing: breastfeeding and particularly exclusive breastfeeding is declining.

Can breastfeeding make a significant difference in the incidence of diarrhoea? Most certainly — in fact "significant" is the wrong word to use — "fantastic" or "dramatic" would be more appropriate. A recent study in Brazil found that infants who received both breastmilk and other milk were 4 times more likely to die from diarrhoea than those who were exclusively breastfed, while those who received no breastmilk were 14 times more likely to die.

The reasons why breastfeeding offers protection against diarrhoea are :

- the immunological and antimicrobial properties of breastmilk
- the gut bacteria of exclusively breastfed infants tend to inhibit the growth of diarrhoea-causing bacteria
- bottlefed infants are at greater risk of bacterial contamination
- breastfed infants have a better nutritional status, and thus less risk of death from diarrhoea.

Too often it is claimed, inaccurately, that bottlefeeding of infants in Bangladesh is a problem confined to urban areas or to a small elite section of the population. To state that 98% of mothers breastfeed their children is irrelevant. What is important to understand is that so-called "combined feeding" is the norm and exclusive breastfeeding rare. Studies in this country have shown that almost 100% of babies receive something other than breastmilk for their first feed and this is the beginning of a pattern of partial breastfeeding combined with giving the baby foods and drinks other than breastmilk.

Another common misconception is that malnourished women are unable to breastfeed their babies adequately and therefore must supplement their breastmilk with other powdered milks. In fact, it has been shown scientifically that malnourished women can produce both the quantity and quality of breastmilk needed for the proper growth of a baby up to 5 months of age. And practically the only option a malnourished woman has to feed her baby safely and adequately is to breastfeed exclusively. Someone who cannot give herself sufficient food cannot possibly afford the expensive and dangerous option of buying tinned formula milk. Breastfeeding is not just the best way of feeding a baby — but easily the cheapest; to feed a baby of feed a baby of 3 months on tinned formula milk powder costs perhaps Tk 30 a day whereas a woman who is breastfeeding requires only Tk 2-5 of extra food. We should find ways of feeding mothers themselves more, rather than urging them to bottlefeed their babies.

Exclusive breastfeeding means giving the baby nothing else but breastmilk — no honey, mustard oil or sugar water soon after birth or cows milk, powdered milk or other fluids afterwards. Breastmilk really does contain everything a baby needs for the first five months — even enough water for a hot climate like ours. Diarrhoea, which is always caused by taking contaminated food or fluids, can be almost totally avoided for the first 5 months of a child's life by exclusive breastfeeding.

At 5 months breastmilk should be complemented with a variety of freshly prepared family foods. The food should be mashed up and fed either by a clean spoon or hand but never by a bottle. Small children need small quantities of food often — their stomachs are not large enough to contain large quantities.

Why does bottlefeeding so quickly lead to diarrhoea? Because it is very difficult to ensure that all the fluids in the bottle are sterile, or completely clean, or that the bottle and the teat are free from bacteria. To be safe, bottles and teats must be boiled for 10 minutes, each time they are used. The water used to mix the feed also needs to be boiled for at least 10 minutes.

To achieve these conditions, money, time, equipment and information are required and even then the product is inferior to breastmilk.

In addition to its nutritional value, and its immunological properties there are many other advantages to breastfeeding — babies that are breastfed are less likely to suffer from allergies such as asthma and eczema. Children who are exclusively breastfed are half as likely to develop cancer before the age of 15 than children not breastfed. For mothers too the advantages are great — the process of breastfeeding helps a woman's body return to its pre-pregnancy condition and it offers good contraceptive protection (if practiced exclusively) for the first 5 months after delivery. The risk of breast cancer and overian cancer in later life progressively decreases with increased breastfeeding duration.

The goal we should be striving to achieve for the optimal health and nutrition of mothers and children is that all women should be enabled to breastfeed exclusively for the first 5 months of a baby's life. This child feeding idea can only be achieved by creating an appropriate environment of awareness and support so that women can breastfeed in this manner. Attainment of this goal means that obstacles to breastfeeding both in the community and the workplace must be eliminated.

Strengthening the bonds !

Precious lives that can easily be lost for ignorance — Courtesy : Facts for Life

Caring for the Treasured Ones

By Rahat Fahmida

"O H Allah ! My four year old daughter died of diarrhoea, last week. It is our bad luck that we survived this catastrophic cyclone, but lost our only child weeks after. I do not know how this happened," cried Morjina of Anwara upazila. Her husband, Kasem is a landless farmer and lived jointly with his elder brother and his family. They have lost whatever little possessions they had. Preparing to start all over again and presently living on reliefs, it was indeed irreplaceable to suddenly lose their little child. But blaming it all on their luck is wrong !

No mother or father, however illiterate or poor, accept the ill-health of a child without sorrow and suffering. The demand for good health and survival of a child, however, is covered over by widespread perception of 'fate'. 'Fate' is what one has no control over. It is in the hands of God. It is the only explanation available to most of the people to help them to bear their suffering.

What we can do is to change the climate of fatefulness through the media, religious leaders, indigenous doctors, teachers and others whose word is ordinarily trusted. Through them the message might be reached that fate is not destiny. Fate is what happens to us. Destiny is what should and could happen to us. If two of the four children born to a family die from preventable disease, people would readily accept that this is a way of fate over which they certainly have no control. There is a need for a change in the habitual attitudes and hygienic practices in the household and more awareness of what is possible within given means to protect children from disease and death.

In some countries the opportunity to go national with vaccination presents itself especially when the will at the top exists and has the authority to be effective throughout the land and can therefore mobilise the media. One value of such an effort is that it proves to other countries that raising the level of immunisation from 15 to 90 per cent and cutting death rates from diarrhoeal dehydration by half is not an impossible dream.

Going to scale and the scaling up of pilot projects or of limited efforts to reach a national coverage with broad, maximum participation, present the most intricate and intractable problem in development.

In industrialised countries it is essential that the general public become aware of the recent breakthrough in social development, and that the potential only now exists to reduce infant mortality and to improve child development on the basis of a combination of, new knowledge and communication capacities that did not exist ten years ago in the developing countries.

The infant mortality rate in Bangladesh is amongst the highest in the world, according to an UNICEF report. It added that each day in Bangladesh over 11,000 babies are born and approximately 900 die within the first 28 days of life. Over and above, during this recent post cyclone and disaster operations, many children will have been born in relief camps, perhaps prematurely induced by stress. Having to give birth in the over crowded and unhygienic conditions of camps will have caused considerable personal discomfort and social distress among mothers who would have been unable to practise even the most rudimentary hygiene.

Even when the current peak of diarrhoea morbidity lessens, evidence from previous disasters shows a long term impact on mortality.

The importance of immunisation programme should be emphasised for measles related mortality, which is quite significant. It is too early to say what the total long term impact will be in human terms. The prevalence of breastfeeding, the use of oral rehydration therapy, the availability of potable water after the initial repairs to wells, the access to govt. and NGO health services — none of these indices are likely to falter seriously. The silent emergency from before the crisis will continue.

Health conditions in our country are in general very poor, with high levels of mortality and morbidity, especially among children and mothers. The disease for which treatment for children is most often sought, even during "normal" times include acute respiratory infections (ARI), diarrhoea, parasitic diseases, skin diseases and ear infections. The cyclone, tornado, and flood have the impact on all these diseases, particularly diarrhoea and ARI. The infants, young children, pregnant and lactating mothers within the landless population form the very high-risk groups.

In subsequent issues, we will deal with the effort, which UNICEF, and various other non-government organisations are doing in order to create awareness, regarding prevention of the above-mentioned diseases.

Women's Banks a Big Success in Sri Lanka

It is hard to believe that women— as poor as they are—could put up capital for a bank, then run the bank themselves.
by Mallika Waningasundara

THE very modest house is reached by jeep down potholed roads. It announces itself with a sing in Sinhala: Siribopura Janasakthi Bank.

In the 8 metre by 8 metre front room is a desk, a few chairs, a small settee and a filing cabinet, as well as charts and posters on the walls. The place, rent-free, has no security guard and hardly looks like a bank.

But it is a bank, one of 20 such small banks located in 20 villages in the district of Hambantota, southern Sri Lanka. They are collectively known as Janasakthi ("strength of the people") or the poor woman's bank.

Patterned after the Grameen Bank, or bank for the poor in Bangladesh, the Janasakthi banks were set up as an alternative to the state and commercial banks whose credit rates are beyond the reach of poor people, and the village moneylender who charges a steep 240 per cent interest rate annually.

Mr. W.G. Mithraratne, the district's top official who initiated the project, said it is also intended to rescue families from the heavy indebtedness common in the villages, and to stimulate savings. Women are the key to the development of the area and thus were made the focus of the banking system , he explained.

The women themselves are quick to give Mr. Mithraratne credit for the effort, but it is they who entirely own and run the banks.

Only four months old in February 1991, the 20 banks have a total capitalisation of 824,451 rupees (US$20,611) and have given out loans amounting to 335,000 rupees (US$8,375).

Given the poverty of the villages, it is astonishing that the women were able to raise such capital. But they did—with their savings and by buying a 10-rupee share every week for 50 weeks.

To establish the banks, the women formed Kantha Samitis (women's societies) which then formed a Women's Development Federation. The Federation set up the banks and supervise them. To date, 126 Samitis have been formed with a total membership of about 7,000.

The sense of accomplishment was expressed by Leela Suriyabandara, president of the Viharagala bank: "We formed the Kantha Samitis during the most dangerous times (of terror and insurgence) in 1989. And now we have a bank, we have overcome."

Members of each bank—all poor people who receive food stamps and a temporary food alleviation allowance—are from six to 12 villages. They know one another and keep well abreast of what is happening. They have an annual general meeting which the women conduct like trained troopers, while their husbands watch from the windows of the hall with infants hoisted on their shoulders.

Having no headquarters or a mother bank, the Janasakthi banks are decentralised units each with its own Constitution, system of checks and balances and a system for hurdling the knotty problem of guarantors and collaterals.

Under the present policy , shareholders, get 8 per cent interest on their shares and 12 per cent on their savings per annum. According to Sumithra Samaratne, president of the Godawaya bank, the women make deposits of even 5 rupees. Some have saved as much as 2,000-3,000 rupees in four months, she says.

Interest on loans, at 3 per cent monthly, is higher than prevailing national bank rates.

But this is the women's decision, since they want the bank to grow fast. In any case, they say, they have been paying infinitely higher rates to local moneylenders.

The banks offer five kinds of loans—amounts of 1,000-3,000 rupees are for cultivation, fisheries, small enterprises and self employment, while 500 rupees is for disaster relief. These are subject to change depending on policy and prosperity.

Among those who have taken out a loan is B.A. Kanthi who started a salt packaging business with a loan from the Salt Packers Association and expanded it with 1,500 rupees from the Janasakthi bank.

Making 1,000 rupees from each van load, she and her husband have been able to pay back 170 rupees to the Janasakthi bank and 236 rupees to the association.

Allan Nona borrowed 1,000 rupees to expand her bean curd business. "During weekends I sell around 300 to 400 pots of curd. But I never had the money to buy the milk or the pots because I paid so much interest to the moneylender. Now I make a good profit," she said.

Another borrower is Samawathie who used to break stones at the quarry. With some savings and a loan of 1,500 rupees, she went into the ropemaking business.

Now Samawathie makes rugs, having bought three coir cleaning machines and trained 13 people. She has orders for rugs to be supplied to ships.

With a loan of 3,000 rupees, Siriyawathie bought fishing nets for her husband. His share of the catch was 15 per cent but as owner of some of nets, he now gets 45 to 50 per cent of the catch. This amounts to earnings of 4,000-5,000 rupees in good months.

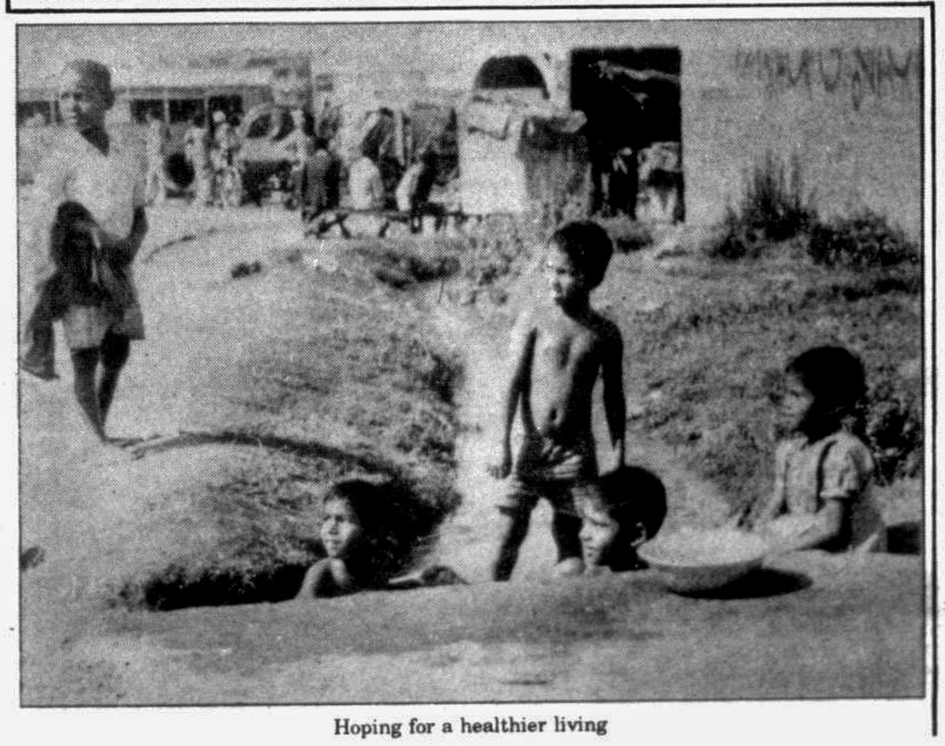
The banks have devised their own method of deciding credit worthiness. In each Kantha Samiti the women form into teams of five. When one team member wants a loan, the others recommend her application and guarantee her loan. If there is default on payment, the team is held responsible. It works.

At present, only women can transact with the banks. The men are asking that they be allowed at least a savings account, but the women are wary about the possible effects of male incursion into their most precious project.

Aside from the benefit of having access to loans, the women are also developing the savings habit, especially knowing that they would have ready money to withdraw in case of emergencies.

Bad roads and poor transport, however, make it difficult for the women to reach the banks.

—Depthnews



Hoping for a healthier living

A Costly Indifference

by Sabah Chowdhury

THE courtyard of Majeda's house was full of people, men were sitting in the open space outside her hut, while the womenfolk inside the house trying to console an unconsolable Majeda. It was impossible to believe that her beautiful child, who even a fortnight ago had been playing so joyfully, should be lying wrapped in a white cloth for burial today. It seemed that if she searched carefully, the impression of her beloved Joinal's small feet barely one year old, may be found in the soft mud in front of her house.

A mother of five children Majeda had given little heed to the repeated requests of Rahima Apa, a neighbour and also a health worker of her village, to immunise her child. Whenever, she was asked if she had gone to the health complex with the youngest baby, her answer was that she would soon do, besides that if the rest of her children did not need any kind of vaccination, why should this one?

Then suddenly one evening Joinal developed fever, she rushed to Asma Bibi, respected by all as the faith-healer of the area.

The lady gave her some water to make the baby drink and said by next morning that child would be all right. But as the clock ticked on, the condition of the baby deteriorated, and by morning she could trace some rashes on the baby.

Some elderly ladies said that this was surely measles, but there was nothing to fear about, as it was common for children to have measles.

Majeda has lost her baby boy, because he wasn't immunised

Majeda noticed that as the days were turning into night the baby was becoming restless and was coughing incessantly.

She now became very worried, and requested her husband to bring in a doctor. The doctor came, and after examining the child carefully asked Majeda and her husband Rahim whether they had immunised the child against whooping cough, and measles, as their child was suffering from both.

They answered in the negative. He said if a child was not immunised against both these diseases, it can often turn fatal.

He further told them that, it was essential for the survival of any child that it be immunised.

Any baby can be immunised against whooping cough as early as six weeks of age, and the vaccination for measles can be given as soon as the child crosses the age of nine months. The doctor told them that it was too late to do anything now. Only perhaps a miracle can save the child.

Days passed by, and the condition of Joinal worsened, and one day the baby died. A dumbstruck Majeda felt as if all sensations had left her. She could not forgive herself for not listening to the health worker, as well as other neighbours of hers, who had immunised their children. Had she also done the same, her fate would have been different today.

She would not have lost a beautiful child. It was her carelessness and foolishness, which caused her son's life.