A study of infant-feeding practices was previously undertaken in a socio-economically disadvantaged community in the Cape Peninsula. This suggested that breast-feeding locally was following the same disturbing trend as seen elsewhere—many of the mothers interviewed had introduced bottle-feeding by the time their infant was 2 weeks old, and 76.3% by the time their infant was 12 weeks old.

The reasons given by most of the mothers for stopping breast-feeding related to the quantity or quality of their milk. Problems of this type can often be solved by offering the mother education and encouragement. It was disturbing to find that insufficient support was given to mothers either before or after the birth of their babies, particularly during the critical early postnatal period when breast-feeding was most often discontinued and bottle-feeding started.

Accordingly, a programme which aimed at promoting breast-feeding through education and support of the mothers was introduced in this area. Two years later a similar analysis of feeding practices was carried out in an attempt to assess what effect, if any, the programme had exerted.

**Methods**

**Details of the educational and support programme**

The following steps were taken to improve the situation:

1. The birth notification form was duplicated so that one copy could be sent to the appropriate health visitor immediately after a birth while the other copy could be processed through the normal channels. This considerably hastened contact between the mother and the local authority. Moreover, support during the first 2 weeks after delivery was stressed to the health visitors and the midwives.

2. Breast-feeding clinics were introduced and were conducted at the same time as the antenatal clinics. Prospective mothers could thus see breast-feeding in action and learn by example. This had the further advantage of separating the breast-feeding clinic from the child welfare clinic, which was often busy and allowed no time for discussion of problems.

3. Talks were given in the community on the advantages of breast-feeding.

4. Contact was made with the Cape Town Breast-Feeding Association, and the telephone numbers of volunteers available to help mothers with problems were circulated to all clinics in the area.

5. A letter was sent to all the local family practitioners, encouraging them to promote breast-feeding among their patients.

6. Health visitors and nurses at the local clinic were encouraged to promote breast-feeding, and their knowledge of this subject was increased by lectures, demonstrations and a symposium.

**Evaluation of feeding practices**

This has been fully discussed in the previous article. In essence, a set of questions was put by a medical officer to mothers of infants aged less than 6 weeks who attended the child welfare clinic. Children were then classified as either fully breast-fed or bottle-fed, the latter group including both those receiving breast-milk supplementation and those being exclusively bottle-fed. The time which elapsed until contact was made between the mother and the local authority was also noted. The mothers who were breast-feeding were then interviewed 6 weeks later by the same medical officer and the children were classified in the same way as before.

**Results**

The second study was performed in the same area as the first. The same questionnaire was used and socio-economic status, age ranges and other demographic characteristics were similar. The two groups were therefore thought to be comparable.

**Patterns of infant-feeding**

At the time of the first interview, 94 (75.8%) of the 124 mothers were still breast-feeding, a significant increase from the previous study when only 52.7% of the mothers were breast-feeding ($\chi^2 = 16.33; P < 0.01$) (Table 1). This trend continued into the next 6-week period with 48 mothers (38.7%) still breast-feeding in comparison with 23.7% in the previous study ($\chi^2 = 7.70; P < 0.01$). It should be noted that the major change took place within the first 6-week period. The percentage of the breast-feeding mothers who were still doing so at the time of the second
Discussion

This study has shown that a significant increase in the rate of breast-feeding took place in the Heideveld area of Cape Town over a 2-year period. It is difficult to estimate to what degree the educational and support programme described was responsible for this change, since an almost infinite number of variables could have played a role. Furthermore, it is difficult to measure an increase in the mothers’ knowledge about breast-feeding since this is hard to standardize and no baseline data regarding this aspect were available from the initial study.

Nevertheless, socio-economic status and several other demographic features were similar in the two groups studied, and we would like to suggest that the programme was at least partially responsible for the increase which occurred. This idea is supported by the fact that contact between the local authority and mothers was definitely streamlined during the second phase of the study (Table II).

It is often said that the health of a socially disadvantaged community will not improve without a change in socio-economic status. This is undoubtedly true but should not be used to rationalize complacency. In the world in general, and in South Africa in particular, even with the correct administrative decisions, it will take many years to develop environmental conditions which are optimally conducive to health. We in no way advocate abrogation of our responsibility for social reform. Rather, if the support and educational programmes described did contribute materially to the increase in breast-feeding in spite of the absence of social change, we suggest that this may provide a practical means whereby we as doctors can be immediate participants in improving the health of the community.

The authors would like to thank Dr R. Coogan of the Cape Town City Health Department for his assistance and for permission to publish these data, and Dr D. Power for encouragement and advice.

**TABLE I. BREAST-FEEDING RATES IN THE HEIDEVELD AREA OF CAPE TOWN**

<table>
<thead>
<tr>
<th>Age (wks)</th>
<th>1st study</th>
<th>2nd study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>&lt; 6</td>
<td>89</td>
<td>52,7</td>
</tr>
<tr>
<td>6 - 12</td>
<td>40</td>
<td>23,7</td>
</tr>
</tbody>
</table>

*χ² = 16,33; P = < 0,01.
†χ² = 7,70; P = < 0,01.

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**TABLE II. AGE OF BABY AT FIRST CONTACT BETWEEN THE LOCAL AUTHORITY AND MOTHERS IN THE HEIDEVELD AREA OF CAPE TOWN**

<table>
<thead>
<tr>
<th>Age (wks)</th>
<th>1st study</th>
<th>2nd study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>&lt; 2</td>
<td>25</td>
<td>14,8</td>
</tr>
<tr>
<td>2 - 4</td>
<td>105</td>
<td>62,1</td>
</tr>
<tr>
<td>≥ 4</td>
<td>39</td>
<td>23,1</td>
</tr>
</tbody>
</table>

χ² = 37,68; P = < 0,01.

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**REFERENCE**