from almost all formulas of long-chain polyunsaturated fatty acids, which are essential nutrients for developing nervous tissue, and which are provided by breastmilk.[8]

Although social change and commercial influence have contributed much to the decline of breastfeeding, health care practices must take their share of responsibility, since the decline is generally greatest where mothers give birth in hospital and the warm chain of protection and support is broken. Practices known to be harmful are still common in maternity wards—eg, separation of mothers and babies, restrictions on the duration and frequency of breastfeeds, giving babies routine supplements of water or formula, and giving mothers free samples of formula to take home. Moreover, forms of care known to be beneficial are often not practised—eg, helping mothers to start breastfeeding as soon as they are ready (if possible within about an hour of delivery) and to position their babies at the breast, and ensuring that the advice given is consistent and that personal support is provided by a knowledgeable individual.[9,10] Important reasons for poor support are that most health workers have not acquired the relevant knowledge and skills in their basic training, and that most administrators lack conviction that change is needed and are unwilling to provide in-service training or the staff time necessary to help mothers.

Families need to be able to make a truly informed choice about feeding their babies. Too often the message they receive is mixed. While they pay lip service to "breast is best", all that many doctors and midwives are able to do when a mother has difficulty with the natural method of feeding is to recommend that she use an artificial one, reassuring her as they do so that "formula is equally good". Such ambivalence is endorsed by the conspicuous presence in many health facilities of breastmilk substitutes and formula manufacturers' leaflets, which likewise imply that breastfeeding can be difficult and that bottle feeding is the easy answer. Although lack of funds is usually blamed for the absence of alternative educational materials, lack of commitment is equally important. Workers who are committed to breastfeeding have managed to fund the production of simple effective materials cheaply.

Too often, a mother who indicates her intention to bottle feed is told nothing more about breastfeeding. Health workers defend their restraint on the grounds that they do not want to make mothers feel guilty. However, such guilt as there may be in this context has not been adequately studied, nor is it clear which mothers if any need such protection. If a mother chooses to bottle feed, her choice should be respected; but it is surely desirable to give clear and complete information about both methods of feeding. If a mother is uncertain, or if she really wants to breastfeed but finds it difficult, or if she had a bad experience previously, then she needs help. She needs a warm chain of skilled support, not cold assurance that failure does not matter. A mother who feels that she has failed may carry the disappointment and pain with her always; her emotional reaction to other women who breastfeed can interfere with her ability to help them, whether they be friends, members of her family, or, if she is a health worker, her patients.

Promotion needs to be clearer and stronger than it has been, and it needs to address barriers to breastfeeding. Messages that only idealise breastfeeding, or that exaggerate its benefits, may be ineffective.[11] But even strong appropriate messages may be counterproductive if they are delivered with no accompanying support. Mothers easily feel pressured to breastfeed, and are criticised if they have difficulties or do not enjoy it. If they lack confidence, they may decide that breastfeeding is impossible. So messages should address locally researched barriers, and be integrated with appropriate health care. Recommended practices are summarised in the "Ten steps to successful breastfeeding" which form the basis for the Baby Friendly Hospital Initiative, now promoted by UNICEF and WHO throughout the world.[12] To complete the warm chain, and sustain breastfeeding, consistent complementary care should be extended beyond the maternity ward, from antenatal clinics to primary care and community services, for sick and well children, throughout the breastfeeding period. To provide such care, health workers need training in appropriate clinical and counselling skills.

It is becoming clear that supportive care and counselling can increase breastfeeding success.[13] To facilitate their widespread introduction, WHO and UNICEF, as well as encouraging and assisting local initiatives, have developed training packages of 18 and 40 hours for health workers with different needs.[14,15] These materials are now being translated and adapted for use world wide.

Policy makers need to understand that provision of a warm chain for breastfeeding is as valuable as provision of a cold chain for vaccines and likewise requires adequate resources. Governments and funding agencies need to be convinced that the investment is worthwhile. Even if a warm chain is not free, it might more than pay for itself.

The Lancet