Uptake of antenatal screening for HIV infection can be high outside of London too

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Letters

Finally, it would be interesting to know whether there are specific variables, other than breastfeeding, associated with reporting of competing interests—for example, the number of authors or the source of funding for each publication.1

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Breastfeeding must consider HIV transmission in Latin America and the Caribbean

Enrro–Betrán et al’s paper confirms the importance of exclusive breastfeeding in reducing infant morbidity and mortality in the Latin American and Caribbean region.1 The authors did not, however, mention other cost effectiveness analyses of the promotion of breastfeeding in Latin America that have been carried out.

In particular, through controlled designs Horton et al examined the effectiveness and cost of hospital based promotion of breastfeeding in urban areas in three Latin American countries (Mexico, Honduras, and Brazil).3 They concluded that investing in the promotion of exclusive breastfeeding and of any breastfeeding is highly cost effective and should be part of the basic public health and clinical services packages of countries in the region.

This work highlighted the relevance of breastfeeding peer counsellors, which was confirmed in a subsequent experimental study in Mexico City.1 There, a threefold to fivefold increase in exclusive breastfeeding rates at 3 months post partum was achieved through prenatal and postnatal home visits by trained peer counsellors.

The AIDS pandemic has major implications for the promotion of breastfeeding as HIV can be transmitted to children through breast feeding. The seroprevalence of HIV among women of reproductive age is relatively low in Latin America compared with sub-Saharan Africa and Asia but is relatively high in several Caribbean countries and some high risk areas of Latin America. Efforts to promote breastfeeding in the region need to take into account the local epidemiology of the AIDS pandemic and available educational and therapeutic strategies for reducing the risk of vertical transmission of HIV from infected mothers to their children.1

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diagnosis of HIV infection must improve outside London.1

Results from an unlinked anonymous surveillance of dried blood spots suggest that Brighton and Hove is a low prevalence area, with an estimated two women with HIV infection giving birth each year. Since the introduction of routine antenatal testing 90% of women have agreed to HIV testing, and in the past 14 months HIV infection has been diagnosed in three women. All have accepted recommended interventions to reduce vertical transmission. Several factors seem to be contributing to the sustained high uptake:

- Before antenatal testing began a coordinator (MO) was appointed who was responsible for the planning and delivery of training to community midwives
- Close links have been maintained with the midwives since this initial period, and the service has had ongoing monitoring and evaluation
- Specific training for new and returning midwives has been provided
- Training is focused on attitudes and skills, reflecting the plethora of research showing that the belief of the midwife in HIV testing is key in a pregnant woman’s decision to have the test.

We have shown that the Department of Health’s target of a 90% uptake of antenatal HIV testing is achievable in low prevalence areas outside London. We hope that this example will inform practice in other areas, especially as—as Cliffe et al point out—over one quarter of pregnant women infected with HIV live outside London.

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4 Hart JT. The inverse care law J Lendas 1971;405-12.

Moses baskets are a potential health hazard

EDITOR—Moses baskets are commonly used items in households around the country. Some are fitted with carrying handles. Within two months in 2000 we encountered three cases of babies falling out of such baskets after an unintentional slip of the handles; two of these cases resulted in skull fractures. A possible diagnosis of non-accidental injury was ruled out.

Close inspection of the Moses baskets showed that the handles did not seem long enough to meet in the middle (figure). This means that a tighter grip around the handles is needed, which increases the risk of an unintentional slip. The British Standards Institute has published guidelines on safety requirements on carrycots and stands but no specific standards on the length of handles have been defined.1 As a result of our correspondence, the British Baby Products Association has promised to raise the matter with CEN, the European Committee for Standardisation, where BS EN 1466:1998 is currently under review.

A literature search using Medline and the library of the Child Accident Prevention Trust did not identify any previously published reports about incidents involving Moses baskets. Several manufacturers did not seem to be aware of the problem. Nevertheless, a computer search of the home accident surveillance system, which is part of the Department of Trade and Industry, shows 24 reported cases in 10 years that were of a similar nature to ours. Taking into account that this database includes only reported cases and monitors only a fraction of the hospitals in the country, it is reasonable to assume that the real incidence of incidents involving Moses baskets may be much higher.

Most of the incidents involving a baby carrier will not result in any harm, especially as the babies concerned usually fall from a low height. Earlier this year a community based study showed an incidence of 22% of falls of all types in premobile infants, with serious injuries occurring in less than 1%.2 By far the commonest site of injury seemed to be the head.

Our cases highlight the importance of raising awareness of parents, health professionals, and manufacturers of the potential health risks that Moses baskets can pose to babies.

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One of the Moses baskets involved in the three cases reported here, highlighting the distance between both handles when loosely put together in the middle.