

WORLD BREASTFEEDING WEEK-2015

World Breastfeeding Week is celebrated every year from 1 to 7 August in more than 170 countries to encourage breastfeeding and improve the health of babies around the world. It commemorates the Innocenti Declaration signed in August 1990 by government policymakers, WHO, UNICEF and other organizations to protect, promote and support breastfeeding. Breastfeeding is the best way to provide infants with the nutrients they need. WHO recommends exclusive breastfeeding starting within one hour after birth until a baby is six months old. Nutritious complementary foods should then be added while continuing to breastfeed for up to two years or beyond.

The CDBPH has produced this booklet as part of the celebration of this World Breastfeeding Week 2015. It proposes plain language summaries of Cochrane systematic reviews on advantages and management of breastfeeding.

SEMAINE MONDIALE DE L'ALLAITEMENT MATERNEL-2015

La Semaine mondiale de l'allaitement maternel est organisée chaque année du 1er au 7 août dans plus de 170 pays pour promouvoir cette pratique afin que les nourrissons du monde entier soient en meilleure santé.

Cette semaine commémore la Déclaration «Innocenti» sur la protection, l'encouragement et le soutien de l'allaitement maternel, signée par l'OMS et l'UNICEF en août 1990.

L'allaitement maternel est le meilleur moyen d'apporter aux nouveau-nés les nutriments dont ils ont besoin. L'OMS recommande l'allaitement au sein exclusif du nourrisson jusqu'à l'âge de six mois et de poursuivre ensuite jusqu'à l'âge de deux ans au moins, en l'associant à une alimentation de complément qui convienne.

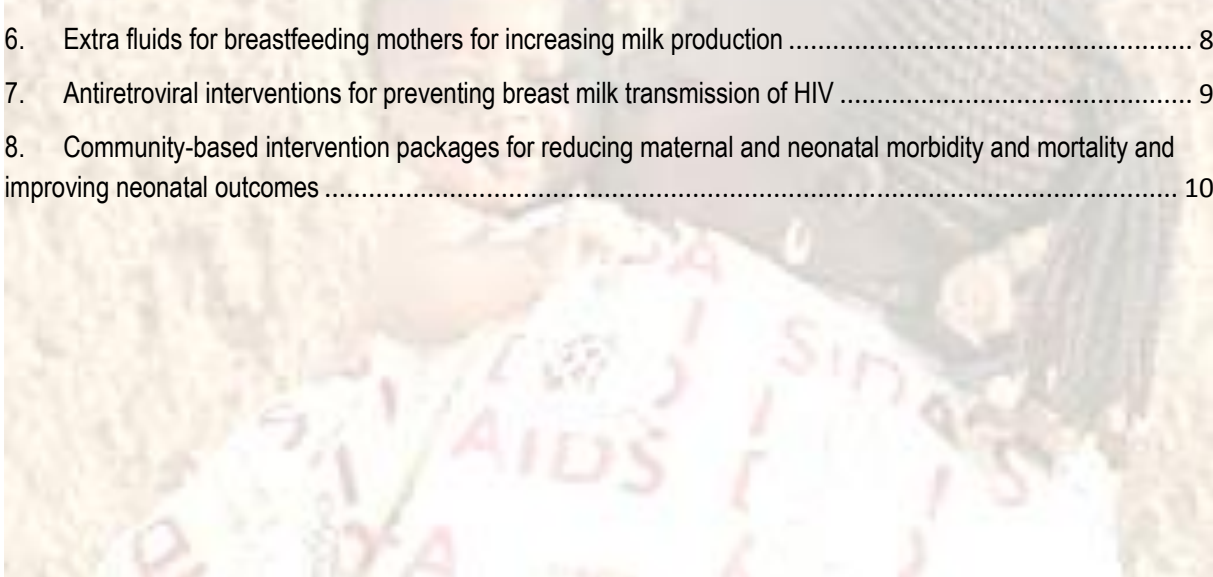
Le CDBPS a produit cette brochure dans le cadre de la célébration de la Semaine mondiale de l'allaitement maternel, 2015. Il s'agit d'un recueil de résumés simplifiés de revues systématiques Cochrane, sur les avantages et la pratique de l'allaitement maternelle.

"Si chaque enfant était mis au sein dans l'heure qui suit la naissance, si on ne lui donnait que du lait maternel pendant les six premiers mois et si l'allaitement maternel était maintenu jusqu'à l'âge de deux ans, on sauverait près de 800.000 vies d'enfants chaque année" (OMS).



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1. Optimal duration of exclusive breastfeeding

Exclusive breastfeeding for six months (versus three to four months, with continued mixed breastfeeding thereafter) reduces gastrointestinal infection and helps the mother lose weight and prevent pregnancy but has no long-term impact on allergic disease, growth, obesity, cognitive ability, or behaviour.

The results of two controlled trials and 21 other studies suggest that exclusive breastfeeding (no solids or liquids besides human milk, other than vitamins and medications) for six months has several advantages over exclusive breastfeeding for three to four months followed by mixed breastfeeding. These advantages include a lower risk of gastrointestinal infection, more rapid maternal weight loss after birth, and delayed return of menstrual periods. No reduced risks of other infections, allergic diseases, obesity, dental caries, or cognitive or behaviour problems have been demonstrated. A reduced level of iron has been observed in developing-country settings.

Durée optimale de l'allaitement exclusif

L'allaitement exclusif pendant six mois (versus trois à quatre mois, avec la poursuite d'un allaitement mixte par la suite) réduit l'infection gastro-intestinale et aide la mère à perdre du poids tout en prévenant une nouvelle grossesse, mais n'a aucun impact à long terme sur les maladies allergiques, la croissance, l'obésité, la capacité cognitive ou le comportement.

Les résultats de deux essais contrôlés et de 21 autres études suggèrent qu'un allaitement exclusif (aucun solide ou liquide autre que le lait humain, hormis les vitamines et les médicaments) pendant six mois présente plusieurs avantages par rapport à un allaitement exclusif pendant trois à quatre mois suivi d'un allaitement mixte. Ces avantages comprennent un plus faible risque d'infection gastro-intestinale, une perte de poids plus rapide de la mère après l'accouchement et un retour tardif des règles. Il n'a été démontré aucune réduction des risques d'autres infections, de maladies allergiques, d'obésité, de caries dentaires ou de problèmes cognitifs ou comportementaux. Un taux de fer réduit a été observé dans les pays en développement.

Notes de traduction :

Citation: Kramer MS, Kakuma R. **Optimal duration of exclusive breastfeeding**. Cochrane Database of Systematic Reviews 2012, Issue 8. Art. No.: CD003517. DOI:

10.1002/14651858.CD003517.pub2

URL: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003517.pub2/pdf>

2. Baby-led compared with scheduled (or mixed) breastfeeding for successful breastfeeding

Patterns of breastfeeding can vary greatly from one country or place to another. Two very different approaches are often used to determine when the baby will breastfeed and for how long. One approach is led by the baby, and is known as baby-led, unrestricted or breastfeeding on demand. The clock leads the other approach, which is known as scheduled, timed or restricted breastfeeding.

From the early 20th century mothers in many health settings were advised to breastfeed according to the clock; timing and restricting both the frequency and length of breastfeeds. This practice changed when

baby-led or demand breastfeeding was advocated. With baby-led breastfeeding, the amount of milk produced is determined by the baby's demand. In this way the baby controls the supply of milk, ensuring that enough milk is produced to meet his or her needs. With this approach, close contact between the mother and her baby is encouraged with no restrictions placed on their time together. However, the mother may not always be in a position to breastfeed her baby on demand due to, for example, being separated from her baby for any reason, and there can be uncertainty for the mother if and when her baby does not demand a breastfeed.

We looked for studies that compared baby-led with scheduled (or mixed) breastfeeding for successful breastfeeding for healthy newborn babies. However, no studies were found that met the inclusion criteria for this review, therefore no conclusions could be taken at this point. It is recommended that no changes are made to current practice guidelines without undertaking further robust research, to include many patterns of breastfeeding and not limited to baby-led and scheduled breastfeeding. Further research is needed to also evaluate the effects of baby-led compared with scheduled (or mixed) breastfeeding on successful breastfeeding, for healthy newborns. However, conducting such a study, particularly a randomised controlled trial is unlikely to receive ethical approval, as the issue of obtaining informed consent from new mothers or mothers to be for randomisation between baby-led and scheduled breastfeeding is a difficult one and it is likely that the Baby Friendly Hospital Initiative practices would prohibit such a study.

Modes d'allaitement maternel, à la demande du bébé ou selon un horaire

Les pratiques de l'allaitement maternel peuvent varier considérablement d'un pays ou endroit à l'autre. Deux approches très différentes sont souvent utilisées pour déterminer quand le bébé va se nourrir au sein et pendant combien de temps. La première approche, où l'allaitement est initié par le bébé, est appelée allaitement sans restriction ou à la demande. Dans l'autre approche, l'allaitement est réglé à l'horloge et appelé allaitement régulé ou aux horaires fixes.

Depuis le début du 20ème siècle, dans plusieurs contextes de soins il a été conseillé aux mères d'allaiter selon l'horloge, en régulant et en limitant la fréquence et la durée des tétées. Cette pratique a changé avec la préconisation de l'allaitement initié à la demande du bébé. Avec l'allaitement à la demande, la quantité de lait produite est déterminée par la demande du bébé. De cette façon, le bébé contrôle la fourniture de lait, ce qui permet d'assurer que suffisamment de lait est produit pour répondre à ses besoins. Avec cette approche, un contact étroit entre la mère et son bébé est encouragé et aucune restriction n'est imposée sur leur temps ensemble. Cependant, la mère peut ne pas être toujours en mesure d'allaiter son bébé à la demande en raison, par exemple, d'une séparation pour une raison quelconque. Cela peut également être une source d'incertitude pour la mère si et quand son bébé ne réclame pas une tétée.

Nous avons recherché des études comparant l'allaitement à la demande à l'allaitement régulé (ou mixte) pour un allaitement réussi de nourrissons en bonne santé. Cependant, aucune étude répondant aux critères d'inclusion de cette revue n'a été trouvée, donc aucune conclusion n'a pu être formulée à ce stade. Nous recommandons de ne pas apporter de modifications aux recommandations de pratique actuelles sans entreprendre de nouvelles recherches robustes, prenant en compte divers modes d'allaitement au lieu de se limiter à l'allaitement à la demande ou régulé. Des recherches complémentaires sont également nécessaires pour évaluer les effets de l'allaitement à la demande par rapport à l'allaitement régulé (ou mixte) sur la réussite de l'allaitement, chez des nouveau-nés en bonne santé. Toutefois, l'approbation éthique de la réalisation d'une telle étude, notamment d'un essai contrôlé randomisé, est peu probable, car la question de l'obtention du consentement éclairé de mères futures ou

nouvelles pour la randomisation entre l'allaitement à la demande ou régulé est difficile, et il est probable que les pratiques de l'Initiative Hôpital Ami des Bébé interdieraient une telle étude.

Notes de traduction

Traduction réalisée par le Centre Cochrane Français

Citation: Fallon A, Van der Putten D, Dring C, Moylett EH, Fealy G, Devane D. **Baby-led compared with scheduled (or mixed) breastfeeding for successful breastfeeding.**

Cochrane Database of Systematic Reviews 2014, Issue 7. Art. No.: CD009067. DOI: 10.1002/14651858.CD009067.pub2.

URL: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009067.pub2/pdf>

3. Interventions for treating painful nipples among breastfeeding women

Background

Although the health benefits of breastfeeding are well established, many women discontinue breastfeeding within the first few weeks after birth. One common reason to discontinue breastfeeding is painful nipples.

Study characteristics

We searched the Cochrane Pregnancy and Childbirth Group's Trials database for clinical trials assessing methods (interventions) of improving nipple pain among breastfeeding women in September 2014. We also looked at healing and infection of nipples, length of breastfeeding, if infants only received breast milk, and if mothers were happy with treatment for nipple problems and breastfeeding in general. Interventions included drug treatments (against bacteria given by mouth, spray, ointment; against fungal infections), non-drug treatments (lanolin, petroleum jelly, peppermint oil, glycerine), dressings, nipple protectors (breast shields or shells), light treatment, or applying expressed breast milk. Interventions were compared with each other or usual care (control).

Key results

We found four trials of good methodological quality involving 656 women, which evaluated five different interventions including glycerine pads, lanolin with breast shells, lanolin alone, expressed breast milk, and an all-purpose nipple ointment. All studies included education to position the infant at the breast correctly as part of routine care to both intervention and control groups.

Currently, there is not enough evidence to recommend any specific type of treatment for painful nipples among breastfeeding women. These results suggest that applying nothing or expressed breast milk may be equally or more beneficial in the short-term experience of nipple pain than the application of an ointment such as lanolin. One important finding in this review was that regardless of the treatment used, for most women, nipple pain reduced to mild levels approximately seven to 10 days' after giving birth (postpartum).

Quality of the evidence

The quality of the evidence for this review did not allow robust conclusions regarding treating nipple pain. We found only four small trials and all four trials compared varying interventions, participants, what was measured, and standards of usual care. While the methodological quality of the included studies was good, the overall quality of the evidence for the primary outcome of nipple pain was of low quality, mainly due to single studies with few participants contributed data for analysis.

Interventions pour le traitement des mamelons douloureux chez les femmes qui allaitent

Contexte

Bien que les avantages pour la santé de l'allaitement maternel soient bien établis, de nombreuses femmes arrêtent l'allaitement dans les premières semaines après l'accouchement. Une raison courante pour l'arrêt de l'allaitement, sont les mamelons douloureux.

Caractéristiques des études

Nous avons recherché en septembre 2014 dans la base de données du groupe Cochrane sur la grossesse et l'accouchement des essais cliniques évaluant des méthodes (interventions) pour améliorer les douleurs des mamelons chez les femmes allaitantes. Nous avons également examiné la guérison et l'infection des mamelons, la durée de l'allaitement, les enfants nourris exclusivement au lait maternel et la satisfaction des mères vis-à-vis des traitements pour les problèmes de mamelons et l'allaitement en général. Les interventions comprenaient les traitements médicamenteux (traitements contre les bactéries administrés par voie orale, en spray ou en pommade ; traitements contre les infections fongiques), les traitements non médicamenteux (lanoline, vaseline, huile de menthe poivrée, glycérine), les pansements, les protège-mamelons (coupelles ou coquilles), le traitement par la lumière ou l'application de lait maternel exprimé. Les interventions étaient comparées les unes aux autres ou aux soins habituels (témoin).

Principaux résultats

Nous avons trouvé quatre essais de bonne qualité méthodologique portant sur un total de 656 femmes et évaluant cinq interventions différentes, à savoir les coussinets de glycérine, la lanoline avec les coquilles d'allaitement, la lanoline seul, le lait maternel exprimé et une pommade tout usage pour les mamelons. Toutes les études comprenaient l'éducation pour positionner l'enfant au sein correctement dans le cadre des soins de routine pour les groupes d'intervention et témoin.

Actuellement, il n'y a pas suffisamment de preuves pour recommander un type spécifique de traitement pour les mamelons douloureux chez les femmes qui allaitent. Ces résultats suggèrent que l'application de rien ou du lait maternel exprimé pourrait être aussi ou plus avantageux que l'application d'une pommade telle que la lanoline dans l'expérience à court terme de douleurs des mamelons. Une conclusion importante de cette étude est que, quel qu'ait été le traitement utilisé, pour la plupart des femmes, les douleurs des mamelons ont diminué à des niveaux faibles environ sept à dix jours après l'accouchement (post-partum).

Qualité des preuves

La qualité des preuves dans cette revue ne permet pas de formuler des conclusions solides concernant le traitement des douleurs du mamelon. Nous n'avons trouvé que quatre petits essais et tous variaient en termes d'interventions comparées, de participants, de variables mesurés et de normes de soins habituels. Bien que la qualité méthodologique des études incluses ait été élevée, la qualité globale des preuves pour le critère principal des douleurs du mamelon était faible, principalement en raison des études individuelles avec peu de participants ayant fourni des données pour l'analyse.

Notes de traduction

Traduction réalisée par le Centre Cochrane Français

Citation: Dennis CL, Jackson K, Watson J. **Interventions for treating painful nipples among breastfeeding women.** Cochrane Database of Systematic Reviews 2014, Issue 12. Art. No.: CD007366. DOI: 10.1002/14651858.CD007366.pub2.

URL: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007366.pub2/pdf>

4. **Supplementation with long chain polyunsaturated fatty acids (LCPUFA) to breastfeeding mothers for improving child growth and development**

Background

Long chain polyunsaturated fatty acids (LCPUFAs) are abundant in the brain and are necessary for growth and maturation of a young infant's brain and the retina of the eye. These particular fatty acids include docosahexaenoic acid (DHA) and are said to be 'essential' because the human body is not efficient in producing them. This means that infants who are breastfeeding obtain the fatty acids from their mothers' diet, mainly from fish oil and ocean fish. We reviewed the evidence about the effect of supplementation of LCPUFA on breastfeeding mothers on growth and neurodevelopment of their children.

Study characteristics

We found eight randomised clinical trials. A total of 1567 women from high-income countries were included in the trials. The quality of evidence was found to be moderate and low.

Main results

This review of trials showed that supplementing a mother's diet with LCPUFA during the pregnancy and the first four months after birth did not improve the child's growth or neurodevelopment in terms of problem-solving ability or intelligence, psychomotor, motor, or language development. In child attention at five years of age, weak evidence was found (one study) favouring the supplementation. The age of the children at the last neurodevelopment assessment was seven years. The children's visual acuity was not different at five years of age compared with children of the control group of mothers who received supplements of soybean or corn oils.

Conclusions

Currently, there is inconclusive evidence to support or refute the practice of giving LCPUFA supplementation to breastfeeding mothers in order to improve neurodevelopment.

Citation: Delgado-Noguera MF, Calvache JA, Bonfill Cosp X, Kotanidou EP, Galli-Tsinopoulou A. **Supplementation with long chain polyunsaturated fatty acids (LCPUFA) to breastfeeding mothers for improving child growth and development.** Cochrane Database of Systematic Reviews 2015, Issue 7. Art. No.: CD007901. DOI: 10.1002/14651858.CD007901.pub3.
URL: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007901.pub3/pdf>

5. **Antenatal breast milk expression by women with diabetes for improving infant outcomes**

Babies born to women who have diabetes during pregnancy, either already existing or gestational, are at increased risk of low blood sugars after birth. This is because the babies have been exposed to higher than usual blood sugar (glucose) levels during the pregnancy and so have been producing relatively high levels of insulin. Some of these babies require additional breast milk, formula feeds or transfer to a special care nursery for intravenous fluids to correct the low blood sugar levels.

Some maternity care providers and women propose that expressing and storing colostrum, the initial nutrient-rich breast milk, during pregnancy, can be given to the baby if they develop low blood sugars after birth. This may help avoid the need for formula feeds if breastfeeding, intravenous fluids and separation from the mother if the baby has to go to the special care nursery. Although this process seems logical and is sometimes recommended, two small observational studies have shown that mothers who expressed breast milk during pregnancy were more likely to have their babies early and more of the babies were cared for in the special care nursery compared with those whose mothers did not express.

This systematic review sought to identify randomised controlled trials comparing outcomes for women with diabetes who were advised to express with women not advised to express and store breast milk during pregnancy. The search did not find any completed trials, although one trial is currently underway.

There is no high level evidence about the potential benefits and harms of the expression and storage of breast milk during pregnancy by women with diabetes.

Expression du lait maternel pendant la grossesse par les femmes atteintes de diabète pour améliorer les résultats du bébé

Les bébés nés de femmes atteintes de diabète (préexistant ou gestationnel) pendant la grossesse courent un risque accru d'hypoglycémie après la naissance. La raison en est qu'au cours de la grossesse, ces bébés ont été exposés à des taux de sucre (glucose) dans le sang plus élevés que d'ordinaire et leur organisme a, en conséquence, produit des niveaux relativement élevés d'insuline. Certains de ces bébés nécessitent un supplément de lait maternel ou du lait infantile, ou doivent être transférés dans une nursery de soins spéciaux pour recevoir des fluides par voie intraveineuse afin de corriger les bas niveaux de glycémie.

Certains services de maternité proposent à des femmes d'exprimer et de stocker pendant la grossesse du colostrum, le lait maternel initial riche en éléments nutritifs, qui pourrait être donné au bébé s'il développe une hypoglycémie après la naissance. Cela pourrait aider à éviter le recours au lait infantile en cas d'allaitement maternel, et les liquides intraveineux et la séparation de la mère si le bébé doit aller à la nursery de soins spéciaux. Bien que ce processus semble logique et est parfois recommandé, deux petites études d'observation ont montré que les mères ayant exprimé le lait maternel pendant la grossesse étaient plus susceptibles d'accoucher précocement et davantage de ces bébés ont été pris en charge dans une nursery de soins spéciaux par rapport à ceux dont les mères n'avaient pas exprimé leur lait.

Cette revue systématique a cherché à identifier des essais contrôlés randomisés comparant les résultats des femmes diabétiques à qui il était conseillé d'exprimer et de conserver leur lait pendant la grossesse aux résultats des femmes n'ayant pas reçu de tels conseils. La recherche n'a pas permis de trouver d'essais terminés, même si un essai est actuellement en cours.

Il n'existe aucune preuve de haut niveau sur les avantages et les inconvénients potentiels de l'expression et du stockage du lait maternel pendant la grossesse par les femmes atteintes de diabète.

Notes de traduction :

Traduction réalisée par le Centre Cochrane Français

Citation: East CE, Dolan WJ, Forster DA. **Antenatal breast milk expression by women with diabetes for improving infant outcomes.** Cochrane Database of Systematic Reviews 2014, Issue 7. Art. No.: CD010408. DOI: 10.1002/14651858.CD010408.pub2.

URL: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010408.pub2/pdf>

6. Extra fluids for breastfeeding mothers for increasing milk production

The World Health Organization recommends breastfeeding for infants during the first six months of life. Despite this, many women wean their babies because of their perceived insufficient breast milk production. In many cases where mothers are concerned about their milk production they are encouraged to increase their fluid intake. The mother also needs water to meet her own needs. Water and all the constituents of body fluid are continually being lost in urine, stool and sweat and, therefore need to be replaced.

This review aimed to assess whether increasing fluid intake of breastfeeding mothers has a beneficial effect on breast milk production and infant growth. However, the review only identified one small quasi-randomised controlled trial (involving 210 women). The trial was of low quality and did not report on two

of this review's important outcomes (satisfactory weight gain in the infant or duration of exclusive breastfeeding). The study did report on breast milk production (this review's other main outcome), but the data were not in a format that would permit further analysis in this review. The trial reported that advising women to consume extra fluids did not result in increased breast milk production, as measured by test feeds (also known as test weighing). In the 1950s, when the study was conducted, it was common for babies in developed countries to be weighed before and after a feed, known as test weighing or test feeding. However, this practice is not now routinely practiced for term infants due to concerns about lack of precision as a measure of breast milk production. The included study did not report any of this review's secondary outcomes: duration of any breastfeeding; mother's satisfaction with breastfeeding; hydration in mother; dehydration in the infant; or episodes of gastrointestinal illness.

The effect of additional fluids for breastfeeding mothers remains unknown, due to a lack of well-conducted trials. However, because the physiological basis for any such improvement remains unclear, the conduct of further clinical trials may not be a priority. There is not enough evidence to support an increased fluid intake beyond what breastfeeding mothers are likely to require to meet their physiological needs.

Citation: Ndikom CM, Fawole B, Ilesanmi RE. **Extra fluids for breastfeeding mothers for increasing milk production.** Cochrane Database of Systematic Reviews 2014, Issue 6. Art. No.: CD008758. DOI: 10.1002/14651858.CD008758.pub2.
URL: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008758.pub2/pdf>

7. Antiretroviral interventions for preventing breast milk transmission of HIV

Worldwide, the primary cause of human immunodeficiency virus (HIV) infection in children is mother-to-child transmission (MTCT). MTCT of HIV can occur during pregnancy, around the time of delivery, or through breastfeeding. Great strides have been made in reducing MTCT during pregnancy and around the time of delivery. However, without intervention, a significant proportion of children born to HIV-infected mothers acquire HIV through breastfeeding.

Where affordable, feasible, acceptable, sustainable, and safe (AFASS) alternatives to breast milk are available, it is recommended that HIV-infected mothers do not breastfeed. However, for a substantial number of HIV-infected women in the developing world, complete avoidance of breastfeeding is not AFASS. These mothers are counseled to practice exclusive breastfeeding (giving a child only breast milk and no additional food, water, or other fluids). Provision of antiretrovirals (ARVs) either to the mother or to the child during breastfeeding represent potential interventions to reduce the risk of HIV transmission to breastfeeding children. This review explores the available evidence regarding the efficacy and safety of ARV prophylaxis regimens to reduce breast milk transmission of HIV.

Citation: White AB, Mirjahangir JF, Horvath H, Anglemyer A, Read JS. **Antiretroviral interventions for preventing breast milk transmission of HIV.** Cochrane Database of Systematic Reviews 2014, Issue 10. Art. No.: CD011323. DOI: 10.1002/14651858.CD011323.
URL: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD011323/pdf>

8. Community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes

While maternal, newborn and under-five child death rates in developing countries have decreased in the past two to three decades, newborn death rates have hardly changed. It is now recognised that almost half of newborn deaths can be prevented by tetanus toxoid immunisation of the mothers; clean and skilled care at the birth; newborn resuscitation; clean umbilical cord care; exclusive breastfeeding; and management of infections in the newborns. In developing countries, almost two-thirds of births occur at home and only half are attended by a trained birth attendant. A large proportion of these maternal and newborn deaths and diseases can potentially be addressed by developing community-based packaged interventions to integrate with local health systems.

The review authors found 26 randomised and quasi-randomised controlled studies evaluating the impact of community-based intervention packages for the prevention of maternal illness and death and in improving newborn health outcomes. These studies were mostly conducted in developing countries (India, Bangladesh, Pakistan, Nepal, China, Zambia, Malawi, Tanzania, South Africa, Ghana) with one additional study in Greece. Women in areas assigned to receive a community-based intervention package and with health workers receiving additional training had less illness and fewer complications during pregnancy and birth and there were fewer stillbirths, infant deaths around the time of birth and maternal ill-health. Community-based intervention packages were associated with improved uptake of tetanus immunisation, usage of clean delivery kits for home births and institutional deliveries. They also improved early initiation of breastfeeding and health-care seeking (by the mothers) for illnesses related to (their) babies. Whether these translate into improved newborn outcomes is unclear. This review highlights the value of integrating maternal and newborn care in community settings through a range of interventions which can be packaged effectively for delivery through a range of community health workers and health promotion groups. There is sufficient evidence to scale up community-based care through packages which can be delivered by a range of community-based workers. Most of the reviewed studies did not document the complete description and characteristics of the community health workers, especially the initial level of education and training, the level and amount of supervision provided, and the community ownership of these workers. This information would be of great relevance to policy and practice.

Citation: Lassi ZS, Bhutta ZA. **Community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes.**

Cochrane Database of Systematic Reviews 2015, Issue 3. Art. No.: CD007754. DOI: 10.1002/14651858.CD007754.pub3.

URL: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007754.pub3/pdf>

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