Practices associated with continuation of breast feeding beyond 10 days. Figures are numbers (percentages) of mothers

	Breast fed for ≤10 days (n=27)	Breast fed for >10 days (n=109)
	(n=27)	(n=107)
Baby fed on demand	12 (44)	89 (83)
Baby fed at set times	15 (56)	18 (17)
	$\chi^2=15{\cdot}4$, df=1, p<0·0001	
	(n=26)	(n=106)
Baby breast fed only	5 (19)	63 (59)
Baby given supplementary bottle	21 (81)	43 (41)
	$\chi^2=11{\cdot}95$, df=1, p<0·001	
	(n=27)	(n=109)
Baby put to breast within 1 hour	10 (37)	69 (63)
Baby put to breast after 1 hour	17 (63)	40 (37)
	$\chi^2=5{\cdot}10$, df=1, p<0·025	
	All mothers who breast fed (n=135)	
Baby not "roomed in" with mother	49 (36) (not significantly associated with duration of breast feeding)	

incidence of breast feeding was low and the duration short: 40-44% of mothers were breast feeding on the tenth day of each month in the second half of 1989.

In January and February 1991 I used a structured questionnaire to interview 257 of the 276 mothers who had given birth in Fife during the last three weeks of November 1990. This was to find out factors relevant in their decisions to choose and to continue to breast feed in order to promote the practice. Of the 136 mothers who had started to breast feed, 27 had stopped by the tenth day after the birth.

The survey showed that practices out of line with current policy were taking place in hospitals in Fife. In addition, although sample sizes were small, I found that most of these practices were significantly associated with breast feeding for 10 days or less. These were late initiation of breast feeding (more than an hour after the birth), giving supplementary bottles while breast feeding, and feeding at set times (table).

Beeken and Waterston emphasise the importance of attitudes of health professionals who supervise and support breast feeding mothers and, in particular, of the need "to increase their awareness of breast feeding issues, promotion, and management." In an attempt to do that the joint breast feeding initiative was launched in Fife with a seminar on breast feeding in September 1990. A breast feeding steering group, comprising hospital staff, health visitors, and voluntary counsellors, meets regularly to discuss current issues. Defects found in the study are being rectified. More opportunities for such interdisciplinary communication would aid the implementation of Unicef's code of practice for baby friendly hospitals[2] and may help us to practise what we preach.

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1 Beeken S, Waterston T. Health service support of breast feeding—are we practising what we preach? *BMJ* 1992;**305**: 285-7. (1 August.)
2 Grant J. *State of the world's children 1992.* New York: Unicef, Oxford University Press, 1992.

EDITOR,—Establishing successful breast feeding depends not only on hospital policy and technique but on acquiring skills to maintain breast feeding in the home. I recently did a study on antenatal education and found that 45 of 200 mothers whose infants were less than 3 weeks old were not breast feeding, although they had expressed a desire to breast feed. Some of the challenges facing a breast feeding mother, often before breast feeding is fully established, are dealing with embarrassed relatives and visitors, male and female; dealing with inappropriate advice, whether requested or not; dealing with physical discomfort; and dealing with a small crying infant.

Though codes of practice can be improved in some maternity hospitals by improving techniques and implementing policy, as Sally Beeken and Tony Waterston suggest,[1] the designation of "baby friendly hospital" should be awarded to those hospitals that help parents to cope with breast feeding in the social setting of their home, which many mothers believe is not currently addressed.

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1 Beeken S, Waterston T. Health service support of breast feeding—are we practising what we preach? *BMJ* 1992;**305**: 285-7. (1 August.)

EDITOR,—Sally Beeken and Tony Waterston's paper on attitudes to breast feeding has important implications for hospital policy,[1] and the code of practice for "baby friendly hospitals" should be enshrined in contract specifications to provider units.[2] When "training all health care staff (hospital and community) in the skills necessary to implement this policy"[2] provider units should take into account the communication problems and cultural differences of Asians and other ethnic groups.

In 1991 a questionnaire survey of attitudes to breast feeding among 35 Asian Muslim mothers from child health clinics in South Birmingham Health Authority found that 21 of the women required an interpreter to help them communicate in English. Although 25 of the mothers had put the baby to the breast at least once by 2 weeks, only 16 were breast or mixed feeding—a higher rate of attrition in the first two weeks than that reported by the Office of Population Censuses and Surveys in 1985.[3] All the women who had given up would ideally have liked to have continued breast feeding and thought that that was the best way to feed a baby.

When asked whom they turned to for advice on feeding none of the women mentioned their community midwife despite her frequent visits during that period, and only two mentioned their health visitor. Most of the women who had given up did not speak English; this highlights the communication problems of health professionals who are trying to support women during this period. The Spitalfields infant feeding project showed that providing a worker who can give mothers information and support in their own language once they are at home can have a considerable effect on the continuation of breast feeding.[4]

All units need adequate numbers of linkworkers or interpreters to be available in maternity wards, antenatal clinics, and the community at all times for this code of practice to succeed. The needs of ethnic groups should be considered when hospital or community breast feeding counsellors are appointed.

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1 Beeken S, Waterston T. Health service support of breast feeding—are we practising what we preach? *BMJ* 1992;**305**: 285-7. (1 August.)
2 Grant J. *State of the world's children 1992.* New York: Unicef, Oxford University Press, 1992:44.
3 Martin J, White A. *Infant feeding 1985.* London: HMSO, 1988.
4 Hilder L. *Infant feeding project report.* London: Tower Hamlets Maternity Services Liaison Scheme, 1989.

EDITOR,—Sally Beeken and Tony Waterston report an unhelpful and muddled attitude of midwives and health visitors to breast feeding despite a campaign on breast feeding aimed at health care professionals.[1] Many breast fed babies were given additional water or formula feeds. Thirty three of 50 mothers who answered a questionnaire had been separated from their babies for the first night.

The authors are unclear and obviously puzzled about the reasons for the professionals' ambivalence to breast feeding. They suggest a possible fear "of making bottle feeding mothers feel guilty or inferior"; there is some truth in this hypothesis. The mothering that a woman has had affects how she cares for her child. Changing attitudes to childrearing involve understanding how we feel about the way our mothers cared for us. Feeding a baby differently from the way we were fed means making implicit or explicit judgments on our own mothers; so midwives and health visitors are uncomfortable about making the mother they have in their minds feel guilty or inferior.

A contented mother with her satisfied baby at the breast can provoke desires in caring professionals to be cared for and nurtured. If unacknowledged this desire to be looked after may get in the way of our being able to provide the conditions that we know to be optimal.

The attitudes of staff towards sensitive subjects like breast feeding are difficult to change by exhortation. Discussions in small groups led by suitably trained staff are necessary. Regular discussion helps to prevent rigid positions developing on sensitive issues. The provision of nurseries that facilitate separation of the mother from her healthy neonate born in hospital reminds us of the struggle to get staff to allow mothers to see and hold their stillborn child; this change in attitudes to a flexible approach has required continuing group discussions.

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1 Beeken S, Waterston T. Health service support of breast feeding—are we practising what we preach? *BMJ* 1992;**305**: 285-7. (1 August.)

Early parenteral penicillin in meningococcal disease

EDITOR,—Jeffrie R Strang and Edwin J Pugh[1] and Keith Cartwright and colleagues[2] have studied the effect on outcome of giving penicillin before admission to hospital in suspected cases of meningococcal disease. We have looked at the early use of antibiotics in Worcester district, where there is a higher than average incidence of meningococcal disease (10·2 cases/100 000 population in 1991).

We have retrospectively studied cases of meningococcal disease reported to Worcester and District Health Authority from 1 January 1986 to 30 June this year. Of 121 recorded cases, 109 have been evaluated by review of medical case notes and the general practitioner's admission letter. In each case meningococcal disease was diagnosed on the basis of one or more of the following criteria: (*a*) *Neisseria meningitidis* isolated from blood or cerebrospinal fluid, or both; (*b*) Gram negative diplococci seen on microscopic examination of cerebrospinal fluid; (*c*) a rise in serum meningo-