

Countdown to 2015 for maternal, newborn, and child survival

Your Countdown Series (April 12, p 1247)¹ fails to reflect a major conclusion of the earlier Series on maternal and child undernutrition²—ie, that suboptimum breastfeeding is responsible for 1.4 million child deaths each year. The relevant proven intervention—breastfeeding counselling—is not identified, and mention is made only of breastfeeding, which is not an intervention, and breastfeeding promotion, which by itself lacks effectiveness.

Breastfeeding counselling, in which mothers receive skilled help to optimise practices, and related education dramatically increases rates of initiation and exclusive breastfeeding.³ Input is needed proactively, antenatally and postnatally, at times when a mother expects it, not just reactively when she experiences difficulties. The more contacts mothers have, the more likely they are to breastfeed.⁴ The new WHO child growth standards, which show faster growth in the early months, are based on breastfed children whose mothers received frequent support.⁵

Infant feeding might improve with behavioural and social change, but supportive health-care practices are a prerequisite, and should be a Countdown imperative. Breastfeeding counselling and education can be included with scheduled antenatal care, immunisation, and growth monitoring; and implemented with existing packages such as skilled attendance at delivery, and postnatal and newborn care.

However, infant feeding must be specified as part of the package, appropriate tasks described and taught, and the procedure recorded; if not, care might focus entirely on the mother's health, or on detection and management of newborn illnesses. One cannot assume that, just

because there is an opportunity for breastfeeding counselling, anything useful will happen.

We declare that we have no conflict of interest.

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30 years ago, WHO declared “health for all”. Where was surgery and anaesthesia? Not deemed relevant in 1978, that was for sure. But now? I see no mention of emergency obstetric care in the Countdown Series on maternal, newborn, and child survival.¹

The figures are stark. In one impoverished Asian country, 80% of district hospitals do no surgery at all.² In Africa the rate of caesarean sections is only 1.0–1.5%, despite the high incidence of obstructed labour.³ For 2 years (1993–95), data from the operations records of 18 African district hospitals were reported.³ Among major operations, 7500 caesarean sections were done per 10 million women in labour per year (rate 1.5%). On the basis of clinical presentations, if

those caesarean sections had not been done, an increased annual fatality of 6750 would have occurred. The actual number of maternal deaths for this population in 1994 was 2200–2500.

It seems from these simple sums that doing no caesarean sections at all would approximately quadruple maternal mortality, even from the high mortality that results from operating on only 1.5% of labouring mothers. The cost of anaesthesia for a 1.5% caesarean rate for sub-Saharan Africa was US\$1.3 million in 1994⁴—a tiny fraction of the costs talked about for Millennium Development Goal (MDG) 5. So it cannot be that anaesthesia is too expensive.

Until district hospitals provide comprehensive emergency obstetric care (ie, anaesthesia and surgery), Countdown will achieve no more than previous attempts to meet MDG5.

I declare that I have no conflict of interest.

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MDGs, Countdown to 2015, and “concern” for Africa

In his excellent Comment summarising the 2015 Countdown process (April 12, p 1237),¹ Richard Horton expresses “concern for a stronger and more just society, one that values every life...”. How will this be seen from an African point of view?

The printed journal includes an image merely for illustration

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