

PN-ABI-291
72106



**EARLY INFANT FEEDING IN HAITI:
A SYNOPSIS AND A PROPOSAL**

WORKING PAPER: 3

October 1990

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**Report Prepared for the
Agency for International Development
Contract #DPE-5966-Z-00-8083-00
Project #936-5966**

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ACRONYMS

AID/W	Agency for International Development, Washington, D.C.
EMMUS	Enquête Mortalité, Morbidité et Utilisation des Services
IHE	Institute Interamérican de Cooperation pour l'Agriculture
INSHAC	Institut Haïtien de Santé Communautaire
HRO	Human Resources Office (USAID)
MOH	Ministry of Health
MOTHCARE	Maternal and Neonatal Health and Nutrition Project
MSP	Ministère de la Santé Publique et de la Population
ORT	Oral-Rehydration Therapy
PAHO/WHO	Pan American Health Organization/World Health Organization
PRONACODIAM	Programme Nationale de Lutte contre la Diarrhée et de Promotion de l'Allaitement Maternel
PVO	Private Voluntary Organization
RICHES	Resources in Community Health Education and Support Project
SES	Socio-Economic Status
TEA	Traditional Birth Attendant
UNICEF	United Nations Children's Education Fund
USAID/Haiti	United States Agency for International Development, Haiti Mission

PREFACE

A STRATEGY FOR BREASTFEEDING PROMOTION AND SUPPORT IN HAITI: Ideas for Next Steps

The USAID-funded MotherCare project has as its goal the improvement of maternal and neonatal health and nutritional status. Part of its strategy to achieve this goal is to provide assistance for the promotion of breastfeeding with an emphasis on the following objectives:

- ▶ initiation within an hour of the birth of the baby; and
- ▶ the feeding of breast milk to the exclusion of all other substances for the first four to six months of the child's life.

To realize these objectives, experience has shown that a comprehensive country strategy is required that can address the specific country problem from a variety of angles. These may include: policy formulation, training, improving formal health services protocols, collaboration with traditional practitioners, and awareness creation and behavior change among the public. At the request of country governments and USAID missions, MotherCare provides experts in breastfeeding programming to assist in making an analysis of the breastfeeding situation, defining a strategy to address major problems and developing activities to improve breastfeeding practices.

In August/September 1990, at the request of USAID/Port-au-Prince, Maria Alvarez, a consultant from The Manoff Group--a collaborator on the MotherCare project--provided technical assistance in a) reviewing the experience to-date in Haiti in the area of breastfeeding promotion, and b) in identifying activities for immediate implementation that would effect initiation rates and timing, and rates and duration of exclusive breastfeeding. Following is a brief synopsis of her report, including additions made by MotherCare, The Manoff Group and AID/Washington. The components and activities of the overall plan identified in Ms. Alvarez' report have been reordered so that they are now more consistent with what experience has shown to be a comprehensive strategic approach to improving breastfeeding practices.

Breastfeeding Practices in Haiti

An extensive literature review and interviews with program managers in Haiti point to several important features of the existing breastfeeding situation. They are:

- Breastfeeding initiation rates are high. Depending on the study area, 99 to 92 percent of the women breastfeed their infants.

However, in some areas this may be changing. In 1979, almost ten percent of urban women (in contrast to one percent of rural women) had never breastfed their infants.

- Initiation of breastfeeding is delayed often for three to five days while colostrum is discarded and the mother "waits for her milk to come". Water is given during these days.

- There is virtually no exclusive breastfeeding. Only 12.5 percent of children under three months are exclusively breastfed.
 - Lok, a castor oil-based purgative, is given soon after birth.
 - Bottles with water, teas, juices, soft drinks, water with laundry starch or flour, soups and "milks" are common and often given as early as the first week of life.
 - In poorer families, the introduction of semi-solids in the first weeks of life has been reported. Otherwise, semi-solids are commonly given in the second month of life.
- Duration of breastfeeding is prolonged, especially compared with many countries in the Caribbean. The median age for the cessation of breastfeeding nationally is 17.5 months. But, this national median may disguise a problem in some areas. Depending on the study area, median ages range from 12 to 21 months and, the mean duration of breastfeeding shows a decreasing trend over time. For example, in 1978, 96 percent of mothers with children between 6 and 11 months were breastfeeding; in 1990, that percentage was 88. In 1978, 63 percent of mothers were breastfeeding their children in the second year of life while in 1990, only 46 percent of mothers were breastfeeding this age child.

Looking at urban/rural differences reveals that urban and metropolitan areas have a significantly earlier weaning age than rural areas. One study found the median age in rural areas to be 18 months, while in urban areas it was 14.5 months, indicating that significant numbers of mothers do not breastfeed for the first year.

The anthropological literature documents some of the reasons for the practices mentioned above and elucidates the barriers that programs must overcome to improve practices. Some of these insights are:

- The mother and child need to be cleansed after the birth--hence the lok purgative for baby and possible purgative for mother.
- Colostrum is not perceived as having any beneficial effect for the baby; however, generally, it is not perceived as harmful.
- Mothers believe their milk is slow to come in so there is nothing for the infant immediately after birth, making other liquids necessary.
- Water is viewed as essential for the newborn to quench thirst and to assist the proper assimilation of food.
- Some women believe breast milk is not a food but a complement to food. Children cry for food. Some are more demanding than others. Therefore, some need solids earlier than others, including during the first weeks of life.
- Mothers feel that they cannot produce sufficient milk to satisfy their babies. Linked to this is the feeling among some women that undernourished mothers who are thin and weak cannot breastfeed.

- An increasing number of women claim they have spoiled milk, let gaté, due to having stopped breastfeeding for a few days because of a serious illness or due to an adverse emotional state because of bad news or a fight.
- The influence health professionals have through their promotion of bottles and formulas is great.
- The influence various media have had by their promotion of breast milk substitutes is also great.
- Many mothers feel they are doing their best by using a bottle and powdered milk because of the status of bottle feeding that is associated with the health establishment and of powdered milk that is sold in stores and is an expensive item.
- Rapid urbanisation is causing breaks with extended family networks and rural traditions. There is a mind-set of changing to new, "modern" practices.
- Younger women and women from a more middle socio-economic class worry about breastfeeding leading to sagging breasts.
- There is a lack of teaching about how to overcome common breast problems, such as engorgement, mastitis, inverted nipples.
- There are economic pressures that force women back to work early to jobs not near home and where they cannot take their child.

Programs that Address Breastfeeding Problems

1. Reform of Maternity Service Protocols

- a) Cité Soleil Hospital has initiated major reforms supportive of breastfeeding with positive results. Examples of these reforms are: encouraging mothers to initiate early breastfeeding, not allowing bottles, establishing a milk bank for premature infants, delivering breastfeeding messages via video, and counselling by staff.
- b) The MOH Family Planning and Maternal/Child Health Unit is interested in initiating a national program to bring comprehensive modifications in protocols to maternity hospitals.

2. Training Programs

- a) The Pediatrics Society dedicated an annual meeting to breastfeeding to update all pediatricians.
- b) PRONACODIAM has retrained prenatal, well baby and maternity health professionals.
- c) PAHO is working with the MOH to revitalize TBA training.

3. Community-based Education

- a) CARE's RICHES program addresses major breastfeeding problems and reports success at decreasing the use of bottles and increasing exclusive breastfeeding. RICHES is a well-designed and tested program that transmits messages by mass media and community workers.
- b) Konesans Farml se Lespwa Timoun, sponsored by UNICEF, promotes improved infant and child development by mobilizing resources to increase the range of services available to meet identified problems. As part of this program, exclusive breastfeeding is promoted. This program has developed a set of educational videos, TV and radio spots, a newsletter, and magazine features. Child care schemes for rural markets and factories are planned.
- c) PRONACODIAM, the MOH's immunization and breastfeeding program, has promoted through a variety of media, the fact that every woman can breastfeed, regardless of occupation or socio-economic level. They have developed a hospital video on breastfeeding and have carried out promotional events such as the exchange of baby bottles for t-shirts in the market place.

Recommendations for Next Steps

1. Develop a Strategy to Unify and Coordinate Breastfeeding Efforts.

While a variety of activities are underway, many of which have demonstrated success, together they will not have a national impact on breastfeeding practices unless they can be expanded, strengthened where needed, and combined with other activities required for them to have their full impact. The following activities are recommended for immediate action.

- Write a comprehensive breastfeeding strategy that would include all of the important components and guidelines now recognized internationally. A five-year work program should accompany the strategy. (Ideas for this strategy follow.)
- Identify a coordinating group or agency that would manage and coordinate the implementation of the strategy.
- Develop and disseminate guidelines on the integration of breastfeeding into child survival and family planning programming. Currently, many of these efforts at integration are tokens. Much more needs to be done. This may necessitate budget modifications as only two to three percent of child survival money is spent on breastfeeding.
- Integrate questions on breastfeeding in major data collection efforts and data analysis plans, for example, EMMUS II and fertility surveys.

2. Improve Breastfeeding Practices in Maternity Wards and Hospitals.

Modifications in hospitals usually include, among other things: institution of rooming-in, initiation of breastfeeding within the first hour, milk banks, cessation of use of bottles and formulas, promotion of exclusive breastfeeding, breastfeeding counselling for women. (See Appendix D, WHO/UNICEF guidelines, Protecting, Promoting and Supporting Breastfeeding : The Special Role of Maternity Services).

- Identify a demonstration hospital. The hospital at Cité Soleil could function as one such site. However, another large, urban hospital could also be selected. These demonstration hospitals would offer guidance to others and be a center for training health professionals.
- Enact legislation on health service delivery related to improving breastfeeding practices in hospital systems controlled centrally.

3. Train Health Practitioners in the Formal and Traditional Sectors.

The full support of health practitioners is critical to the success of changing hospital norms, conducting popular education and many other reforms.

- Send teams from major, public and private hospitals, to WellStart/San Diego Lactation Management Center for their one-month course in lactation management.
- Run WellStart-style courses in Haiti. This possibly could be done through INSHAC.
- Review pre-service medical and nursing curricula and update them on breastfeeding-related topics.
- Train TBAs With 70 percent of Haitian mothers delivering their babies at home, training TBAs is important. The Ministry of Health/UNICEF project is developing a new training curriculum.
- Develop Training Materials. It merits mention that all of the different training activities will need their requisite training materials. Coordinating their development will save money and harmonize messages among a variety of health practitioners. Training and training materials development should feature a unit on how to counsel women.

4. Enforce Policy and Legislation

- Work to develop, disseminate and enforce the Code of Marketing of Breast Milk Substitutes for Haiti.
- Enforce the laws that are written for working women, allowing breastfeeding breaks and the establishment of a day care center at the work site by any employer with more than 50 women employees.

5. **Conduct Research**

- Demonstrate that infants can survive in Haiti on breast milk alone for four to six months. Begin with qualitative research with a nationally-representative sample to carefully document perceptions, attitudes, images, etc. of breastfeeding. Next, establish incentives/motivations that can be used to encourage women to exclusively breastfeed. Then enlist the participation of women in communities throughout Haiti in exclusively breastfeeding their infants. Establish a monitoring system to track growth and illness rates among these children.

6. **Promote Communications**

- Establish a clearinghouse for the collection and dissemination of up-to-date materials on breastfeeding. These should include, for example, recent medical insights and successes in counselling/communication. The clearinghouse would also be the repository for all Haitian materials, statistics, etc. and could be charged with generating a breastfeeding report each year.
- Establish a sustainable public communications program that would promote and motivate specific behavioral changes. This program should be geared to non-literate or low-literacy adults and should put priority on expanding the successful efforts of existing programs.

7. **Enhance Women's Support**

- Follow-up the demonstration research on exclusive breastfeeding by establishing a system for women supporting one another or of a lay counsellor to disseminate the research experience and motivate women to begin and continue exclusive breastfeeding.
- Expand community child care and market-based child care schemes.

Marcia Griffiths
President
The Manoff Group

I. EXECUTIVE SUMMARY

Exclusive breastfeeding by Haitian mothers would enhance child survival in four ways:

- a. immunization and illness protection;
- b. diarrhea control;
- c. nutritional status; and
- d. child spacing.

Prolonged breastfeeding of infants has, in fact, been an important tradition in Haitian child care practices. There is, however, also a countervailing tradition of early complementation, from birth on, which diminishes the positive impact which breastfeeding would otherwise have.

Though USAID/Port-au-Prince has been active in the promotion of exclusive breastfeeding since the mid-eighties, a more recent institutional commitment by AID/W (1990b) to issues of breastfeeding worldwide led the Haiti Mission to consider a systematization and possible expansion of its own initiatives in this sector. In this context, the Mission invited MotherCare and the Manoff Group to assist in the development of a comprehensive country breastfeeding strategy.

The overall goal of the consultancy was to prepare a baseline document containing the elements of an overall design and the background considerations justifying each element. During a three-week visit to Haiti, individual and group meetings were held with personnel of USAID/Port-au-Prince, members of all pertinent divisions in the MOH, and with representatives of bilateral agencies and local health and education PVOs. Meetings were held with AID/W and MotherCare staff prior to the visit to Haiti.

A. Major Findings

National figures on breastfeeding in Haiti present a favorable scenario. They indicate breastfeeding is common, especially in rural areas and its duration is adequate. Yet underlying the favorable figures are several problematic patterns:

- the decrease in breastfeeding age noted in the last two decades;
- the differences in urban and rural feeding practices;
- the higher mortality among children never breastfed;
- the increased use of bottle feeding; and
- the very early introduction of complementary foods into the infant's diet.

In reviewing the early infant feeding sequence, several major problems were identified on which program intervention should focus:

- the feeding of a purgative, lok, as a newborn's first food;
- the lack of recognition for the value of colostrum, which is either expelled or spontaneously ejected;
- the lack of tradition for immediate initiation of breastfeeding, the time gap being from two to five days postpartum in many cases; and
- the belief that infants need other liquids in addition to breast milk.

While the heavy reliance on early complementation is the major barrier to exclusive breastfeeding, other aspects were identified that would need to be addressed as part of a breastfeeding promotion effort:

- Breast milk is not perceived as food but as a complement, so children need to be introduced to solids as quickly as possible.
- the construct of insufficient milk.
- The undocumented belief (found even among health care personnel) that mother's nutritional status does not permit exclusive breastfeeding.
- The construct of spoiled milk, let gaté, whereby a woman's milk is believed to spoil in her breast under certain circumstances.
- Directives from health personnel.
- Response to advertising and marketing strategies.
- The bottle as a status symbol.
- Absence of health education discouraging bottle feeding.
- Urbanization and social change.
- Aesthetic concerns.
- Possible medical underpinnings in at least a small number of women.
- Economic pressures.

A review of current program initiatives indicates that important steps have already been taken for breastfeeding promotion in Haiti. Systematic attempts have been made not only to modify hospital procedures but also to design face-to-face popular health education programs addressing current knowledge gaps with regard to breast milk and utilizing culturally appropriate pedagogical tools. Evaluations of these localized attempts have shown positive results. The capacity for collaboration among different organizations (public/private, national/bilateral) has also been found to be quite high, a strength to be capitalized on in any future initiatives.

B. Recommendations for a National Strategy

1. Five measurable outputs which should be given high priority in any national strategy:
 - initiation of breastfeeding within 24 hours of birth;
 - promotion of exclusive breastfeeding during the first three months of life;
 - postponement of the early introduction of complementary foods into the infant's diet until the second trimester of life;
 - decrease in the rate of bottle feeding; and
 - preservation of current breastfeeding rates.

2. The strategy should have a "grafting" provision for inserting a breastfeeding module into already existing programs. Programs where lactation might be inserted include:
 - child survival programs;
 - existing and planned research efforts;
 - maternity wards and hospitals; and
 - pre-service and in-service training of health workers.

While also considered pertinent integration into policy and legislation is not considered an immediate priority.

3. A strategy should provide for the training of a cadre of Haitian professionals in lactation management who can act as resource people, trainers, liaisons, and advocates for breastfeeding.
4. A national strategy should also undertake localized pilot demonstrations of the feasibility of:
 - surviving on breast milk alone for the first three months of life; and
 - changing breastfeeding practices by changing hospital practices.

Demonstrations in these areas are urgently needed, not only for the general public, but also for health workers themselves.

5. The research component of a national strategy should place high priority on ethnographic probes of the behaviors and beliefs which have at least in part, contributed to the large scale mortality and morbidity patterns that have already been documented. Rapid rural assessment techniques could not only identify regional variations in infant feeding (and thus permit local fine-tuning of interventions), they could also be used to identify incentive packages to motivate pilot project mothers to breastfeed exclusively. Appropriate information gathering procedures must be instituted to monitor both the compliance of such pilot project mothers with program norms and the differential biomedical outcomes (e.g., through growth monitoring) that will presumably distinguish their exclusively breastfed children from traditionally supplemented children.
6. The strategy should have an information, materials development, and dissemination component. Information materials should incorporate techniques appropriate for non-literate or low-literacy populations. The help of a communication specialist would be needed in this area. A modest clearinghouse where all information related to lactation in Haiti is assembled is an important aspect of this component.
7. It is essential for the planning and survival of the strategy to identify the key personnel and the appropriate institutional channels. An initial plan as to how organizations might be linked together in the strategy is proposed. Creation of an Inter-Agency Committee on Breastfeeding is also suggested.
8. This report should be translated into French and disseminated as a working document in planning the overall strategy.

II. INTRODUCTION

The analysis that follows is based on several weeks of immersion into the question of breastfeeding and early infant feeding practices in Haiti and on previous work concerning health and nutrition in Haiti (Alvarez, 1983; 1989; Alvarez & Heurtelou, 1982; Alvarez & Murray, 1981; Alvarez, O'Rourke, & Heurtelou, 1985; Murray & Alvarez, 1973). In preparation for the Haiti visit, I met in Washington D.C., with staff from AID/W, MotherCare, and the Manoff Group. I did library research at the Clearinghouse on Infant Feeding and Maternal Nutrition in Washington D.C., and at the University of Florida libraries. Additional literature was consulted in Port-au-Prince using USAID library resources and HRO office files. The search for recent statistics, reports, and publications regarding early infant feeding, nutrition and maternal/child health was thorough, which I think is reflected throughout the report.

While in Haiti, I met individually and/or in groups with staff of different organizations working in the domains of health and education. In USAID/Port-au-Prince, I met with people in the Human Resources Office, especially those concerned with nutrition, population, and child survival; in the Agriculture office; and with consultants working on several related special projects.

Group meetings were held at USAID, at MSPP's PRONACODIAM Program; at PAHO/WHO and at IICA, an agricultural development institute. Individual meetings were held with representatives of USAID/Haiti, AID/W, AIDSTECH/Haiti, CARE, the Centre pour le Développement et la Santé, Eye Care Provax, Haitian Health Foundation, Child Health Institute, and personnel from different programs within the MOH, PAHO/WHO, and UNICEF.

Most work while in Haiti took place in Port-au-Prince. A one-day field trip to a rural community in the Cul-de-Sac Plain provided the opportunity to conduct a focus-group interview with a group of mothers of varying ages, which allowed me to update and clarify important issues.

This report is considered a baseline document containing the elements of an overall design and the background considerations justifying each element. It is organized into four major sections:

1. An introduction to breastfeeding within an international and national perspective.
2. An analysis of breastfeeding in Haiti, where statistical and ethnographic perspectives are offered on the subject.
3. A description of past and current efforts aimed at breastfeeding promotion in Haiti.
4. A description of the proposed strategy.

The strategy itself also consists of five major components emphasizing:

1. Integration of breastfeeding into existing programs
2. Pilot demonstrations
3. Research
4. Information, materials development, dissemination
5. An institutional component

III. INTERNATIONAL AND NATIONAL CONTEXTS FOR A BREASTFEEDING PROMOTION STRATEGY

A. An International Call for Action on Breastfeeding

While declining rates in breastfeeding were observed throughout much of the world in the 1960s, the value of breast milk and of its numerous protective properties for the human infant have been the source of renewed interest, substantial research, and legislative efforts in the last two decades. Breast milk has been subjected to increased scrutiny and has come out with flying colors. It continues to be the single most appropriate food in an infant's diet. To quote from a recent publication, "it is the best food a child will ever have. All substitutes, including cow's milk, milk-powder solutions, and cereal gruels, are inferior." (UNICEF/WHO/UNESCO, n.d., page 18).

The momentum for assuring that this natural resource gets to the children of the world has been building up for several years and has taken the form, among others, of inter-agency workshops, national breastfeeding promotion strategies, implementation of marketing codes for milk substitutes, training programs on breastfeeding and lactation management, and renewed research interest. This momentum reached a peak at a recent meeting (July 30 - August 1, 1990) co-sponsored by UNICEF, WHO, USAID and SIDA, where representatives from UNICEF, WHO, USAID, SIDA, FAO, ODA, UNDP, UNFPA, WFP, and the World Bank plus representatives from 30 different countries came together at the UNICEF Innocenti Centre in Florence, Italy.

The purpose of the meeting was to increase policy makers' awareness of the importance of breastfeeding and to generate commitment for breastfeeding promotion. A declaration was drafted to ensure the protection, promotion, and support of breastfeeding. Specifically, the Innocenti Declaration proposes a global goal of enabling all women to exclusively breastfeed their infants through the first 4-6 months of life and to continue breastfeeding while giving appropriate complementary foods to their children for up to two years of age or beyond. Countries were urged to assess their current breastfeeding situation to design programs to improve it and to monitor and evaluate the progress of these efforts. Donor agencies, in turn, were called upon to assist countries in these efforts.

Exclusive breastfeeding has direct implications for four major areas essential to child survival:

1. immunization and protection against common illness;
2. diarrhea control;
3. nutritional status of children; and
4. child spacing (USAID, 1990a; 1990b).

Less quantifiable but equally important is the psychological bonding established between mother and infant as a result of the breastfeeding interaction and the benefits of breastfeeding to maternal health. Current breastfeeding practices in Haiti, with their heavy emphasis on early complementation, undermine the potential impact of breastfeeding in all four areas.

Breastfeeding has positive implications for ALL children regardless of social or economic circumstances. As such, it is not a Third World versus industrialized-country issue: European countries such as Sweden, Norway, and Hungary have some of the highest breastfeeding rates in the world and have actively labored to reverse declining breastfeeding trends (Helsing, 1990). Yet, breastfeeding is particularly crucial for survival of children in seriously compromised sanitary and economic conditions. In such circumstances, the efforts towards its promotion should be even more vehement.

B. A National Call for Action on Breastfeeding in Haiti

The four areas where exclusive breastfeeding has major positive impact, namely illness protection, nutritional status, diarrhea control, and child spacing, have been traditional domains of concern for the Haitian population and for public, private, and bilateral-sector institutions working to improve health status in Haiti. Energetic efforts have been made in the past decade to improve the health and well-being of the general population of Haiti and particularly of its children and youth. Marked reductions in child mortality and morbidity have been attained. In 1987, infant mortality was estimated at 101/1000 vs 144 in 1975 and 197 in 1960; mortality among the 0-5 year group was 151/1000 in 1987 versus 215 in 1975 and 294 in 1960 (Cayemittes & Chahnazarian, 1989; Grant, 1987).

An analysis of accomplishments and needs in each of the four critical areas indicates that despite unprecedented advances, each area is still seriously compromised.

1. Immunization and Protection Against Illness

Major gains include increased immunization coverage and concrete accomplishments in combatting contagious diseases. For instance, between 1985 and 1988, the rate of measles immunization increased from 21 to 63% and DPT coverage increased from 19 to 54% (USAID, 1990c). And although neonatal tetanus is still responsible for 12% of neonatal deaths in Haiti (Cayemittes & Chahnazarian, 1989), the rate of tetanus immunization among pregnant women grew from 16% in 1981 to 61% in 1985 (Grant, 1987). Further efforts to increase coverage are arduously planned, but it is clear that the goal of universal immunization is still several years away. In the meantime, a major protection against illness most children do have is their mother's own colostrum and breast milk.

2. Nutritional Status

Despite encouraging advances in health, the nutritional status of Haitian children continues to be seriously compromised. Data from three Northern Departments, the Artibonite and the Centre regions, taken from the most recent survey of nutritional status of children under 5 in Haiti (Bassett & Scanlon, 1990) indicate considerable deterioration in the nutritional status of children when compared to equivalent regions (I, II, and III) in the 1978 Haiti Nutrition Status Survey (Bureau of Nutrition, 1979).

Increases are noted in the proportions of wasting (3.1 vs. 2.9%), stunting (31.7 vs. 23.6%), and wasting and stunting (3.2 vs. 3.1%) for all children 3-59 months based on Waterlow classification. In addition, the 1990 survey indicates that malnutrition begins in infancy, with the most dramatic increases in wasting and stunting registered among the 12-23 and the 24-36 month age-groups. By Gomez classification, 67.4% of Haitian children under 5 exhibit some kind of malnutrition based on low weight for age (Grade 1 or mild = 47.3%; Grade 2 or moderate = 18.4%; Grade 3 or severe = 2.7%).

In Haiti, malnutrition is attenuated by economic circumstances, by environmental sanitary conditions, and by harsh living conditions. A recent survey of health conditions and expenditures in Haiti (Jensen, Johnson, & Stewart, 1990) links malnutrition to family per capita income (measured as total expenditures), contaminated water, and rural residence.

3. Diarrhea Control

Breastfeeding is essential to the prevention and management of diarrhea. An official statement by the Interagency Workshop on Health Care Practices Related to Breastfeeding (1990) asserts that breastfeeding contributes to the prevention of diarrhea in four major ways by:

- decreasing exposure to pathogens;
- enhancing the infant's immunological response;
- contributing to positive nutritional status; and
- providing factors that protect the gut and assure appropriate flora.

Its major contribution to the treatment of diarrhea is in preventing dehydration and malnutrition.

In Haiti, arduous campaigns regarding the treatment of diarrheal diseases have been mounted in the past decade with consequent reduction in diarrhea-related deaths and increased domestic and hospital use of oral rehydration solutions (Cayemittes & Chahnazarian, 1989). Yet diarrhea remains a leading cause of child mortality in Haiti and continues to attack children with insidious persistence.

The Haiti Nutrition Status Survey (BON, 1979) found that 44% of children under 5 had a history of diarrhea during the seven days prior to the survey. The 1987 Enquête Mortalité, Morbidité et Utilisation des Services or EMMUS (Cayemittes & Chahnazarian, 1989), found a prevalence of 41.4% in the two weeks preceding the survey for children under 5. Particularly vulnerable were children aged 6 to 23 months. Just about six out of ten children between the ages of 6 and 11 months had an episode of diarrhea during the two weeks preceding the survey. The more compromised age-bracket, however, are children under one month: some 43% of infant deaths occur within the first month of life, and while some may be attributed to tetanus and low birth weight, many result from diarrhea.

EMMUS found diarrhea to be alleviated by controlled water source, use of latrines, and exclusive breastfeeding. Children from homes with controlled water source and latrine reported 50.8% episodes in the two weeks preceding the survey vs. 59.5% for those from homes without latrines or controlled water sources. Children exclusively breastfed reported 36.8% diarrhea vs. 55.5% episodes in those with breast plus complementation and 53.8% for those without any breast milk. Thus, the environmental sanitary conditions currently present in Haiti further compound the problem of diarrhea.

4. Child Spacing

Despite widespread efforts at family planning in Haiti, use of contraceptive methods by Haitian women of child-bearing age in union -- a high risk group -- is a low 6.5%, while the average 6.3 children per woman found by EMMUS (Cayemittes & Chahnazarian, 1989) is rather high. Yet it is essential for the health of mothers and children to maintain adequate spacing between births.

Columbia University researchers (cited in Augustin & Gourdet, 1987) working with World Fertility Survey data found that when a mother experiences two births within a short period of time (i.e., less than 24 months), both children are at higher risk of dying than children born after a long birth interval. Augustin and Gourdet (1987) reported that some 25% of births in Haiti occur within an interval of less than 24 months and that mortality rates for infants born

after a long birth interval were 106/1000 vs 174/1000 for infants born after a short birth interval. Thus, just by extending birth intervals, infant mortality could be reduced by 16%. Exclusive breastfeeding during the first six months provides a natural means of lengthening the birth interval if menses have not returned, known as the lactational amenorrhea method. This method has been underutilized up to the present given the strong tendency to early complementation found in Haiti, and the lack of promotion given to lactational amenorrhea as a child-spacing method.

The case for incorporating breastfeeding into family planning programs has reached much momentum. An international group of scientists gathered at the Bellagio Study and Conference Center in 1988, recommended that lactational amenorrhea should be regarded as an appropriate method of fertility regulation for many women and that the strategy should be incorporated into family planning programs (Consensus, 1988). More specific feedback as to how this might be accomplished is provided by a recent publication of the Institute for International Studies in Natural Family Planning of Georgetown University Guidelines for breastfeeding in family planning and child survival programs (1990) for use in promoting breastfeeding within family planning and child survival programs. Likewise, WHO (1988) as prepared the manual Breastfeeding and Child Spacing providing guidelines for linking both these areas.

IV. AN ANALYSIS OF BREASTFEEDING IN HAITI

Since exclusive breastfeeding can have an impact on each of the areas essential to child survival, and each one of these areas is currently compromised, it is clear that the promotion of exclusive breastfeeding has a place in Haiti. Yet the major challenge is not to reach this conclusion but to identify ways in which a breastfeeding promotion effort in Haiti can be effectively approached. A strategy of this nature has at least three essential components:

1. to define what breastfeeding means in Haiti from a statistical and ethnographic perspective;
2. to identify the most effective demonstrations, research, and materials;
3. to identify the most effective conduits for channeling this implementation.

The following sections of this report address themselves to these three issues.

A. Defining and Understanding Breastfeeding in Haiti

National figures on breastfeeding in Haiti present a rather favorable scenario. From them, one would infer that breastfeeding is common, especially in rural areas. EMMUS (Cayemittes & Chahnazarian, 1989) found high rates of breastfeeding for rural (99%), urban (96%), and metropolitan (92%) women. Median age at stopping breastfeeding was 18 months for rural children, 14.5 months for urban children and 16 months for metropolitan children, with a median breastfeeding duration of 17.5 months for the country as a whole.

Equally strong breastfeeding patterns are reported in the Jacmel area, where 95% of children had been breastfed and where breastfeeding duration was between 12 and 17 months (Wilson, Castera, & Laforest, 1988). A baseline study in several communities (O'Rourke, 1988) yielded 97.8% breastfeeding rates. Average breastfeeding duration for the Petit-Goave area was reported to be 20 months (Dieudonne, 1981); for the Deschapelles area, 18 months (Berggren & Berggren, n.d.); for Grand-Goave, 18 months (Wooly, Berggren & Berggren, 1981); for Trou Chouchou and Meilleur, 21 months (Wooly, Berggren, & Berggren, 1981); and for the North Region 15.6 months (Baer & Rohde, 1981).

These favorable figures, however, mask five problematic patterns in Haiti:

- the decrease in breastfeeding duration noted in the last two decades
- the differences in rural and urban feeding practices
- the higher mortality among children never breastfed
- the increased use of bottle feeding
- the early introduction of complementary foods into the infant's diet.

1. Decrease in Breastfeeding Duration

Data from the most recent nutritional survey (Bassett & Scanlon, 1990) and the 1978 Nutrition Status Survey (BON, 1979), reveals a decrease in breastfeeding duration over time. A comparison of data from the first 30 clusters of 1990 with those of regions I, II, and III in the 1978 survey shows that while children in the 3-5 month bracket are almost universally breastfed in the rural areas, decreases are noted at 6-11 months (96% in 1978 vs 88% in 1990) and at 12-23 months (62.3% in 1978 vs 46.2% in 1990).

Looking into the decrease in breastfeeding duration, Alvarez & Murray (1981) found that for village children aged 8 to 15 years, the reported mean age at complete weaning was 16.2 months; for children 2 to 7-11 years, complete weaning age was 14.7 months; while for children less than 2 years, mean complete weaning age came closer to 12 months. They also found village criteria to have shifted from a stated norm of 18 months in 1972 to a norm that came close to 12 months in 1980. A follow-up visit to the same village by Alvarez in 1990 indicated the norm now to have switched to 12 months and even less.

2. Urban and Rural Differences

The status of breastfeeding in urban and metropolitan areas differs from the rural situation. EMMUS (Cayemittes & Chahnazarian, 1989) found a median breastfeeding duration of 18.0 months in the rural areas and 14.5 in the urban areas. Likewise, 3.8% of urban and 8.4% peri-urban children had either never been breastfed or were weaned completely by 3 months of age, in contrast to 0.7% among rural infants. The Haiti Nutrition Status Survey (BON, 1979) found that in contrast to the rural 1%, 9.7% of urban mothers had never breastfed their child. In Port-au-Prince, the survey found that 71.7% of children 6-11 months were still breastfed; but among the 12-23 month age-group, the figure had declined to 28.9%. While such analyses are pending for the 1990 data, this trend toward declining breastfeeding rates is likely.

3. Increased Mortality of Children Never Breastfed

The EMMUS survey (Cayemittes & Chahnazarian, 1989) looked into breastfeeding patterns for deceased children under 5. The proportion of live rural infants who had been breastfed was 99%, in contrast to 88% for deceased rural children; in urban areas, the proportions were 96% vs 89%. Most dramatic were the peri-urban proportions: only 72% of deceased children had been breastfed. While certain confounding dynamics (e.g., low birth weight, neonatal tetanus) are masked by the data, it is clear that breastfeeding increases children's survival chances.

4. Generalized Use of the Bottle in Infant Feeding

The use of the bottle as a complement to breast milk has become dangerously widespread especially in urban areas. The trends over time indicate that -- if the problem is not addressed -- bottle feeding may soon be universal. While bottle-usage figures for urban areas were high even a decade ago [80% in Cité Soleil according to Berggren and co-workers (1981) and 96% in Port-au-Prince as a whole (BON, 1979)] in the rural areas, only 60 (BON, 1979) to 70% (Baer, Franklin, & Bertrand, 1981) of mothers reported using a bottle.

Yet recent figures from the Jacmel area (Wilson, Castera, & Laforest, 1988) indicate that 82.6% of children had been bottle fed by 12 months. In fact, according to their findings, the process begins early in life: by the first week, 17.2% of infants are given the bottle; by one month the figure escalates to 70.2%; and by 3 months of age, 80% of children are using a bottle for regular feeding. The authors caution that the bottle does not necessarily contain milk substitutes, but rather other liquids like water, teas, juices, or soups. However, O'Rourke (1988) found that 79.5% of the children being bottle fed were given breast milk substitutes in the bottle. Likewise, Berggren (1981), whose interviewees asked to see the contents of the bottle found that some contained soft drinks like kola and 7-Up but that the bottle was regularly used for feeding milk. In fact, the "milk" was prepared by mixing water, laundry starch, and enough milk to give it taste and color. Some mothers bought a small (6 oz) can of Carnation evaporated milk, and -- judiciously distributed -- that would last them through a whole day of feedings.

Another confounding aspect in the bottle feeding issue is the lack of distinction rural mothers make between infant formula and regular milk-powder. While rural mothers in a community of the Cul-de-Sac Plain mentioned "mamex" (an infant formula) and let famasi as being the appropriate substitute milk for babies (in Haiti, formula is sold in pharmacies), when the writer went into the women's homes, all the cans of milk shown were actually of regular powdered milk, not of infant formula, and they had been purchased not in the pharmacy but either in the market or city store. To add to the confusion, the cans of at least two manufacturers of regular powdered milk observed in Port-au-Prince supermarkets portray a baby's face on the outside. Others at least portray a cow!

The cost of proper feeding with a breast milk substitute totals at least US\$200-300 for the first year of life (McCann et al., 1984), which in Haiti comes close and/or exceeds the average annual per capita income of US\$260 (UNICEF, 1987). Specific calculations by Oriol in Haiti (1989) reveal that the cost of adequate formula feeding for a two-month old infant in 1985 was US\$24-28/month, roughly equivalent to half the salary of a factory worker (\$60), or just about the entire salary of a domestic worker (\$30). Berggren and co-workers (1982) estimated that an adequate supply of cow's milk to feed an infant would absorb half the income of the average poor working-class woman in Port-au-Prince. Habicht and associates (cited in Wray, n.d.) showed that in Guatemala, the cost of adequate bottle feeding is ten times greater than that of extra food required by a mother for lactation.

The economic burden on families is only surpassed by the negative health consequences. When formula feeding is attempted under the harsh economic and sanitary conditions prevailing in many developing countries, it results in diluted feedings, use of contaminated waters and unclean bottles. In Haiti, the mortality associated with bottle feeding under present conditions is dramatic. Working in an urban slum, Berggren and associates (1981) found that mortality by 18 months of age among children who were only given breast in the first month was 32/1000; by contrast those who had received breast + bottle had a 160/1000 mortality rate.

5. Very Early Introduction of Complementary Foods, including the Bottle

Exclusive breastfeeding is extremely rare in Haiti. The EMMUS survey (Cayemittes & Chahnazarian, 1989) revealed only 12.5% exclusive breastfeeding for the country as a whole among infants under 3 months. While the bottle is a relatively modern addition to the complementation sequence, the practice of early introduction of solids and other liquids is not. Baseline data for a child survival project (Augustin, Garcia, Harvey & Hirsh, 1989) indicated that by the first week, 13% of mothers started their newborns on flour mixtures cooked with either condensed or evaporated milk and sugar.

As described in previous works (Alvarez & Murray, 1981; Alvarez & Heurtelou, 1982), an infant's first food is a castor-oil purgative (lok, medsin, lwil klarifyé), which is supposed to clean a child's insides by ejecting the meconium (kras noua or goudron). From there, the child proceeds to breast milk. The complementation sequence includes sweet baby foods (manjé dous) in the form of various paps and porridge (labouyis), made with different cereal and tuber flours, and an occasional fruit pap. The infant then moves on to salty foods (manjé sel) such as white rice, plantains, mazombel, lam veritab, yam, or sweet potatoes, boiled with salt and ideally prepared in a pot of its own (ti bom apa). The sequence eventually ends in partaking from the family cooking pot (manjé chodyé), once the infant is equipped to handle family foods.

The major change noted in the early infant feeding sequence in recent years is the early introduction of milk supplements via bottles. The sequence now appears to be: lok (where still used) - breast milk - bottle milk - sweet foods - salty foods - cooking pot foods. Liquids, especially water and sweet teas, continue to be introduced very early in life, water in many cases as of the first day. In fact, Boulos and co-workers (1986) report use of boiled water for the first three to five days, followed by ejection of colostrum on the mother's part and lok for the infant.

There is also evidence that the sequence is becoming more and more compressed. In a rural community in the Jacmel area, researchers (Alvarez, O'Rourke & Heurtelou, 1985) found an association between early introduction of solids and economic status of the families. The poorest families tended to introduce solids during the first week(s) of life, apparently under pressure to have the young child partake of the family cooking pot as early as possible. Better off families could afford to extend the sequence a little longer: Middle SES families would introduce solids about the first/second month of life, while Higher SES families waited until the third month. In a recent review of the literature, investigators found that the tendency to introduce supplements at a very early age has increased during the past 12 years (Mock, Bertrand, Piard, Segala & Verna, 1988).

The practice of early complementation has been observed, among others, in the Cul-de-Sac Plain (Alvarez & Murray, 1981), in the Southern Peninsula (Alvarez & Hertelou, 1982), and in Port-au-Prince (Barthélemy, 1989; Boulos et al., 1986). In the Jacmel area, Wilson, Castera and Laforest (1988) found -- based on a 24 hour recall -- that the diet of children in the 0-2 months age bracket already included items such as rice, corn, bean sauce, plantains, and yellow vegetables, in addition to the liquids (teas, juices, water); and cereal/tuber flours traditionally fed to infants.

To summarize, the major problem in Haiti does not reside in the abandonment of breastfeeding, but rather in the early introduction of complementary foods into the breastfed infant's diet, of which bottle feeding now forms an important part. It is to the issues of early complementation and to the use of the bottle in that early complementation sequence that any breastfeeding promotion effort should address itself. Two major shifts are essential:

1. Shift complementation from the first to the second trimester; and
2. Shift economic inputs from feeding the infant to feeding the mother during the first trimester of life.

Already there is a tradition in Haiti of providing extra food to postpartum mothers so as to allow them to fill up the cavity left hollow by the child (Alvarez & Murray, 1981). What is needed is to encourage families to extend that effort further, into at least the whole first trimester.

B. Identification of Major Gaps Regarding Infant Feeding

There is currently ample justification for action regarding infant feeding practices. Early supplementation is at the root of the problem. In Haiti, it is not a matter of breast vs bottle, but a matter of breast vs supplements, of which the bottle forms an integral part. In reviewing the early infant feeding sequence, several major problems have been identified on which program interventions should focus.

1. Lok: A Newborn's First Food

A traditional first food for children in Haiti is a castor-oil based purgative commonly referred to as lok, medsin, or lwil klarifyé. While the recipes vary, lok is usually prepared by mixing castor oil, cooking oil, muskat, and cow's milk. Aware of this generalized practice, several programs in recent years have specifically addressed the practice of lok feeding and have emphasized the protective value of colostrum and the value of breast milk as a child's first lok. CARE's RICHES program (see Appendix A) allocates a lesson to lok in its health curriculum for mothers, and has met with success. O'Rourke (1988) reported that 51.2% of mothers in her RICHES sample had not given lok as the baby's first food. The reduction of this practice as a result of program intervention is corroborated by Essink & Nijboer's study (1989) comparing two communities in the Southwest: Marfranc and Dame Marie. In Dame Marie, mothers reported 100% lok use. In Marfranc -- where RICHES has worked -- the investigators found lok was used only by 57.6% of mothers.

2. Value of Colostrum is not Recognized

In their research in the Southern Peninsula, Alvarez & Heurtelou (1982) found that rural women do not usually attach any positive or negative value to the first milk (let jon). It is not perceived as having a harmful effect on the infant but by the same token, no benefits are felt to derive from it either, and no particular advantages are attributed to it.

Though women who have specific objections would reportedly squeeze colostrum out, most women appear to lose it as a result of the time that elapses between delivery and first feeding, and while de facto not feeding it, they appear to harbor no strong opposition to giving their babies this first milk. Research in the Southwest (Essink & Nijboer, 1989) confirmed this neutrality regarding colostrum, but also identified specific beliefs that the colostrum should not be fed and should be thrown away. Such negative beliefs about colostrum were also observed by Boulos and co-workers (1986) for mothers in their sample who drew out the colostrum on purpose. Working in several rural communities, Henrys (1989) found great variation from community to community; altogether, 58.3% (N=56) women in his sample threw colostrum out, but 40.6% (N=39) did feed it.

3. No Tradition of Immediate Initiation of Breastfeeding

Research shows there is a time gap of several days between childbirth and putting the neonate to the breast (Alvarez & Murray, 1981; Alvarez & Heurtelou, 1982). While some mothers begin as early as the first or second day, the time gap may last three to five days. After a child is born, it is customary to feed a purgative; and while its insides get cleansed with the purgative, sugared water is offered. In some parts of Haiti, mothers also wait for themselves to be

cleansed externally and/or internally by taking several prescribed postpartum baths and/or a purgative. Even when children were born at hospitals, mothers would keep them on a sugared-water diet and then return home for the appropriate cleansing treatments.

When mothers were asked by investigators (Boulos et al., 1986) why they waited to initiate breastfeeding, 83.8% attributed it to delayed milk production, 5.6% claimed illness, and 2.0% said they had not yet given lok. Some 48% of mothers reported efforts on their part to stimulate milk production: 23% had taken leaf baths, 14% breast massages, and 11% infusions.

Yet this practice seems amenable to change, given clearly articulated directives from health personnel. As part of a breastfeeding promotion effort, Cité Soleil's Saint Catherine Hospital instituted the practice of same-day breastfeeding after childbirth. This has resulted in 65% breastfeeding at discharge, and the discharge usually occurs within 24 hours of birth (R. Boulos, personal communication, September 27, 1990).

4. Infants Need Other Liquids in Addition to Milk

Deeply ingrained in the infant's early diet are sugared water and sweet teas. Water feedings begin on the first day. Ideally, boiled water or ollo culligan is used for the very first days, and the ideal is to sweeten it with white sugar which is believed to be cleaner (pi prop) than the most commonly used -- and less expensive -- brown sugar. Sweet teas may appear in the first weeks followed by juices and salted teas later on. In a 24-hour recall of foods consumed by infants 0 to 2 months, Wilson, Castera, and Laforest (1988) found 65% were fed water, 15.4% teas, and 7.7% juices.

There may be two major reasons for feeding water to infants. First of all, there is a belief that infants get thirsty just as adults do and thus need water to quench their thirst. Secondly, water is perceived as essential for the proper assimilation of foods. For a rural village, Alvarez & Murray (1981) reported the practice of both adults and children drinking a glass of water after a meal; it is believed that if you do not do so, the food will do no good (li pap fe anyen pou ou). It is not known to what extent this applies to infants, but it would certainly be something to consider.

The evidence from other tropical settings is that exclusively breastfed infants do not need to consume any liquids other than breast milk in order to meet their water needs (Almroth, 1978; Almroth and Bidinger, 1990; Armelini, 1979; Brown, Creed, del Aguila, López de Romana & Black, 1986). In fact, the use of other liquids can be detrimental, where water is likely to be contaminated and may increase chances of diarrhea. The consensus is that supplemental liquids should be avoided during the first 4-6 months of life.

C. Barriers to Exclusive Breastfeeding

There are many barriers to exclusive breastfeeding in Haiti. The heavy reliance on early complementation seems to be the major barrier. Yet there are other aspects to be considered that would need to be addressed in any breastfeeding promotion strategy.

1. Breast Milk is not Perceived as Food, But as a Complement

Western science posits milk as the basic food for infants and calls other foods "complements" to continual breastfeeding after 4-6 months of age. By contrast, at least some Haitian women have been heard to phrase it the other way around: Milk is a complement to food. Thus, infants are introduced as early as possible in life to "real" foods; i.e., solids, and milk is seen as a complement, a ti deze. Women in the Cul-de-Sac plain, among who the author conducted a focus-group interview in preparation for this proposal, described children as "hungry from in the wombs," (piti-la grangou depi li nan vant), and as crying for food. Mothers thus feel compelled to produce the foods for which their infants cry, and in this matter, it is understood that some infants may be more demanding than others and may need solids earlier than others.

2. The Construct of Insufficient Milk

The construct of insufficient milk, also observed in many other parts of the world (Greaves & Hendrata, 1990; Savage, 1990) has been gaining popularity in Haiti. Mothers claim their milk production is not enough to satisfy their babies and they find themselves forced to supplement with bottle feedings or other solids. This becomes a self-fulfilling prophecy when babies are kept from breast sucking by feeding them other liquids and/or solids, thus reducing their interest to suck vigorously from the breast and stimulate adequate production.

RICHES, a health education program for mothers developed by CARE, emphasizes in one of its health lessons the well known physiological fact that the more an infant sucks, the more milk the mother produces. An evaluation of RICHES found the highest rates of exclusive breastfeeding ever reported in Haiti for children under 3 months: 47.5% exclusive breastfeeding, in contrast to the regular rural rate of 14.4% identified by EMMUS (Cayemittes & Chahnazarian, 1989), and the 20% reported in a Child Survival project (Augustin et al, 1989).

In other places, mothers' confidence in their ability to produce enough milk has been enhanced by providing regular weighing and growth monitoring by well-trained, sensitive staff. This restores mothers' confidence by showing their baby's satisfactory growth (Greaves & Hendrata, 1990).

3. Belief that Mothers' Nutritional Status Does not Permit Exclusive Breastfeeding

Related to insufficient milk is the belief that malnourished mothers cannot feed an infant adequately. Interestingly, this is a belief not only held by many mothers, but also espoused by health workers of various status. Focus-group interviews among community-based health care providers in Haiti (Carnell, 1988) revealed that the workers themselves did not feel women or babies in their area could support breastfeeding as the sole food for 3-4 months, due to their inadequate nutrition. To be sure, the international literature is not lacking on controversy -- especially when it comes to the wear and tear breastfeeding might have on malnourished mothers -- but essentially, it upholds the value of the breast milk of even suboptimally-fed mothers (McCann et al., 1984; Brown et al., 1986a; Brown et al., 1986b; Anderson, 1988). Yet this is a sensitive issue in Haiti, and there is a need for addressing this issue within the Haitian context.

A concise study comparing the breast milk of five malnourished and five healthy mothers was conducted by Barthélemy (1989) among a sample of urban Haitian mothers. She found that the milk of poor malnourished mothers had more fat, more calories, less protein, but an equal amount of carbohydrates than the milk of healthy well-to-do mothers. In Brazil (Martin, personal communication, 1983), quality was ruled out as a factor and the issue of quantity was ruled out indirectly by following up "breastfed only" children of well-nourished and malnourished mothers. The strongest association resided in the women's self-perceptions: poor mothers had such low self-esteem that they could not view themselves as capable of adequately feeding their child and this prompted them to early complementation.

In fact, one health worker pointed out that in Haiti, a poster depicting an obviously well-to-do mother breastfeeding her infant would likely backfire. Rather than responding to the cure that "even well-off women breastfeed, not just poor women" the worker feared that poor Haitian women would interpret it as meaning "someone like that can do it, but not us". Thus, status and prestige promotion options, used effectively in other countries, may not be suitable for Haiti. Growth monitoring seems to be key for alleviating fears of insufficient milk and counseling on techniques for optimal milk production (i.e., frequent feeding on demand and exclusive).

4. The Construct of Spoiled Milk (Let Gaté)

Spoiled milk, known in Creole as let gaté, is a condition whereby a woman's milk is believed to spoil in her breast and to become harmful to the child. Let gaté may result from a variety of causes:

- a strong emotional state arising from bad news, e.g., a death;
- a serious quarrel, fight or strong impression that leads to a negative stir up of energies (mové san);
- interruption of breastfeeding for two or three days (e.g., a planned short trip that is unexpectedly prolonged, a temporary illness on the mother's part);
- a serious illness such as tuberculosis on the part of the woman.

Two decades ago, let gaté was known but few women actually suffered from it. Today, an increasing number of women claim they have been forced to wean their child in order to protect it against the effects of let gaté.

5. Directives From Health Personnel

Health personnel have contributed in no small measure to the rise in bottle feeding. In Cité Soleil, before breastfeeding promotion efforts were undertaken, mothers were asked who had recommended bottle feeding to them; and the most common response was "nurses", "auxiliaries", or someone else at the health center (Berggren et al., 1981). Rural women from a community in the Cul-de-Sac Plain reported the government maternity hospital, Chancerelles, required them to bring a bottle as part of their maternity packet (Alvarez & Murray, 1981). This bottle was reportedly used for boiled sugar water, yet it invariably led to formula feeding once in the village. It also seemed to convey to women that:

- the hospital sanctioned the use of bottles and considered them necessary for all infants; and
- infants need other liquids in addition to breast milk.

6. Response to Advertising and Marketing Strategies

Advertising and promotion of breast milk substitutes in Haiti is blatant. While no systematic study has been done on how marketing strategies have affected consumption patterns in Haiti, this has been conclusively documented in other parts of the world to the extent that the sale of breast milk substitutes is now subject to international regulations and conventions. While Haiti was one of the original signing countries of the WHO/UNICEF Code of Marketing for Breast Milk Substitutes, the code has never been implemented in the country.

7. The Bottle as a Status Symbol

The bottle is associated with the hospital and with health personnel. And rather than being a traditional marketplace, good powdered milk is sold in pharmacies and stores and has a high monetary value. The combination of bottle and powdered milk results in a "package" of status. In offering both, a mother is doing the best she can for her child. All recent data point to the fact that it is the more educated, economically better-off women that are using the bottle with more assiduousness (Berggren et al, 1981; Graitcer, Allman, Amadée-Gédeon, & Duckett, 1984).

Not that others ignore the value of breast milk. When asked to rank types of milk, village mothers ranked breast milk first, cow's milk second, and powdered milk third (Alvarez & Murray, 1981). In their sample of urban mothers, Boulos and associates (1986) found that 98.7% of mothers rated breast milk as best.

Yet, while powdered milk does not rank as high as breast milk, it is considered an adequate substitute and its shortcomings are not known. Thus, formula cans, Gerber cereal boxes, and other such store-purchased goods, have become sought-after infant feeding products and are proudly shown to visitors. They are symbols of how much a family has dégagé (gone out of its way) on behalf of its young member. Their high price and the weekly consumption a child requires are frequent subjects of conversation. In Cité Soleil, investigators (Berggren et al., 1981) found women were over-reporting the use of the bottle. While 86% of women reported using a bottle, many of them could not find it -- unlikely in a one-room house -- when asked to show the bottle to the interviewers. This would indicate that the bottle has attained such a prestigious position in infant feeding that families who do not own or use one somehow feel they should and pretend they do.

Interestingly, among a group of mothers who had been through the RICHES health training course, 72.2% had heard of the disadvantages of the bottle and said it contained germs and caused diarrhea. And among those mothers, O'Rourke (1988) found the highest rates of exclusive breastfeeding ever reported in Haiti (47.5%). Thus, when made aware of the consequences of bottles, women seem to apply this knowledge accordingly.

8. Absence of Health Education Discouraging Bottle Feeding

There is little health education focused on conveying how harmful the bottle can be to infants and the effects it may have on mortality, morbidity and child spacing. People are being offered little competing information about the bottle. In fact, in one rally post visited in the context of an evaluation (Harrison, Overbolt, & Huff, 1986), health workers were teaching others how to use and care for bottles appropriately, in the belief that since the mothers were going to use

bottles anyway, they might as well do it right. Thus, even health workers have come to accept the current status quo and do not see themselves as agents of change.

A very active anti-bottle stand has been taken by the RICHES project, with its log of dechouké bibron (uproot the bottle), and bamn godé ak kiyé (give me a cup and a spoon) as the desirable alternative (see appendix A). Messages regarding the hazards of bottle feeding are transmitted via songs, skits, t-shirts, pictures of a baby breaking a bottle with a hammer, and formal and informal lessons.

9. Urbanization and Social Change

A rapid urbanization process is taking place in Haiti, where the estimated annual growth rate of the urban population is 4.2% (Grant, 1987). Many of the migrants are women. According to World Bank (1976) figures, in Port-au-Prince, females exceed males by 33%. This exodus of women to the cities is a practice World Bank experts associate with the decline in breastfeeding and the rise in bottle feeding. Urbanization also leads to rapid social change. The uprooting of people, the reduction in the extended family resources and supports characteristic of village life, facilitates the break with past traditions and the incorporation of new practices. In addition, part of the urbanization mind-set is precisely the incorporation of new behaviors and the leaving behind of old traditional practices.

10. Aesthetic Concerns

The issue of sagging breasts and aesthetics comes up more often among middle-class urban women than among rural women, among younger rather than older mothers. But it surfaces enough times that it would be necessary to include it in educational efforts aimed at breastfeeding promotion.

11. Possible Medical Underpinnings

Medical barriers (some of which are medically-induced) have traditionally prevented a number of women from breastfeeding. Among the problems are mastitis, sore nipples, engorged breasts, and the uncommon condition of inverted nipples. These deserve special attention, for many conditions can be prevented by simple exercises during the last trimester of pregnancy and by immediate initiation of breastfeeding within the first hour of birth and not giving sugar water. Given the climate of propensity of bottle feeding, even small complications may tilt the balance in favor of bottle feeding. Such problems thus warrant early detection and treatment.

Another issue that has presented itself in recent years is the question of AIDS (SIDA). There are now clear directives and an international consensus that the advantages of breastfeeding far outweigh the potential for harm (WHO, 1987) even in the case of HIV-infected mothers. This consensus needs to be communicated loud and clear and incorporated into AIDS-related information and education activities in Haiti.

12. Economic Pressures

Last but not least, are the economic pressures impinging on both rural and urban families. The price of both food and fuel has increased while purchasing power has remained stable or even decreased. In their follow-up study of health and food practices in a rural village, Alvarez and Murray (1981) found that women in 1980 were no longer able to remain economically inactive for the 18-month period the investigators had observed to be the norm in 1972. Not being at all customary to take infants to market in Haiti -- a practice common in West Africa but stamped out of the Haitian repertoire through past government regulations -- women had introduced two practices:

1. early weaning; and
2. bringing their unweaned infant with them to the city in an attempt to combine breastfeeding with their regular trading activities.

But this practice more often than not resulted in eventual bottle feeding and early weaning. The labor-intensive, competitive nature of female trading in Haiti is difficult to combine with breastfeeding.

Urban women are subject to the same pressures. They cannot afford to wait to resume their economic activities. This is especially so among women who hold formal employment. In Cite Simone, women factor workers tend to begin bottle feeding significantly earlier than other women (Berggren et al., 1981). And even when these women are offered a paid maternity leave, many make the leave payment a welcome supplement and get back to work as soon as they can.

Supplementation is related to, but cannot be solely attributed to, economic pressures. While it is easy to understand the dilemma of factory workers, or of women whose trading and marketing activities force them to be away from home for extended periods of time, it is more puzzling to see early supplementation even among women who do stay home and who suspend, de-intensify, or modify their economic activities while they are in the *ti nourris* stage, i.e., while their baby is very young. Yet even among these women, there is no tradition of exclusive breastfeeding. And exclusive breastfeeding could in the long run save time by reducing the vulnerability of infants and preventing illness. Also, there is no tradition of expressing milk and storing it so the child can be fed in their absence. Knowledge about expressing and storing milk (which may keep up to 8 hours without refrigeration) should be part of the educational component of any breastfeeding strategy. Women's repertoire of options needs to be expanded.

To summarize, an attempt has been made to define and understand what breastfeeding means in the Haitian context. The major problem in Haiti does not reside in the abandonment of breastfeeding but rather in the early introduction of supplementary foods into the infant's diet, of which bottle feeding now forms an integral part. I have also attempted to identify the major knowledge-gaps in the early infant feeding sequence that have programmatic implications as well as the major barriers to exclusive breastfeeding present in Haiti today. All of these elements to which we have alluded would need to be addressed in one or another fashion within a breastfeeding strategy.

V. CURRENT BREASTFEEDING PROMOTION EFFORTS IN HAITI

The present time for launching a breastfeeding promotion effort in Haiti is auspicious. For several years, a momentum has been building up, coming from various organizations: public and private, service-oriented and professional. This section of the report reviews and describes past and current programs and initiatives that have addressed the question of early infant feeding in an effort to identify which strategies are ready for immediate incorporation into a core comprehensive effort, and which ones still await validation within the Haitian context.

A. Description of Current Initiatives

1. Systemic Modifications at the Cité Soleil Hospital

As part of a breastfeeding promotion effort launched in the mid-1980s at the Complexe Médico-Social in Cité Soleil, the Complexe's hospital set up specific directives:

- no bottles are allowed in the maternity ward;
- immediate breastfeeding is encouraged;
- establishment of a milk bank for premature babies;
- health messages encouraging breastfeeding delivered via video players set up at the maternity ward; and
- provision of lactation education services to others in the maternity and neonatology wards.

Another area where a strong breastfeeding promotion component was introduced is the Nutrition Demonstration Foyer, a mother's health and nutrition education group, sponsored by the Complexe.

While the author was unable to locate the report containing formal evaluations of the Complexe's breastfeeding efforts, reliable sources (Regionald Boulos, personal communication, September 27, 1990) reported that one of the Complexe's major attainments has been the high percentage of women who are already exclusively breastfeeding at discharge, which usually occurs within 24 hours of birth: by the time they leave the hospital, 65% of mothers are already breastfeeding exclusively. (Anyone familiar with Haiti would know how much of an accomplishment these figures represent!) Another major breakthrough has been the milk bank for premature babies, which not only provides infants with breast milk while in the hospital, but equally important, serves to communicate to mothers the value placed on breast milk by health personnel. In sum, the success of the Cité Soleil programs argue favorably for the use of modification in hospital practices and for the value of face-to-face health education programs for mothers and pregnant women. Both appear to be viable approaches for use in Haiti.

2. Face-to-Face Health Education Programs of Mothers

CARE's RICHES model is perhaps the most culturally appropriate, research-based, and field-tested model for health education of mothers in Haiti today. Among other topics related to health and nutrition, the RICHES curriculum addresses some of the major issues and problem areas in infant feeding identified by research (O'Rourke, 1989). Among these are: lok, value of breast milk, exclusive breastfeeding, dangers of bottle feeding, gradual weaning, use of cup and spoon (godé ak klyé).

The RICHES curriculum, geared towards non-literate Creole speakers, is based on active participation by mothers, live demonstrations, and the use of community-based monitors. The educational methodology includes songs using familiar melodies, skits, and riddles. Conway (1989) considers these to be the most important pedagogical tools used in the project. He believes composing and singing songs, and Krik/Krak-type riddles are popular forms of entertainment in rural Haiti. In addition, they not only facilitate the recall of health messages (e.g., recipes for ORT, differences between DPT and polio vaccines) but stand a chance of being passed on to neighbors.

Conway (1989) also points out that one of the most important slogans to come from RICHES is Déchouké bibwon (uproot the baby bottle), which was incorporated into television and radio messages outside of the project. The word déchouké was invented at the time the Duvaliers left Haiti and symbolizes the attempt to get rid of all the bad things in their legacy. Applying the word to the baby bottle is a clever play on words.

RICHES' success has been remarkable in meeting its educational goals (Conway, 1989; O'Rourke, 1988), and has shown that when adequately designed and field-tested, health and nutritional education interventions can have a positive impact. RICHES' success also upholds the viability of face-to-face health education for adult non-literate rural Haitian women.

3. Integrating Breastfeeding into a Broad-Based Curriculum

The broad-based Konesans Fanmi se Lespwa Timoun, whose purpose is to promote the health and development of children by increasing the range of services available to them through mobilizing society's resources, appears promising as a conduit for breastfeeding promotion and health education. After only two years in existence, Konesans Fanmi already has the support of 29 institutions and 20 media groups. Among the institutions are public and private entities, educational and health organizations, bilateral and local agencies, religious and lay groups, plus professional associations. Each institution assigns one representative to the program, thus linking their organization with the Konesans Fanmi network.

In its work Konesans Fanmi essentially follows an information, education, communications strategy. With financial and technical sponsorship from UNICEF, materials have been developed that address the gamut of early infant and child development topics among which is reinforced the concept of exclusive breastfeeding during the first three months of life (see Appendix B for those age-levels that address breastfeeding). With USAID's sponsorship, a set of educational videos was developed. In addition, media gatherings, radio and TV spots, a newsletter, and regular features in local magazines, are also part of Konesans Fanmi's educational strategies. Attesting to its broad-based scope, the educational materials for child development have three guides:

1. one for use by educators;
2. one for use by health professions; and
3. one for use by media people.

A program at rural markets is planned where child care will be provided to children while mothers are at market, to be followed by health education and other various interventions for mothers after market. Other interventions with factory workers are also being considered.

4. Efforts of Existing Professional Organizations

In 1985, the Société Haïtienne de Pédiatrie dedicated its fifth annual meeting to the issue of breastfeeding in Haiti. The conference entitled L'Allaitement Maternel: Une nécessité en Haïti, underscored the support and interest of the association in breastfeeding. Recently, UNICEF (1989) sponsored the publication of the proceedings into a book.

5. Ministry of Health Initiatives

The program on immunizations and breastfeeding (PRONACODIAM) has developed posters, cassettes, radio spots, t-shirts, and materials for breastfeeding promotion, and currently has some more under preparation. An important aspect of their campaign (see Appendix C) has been to communicate to women that any woman can breastfeed, regardless of occupation, or socio-economic and nutritional status. Another component of the interventions has entailed development of a breastfeeding promotion movie and placing video players in maternity wards at several major hospitals. A third component is the stratégie de marché in coordination with UNICEF, whereby women are reached at market places through various approaches: loudspeakers, exchange of baby bottles for t-shirts, and general breastfeeding promotion. Other project strategies include the retraining of health personnel in prenatal clinics, well baby clinics, and maternity hospitals; training of secondary school teachers, child-care teachers, and religious leaders; focus groups (groupes de réflexion) with women; extensive mass media outreach; and building of a broad-base of support from within government, industry, and business (MSPP, 1986, 1988).

The Nutrition Program in MSPP (Ministère de la Santé Publique et de la Population), which places a major emphasis on Vitamin A distribution and weight surveillance, has modified its Health Card Chemin de la Santé (see Appendix C) to include the picture of a breastfeeding mother and infant for the first three months of life, and a cup and spoon thereafter. The Family Planning and Maternal/Child Health Units is interested in promoting breastfeeding as a child-spacing alternative and in approaching the issue of a national initiative from the point of view of establishing systemic modifications within maternity hospitals and/or within maternity wards.

6. Bilateral Sponsorships

USAID, UNICEF, PAHO/WHO have been supportive of various efforts and have provided logistical, financial, and technical support to many of the strategies currently in place or in the planning. USAID, for instance, was instrumental in planning the breastfeeding promotion effort in Cité Soleil, as well as in providing sponsorship for the various preschool intervention programs that eventually led to the development of RICHES. In turn, UNICEF has assisted in promotion, information, and development of educational materials in coordination with Konesans Fanmi, and in launching the above-described stratégie de marché in coordination with the Ministry of Health. PAHO/WHO in turn, has been providing technical assistance for the revitalized TBA training program, in coordination with the Ministry of Health.

7. Policy and Legislation

In other countries, major policy changes have entailed maternity protection legislation regarding work: maternity leave, job protection, child care facilities that enable employed mothers to feed their babies, and the like. In Haiti, much of that legislation already exists. As Oriol (1989) indicates, Article 389 of the Code du Travail provides breastfeeding mothers with two daily work-breaks of 30 minutes each, or with 15-minute breaks every three hours. Furthermore, Article 390 of the same code requires that employers hiring over 50 women provide child care (creches) at the work-site for children under 24 months so mothers can breastfeed. Neither article provided for in the code is currently implemented, however.

Another legislative task for protecting breastfeeding in other countries has focused on regulating the advertising, sales, and distribution of breast milk substitutes, following the WHO/UNICEF Code of Marketing of Breast Milk Substitutes passed in 1981. While Haiti was one of the original signing members of the code, there has been little application of the Code in the country, besides taking down pro-bottle poster ads from the maternity wards (Lerebours, 1989).

Thus breastfeeding in Haiti is already protected by pertinent maternity legislation. The major challenge ahead will undoubtedly be implementation.

B. Potential Effectiveness of Current Initiatives

With regard to the effectiveness of the various interventions described above, the impact of some initiatives has been ascertained, while the impact of others is still to be assessed. For instance, there is information available to show the positive effects that changes in hospital policies have had on breastfeeding, to uphold the value of face-to-face health education interventions, and to demonstrate the feasibility of integrating a breastfeeding component into a broad-scope program. Yet, due to their newness and wider aim, the impact of many of the initiatives described above (e.g., radio spots, TV spots, videos at maternity wards, breastfeeding promotion at markets) has not yet been ascertained. For some strategies, such as the educational materials developed by Konesans Fanmi, an indirect measure of impact may be the interest other organizations have shown in using the package of materials and in incorporating it into their own health and educational activities, and that interest is extremely high at present.

The Haitian experience regarding breastfeeding so far has also underscored the viability of organizations working together towards a common goal. This is perhaps best exemplified in a poster promoting breastfeeding that acknowledges the cooperation of MSPP, UNICEF, PAHO/WHO, USAID, and Konesans Fanmi (see Appendix C). Such linkages are essential to a comprehensive strategy.

VI. RECOMMENDATIONS: A COMPREHENSIVE BREASTFEEDING STRATEGY FOR HAITI

The breastfeeding initiative is conceptualized along five major components:

1. An integrated component whereby breastfeeding is inserted into already existing programs.
2. A demonstration component.
3. A research component.
4. An information, materials development, and dissemination component.
5. An implementation component.

A rather broad "menu" of possibilities is offered in the hopes the report will serve as a working document for use in discussions among concerned groups.

The overall strategy would have five measurable outputs:

1. To promote immediate breastfeeding so that onset of breastfeeding occurs within 24 hours of birth;
2. To create a climate which is conducive and supportive of exclusive breastfeeding during the first three months of life. (Three months is the standard used by Konesans Fanmi and MSPP, and given current early supplementation practices and economic pressures, may be a more attainable goal than the 4-6 months currently advocated worldwide.);
3. To postpone the early introduction of supplementary foods into the infant's diet until the second trimester of life.
4. To decrease the rate of bottle feeding.
5. To maintain and preserve the current solid rates of breastfeeding.

A. The Integrated Component of the Strategy

The promotion of breastfeeding can be achieved as the cumulative effect of various activities that contribute to changes in existing infant feeding patterns. An area such as breastfeeding, with implications for disease and diarrhea control, for nutrition, and for child-spacing, lends itself to integration into already existing programs focusing more specifically on those issues. Some of the existing programs where a breastfeeding component might be attempted are listed below:

1. Integration into Existing Child Survival Projects

Given breastfeeding's impact for each and every one of the major Child Survival components (immunizations; nutrition, including Vitamin A distribution; diarrhea and ARI control; and child spacing) it would seem natural for breastfeeding activities to find a niche in Child Survival programs. Most existing programs in Haiti, however, only allocate 2 to 3% of their budget to breastfeeding, according to my own inspection of responses to the 1989 USAID Health and Child Survival Project Questionnaire. Thus, largely due to funding constraints, most programs have not addressed the subject head on, but have given priority to what their budgets prioritize: namely, immunizations, diarrhea control and health care financing. It is clear that either adding or reshuffling funds is needed to make insertion of breastfeeding a reality.

Some Child Survival programs whose funding has permitted it, have addressed early infant feeding decidedly and actively, and have met with success. With some creativity and appropriate planning, breastfeeding promotion efforts could be inserted into many of the other programs. The integration of a breastfeeding component, however, should not just be a token but breastfeeding should be energetically approached from the standpoint of its own worth and of its implications for a particular area. AID/W (1990b) has developed guidelines for linking breastfeeding with the following programs:

- diarrhea control;
- immunizations;
- nutrition and growth monitoring;
- food supplementation;
- health care financing;
- private sector activities; and
- women in development activities.

As previously mentioned, other institutions have developed guidelines for inserting breastfeeding into family planning programs.

Armstrong (1990) cautions against what she calls "the myth of integration". What looks good on paper may in reality be limited to simple exhortations to breastfeed or to distribute a pamphlet or a poster. She advocates for providing specialized training in breastfeeding plus giving it emphasis, time, and funding consistent with its complexity and central importance in child survival.

2. Integration into Existing and Planned Research Efforts

Breastfeeding questions can be included in major planned research efforts, or data can be analyzed and broken down in such a way that it answers questions relevant to early infant feeding. Several large-scale surveys in the planning (e.g., EMMUS 2, fertility surveys) could include questions with implications for early infant feeding, such as:

- Did you give lok to your babby?
- Is (was) the baby breastfed?
- How long was baby breastfed?
- When did you begin breastfeeding? (day 1, day 2, day 3, etc.)
- Are you still breastfeeding?
- How many times a day do you breastfeed?

- Have you ever used a bottle?
- Who recommended that you use a bottle?
- When did you begin using a bottle?
- What do you use the bottle for?
- Do you also use the bottle for feeding milk? What kind?
- When did you begin feeding solids like labouyi?

It would be useful to add the same questions as in the Demographic and Health Survey (DHS II) on breastfeeding so that data collected can be compared with that from other countries.

When analyzing breast/bottle feeding data -- traditionally broken down into three-month chunks -- a one month breakdown during the first six months of life would be more revealing. Knowing that supplements are introduced between 0 and 3 months is not the same as knowing that they are introduced by the first, the second, or the third month. More precise data are more relevant for program planning. Likewise, finer differentiations are also needed to enhance the potential the data might have for assessing program effectiveness: large-scale survey data can be used as an indirect measure of effectiveness of the breastfeeding efforts on the population surveyed, only if the categories are fine enough to allow for detection of small differences. In Haiti, withholding supplementary foods for two or even for one month by a certain percentage of women may be a large victory indeed.

3. Integration of Breastfeeding into Maternity Wards and Hospital

Changes in hospital norms and directives have yielded positive results in countries around the world where they have been seriously implemented. In Honduras, major changes in hospital practices included: an inter-disciplinary coordinating committee for the breastfeeding program, hospital norms postpartum education for mothers, rooming-in, suppression of routine bottle feeding, milk banks for premature or sick newborns, support and technical assistance to Maternal and Child programs, and direct assistance to mothers with breastfeeding problems (Canahuati, 1990).

In Costa Rica (Mata et al., 1983), the introduction of rooming-in in two rural hospitals resulted in a higher prevalence and duration of breastfeeding. For instance, 52% of women were still breastfeeding by 8-11 months compared to 10% prior to instituting rooming-in. Breastfeeding promotion was associated with a reduction in neonatal mortality and with virtual disappearance of neonatal mortality by diarrhea and by lower respiratory infections. In the Philippines (Gonzales, 1990), the introduction of a lactation management program in a hospital is believed to have resulted in the reduction in postpartum bleeding; reduced hospital stays; yearly savings of US\$107,296.72; additional space vacated by the central nursery; better use of hospital staff; and in improved health of infants through reduction of diarrhea.

WHO and UNICEF (1989) have devised guidelines for hospital-based changes in their joint publication Protecting, Promoting and Supporting Breast-Feeding: The Special Role of Maternity Services. A copy of their ten steps to successful breastfeeding given in Appendix D, together with their checklist for evaluating the adequacy of support for breastfeeding in maternity hospitals, wards, and clinics.

A major breakthrough in the movement towards changing current hospital practices in support of breastfeeding and in leadership training in the areas of breastfeeding and lactation management is the Wellstart/San Diego Lactation Management Education Project in California, USA. Wellstart is aimed at training multi-disciplinary teams from teaching hospitals in developing nations as lactation specialists. Team members may include

physicians, nurses, chiefs of departments, chiefs of nursing services, chiefs of hospitals, and staff from ministries of health. Wellstart staff have found that the more senior team members are, the faster change takes place (Naylor, 1990). In fact, many of the leaders, trainers, and advocates now working in their respective countries towards breastfeeding promotion are Wellstart trainees.

Wellstart courses last one month. Training is both theoretical and practical, and includes preparation of a plan to be implemented once the team returns home. A follow-up consultative visit by Wellstart staff to the actual countries is also part of the program, as are also periodic mailings of relevant articles. A type of network is created linking trainees to the Wellstart Project and to colleagues around the world. A description of services, course dates for 1990-1991, and prices are given in Appendix E.

While courses are currently offered only in English and in Spanish, the lack of program offerings in French will not be a barrier as many health professionals in Haiti are fluent in both languages. What is important is to identify the right people, those with the training, interest, and motivation to take on this commitment.

4. Integration of Breastfeeding into Pre-service and In-service Training Programs

A lactation component can be added to pre-service and in-service activities already in place. We have already alluded to the possibility of training potential leaders in breastfeeding and lactation management at the Wellstart/San Diego Program. For purposes of in-service training in-country, existing facilities such as the Institut Haïtien de Santé Communautaire (INSHAC) could be used. INSHAC already has the categories of Specific Courses (offering training in individual topics), and of Special Courses (offering training that responds to special requests by particular institutions), and has the physical facilities from which to operate.

The key factor in training is to identify discrete technical and professional roles which as an example could be broken down thus:

- professionals (physicians and nurses);
- auxiliaries, nurses' assistants, delivery room personnel;
- community collaborators; and
- traditional birth attendants (TBAs)

TBA training is probably the best place to begin, since a new training curriculum for TBAs is currently in the planning as a joint MSPP/PAHO/WHO effort. Traditional birth attendants are key agents in any breastfeeding promotion effort, since some 70% of Haitian women deliver their babies in their homes with the aid of friends or relatives (9%), but mostly with the aid of TBAs -- an estimated 41% of which are still not d'plomé which means they have not been through the government-training course (Westinghouse, 1985), so their training is still pending.

Pre-service training initiatives could take the form of adding to medical and nursing school curriculum a lactation component. Likewise, as mentioned above, the curriculum for TBAs is extremely important, given the number of women TBAs reach each year and the important role they have been observed to play as consultants and resource people following delivery (Alvarez, O'Rourke & Heurtelou, 1985).

Also important -- but of lesser initial priority -- is the outreach to elementary and secondary schools where young boys and girls can be educated as to the benefits and importance of breastfeeding. Additionally, training modules can be prepared for church groups, hospitals, dispensaries, rally posts, media groups, and other natural groups such as existing mother's groups and groupmans.

Training at all levels should have both a theoretical and a practical component, and content should address the major issues identified to be relevant in Haiti (see section on Analysis of Breastfeeding in Haiti in this report). Formats may vary: short courses based over a couple of weeks or months, workshops of various lengths, separate teaching modules to be inserted into various programs, seminars, poster sessions, presentations at professional meetings, public conferences. There should be flexibility as to geographic site. Instructors should be prepared to travel to specific sites, or the to countryside, rather than concentrating efforts in the capital city or in regional capitals.

Each group, at its own level, will receive training on issues that may include but are not restricted to the following:

a. Breastfeeding vs bottle feeding

- Breastfeeding promotion efforts in international perspective
- Approaches to breastfeeding promotion
- The current situation in Haiti: strengths and gaps
- The Haitian feeding sequence and its risks
- Understanding the barriers to exclusive breastfeeding
- Benefits of breastfeeding, especially exclusive through 4-6 months
- Importance of early exclusive breastfeeding initiation
- Weaning methods, weaning foods
- Importance of the mother/infant bonding
- Morbidity association with partial breastfeeding and bottle feeding
- Child spacing benefit

b. Physiology and immunology of breastfeeding

- Production of milk; role of suckling
- Composition of human milk
- Effects of early supplementation with solids or liquids
- Medications and lactation
- Effects of early weaning; effects of hormones
- Immunological properties of breast milk

c. Breastfeeding in child survival

- Breastfeeding in diarrhea control
- Breastfeeding in nutrition and growth monitoring
- Breastfeeding in child spacing
- Breastfeeding in immunization programs; value of colostrum
- Breastfeeding and HIV-AIDS
- Breastfeeding strategies for working mothers

d. **The role of health personnel in breastfeeding**

- Role of physicians
- Role of nurses
- Role of health collaborators
- Role of TBAs

5. **Integration into Policy and Legislation**

The political and economic period through which Haiti is currently traversing is not an opportune time for major legislative changes or for pressuring so that current laws are implemented. Rather, these changes should arise as a result of changes in the political structure and in the political climate of the country. The momentum on behalf of the benefits of exclusive breastfeeding should also have peaked and a climate of advocacy for channeling this resource back to the children should be at a high point. Then and only then can legislation be accompanied by real and meaningful action.

In general, regarding maternity legislation protecting breastfeeding, when the conditions are appropriate, the task will be to work towards implementation of the maternity legislation which already exists on paper. Regarding the marketing of breast milk substitutes, Haiti would need to develop its own code of marketing and to legislate regarding advertising, sales, substitute milk sample distribution, and such. It should be mentioned that currently there seems to be little awareness regarding WHO/UNICEF's Code of Marketing, even among health professionals working in maternal/child fields. Lerebours (1989) surveyed a group of 42 physicians (26 pediatricians, 16 obstetricians) and found that only 21% had heard of the Code; many of them however, reported they did recommend breastfeeding to their clientele.

B. **The Demonstration Component of the Strategy**

A second element of a national strategy, complementary to the integrated efforts just discussed, is to set up concrete and visible demonstration models. Two types of demonstrations are needed:

1. One of them involves demonstrating that Haitian children can thrive on exclusive breastfeeding and that maternal undernutrition is not a real obstacle;
2. The other demonstration would show how changes in hospital policies impact on the exclusivity of breastfeeding, and would serve as a training center and demonstration site for other hospitals.

1. **Demonstration One: Can Infants Grow Normally and Survive on Breast Milk Alone?**

Showing that children can grow and develop during the first three months of their lives only on breast milk and that these children get ill less often is important not only to Haitian mothers but to Haitian health workers as well. Under present nutrition conditions in Haiti, there is a great deal of disbelief. A concrete demonstration will provide not only an opportunity for documenting healthy growth even under present circumstances, but also will create a pool of women who might become local leaders and advocates on behalf of exclusive breastfeeding.

Out of these groups of women could come the mothers who can later give testimony by radio, TV, or other media; who can become the trainers of other mothers at rally posts; or who can form the nucleus for the mother-to-mother support groups so badly needed in local communities.

A pilot demonstration project. The first task of the demonstration project would be to document, hopefully with several hundred women from a variety of regions, that withholding of supplements (liquids and solids) until after the second trimester leads to healthier babies. Until this has been demonstrated behaviorally in a highly visible manner, there is little reason to hope that educational messages alone will suffice to bring about behavior change.

During the first phase of the demonstration, which must last at least one to two years, priority will be given to successfully motivating women (by convincing incentives) to withhold supplementary foods for several months after birth. During this phase, sustainability issues will be given a low priority. That is, the project will willingly "subsidize" the several hundred women who constitute the pilot non-supplementers, fully cognizant that such subsidies will have to be phased out after the effectiveness of non-supplementation has been demonstrated. Until that time, however, incentives and subsidies should be liberally provided.

Pregnant women in localized communities will be invited to participate in the project. Women who agree to participate will be told that the prime purpose of the program is to keep children healthy and alive after birth and that the prime measure is putting children to the breast within an hour of birth, breastfeeding on demand, and offering only breast milk during the first 3-4 months of their lives. Participation is totally voluntary.

Participants will form into small groups that regularly meet. The frequency of meetings and the locale will be decided upon during the project design stage. At the meetings women will be shown various types of educational materials or locally-tested health curricula, such as RICHES, may be used. In addition, during their pregnancy, incentives will be given, such as perhaps the waiving of fees for prenatal care. They will also be given other incentives during pregnancy and after delivery during the period in which they participate. The nature of these incentives will be decided during project design stage on the basis of pilot research into possible incentives.

Monitoring strategies of both mother and child will be set up. The health status of the mother and infant will be carefully monitored by regular weight surveillance and careful recording of any morbidity during the period in which mothers participate in the project, to make sure their growth is not faltering. Other well-baby interventions such as immunizations will be offered at the appropriate times. In addition, women themselves will be offered lactation support from the time they are pregnant, and especially during the critical first and second week postpartum.

Identifying the incentives. The prime motivating factor for delayed supplementation will eventually, we hope be the reduction in mortality and morbidity that derive from this new practice. But until these increased survival rates are attained, creative incentives must be provided to generate the new behaviors and to sustain them through the critical first months of the child's life.

There is a common programming tradition that places emphasis on the promulgation of educational messages as the prime vehicle of behavior change. While this is important, they must be combined with other measures and incentives, temporary program devices to motivate and sustain new breastfeeding practices until the predicted drops in neonatal

mortality/morbidity come. Once these drops actually occur as a clear result of the new practices, then the practices will catch on by themselves. But until that time, the program itself must build in various types of incentives to provoke and sustain the new behaviors and reasonable information-gathering techniques to monitor compliance.

In designing localized projects, designers should be on guard against the common tendency to allocate most of the budget to "delivery costs" -- e.g., salaries of trainers, training materials, etc. Village women are skeptical of work surveyors; they want to know sa map jwenn ("what's in it for me?"). They are very responsive to concrete material incentives. The localized project should be very creative in identifying material incentives to channel toward those women who show themselves willing to adopt non-supplemented breastfeeding.

The result of such a program will hopefully be groups of women in different parts of Haiti with higher infant survival rates than non-participating peers.

2. Demonstration Two: A Showcase Hospital

The second component of the demonstration strategy would be to demonstrate how changes in hospital policies impact on the exclusivity of breastfeeding. There needs to be a maternity hospital or ward where exemplary policies supportive of exclusive breastfeeding can be institutionalized. This hospital can serve not only as a research and demonstration center, but also as an active training center for staff from other institutions. In Haiti, the importance of maternity wards or hospitals does not lie in the volume of women they handle, for only 30% of all births actually take place in hospitals (Westinghouse, 1985). Rather, hospitals are important because of the kind of women that tend to deliver their babies there. There is a tendency among many rural and even urban women to have their first child at the hospital; once they ascertain that yo pa mal pou akouché (they have no trouble delivering a baby), they tend to have future children in their own homes (Alvarez & Murray, 1981; Berggren et al., 1981).

These young, first time mothers, are an extremely important group to reach: they show the highest tendency towards shortened breastfeeding and towards increased bottle feeding. And by the time women have begun using bottles and developing their own systems of feeding, it may be more difficult to change their infant-feeding behaviors, thus the importance of focusing on hospitals and maternity wards in Haiti.

The demonstration program could be set up at a hospital, possibly one of the large maternity hospitals in Port-au-Prince or in another town, whose staff upon being approached, demonstrate interest and commitment to the idea of instituting new norms and practices. A team from the hospital, or a combination hospital/MSPP team may receive specialized training (preferably at Wellstart), and then proceed on to conceptualize and implement a plan of reforms. An initial evaluation of hospital practices could be made using WHO/UNICEF's Check-List for Evaluating the Adequacy of Support for Breastfeeding in Maternity Hospitals, Wards, and Clinics presented in Appendix D. Modifications suggested for hospitals usually deal with policy, identification of a coordinator, instituting rooming-in, breastfeeding within the first hour following delivery, staff training, structure and functioning of services, health education and lactation support. A key indicator of impact to be monitored would be the percent of mothers exclusively breastfeeding on discharge from the hospital.

Caution should be exercised in evaluating a hospital's commitment to this process. A difference between Haiti and other countries is that in Haiti, hospitals do not normally provide bottles and substitute milk to patients; rather patients bring them along or procure them on their own once they are in the hospital. It is widely known that in Haiti, assorted hospital personnel (usually low-level) make it their business to sell bottles and substitute milks right in the hospitals, a practice that, to our knowledge, benefits them directly, rather than the hospitals. Thus, private initiative has flourished to fill a gap that hospitals, due to their own budgetary restrictions, had left void. This "parallel" market would have to be stamped out, if a program is to succeed. While hospitals in other parts of the world have restricted bottles only to justified medical cases, this would be meaningless in Haiti, for most hospitals -- while they sanction the use of bottles and ask mothers to bring them along -- do not actually provide bottles or milk.

Another related issue is that the economic incentives some hospital administrators have of saving thousands of dollars in formula and bottles, plus in sterilization and staff time, would not be so considerable in Haiti: these extras were never part of the "maternity package". Also, stays tend to be briefer in Haiti than the regular three days customary in other places, so in this sense, the saving in staff time and other expenses characteristic of longer stays, would not be so considerable either. Thus, the motivation has to come from less concrete payoffs, which might make it harder.

Another dynamic to be considered is the additional cultural barriers a Haitian hospital trying to implement change would run into once institutional modifications are ironed out: the prescribed internal and external cleansing routines for mother and child which are felt to be a prerequisite for breastfeeding initiation -- not included; postponement of breastfeeding for several days; belief in the need to feed water to babies. It seems many of these obstacles have been ironed out at Cité Soleil's St. Catherine Hospital, and a first step in any hospital norm-modification effort should include learning from Cité Soleil's experiences. In fact, the reason why I advocate learning from Cité but not making it the model site is because the "debugging" experience has to occur within a setting that is more typical of Haiti. When changes in hospital practices were instituted in Cité Soleil, St. Catherine was a small, almost brand-new facility servicing a geographically defined area in the context of comprehensive health services with innovative leadership, a serious commitment to breastfeeding promotion, and offering regular in-service training to its health personnel. The nature of the challenges and problems from hospitals handling larger and more heterogeneous populations, with extra-official substitute milk businesses in operations and handling women on a "one-shot" basis with no prior postnatal follow-up opportunity, may be altogether different from Cité Soleil and deserves closer scrutiny to ensure generalizability.

C. The Research Component

Especially with EMMUS 2 coming along soon, there seems to be adequate current statistical data regarding breastfeeding prevalence, duration and exclusivity that a breastfeeding effort need not gather independent baseline data of its own but can profit from what is already available. With appropriate planning, it can take advantage of research efforts such as EMMUS 2, to be conducted in the near future. Another source of indirect data comes from specific projects' own internal evaluations. More and more projects are including early infant feeding as a separate category and are gathering data to that effect. Research resources may be better spent on other endeavors, and in combination with the demonstration component here proposed. We can identify at least three areas in which research should be carried out.

1. Rapid Rural Ethnography

Our body of information on beliefs and practices concerning early supplementation is solid but geographically limited. If other demonstration groups are going to be set up in several areas, there is a need for rapid ethnographic information for a broad variety of communities, urban and rural. Such information can be rapidly gathered using tape-recorded focus-group methodologies. The interviews should be transcribed and a set of "propositional inventories" derived -- a corpus of statements embodying traditional beliefs of Haitians about the first months of their children's lives.

2. Incentive Identification

A special type of information about the types of program incentives that could be used to get women through several months of non-supplemented breastfeeding in defiance of local tradition is needed. A creative and rich menu of alternative incentives should be devised at project identification stage as well as the per-woman cost that will have to be budgeted to underwrite those incentives. This menu can be devised perhaps in conjunction with the focus group interviews mentioned above.

3. Program Monitoring

Once the project is underway, there will be a need for careful monitoring of the behavior of the project participants and of carefully recording and monitoring growth among the children and mothers' weight to make sure they are progressing normally and give periodic feedback to mothers. There would also be a need to document the differential biomedical outcomes especially in terms of morbidity for diarrhea and ARI found in children of non-supplementing and traditionally supplementing women. Length of lactational amenorrhea is another important outcome. These methodologies can be proposed during the project paper stage.

D. Information, Materials Development and Dissemination Component

This component of the strategy consists essentially of several kinds of materials: those to be used for informational purposes and those to be used for training. A third aspect concerns the issue of gathering those materials and disseminating them to interested parties. A communication specialist familiar with materials development is an important actor in this component of the strategy.

1. Information Materials

There is a need to inform the public as to the current situation in Haiti regarding early infant feeding and its detrimental consequences, and there is also a need to convey the goals and objectives of the strategy: breastfeeding with 24 hours of delivery and exclusive breastfeeding for the first three months need to be communicated loud and clear; a shift of complementary foods from the first to the second trimester also needs to be communicated unequivocally; and so is the message that cups and spoons, rather than bottles are safer for feeding complements. At the same time, there is a need to provide information, support, and advice for nursing mothers, for pregnant women, and for women of all ages.

While the emphasis on the strategy will be breastfeeding and early infant feeding, informational materials should cover a wider developmental field. Data from the most recent nutrition status survey (Bassett & Scanlon, 1990) show that children 12 to 23 months are in a serious nutritional predicament. Such topics as weaning, weaning foods, prolonged breastfeeding, frequent feedings, and efforts to dégagé (go out of one's way) on behalf of children can be addressed. The intent will be more motivational due to economic constraints. Yet there is a need to urge parents to go the extra length on behalf of their children.

In developing informational materials, care should be taken that they be geared towards non-literate or low-literacy groups. Thus, heavy reliance on words, cluttered pages, or incorporation of too many messages at once should be avoided.

If reading is required, the vocabulary should be limited to a low elementary level of difficulty to ensure readability and comprehension. If pictures are used, pre-testing is needed to make sure they are correctly perceived and interpreted. Picture recognition is sometimes taken for granted by people whose world is dominated by print. It is, however, a learned skill. Populations for whom two-dimensional pictures are not part of their everyday life can misperceive, fail to make out the image altogether, or simply perceive it and/or interpret it differently. Working in Haiti, Gustafson (1985) found that only 75% of village women in the research sample were able to accurately identify the picture of a mother and her breastfeeding baby; and only two mothers identified the picture of a pair of hands being washed. Pre-testing at all levels -- whether it be words or pictures -- should be the rule; the elimination of ambiguity should be the goal.

Informational materials need not be restricted to the visual realm, but should be expanded to use various mediums such as audials and videos. Among the most successful oral techniques tried out in health programs in Haiti are songs, krik/krak-type riddles, and skits. The latter are already part of the popular repertoire and verbal folk lore and have been a proven way of transmitting information. There may also be potential for stories.

Another aspect in materials development and/or adaptation has to do with content. There has to be agreement as to what content needs to be communicated both in general information and in training. There also has to be a sense on how already existing materials coincide or differ from that basic corpus of information. For instance, in using Konesans Fanmi's materials from the point of view of breastfeeding, some information would need to be added. At 0-3 months: first-day breastfeeding, exclusively breastfed infants do not need water or other liquids, the more an infant sucks the more milk a mother produces, mothers rather than infants should get supplements during the first trimester. At 3-6 months: additional emphasis on beginning to introduce complements, but giving priority to breastfeeding; continuation of breastfeeding during diarrhea episodes. At 9-12 months: again the continuation of breastfeeding would be emphasized to make sure the message gets communicated. Other concepts such as let gate or insufficient milk would also be inserted at some point in the sequence. While some materials may need additions, others can be readily used, such as DSPP's An nou okipé timoun yo byen, pou yo kapab profité, presented in Appendix C.

2. Training Materials

There is a need for training materials at every level. Materials are needed in conjunction with the different levels of training: physician/nurse, auxiliaries, health agents. They are also needed for the training modules, workshops, seminars or conferences. Though geared towards a more select group, some of the aspects mentioned under information also apply to training. In addition, health workers need to have materials with which to do their work. It is important they be given the tools to make their own teaching more meaningful and effective.

3. Dissemination

Given the numerous PVOs currently working in the areas of health and education in Haiti, and given the variety of programs they sponsor, it is important to track down and collect all information and materials related to breastfeeding and to early infant feeding that can have programmatic relevance. Whether it be statistics, research, audios, videos, songs, riddles, demonstrations, conference, training, recipes for weaning foods, whatever: a sort of local Clearinghouse on Breastfeeding and Early Infant Feeding. Another important element in this effort would include gathering books, articles, newsletters or pamphlets produced outside of Haiti so as to begin putting together a modest resource library. Breastfeeding is an area where a great deal is happening at this time and it is essential to consolidate this information.

But more important is the idea of keeping track of Haitian activities and experience, to keep a record of what is being tried, what has worked, what has failed, so that in-country expertise can be built upon. For instance, while interviewing a group of village mothers, I came across a rather unpublicized project. One young woman mentioned that every Thursday, a group of health people came to the community to offer health consultations and to conduct a mother's group for young pregnant women. The young woman then proceeded to show me the little booklet they had used to teach her some basic child care lessons (well designed, accurate, dealing with key infant feeding topics but clearly very low-budget) and the little diploma she had received at the end of the eight session. There is a great deal happening in Haiti, and there is a need for programs to learn from and to feed into one another so as to avoid duplication and improve service delivery.

A mini-clearinghouse, geared to collect and track down all that concerns this particular area, can be of great use. A newsletter could be one of the tools through which interested parties can be kept abreast of what is happening in other parts of Haiti, in other programs, and what resources have been added to the clearinghouse.

E. Implementation Component: The Search for a Focal Point

The most delicate yet crucial aspect of the whole initiative is the identification of key personnel and of the appropriate institutional channels for supporting a national breastfeeding promotion effort in Haiti. To ensure its chances of success and survival over time, and in keeping with the complexity of an issue that links together cultural practices, belief systems, environmental sanitary conditions, health and education issues, economic concerns, small micro economic aspects of family budget and large financial interests of milk substitute importers, the strategy can be best conceptualized as a cooperative effort among several institutions: public and private, bilateral and national health or education-oriented. But the effort should not burden any one institution unduly, because each institution has its own functions to perform.

One of the ways through which institutions could be linked together is by creating an Inter-Agency Committee on Breastfeeding. Based on the principle that involvement in planning brings commitment to implementation, the intervention should count with the support of an initial nucleus of institutions who have demonstrated interest in this area and who preferably have already taken steps regarding breastfeeding promotion. Each group could designate a breastfeeding person, to represent them at the Inter-Agency Committee. The Inter-Agency Committee could have a full time technical coordinator, possibly sponsored through one of USAID's contractors such as MotherCare, and housed within an existing structure.

We are proposing a breastfeeding strategy for Haiti that has both horizontal and vertical components. Thus, some aspects can stand on their own and might be implemented by several institutions as separate pieces in a puzzle that will then all interlock together to reinforce a common goal. A collaboration on behalf of breastfeeding in Haiti might initially look like this:

- PAHO/WHO might be uniquely suited to work in the area of curriculum development on which they already have expertise. In fact, PAHO/WHO is currently collaborating with the MSPP in elaborating the new TBA-training curriculum in which a strong lactation component could be inserted. Curriculum modification efforts could also be extended to pre-service training of students currently enrolled in medical and nursing schools: Incorporation of a lactation component in training of such health workers is vital to the overall strategy.
- UNICEF might assist in development of educational materials for both information and training purposes and in legislative/policy issues. In the first aspect, it already has an expertise in Haiti; in the second aspect, it has expertise in other countries.
- The MSPP, through its various divisions, might be uniquely suited to undertake the modification of maternity hospitals and wards (which initially will be an intensive one-center experimental effort), and the training of health agents, collaborators, and TBAs. In fact, MSPP is currently revising its whole TBA training program; the time is auspicious for inserting a strong breastfeeding component into this revised curriculum. Similar revisions can take place for the training of health agents.
- INSHAC, with its experience in in-service training of health care professionals, might be responsible for the training of physicians, nurses and auxiliaries, and for development of materials geared towards teaching those trainees.
- The IHE might provide technical assistance in all stages of the process, especially in elaborating the demonstration and research components and in linking breastfeeding/early infant feeding to ongoing research activities. IHE might also be a conduit for identifying ways in which individual Child Survival projects can insert a breastfeeding component into their overall child survival strategies.
- CARE, or another PVO with experience in face-to-face health education of mothers and/or in organizing mothers, might be an appropriate conduit for the demonstration component of the initiative. As part of this component a group of mothers will be asked to voluntarily withhold any complements and will be provided pre- and postnatal health monitoring.
- Konesans Fanmi, through its wide network of institutions throughout Haiti might provide the conduit for facilitating a national outreach.
- Professional organizations such as the Société Haïtienne de Pédiatrie, which have taken a standpoint and fueled the momentum for breastfeeding in Haiti, might want to identify their own role in the overall initiative.

- Financial support for various aspects of the initiative might come from USAID and its own resource-channelling network assisting in the worldwide breastfeeding effort promoted by AID/W in coordination with other bilateral agencies around the world. The Washington-based Manoff Group, with experience in social marketing research, through MotherCare may take up the focus-group component for rapid ethnographic assessment and incentive identification. Another role for these agencies would be to provide a communication specialist that can assist in developing materials for both informational and training purposes. Funding for sending one -- and possibly another team at a later date -- for Wellstart training would also have to be negotiated with USAID.
- USA-based MotherCare, whose parent institution John Snow, Inc, already has a presence in Haiti through REACH, might exercise a coordinating role through the local hiring of a person who can serve as coordinator/promoter of the overall effort. Part of this coordinating function would be to establish a modest clearinghouse on information regarding breastfeeding and to gather materials or initiatives already developed and field tested. The coordination of the Inter-Agency Committee on Breastfeeding might also rest with this locally-hired person. Commitment and adequate technical skills would be prerequisites for a person in that role.
- The US-based Clearinghouse on Infant Feeding and Maternal Nutrition might provide technical assistance in helping establish a mini-clearinghouse on breastfeeding and early infant feeding in Haiti.

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APPENDIX A
EDUCATIONAL MATERIALS FROM CARE'S PROJECT RICHES

**Gid kolaboratris
pou fè edikasyon
nan domèn lasante**

RICHES – CARE

1989

Moun ki te patisipe nan devlopman gid sa a:

**Amélie Charles, Rose Marie Chérilus, Ann C. Devine, Ghislaine Dumorné, Phillip Hall, Irlande P. Irène,
Rita Jean Joseph, Debbie Kallina, Wendy Lowe, Susanna Molnar, Linda Neufeld, Andronique Pierre,
Kim Puterbough, Ines P. Quitel, Laura RoCHAT, Shelagh O'Rourke, Helen Welle.**

Developed by RICHES – CARE

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Rezimen tout sak nan gid la

Leson pou fanm ansent

Manje pou fanm ansent	Paj 7
Vaksen tetanòs	11
Preparasyon pou akouchman	13
Premye lèt se pi bon lòk	17
Siy danjere pou fanm ansent	19
Vitamin A	23

Leson pou fanm nouris

Manje pou fanm nouris	25
Vaksen timoun	29
Peze timoun regilyèman	31
Manje pou timoun ki gen dyare	37
Sevraj	39

Leson pou fanm ansent ak fanm nouris

Vitamin ak fè	41
Enpòtans lèt manman	45
Dechouke bibwon	47
Sewòm nan bouch	51
Resèt Sewòm yo	53
Leson pandan vaksinasyon fanm	55
Leson pandan vaksinasyon timoun	

Manje a 3 Mwa

An nou pataje eksperyans nou:

1. Ki manje yo konn bay pitit yo lè yo fèk fèt? Ki lòt manje yo konn bay tibebe anvan li gen 3 mwa?

Mesaj kle:

Lèt manman gen tou sa tibebe a bezwen pandan premye 3 mwa. A 3 mwa gen yon kalite manje pou chak laj timoun nan rive.

Metòd: Ti koze, maryonèt.

Depi lè tibebe a fèk fèt jiska lè li gen 3 mwa, li pa bezwen anyen anplis tete a. Lèt manman an gen tou sa li bezwen ladan pou li byen devlope.

Bay tibebe a tete lè li vle li.

Lè bebe a gen 3 mwa jiska 6 mwa, li ka kòmanse manje ti manje. Li ka kòmanse bwè labouyi likid ki fèt ak farin mayi, diri, ou manyòk ki kwit ak lèt. Fig mi ak papay kraze bon tou. Nou ka ba li ji fwi. Bay manje ak ti kiyè e ti gode byen pwòp espesyal pou bebe a sèlman. Kontinye toujou bay bebe a tete.

Lè tibebe a gen 6 mwa jiska 9 mwa li ka kòmanse manje legim byen kraze. Mayi, pitimi ak diri byen kwit tou. Bay bebe a manje ki fèk kwit pou li pa manje manje dòmi. Manje dòmi ka bay bebe a dyare. Bebe a toujou bezwen tete a.

Lè bebe a gen 9 mwa jiska 12 mwa nou gen dwa bay bebe a vyann byen kwit, byen kraze ak legim. Tout kalite viv byen kwit ak lèt, bon anpil pou bebe a. Ba li AKAMIL tou, se yon manje konplè.

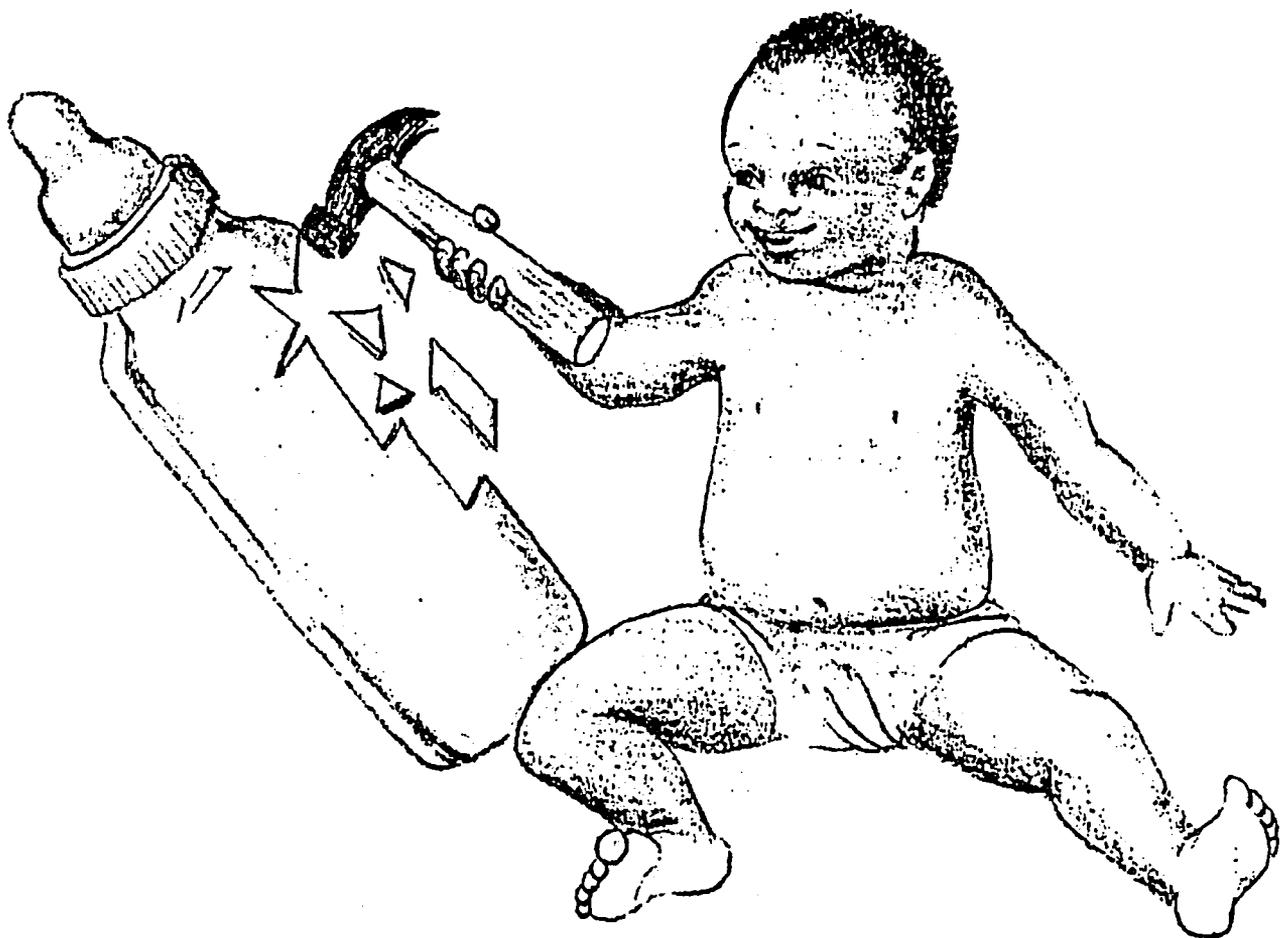
Kontinye sèvi ak yon ti kiyè ak ti gode pou bebe a sèlman. Epi li enpòtan pou nou kontinye bay bebe a tete toujou. Apre timoun nan gen 1 an, li mèt kòmanse manje nan manje granmoun, men nou pa dwe mete anpil epis ak anpil grès. Manman yo, bay timoun nan tete pou li pwofite toujou.

Kesyon:

1. Ak kisa nou dwe nourir pitit nou jis lè yo gen 3 mwa?
2. Ki lè nou dwe bay tibebe a tete?
3. Nan ki laj yon bebe kab kòmanse bwè labouyi ak manje ti manje?
4. Ki ti manje nou gen dwa ba li a 3 mwa?
5. Nan ki bagay pou nou mete labouyi a?
6. Ki lòt bagay pou nou ajoute lè li gen 6-9 mwa?
7. Eske yon manman gen dwa sispann bay timoun nan tete paske bebe a manje?
8. Ki jan pou nou prepare vyann, legim ak viv pou li, lè li gen 9-12 mwa?
9. Poukisa yon bebe dwe manje manje ki fèk kwit?
10. A ki laj bebe a ka manje jòn ze? A ki laj li kab manje yon ze antye?

Aplikasyon:

1. Pitit ou pral gen 3 mwa. Ki manje ou pral ba li lè sa a?



An nou pataje eksperyans nou:

1. Konbyen manman ki konn achte bibwon lè yo pral akouche?

Mesaj Kle:

Pou pwoteje timoun nou kont dyare, annou dechouke bibwon.

Metòd: Istwa, pyès, teyat.

Si ou bay timoun ou bibwon, li gen dyare pi souvan. Bibwon an gen anpil mikwòb ladan e yo bay timoun dyare. Bibwon konn lakòz anpil timoun mouri.

Bibwon pa gen avantaj ditou ditou. Fò ou fè anpil efò pou kenbe yo pwòp. Ou bezwen yon pakèt kòb pou achte tout chabon pou bouyi yo e pou achte lèt ak sik pou mete nan bibwon. Ou pa gen pou peye senkòb pou lèt manman e li toujou pwòp.

Pou timoun yo pa gen dyare fasil pa janm ba yo bibwon. Bay timoun manje, ji, lèt, dlo nan yon gode ak yon ti kiyè espesyalman pou timoun nan manje oubyen likid nan gode ak ti kiyè. Lave yo byen pwòp e sere yo.

Kesyon:

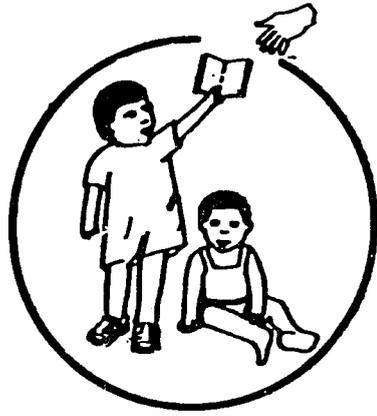
1. Poukisa pitit ou ap gen dyare pi souvan si ou sèvi ak bibwon?
2. Esplike ki jan bibwon fè ou depanse youn pakèt kòb.
3. Ki avantaj lèt manman genyen?
4. Nan ki sa pou nou bay pitit nou manje oubyen bwè lèt?
5. Ki jan pou nou okipe gode ak ti kiyè a?

Aplikasyon:

1. Lè pitit nou fin gen 3 mwa ak ki sa ou pral sèvi pou ba li manje?

APPENDIX B

**SAMPLE MATERIALS FROM
KONESANS FANMI SE LESPWA TIMOUN**



Ti Liv Pou Fòmasyon Paran

Sante ak
Devlopman
Timoun

KONESANS FANMI SE LESPWA TIMOUN

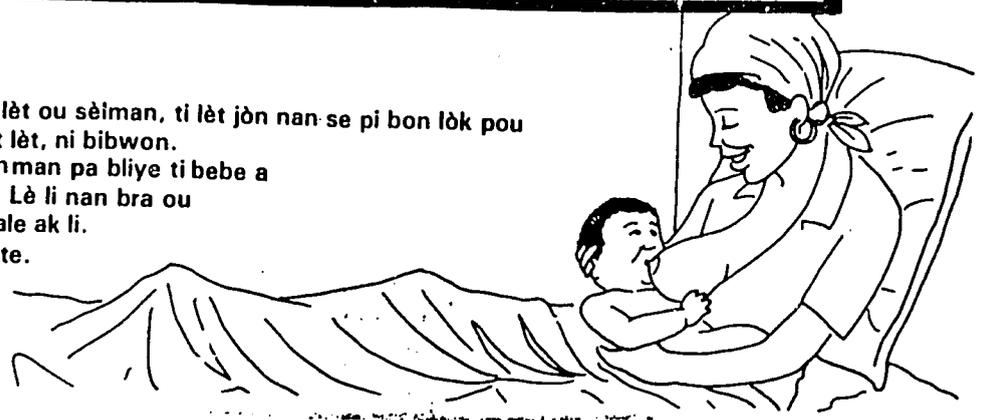


Urive mwa

ak Devlopman Timoun

KONESANS FANMI SE LESPWA TIMOUN

Depi mwen fèk fèt ban mwen lèt ou sèiman, ti lèt jòn nan-se pi bon lòk pou mwen. Mwen pa bezwen ni lòt lèt, ni bibwon. Ban mwen lèt ou tout tan. Manman pa bliye ti bebe a depann de ou pou tout bagay. Lè li nan bra ou li santi l byen, gade l nan je, pale ak li. Pi bèl plezi l, se lè w ap ba l tete.



Ban mwen tete souvan. Kò mwen gen pou li gwosi jou apre jou. Men sa ou dwe fè pou gen anpil lèt. Ou bezwen bwè anpil dlo epi manje pi plis. plis mwen rale tete, plis w ap gen lèt.



Ti kò mwen fèb anpil, mwen bezwen pwoteksyon. Depi mwen fèt, menmen m al pran vaksen BCG kont maladi tibèkilòz (pwatrinè).



Depi mwen rive sou 6 semenn, mwen bezwen pran premye dòz vaksen polyo ak DTP. Fòk mwen pran 3 dòz vaksen sa yo pou yo pwoteje m kont maladi polyo, koklich, tetanos (kò rèd) al difteri. Ti dyare, ti la fyèv, ti tous pa ka anpeche m pran vaksen. Pa bliye vaksen gratis.



Mwen fèk fèt, se vre, men mwen konnen anpil bagay deja, menm si ou wè m ap dòmi anpil. Mwen konn tete pou kont mwen, ou pa bezwen aprann mwen. Si kouchèt mwen sal ak si mwen grangou, nan jan pe mwen ma p fè ou konnen se, m ap kriye. Mwen tandè bwil, mwen wè si fè nwa, si l fè klè. Mwen wè tou si koulè pa menm. Sa k pi bòl la, mwen ka kenbe rad ou byen di ak dwèt mwen.

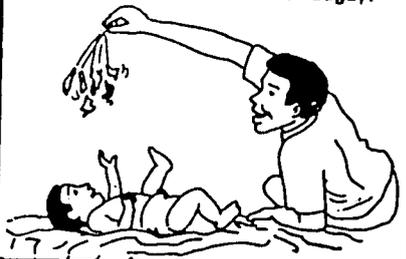
Mennen m chak mwa al nan sant. pou pran pèz mwen pou mwen ka toujou an sante.

Mwen poko konn pale se vre, mwen poko konn mache se vre tou, men se yon moun tout bon mwen ye deja. "Timoun sa moun". Kidonk, pandan w ap okipe mwen pale ak mwen, jwe ak mwen, karese mwen.

Ti kò m bezwen anpil swen, pwòpte, lave kò mwen, lave cheve m, chanje kouchèt mwen souvan, pa janm kite m pou kont mwen.



Sa mwen konnen deja, mwen pral aprann sèvi avèk li : m ap gade, m ap tandè lan-touraj mwen, mwen kòmanse vie manyen sa ki bò kote m. Tout bagay m ap wè, m ap tandè, m ap manyen fè tèt mwen travay. Se konsa lespri mwen ap devlope. Fè m pran lè, fè mwen wè divès lòt bagay.



Sou twa mwa, mwen rekonèt figi moun. Depi ou panche sou mwen w ap gade m w ap pale ak mwen, m ap scuri ba ou.



"PLIS MWEN PITI, PLIS MWEN BEZWEN SWEN: BAN'M TETE, VAKSINEN'M"



Illustration: Jean-Marie Charpentier - Dessin: Guy Lecomte - Illustration: Catherine Mouchon

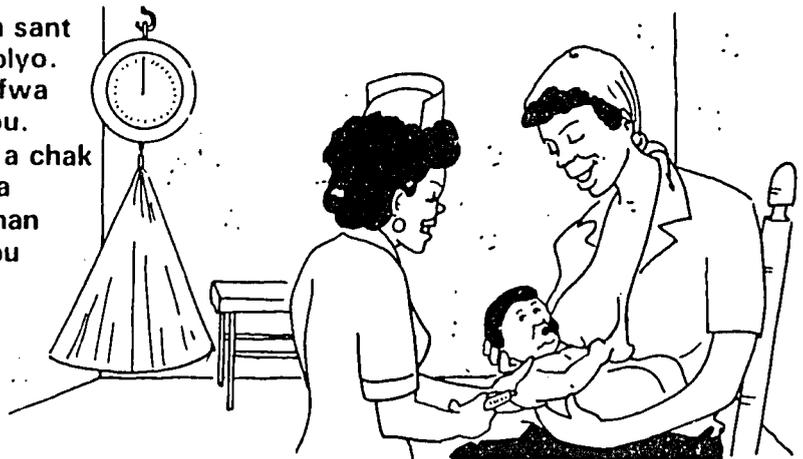
3ive 6mwa

Sante ak Devlopman Timoun

KONESANS FANM! SE LESPWA TIMOUN

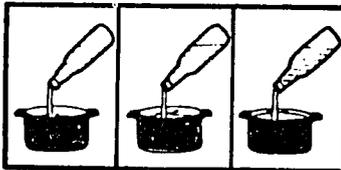
Sou 2 mwa edmi, pa bliye mennen m nan sant lan al pran dezyèm dòz vaksen DTP ak polyo. Kounye a, mwen fèt pou mwen peze de fwa pèz ke lè m te fèt. M ap gwosi jou apre jou.

mwen al peze nan sant ki pi pre a chak mwa pou wè si ma p pwofite. Kontwòle sa nan kat chemen la sante mwen. Lèt manman toujou bon pou mwen. Manman, se lèt pa ou la menm ki bon pou mwen.



Bibwon ak veso sal ka ban m dyare. Dyare se maladi ki tiye anpil timoun paske yo pèdi dlo ak anpil lòt bagay ki nesèsè pou kò yo.

Depi ou wè m pou pou dlo, menm si se yon sèl fwa, ban m bwè anpil dlo, anpil ji ou anpil rafrechis oswa sewòm oral.



Men kijan ou prepare sewòm oral: plan yon boutèy kola vid byen pwòp 3 fwa ak dlo pwòp, vide l nan yon veso pwòp, lage poud ki nan sachè sewòm oral la nan dlo a epi brase l byen.



Kounye a, timoun nan pa pase tan l ap manje, dòmi sèlman, Je l byen klere, li kòmanse fè yon dal bagay ak kò l, pye l, men l, li ka chita si ou mete yon zorye dèyè do l.

Li seye atrap, li atrap tout bagay ki bò kote l.

Gen yon seri mouvman li pase tan l ap refè yo. Se aprann l ap aprann. Tankou nan jete, ranmaso: l ap aprann sèvi ak men l.



Nan fè, refè mouvman, yon lòt bagay li fè souvan: li met tout bagay ki tonbe anba men l nan bouch li.

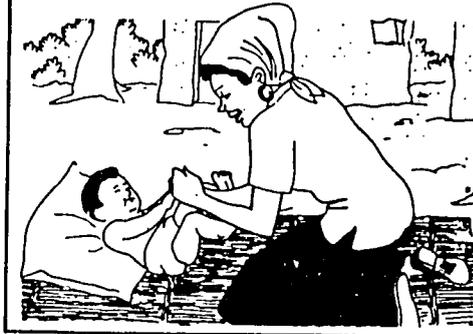
Sonje se nan bouch li li jwenn pi gran plezi pa l.

Si ou wè yon timoun pa vle manje, pa fòse l. Chèche konprann poukisa.

"Pa kite bagay sal al nan bouch li.



Bezwen timoun nan chanje; nou wè jan li vinn konn fè yon dal lòt bagay ak kò l, ak pye l, ak men l. Se vre, men se yon timoun piti li ye toujou. Li toujou bezwen manman l. Li toujou depann dè li pou tout bagay. Toujou kontinye okipe l, men kite l dekouvri sa ki alantou l.



Ou ka kòmanse ban m ti ji, ti bouyon fèy, ti bouyon viv ak ti lahouyi farin.

Se pou ban m manje ak ti kiyè byen pwòp ou byen ti gode byen pwòp. Ou pa bezwen sèvi ak bibwon pou mwen.



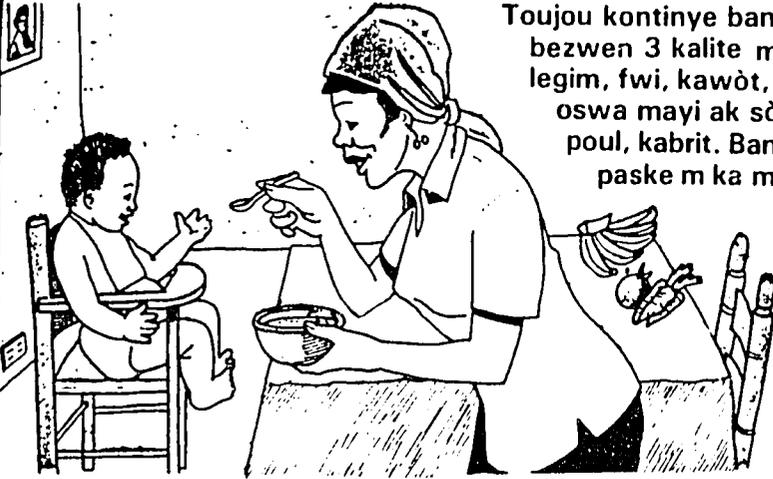
"SWEN M, PRAN KA M, RENMEN M: TI PYEBWA BEZWEN ROUZE POU LI POU SE"

unicef

6 9 rive mwa

ak Devlopman Timoun

KONESANS FANMI SE LESPWA TIMOUN



Toujou kontinye ban m tete. Pou m byen devlope, mwen bezwen 3 kalite manje sa yo: manje ki pwoteje kò m, tankou: legim, fwi, kawòt, tomat, fig; manje ki bay fòs, tankou: diri, oswa mayi ak sòs pwa; manje ki bati kò: vyann, ze, lèt, poul, kabrit. Ban m bouyon legim, ze, fwi, mayi moulen, paske m ka manje gwo manje ki gen sèl.

Lè yon timoun pa kenbe yon bagay nan men l ou lè li pa wèl, li pa konn si l la toujou. Se pou sa nan jwe li renmen lage l pou l pèdi l pou l ranmase l ankò.

Lap chache konnen kouman li fè la toujou paske li te disparèt. Se menm jan lè l pa wè manman l, lè manman l pa bò kote l, li konnen li pèdi l, li kriye. Se pa kapris l ap fè.



A laj sa a, non sèlman li konn figi moun, men li rekonèt trè byen figi moun ki nan lantouraj li ak figi moun ki okipe l.

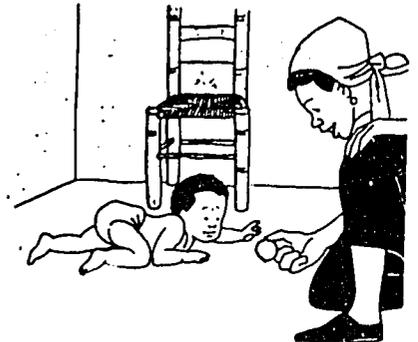
Lè yon figi li pa rekonèt parèt sou li, li fè l pè. Li ka menm kriye.

Pa lege l konsa nan men moun li pa konnen.



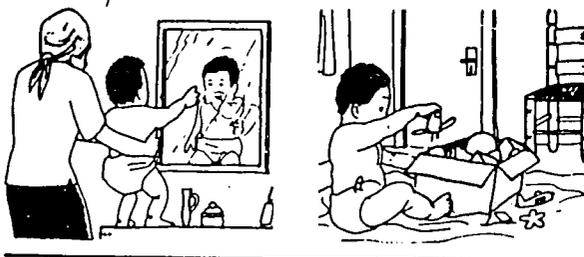
Timoun nan chita fèm e li kòmanse rale. Sa pèmèt li dekouvri yon dal lòt bagay pou kont li. Kenbe kay la pwòp, koupe ti zong li ak yon ti sizo pwòp pou li pa kenbe kras; kenbe l pwòp.

Pa rete l sou kous li, men veye l tout tan; gen danj; ti wòch, dife, eks...



Menm jan timoun nan kapab rekonèt figi moun nan lantouraj li li ka rekonèt tèt li nan yon glas. Sa fè l sezi, li ri.

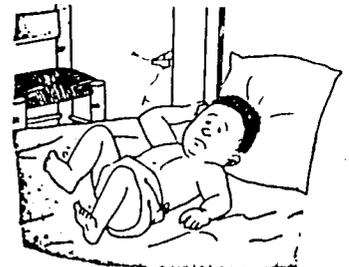
Tou sa fè tèt li travay, li kòmanse chache sa pou l fè lè l bezwen pran ou byen lè l vle yon bagay.



Sonje, manman: yon chodyè pa kanpe sou de wòch. Sou 6 mwa, si mwen poko pran twazyèm dòz vaksen ditepè ak polyo, se lè pou mwen al pran yo.



Si mwen mal manje, men sa k ap rive pye m ap plèn, figi m ap anfle, po m ap chanje koulè, cheve m ap kase fasil e m ap chagren. Yo rele maladi sa a malnitrasyon. Si mwen gen lafyèv, si souf mwen kout, mennen m nan sant ki pi pre a, pa pèdi tan.



**"DEPI'M POUPOU DLO:
BAN'M SEWOM ORAL KI ANPECHE TIMOUN SECHE ANBA DYARE"**

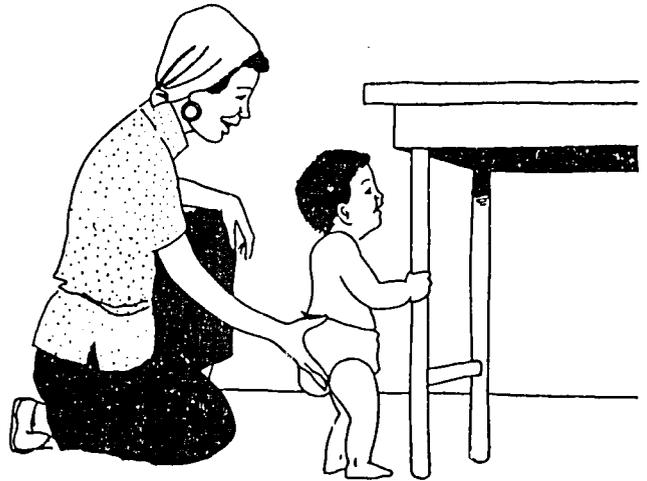
unicef

9 12 Grive 12mwa

ak Devlopman Timoun

KONESANS FANMI SE LESPWA TIMOUN

Timoun nan kanpe, men li bezwen yo ede l anvan l kapab fè l pou kò l. Lè ou kenbe men l, li pa pè, sa ede l vanse.
Kenbe men l pou l pran fòs.



Tout bagay nèt sa yo ke timoun nan vinn konn fè, sa mande enkourajman ak aplodisman pou li ka kontinye pi devan.

Timoun nan konn di kèk mo, li konprann sans mo pa ou yo tou.

Pale ak li, chante pou li.

Gen yon lòt jan timoun aprann tou. Se nan gade sa granmoun ap fè pou yo fè menm jan ou byen nan repete sa ou aprann li fè.

Aprann li fè si lès ak ti lwèt.



Chak jou, kò m bezwen divès kalite manje.

Ban m manje ki kab pwoteje m, tankou fwi, legim, fèy vèt ak lòt. Ban m manje ki bati kò m tankou vyann bèf, poul, pwason, ze.
Ban m manje ki kab ban m fòs tankou mayi, pwa, pitimi, biskwit ak lòt kalite viv.

Yon manje ki trè enpòtan pou mwen, se AKAMIL. Li fèt ak 2 mezi mayi, diri oswa pitimi epi yon mezi pwa. Tout moulèn ansanm pou fè yon farin. Farin sa a nourisan anpil.



Lè m pa pwofite, ban mwen plis manje. Ban m tou sa mwen renmen. Chak mwa lè ou mennen m el nan pèz, toujou vini ak kat chemen lasanta mwen pou wè si m ap pwofite. Pa pèdi l.
Se nan kat chemen la sante m pou wè si m ap pwofite.
Pa pèdi l. Gade l tankou batistè m.

Kounye a mwen gen nèf mwa mwen kab gen saranpyon, maladi lawoujòl. Mennen m pran vakson ki pou pwoteje m kont maladi sa a. Vakson sa a, se yon sèl dòz ki nasesè.



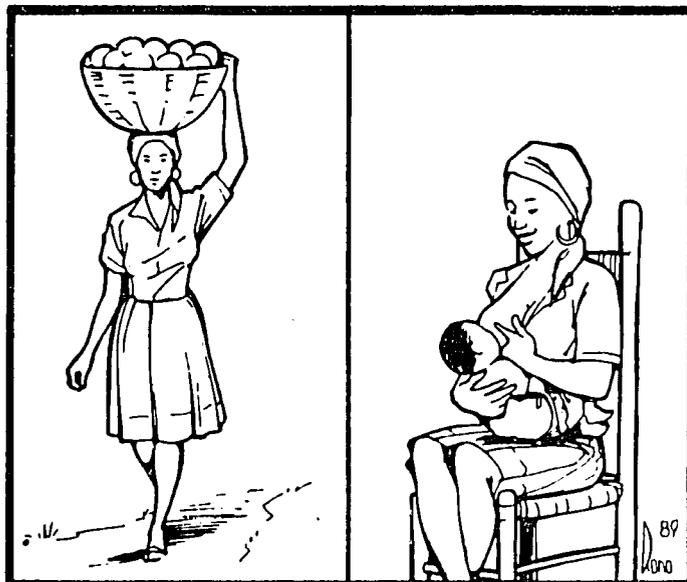
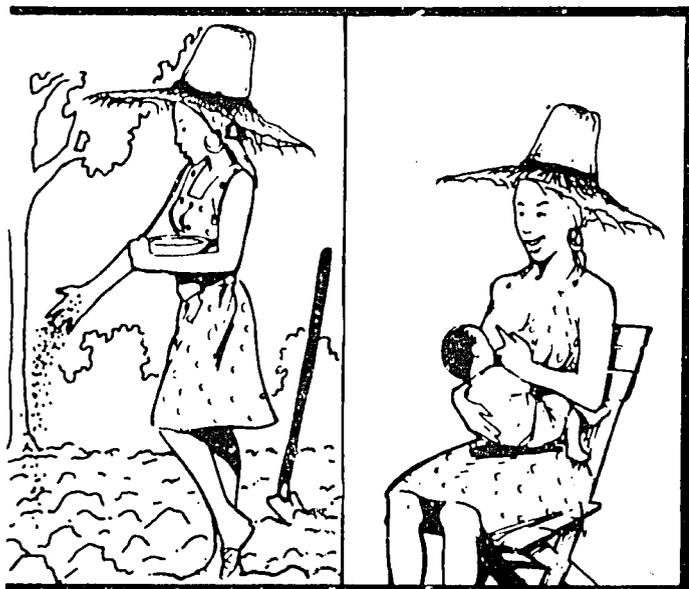
"RALE, KANPE, MACHE: VEYE'M PA FRENNEN'M"

APPENDIX C

MSPP MATERIALS WITH BREASTFEEDING PROMOTION EMPHASIS

68

TOUT MANMAN KA BAY TETE



LÈT MANMAN PA GEN PARÈY

CHEMEN LA SANTE

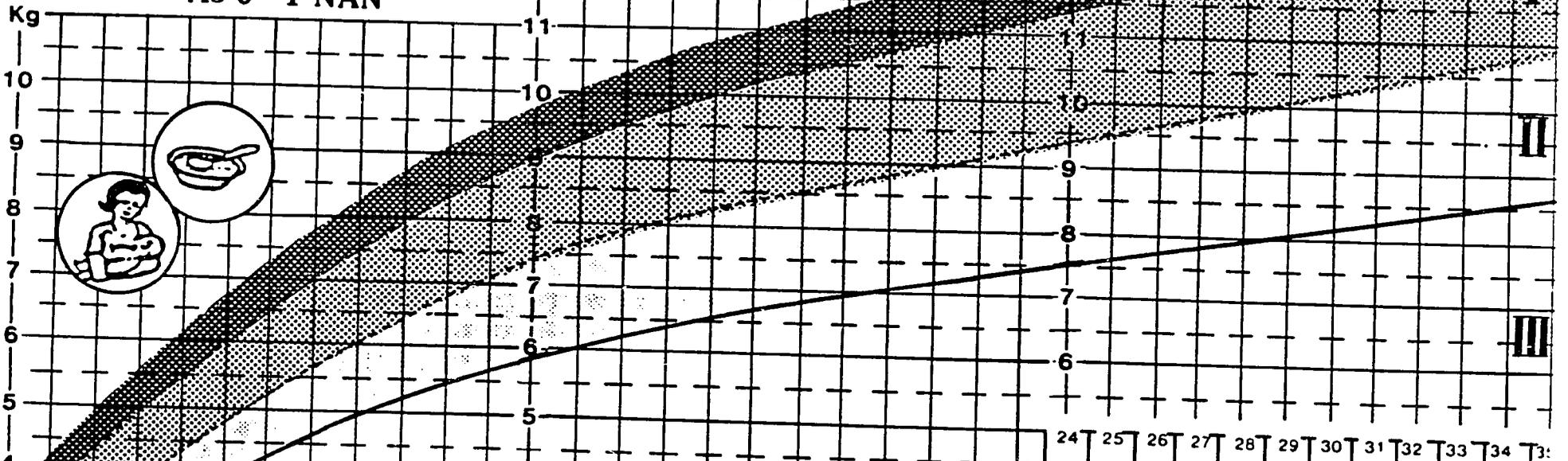
AJ 2 - 3 ZAN

BAY TIMOUN YO TETE

Lèt manman se pi bon lèt

AJ 1 - 2 ZAN

AJ 0 - 1 NAN



ANE	2	1	2	3	4	5	6	7	8	9	10	11
MWA												

	12	13	14	15	16	17	18	19	20	21	22	23
--	----	----	----	----	----	----	----	----	----	----	----	----

	24	25	26	27	28	29	30	31	32	33	34	35
--	----	----	----	----	----	----	----	----	----	----	----	----

KONBLE KOLO-N SA AVEK MWA E ANE TI MOUN NAN FET LA.
KONBLE LOT KOLO-N YO AK TOUT MWA KI SWIV YO

- Ti moun sa profite
- Ti moun sa pa profite
Ball plis manje
- Ti moun sa mafad
Bali plis manje e
minnin li nan sant

Kijan pou nou prepare seròm nan bouchel nou pa jwenn sachèl pars ?

- Mete ansanb nan yon veso pròp :
- 3 boutèy kola vid plen dlo pròp [se yon lit dlo] e yon ti kiyè byen kraze
- 2 gro kiyè sik
- kèk gout ji sitron

[seròm sa-a pa dwe genyen ni gou sik ni gou sè].

13

Comment est-ce que nous devons préparer la nourriture de l'enfant ?

- Nous devons placer les aliments de l'enfant à part dans une assiette, ensuite les écraser.
- Il faut lui donner sa nourriture avec de la sauce, l'enfant mangera avec plus d'appétit si la nourriture a un peu de graisse, de légumes.

14

Quand pouvons-nous sevrer un enfant ?

- Nous pouvons sevrer un enfant quand il a 18 mois, lorsqu'il se développe bien et qu'il est habitué à prendre toutes sortes de nourritures.

15

Que peut-on donner à un enfant qui vient d'être sevré ?

- On peut lui donner du lait de vache pour remplacer le lait maternel.
- Il faut prendre soin d'avantage de lui pour éviter qu'il ne soit triste.
- Donner lui beaucoup plus d'aliments pour qu'il puisse grandir.

16

Que peut-on faire lorsqu'un enfant n'a pas d'appétit ?

- L'enfant aura plus de goût à manger si la nourriture est variée et si le repas lui est servi avec d'autres enfants.
- Il faut être très patient avec l'enfant.
- Si le problème continue, emmenez-le au dispensaire.

Am nou okipe
tîmoun yo byen,
pou yo kapab profite



Depatman Sante Piblik ak Popilasyon
Direction Edikasyon Sanitè ak Antrenman

JANVYE 1984 --

Utilité de ce livret

Vous pouvez utiliser ce livret pour apprendre aux autres comment prendre soin de leurs bébés pour que ceux-ci puissent grandir en santé.

Les questions et les réponses que vous trouverez dans ce livret vous aideront à animer les discussions pour que les gens comprennent :

- l'importance de l'allaitement maternel ;
- les dangers du biberon ;
- l'alimentation de l'enfant de moins de 3 mois ;
- l'alimentation de l'enfant de plus de 3 mois ;
- la façon appropriée de sevrer l'enfant.

Utilité ti liv sa-a

Ou kapab sèvi ak ti liv sa-a pou ou aprann lòt moun kijan pou yo okipe timoun yo byen pou yo profite epi pou yo byen vini.

Kesyon ak repons yo ou wè nan ti liv la se pou ede ou fè diskisyon ak moun yo pou yo konprann :

- enpòtans lèt manman ;
- danje ki genyen nan bibon ;
- ki manje nou bay timoun ki poko gen 3 mwa ;
- ki manje nou bay timoun ki gen plis ke 3 mwa ;
- kijan nap sevre timoun yo.

NOTE : Voir page 12 pour le texte en français

Jan pou nou konseye yon manman ki fèk akouché

1 **Ki manje ki pi bon nouriti pou ti bebe ?**

Se lèt manman ki pi bon nouriti pou ti bebe.

2 **Poukisa lèt manman bon anpil ?**

- Lèt manman se fòtifyan.
- Lèt manman gen anpil bon bagay ladan-l ki pou proteje timoun nan kont dyare ak infeksyon.
- Lèt manman kap kenbe timoun toujou an sante.
- Lèt manman tou pare.



Lèt manman pa koute anyen

3

Kilès nou dwe kòmanse bay timoun nan tete?

- Bay timoun tete menm jou li fèt la paske premye lèt manman se bon manje, se yon bon lòk tou.
- Lèt manman se sèl lòk ki bon pou ti bebe-a.

4

Ki prekosyon pou manman pran avan li bay timoun nan tete?



— Manman dwe lave tete li chak fwa ak dlo yon twal prop, epi byen rinse li.

5

Eske lèt manman sifi pou timoun nan pandan twa (3) premye mwa yo?

- Wi, jiskaske timoun nan gen twa (3) mwa, lèt manman sifi pou kenbe li an sante.
- Li pa bezwen lòt manje, paske nan manje sa yo ka gen mikròb kache ki kapab fè timoun nan malad.

6

Si nou oblije bay timoun lòt manje kisa pou nou fè?

- Se labouyi fèt ak lèt nou kap bali, se ji fwi.
- Menm lè nou fin bay labouyi, se pou nou bay timoun nan tete tou.
- Nou bali sèlman manje ki fèk kwit. Manje dòmi kapab fè li malad.
- Nou bali manje avèk yon ti kiyè oubyen yon gode byen prop.



Sa pou nou fè lè yon timoun ki piti ke 3 mwa pa profite

- Bibon mande anpil preparasyon, anpil pròpte. Nou pa konseye manman sèvi ak li. Mikrob ki bay maladi kap grandi fasil ladan li.
- Timoun ki manje nan bibon malad trè souvan.
- Se pou nou bay timoun nan manje ak yon ti kiyè oubyen yon gode byen pròp.



- Se pou nou bali tete plis epi pi souvan.

7

Kisa nou fè si manman pa gen anpil lèt?

- Manman dwe kite timoun nan rale tete-a. Plis piti la rale tete-a, piis manman ap gen lèt.
- Manman-an bezwen byen manje e bwe anpil dlo, anpil ji ak lèt tou si li kapab.
- Manman-an dwe bwe pi souvan ke jan li te konn bwe a, 2 oubyen 3 vè an plis nan yon jounen.
- Yon fi nouris fèt pou manje pou li menm ak pou timoun ke lap bay tete-a.



Eske lèt manman kap fè timoun nan malad ?

- Lèt manman pa janm gate. Li pa ka fè timoun nan mal.
- Menm apre plizyè jou san tete nou kapab rekòmanse bay timoun lan tete. Pire premye gout yo.



Lè timoun nan malad, eske fò nou kontinye bali tete ?

- Wi, fòk nou kontinye bali tete.
- Li bezwen pran lèt manman pou remonte-l.

Sa pou nou fè lè yon timoun ki gen plis ke 3 mwa pa profite

- Se pou nou bali anpil manje anplis tete-a.
- Se pou nou bali manje trè souvan.
- Se pou nou bali manje ki pou remonte li.

Kisa nou kapab bay yon timoun ki gen 3 oubyen 4 mwa ?

- Anplis tete-a, mod kapab bali mit labouyi ak lèt, pak nan farin manyòk oubyen farin din ak lèt. Nou kapab bali sòs pwà tou. ^{kontinye bay tete} Nou kontinye bay tete.
- Chak fwa nou fini bay timoun lan manje se pou nou bali tete tou.

Konbyen fwa nou bay timoun yo manje pandan la jounen an ?

- Timoun yo paka sipòte grangou tankou gran moun yo merite manje 3 jiska 5 fwa nan yon jounen. Bayo yon ti bagay tanzantan tou.



12 Kijan manje manje se ki manje ki bali vyanm sou zòfè li pi byen vini ?

- Se chè ki nouri chè. Lòt manje ki nouri chè tou, se sòs pwa ak mayi oubyen sòs pwa ak diri, oubyen sòs pwa ak pitimi. Se lèt, ze, pwason.

13

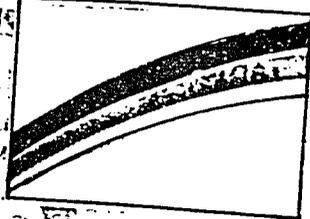
Kijan nou kwit manje timoun yo ?

- Nap mete manje timoun nan apa epi nou dwe byen kraze-l.
- Timoun yo pa renmen manje chèch. Fò gen yon ti grès, fò gen legim, fò gen kek sòs kanmenm.
- Nou bay timoun tout manje avèk yon ti kiyè byen prop.

14

Kilè nou kap sevre timoun nan ?

- Nou kap sevre timoun nan :
 - lè li abitye avèk manje chodyè,
 - lè nou wè li byen profite, li nan chemen la sante,
 - lè li gen 18 mwa.



15

Kijan nou sevir ak timoun lè li fèk sevre ?

- Nap bali lèt bèf nan plas tete-a.
- Fòk nou okipe-l plis pou-l pa chagen.
- Nap bali manje piis pou-l grandi.

16

Kisa pou nou fè lè timoun pa vle manje anpil ?

- Timoun lan ta manje pi byen si se divès kalite manje lap manje e si lap manje tou avèk plisyè timoun.
- Se pou nou pran anpil pasyans ak timoun nan.
- Si sa kontinye, nap mennen li nan dispansè.



APPENDIX D

**PROTECTING, PROMOTING, AND SUPPORTING BREASTFEEDING:
THE SPECIAL ROLE OF MATERNITY SERVICES,
A JOINT WHO/UNICEF STATEMENT**

Appendix 3: Protecting, promoting and supporting breastfeeding: the special role of maternity services

A joint WHO/UNICEF statement

Foreword

In our world of diversity and contrast, we believe that this statement on the role of maternity services in promoting breastfeeding is striking for its universal relevance. The principles affirmed here apply anywhere maternity services are offered, irrespective of such overworked labels as “developed” and “developing”, “North” and “South”, “modern” and “traditional”. And the health professionals and other workers responsible for these services are well placed to apply them by providing the leadership needed to sustain, or if necessary reestablish, a “breastfeeding culture”.

While discoveries are still being made about the many benefits of breast milk and breastfeeding, few today would openly contest the maxim ‘breast is best’. Yet slogans, however accurate, are no substitute for action. That is why we invite all those concerned with providing maternity services to study this statement to see how they are helping or hindering breastfeeding. Are they encouraging and supporting mothers in every possible way? We urge them, wherever they might be, to ensure that their services are fully mobilized to this end and thereby to bear witness to the unequalled excellence of breastfeeding for infants and mothers alike.

Hiroshi Nakajima, M.D., Ph.D.
Director-General
World Health Organization

James P. Grant
Executive Director
United Nations Children’s Fund

Ten steps to successful breastfeeding

Every facility providing maternity services and care for newborn infants should:

- (1) Have a written breastfeeding policy that is routinely communicated to all health care staff.
- (2) Train all health care staff in skills necessary to implement this policy.
- (3) Inform all pregnant women about the benefits and management of breastfeeding.
- (4) Help mothers initiate breastfeeding within a half-hour of birth.
- (5) Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants.
- (6) Give newborn infants no food or drink other than breast milk unless medically indicated.
- (7) Practise rooming-in — allow mothers and infants to remain together — 24 h a day.
- (8) Encourage breastfeeding on demand.
- (9) Give no artificial teats or pacifiers (also called dummies and soothers) to breastfeeding infants.
- (10) Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Reproduced, by permission, from *Protecting, promoting and supporting breast-feeding: The special role of maternity services*. A Joint WHO/UNICEF Statement. Geneva, World Health Organization, 1989. The Joint Statement has also been published by WHO in Arabic, French and Spanish editions.

Health care practices related to breastfeeding

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supports this decision in every way. This implies that mothers are adequately informed about matters relating to infant feeding, receive appropriate family and community support to facilitate and encourage breastfeeding, and are protected from influences that inhibit it. In particular, every effort should be made to protect, promote and support breastfeeding in and through the health services. This statement and its annex can serve as a guide to the kinds of practical steps that should be taken by maternity services in this regard. The competent authorities in countries are invited to adapt it to suit local health and socioeconomic circumstances so as to encourage and facilitate the initiation and establishment of breastfeeding by the mothers in their care.

Check-list for evaluating the adequacy of support for breastfeeding in maternity hospitals, wards and clinics*

The following check-list has been prepared for use by the competent authorities in countries: health and nutrition policy-makers; managers of maternal and child health and family planning services; clinicians, midwives, nursing personnel and other support staff in maternity services and facilities for the care of newborn infants: health workers' organizations; and mothers' support groups. It is intended to be a suggestive rather than exhaustive inventory of the kinds of practical steps that can be taken within and through maternity services to protect, promote and support breastfeeding, and should be used in conjunction with the main text of the joint WHO/UNICEF statement. Under ideal circumstances, the answer to all of the questions in the check-list will be "yes". A negative reply may indicate an inappropriate practice or routine that should be modified in accordance with the statement.

Policy

(1) Does the health care facility have an explicit policy for protecting, promoting and supporting breastfeeding?

*Hereinafter collectively referred to as "health care facilities".

(2) Is this policy communicated to those responsible for managing and providing maternity services (for example in oral briefings when new staff are employed; in manuals, guidelines and other written materials; or by supervisory personnel)?

(3) Is there a mechanism for evaluating the effectiveness of the breastfeeding policy? For example: Are data collected on the prevalence of breastfeeding initiation and breastfeeding at the time of discharge of mothers and their infants from the health care facility? Is there a system for assessing related health care practices and training and promotional materials, including those commonly used by antenatal and postnatal services?

(4) Are the cooperation and support of all interested parties, particularly health care providers, breastfeeding counselors and mothers' support groups, but also the general public, sought in developing and implementing the health care facility's breastfeeding policy?

Staff training

(5) Are all health care staff well aware of the importance and advantages of breastfeeding and acquainted with the health care facility's policy and services to protect, promote and support breastfeeding?

(6) Has the health care facility provided specialized training in lactation management to specific staff members?

Structure and functioning of services

(7) Do antenatal records indicate whether breastfeeding has been discussed with a pregnant woman? Is it noted:

— Whether a woman has indicated her intention to breastfeed?

— Whether her breasts have been examined?

— Whether her breastfeeding history has been taken?

— How long and how often she has already breastfed?

— Whether she previously encountered any problems and, if so, what kind?

— What type of help she received, if any, and from whom?

(8) Is a mother's antenatal record available at the time of delivery? If not, is the information in point (7) nevertheless communicated to the staff of the health care facility? Does a woman who has never breastfed, or who has previously encountered problems with breastfeeding, receive special attention and support from the staff of the health care facility?

(9) Does the health care facility take into account a woman's intention to breastfeed when deciding on the use of a sedative, an analgesic or an anesthetic, if any, during labor and delivery? Are staff familiar with the effects of such medications on breastfeeding?

(10) In general, are newborn infants: Shown to their mothers within 5 min after completion of the second stage of labor? Shown/given to their mothers before silver nitrate or antibiotic drops are administered prophylactically to their infants' eyes? Given to their mothers to hold and put to the breast within a half-hour of completion of the second stage of labor, and allowed to remain with them for at least one hour?

(11) Does the health care facility have a rooming-in policy? That is, do infants remain with their mothers throughout their stay? Are mothers allowed to have their infants with them in their beds? If the infants stay in cots, are these placed close to the mothers' beds? If rooming-in applies only during daytime hours, are infants at least brought frequently (every 3—4 h) to their mothers at night?

(12) Is it the health care facility's policy to restrict the giving of prelacteal feeds, that is any food or drink other than breast milk, before breastfeeding has been established?

Health education

(13) Are all expectant mothers advised on nutritional requirements during pregnancy and lactation and the dangers associated with the use of drugs?

(14) Are information and education on breastfeeding routinely provided to pregnant women during antenatal care?

(15) Are staff members or counselors who have specialized training in lactation management available full time to advise breastfeeding mothers during their stay in the health care facility and in preparation for their discharge? Are mothers informed: About the physiology of lactation and how to maintain it? How to prevent and manage common problems like breast engorgement and sore or cracked nipples? Where to turn, for example to breastfeeding support groups, to deal with these or related problems? Do breastfeeding support groups have access to the health care facility?

(16) Are support and counseling on how to initiate and maintain breastfeeding routinely provided for women who: Have undergone cesarean section? Have delivered prematurely? Have delivered low-birth-weight infants? Have infants who are in special care for any reason?

(17) Are breastfeeding mothers provided with printed materials that give relevant guidance and information?

Discharge

(18) If "discharge packs" containing baby- and personal-care products are provided to mothers when they leave the hospital or clinic, is it the policy of the health care facility to ensure that they contain nothing that might interfere with the successful initiation and establishment of breastfeeding, for example feeding bottles and teats, pacifiers and infant formula?

(19) Are mothers or other family members, as appropriate, of infants who are not fed on breast milk given adequate instructions for the correct preparation and feeding of breast-milk substitutes, and a warning against the health hazards of incorrect preparations? Is it the policy of the health care facility not to give such instructions in the presence of breast-feeding mothers?

(20) Is every mother given an appointment for her first follow-up visit for postnatal and infant care? Is she informed how to deal with any problems that may arise meanwhile in relation to breastfeeding?

APPENDIX E
WELLSTART INTERNATIONAL LACTATION MANAGEMENT
EDUCATION PROGRAM



WELLSTARTSM
THE SAN DIEGO LACTATION PROGRAM

**Wellstart's International Lactation
Management Education Program**

Program Participation Fees: The participation fee for the Wellstart Program is \$3,000.00 per participant. The fee covers much more than a training course. The Wellstart Program utilizes a multi-faceted and comprehensive approach to lactation management education which includes a 4-week course in San Diego, provision of audiovisual and other teaching material support, and ongoing follow-up technical assistance, including a follow-up visit to the participant team's country.

Living Costs: Living costs (housing, meals, and incidentals) for San Diego are estimated at \$2,500-\$3,000 per participant for the 4-week course (\$100/day per diem x 28-30 days).

Transportation: Transportation costs for round trip airfare to and from San Diego are estimated at \$1,500-\$2,500, depending, of course, on distance to be traveled and fare availability.

Upcoming Course Dates:

- | | |
|--|------------------|
| 1. Monday, November 19 - Friday, December 14, 1990 | English Language |
| 2. Monday, February 11 - Friday, March 8, 1991 | Spanish Language |
| 3. Monday, June 3 - Friday, June 28, 1991 | English Language |
| 4. Monday, August 26 - Friday, September 20, 1991 | English Language |
| 5. Monday, November 18 - Friday, December 13, 1991 | English Language |

The Wellstart Program is designed to provide comprehensive lactation management education, training, and support to multidisciplinary teams of faculty-level health professionals from teaching hospitals. The Program has also been provided for other teachers/trainers of health professionals such as Ministry of Health workers. This "teaching the teachers" program design, coupled with the provision of material support and follow-up, has been successful in effecting long-term and sustainable changes in the quantity and quality of lactation management education/training in-country.

For additional information and/or applications for participation, please contact:

Audrey Naylor, MD, DrPH

or

Janine Schooley, MPH
Wellstart
P.O. Box 87549
San Diego, CA 92138 USA

Telephone: (619) 295-5192

Telex: 695416

Fax: (619) 294-7787

A-SCHOOLEYBROCHURE.INS

Wellstart is a non-profit organization

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The Importance of Lactation Management Education

Breastfeeding is a basic component of any successful child survival strategy. The superbly balanced nutrients and enzymes, the life-protecting immunological substances and epidermal growth factor, and the adjustment of this content to match the changing needs of the infant, are remarkable. The frequent physical contact entailed in breastfeeding also assures continuing protection and warmth for the infant while the cooperative nature of the dyad interaction during nursing enhances the baby's emotional development and socialization.

Breastfeeding also contributes to a mother's maternal sensitivity and to her successful transition from a pregnant to non-pregnant state. Post-partum bleeding is minimized and uterine involution assured by the oxytocin-induced uterine contractions which accompany suckling. Maternal protein, iron and other nutrients needed during the postpartum period are conserved by lactational amenorrhea. The anovulatory state which accompanies the frequent nursing pattern characteristic of exclusive breastfeeding can extend pregnancy intervals to 18 months or more. A totally dependent infant can thus become a somewhat more independent toddler before maternal attention must be diverted to the next baby.

The benefits lost through the gradual decline in both the incidence and duration of breastfeeding reported in developing nations during the past 10 to 15 years is a major concern to all who have an interest in child survival. The declines, concentrated in the urban and periurban areas, are the result of the complex interaction of several phenomena: availability and aggressive marketing of a substitute; an erroneous belief that to use the substitute is modern and healthier; a widespread and incorrect belief that breastfeeding and working are incompatible; and the absence of extended families to assist new parents during their adjustment.

The urban declines are also influenced by increasing utilization of a modern medical system for prenatal, intrapartum and postpartum care. Nurses, physicians and others who provide care and establish institutional policies and procedures for new mothers and infants rarely have the knowledge and skills to support and assist lactation and the breastfeeding mother. The complexity of breast and neonatal physiology, as well as newborn and infant neurodevelopmental factors involved in successful lactation and breastfeeding, are poorly understood by most health care providers. In addition, many health care providers are still not well informed regarding the extent of the benefits of breastfeeding and have no professional commitment to it. These deficiencies in health care provider knowledge lead to expectant and new mothers being given incorrect information with which to face a variety of barriers to both the initiation and continuation of breastfeeding.

The influence of these deficiencies in health care provider knowledge is not limited to the urban setting. These same professionals establish policies and procedures which effect care in outlying regions, have assignments in those regions, or are responsible for teaching those who do. It is thus essential to include the education of health care providers in any serious plan to promote and protect breastfeeding nationwide.

WELLSTART'S STRATEGY

Wellstart's International Education Program encompasses much more than its courses. Its multi-faceted, seven component approach helps insure sustainability and positive results.

THE 7 PROGRAM COMPONENTS

1

RECRUITMENT/SELECTION

Wellstart recruits teams of 2 to 3 participants from interested institutions for each course. Each team usually includes a pediatrician, obstetrician, and perinatal nurse who can work together to train colleagues and students and promote hospital and community changes.

2

EDUCATION/MOTIVATION

Each course, given for 4 weeks in San Diego:

- focuses on the science and clinical management of lactation, breastfeeding problems, maternal and infant nutrition, fertility issues, promotional strategies and other related topics
- includes classroom instruction, rounds, clinic sessions, nutrition counseling, observations and field trips
- is guided by an expert interdisciplinary teaching team including the Wellstart staff and well-known adjunct faculty.

3

INTERVENTION PLANNING

Wellstart faculty assists teams in developing action plans for organizing model service and teaching programs and other activities upon returning home.

4

MATERIAL SUPPORT

Each team is provided with a basic collection of teaching materials for use in their own programs, including:

- session plans and course texts
- audiovisual teaching aids
- books and reprint articles.

5

INTERVENTION IMPLEMENTATION

Wellstart assists teams in implementing their action plans through:

- technical assistance
- networking and communication
- leadership development.

6

FOLLOW-UP

All teams are provided with on-going technical support, continuing education and motivation through:

- follow-up visits
- a newsletter
- monthly reprints from current literature.

7

EXPANSION OF ACTIVITIES

Graduates expand their efforts by:

- training other health professionals and paraprofessionals and improving curricula
- modifying hospital policies and procedures
- working jointly with poor rural and urban communities to identify infant nutrition problems and plan for their solution
- developing promotional campaigns and services for mothers, infants and families

COURSES IN SPANISH

Although Wellstart's lactation management courses are usually given in English, modified courses in Spanish may be arranged.

FOR FURTHER INFORMATION:

WELLSTART
P.O. Box 87549
San Diego, CA 92138 U.S.A.

Telephone: (619) 295-5192
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STATEMENT OF CORPORATE CAPABILITIES

June, 1990

WELLSTARTSM

THE SAN DIEGO LACTATION PROGRAM

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I. BACKGROUND

Forty thousand children die each day (28 every minute) in developing countries, the victims of malnutrition and frequent illnesses made worse by malnutrition. In many developing areas, 25% of all children die before reaching their fifth birthday. In the last few years, it has become clear that seven simple techniques can be effective in saving millions of these children's lives:

G rowth monitoring and promotion	
O ral rehydration therapy	F amily planning
B reastfeeding	F emale education
I mmunization	F ood distribution

These techniques, known by the acronym GOBI-FFF, form the core of the Child Survival Strategy.

Breastfeeding is a fundamental component of this strategy. The superbly balanced nutrients and enzymes, the life-protecting immunological substances and epidermal growth factor, and the adjustment of this content to match the changing needs of the infant, are remarkable. Exclusively breastfed infants have 2 1/2 times fewer episodes of illness and are 25 times less likely to die of diarrhea during the first six months of life than those fed substitutes. The frequent physical contact entailed in breastfeeding assures continuing protection and warmth for the infant, while the cooperative nature of the dyad interaction during nursing enhances the baby's emotional development and socialization.

Breastfeeding also contributes to a mother's maternal sensitivity and to her successful transition from a pregnant to non-pregnant state. Postpartum bleeding is minimized and uterine involution assured by the oxytocin-induced uterine contractions which accompany suckling. Maternal protein, iron and other nutrients needs during the postpartum period are conserved by lactational amenorrhea. The anovulatory state which accompanies the frequent nursing pattern characteristic of exclusive breastfeeding is estimated to provide 30% more protection against pregnancy than all organized family planning programs in the developing world combined. Lactation infertility can extend pregnancy intervals to 18 months or more. A totally dependent infant can thus become a somewhat more independent toddler before maternal attention must be diverted to the next baby. Overall it is estimated that the promotion and protection of breastfeeding in developing nations can save one million infant lives each year.

The loss of these benefits through the gradual decline in both the incidence and duration of breastfeeding reported in developing nations since the 1970's is a major concern to all who have an interest in child survival. The declines, concentrated in the urban and peri-urban areas, are the result of the complex interaction of several phenomena: availability and aggressive marketing of a substitute; an erroneous belief that to use the substitute is more modern and healthier; a widespread and incorrect assumption that

breastfeeding and working are always incompatible; and the absence of extended families to assist new parents during their adjustment to parenthood.

The declines are also influenced by increasing utilization of modern health care systems for prenatal, intrapartum and postpartum care. Nurses, physicians and others who provide care and establish institutional policies and procedures for new mothers and infants rarely have the necessary knowledge and skills to support and assist lactation and the breastfeeding mother and infant. In addition, many health care providers are still not well informed regarding the extent of the benefits of breastfeeding and have minimal professional commitment to it. These deficiencies in health care provider knowledge result in expectant and new mothers being faced with a variety of barriers to both the initiation and continuation of breastfeeding. Thus a successful Child Survival Strategy must include lactation management education for health care providers.

Wellstart, an independent, multidisciplinary, non-profit educational organization (initially launched at the UCSD Medical Center in 1977 as the San Diego Lactation Program) offers a special education program designed to contribute to this aspect of the Child Survival Strategy. While Wellstart is concerned about many facets of education for maternal and child health professionals, particular emphasis is given to maternal nutrition, breastfeeding, weaning, and parenting. Both direct services to mothers, infants, and their families and health professional education regarding lactation management are carried out. With grant funding from the Office of Nutrition of the U.S. Agency for International Development (USAID), Wellstart has extended its expertise in lactation management education (LME) to faculty from teaching hospitals and policy makers from ministries of health in developing countries. Since this special program began, over 250 faculty-level health professionals from 22 countries around the world have received in-depth training in San Diego and have been provided with much needed teaching materials and follow-up technical assistance. The Wellstart program focuses on "teaching the teachers" and decision makers to create a "multiplying effect" by which information and changes are rapidly and widely spread and are more long-term in nature. Through the secondary teaching which Wellstart participants have done, it is estimated that over 60 million mother-infant pairs will have been affected in the developing world by Wellstart's LME Program by the end of 1993.

II. OVERVIEW

Goal and Objectives

The goal of Wellstart's International LME Program has been to assist the promotion of breastfeeding in developing countries by improving the knowledge of current and future perinatal health care providers regarding the clinical management of lactation and breastfeeding.

In order to meet this goal, the LME Program is designed to:

- Train multidisciplinary teams, primarily from teaching hospitals, as lactation specialists. These teams will be prepared to assume responsibility for breastfeeding programs designed to offer both service and teaching and to function as models for possible replication in other teaching hospitals.
- Assist these teams in developing a model service and teaching program appropriate to their own setting.
- Assist these teams in designing inservice and continuing education activities regarding lactation and breastfeeding for their physician, nurse and nutritionist colleagues.
- Assist these teams in selecting or developing appropriate teaching materials for their own programs.

Program Components

A seven component approach is utilized to meet this goal and objectives:

- Recruitment and selection of faculty-level multidisciplinary teams of health professionals from teaching hospitals or ministries of health;
- Education and motivation of participant teams in an intensive four-week course of study in San Diego which includes didactic, clinical and field experiences;
- Development and formal presentation during the course of an intervention plan by participant teams;
- Provision of material support to participant teams, including a team "teaching kit" comprised of text books, reprint articles, audiovisual and other teaching aids for use in the teams' own teaching, clinical and promotion programs;
- In-country implementation of the teams' planned interventions;
- Provision of follow-up including a Continuing Education and Support visit made by Program faculty sometime after the LME course, monthly distribution of reprint articles, distribution of a Program newsletter; and
- Expansion of participant teams' activities by: training other health professionals and paraprofessionals and improving curricula; modifying hospital policies and procedures; working jointly with communities to identify problems and plan solutions; and developing promotional campaigns and services for mothers and infants.

Key Elements of the Program

- ***Education of Educators and Decision Makers*** By reaching senior, faculty-level health professionals, hospital administrators, and ministry of health officials, and relying on them to in turn train other perinatal health providers, the LME Program has created rapid and efficient changes in professional knowledge, attitudes, and practices. When the teachers, leaders, and decision makers are involved in the process of change, the process is facilitated and more likely to become self-sustaining.
- ***Collaboration with Country Professionals to Adapt the Program to Local Needs and Situations*** The LME Program is designed to utilize participants' expertise in the sociocultural framework operating within their countries. The Program reaches its participating health professional teachers and leaders through a common language of basic science and clinical practice. The participant teams then adapt their knowledge and skills to the particular sociocultural milieu within which they operate. The breastfeeding promotion and protection programs in participating countries are therefore run for and by the in-country health professionals themselves.
- ***Sound Scientific Foundations and Clinical Expertise*** To successfully reach and influence health professionals, especially those at senior decision making levels, course content must have a sound scientific basis, be as current as possible, and include practical application. Additionally, teaching the practical skills needed for clinical service is most effective when the scientific rationale is clear. Teaching of clinical skills needs to be carried out in a clinical setting by faculty whose instruction is based upon expertise acquired and maintained through their own continuing responsibility for providing clinical services.
- ***Multidisciplinary Team Approach*** Bringing the disciplines of medicine, nursing, and nutrition together to work on issues relating to mothers and children is challenging but rewarding. Service and teaching teams work best if they are multi- or interdisciplinary. The most successful LME teams work together in the same institution or in close affiliates. Because of the synergy involved, a true team of three or four is much more powerful than three or four individuals from different institutions.
- ***Continuity and Follow-up*** Follow-up, material support, and ongoing emphasis on institutionalization and spin-off activities are essential and feasible, even with limited resources. Efforts to create enthusiasm, sustain momentum, and provide continuing education are essential for sustained positive results.
- ***Flexibility and Adaptability*** Teams and their participant members vary widely in their past experience, seniority, cultural characteristics, and professional relationships. Adjustment and adaptations in course plans, content, and methods are often needed and such flexibility is often essential to success.

III. ORGANIZATION AND RESOURCES

Organization

Wellstart is an independent, non-profit organization [501(c)(3) classification], incorporated in California for the primary purpose of providing an educational program.

Wellstart's educational activities focus on teaching lactation and breastfeeding management to health care providers, particularly those working with mothers and infants. To carry out the teaching program, Wellstart is organized to provide didactic classroom teaching as well as clinical observations and experiences.

An experienced multidisciplinary core faculty guides the teaching program and includes board certified pediatricians, pediatric and family nurse practitioners, a clinical nurse specialist, and a perinatal nutritionist. In addition, an extensive list of internationally respected experts and scientists from fields such as biochemistry, endocrinology, cellular biology, growth and development, diarrheal disease control, reproductive physiology, social marketing, and other important subject areas, serves as a source of adjunct faculty for selected course presentations.

In order to provide clinical observations and experiences, Wellstart maintains a model clinical service. Core faculty assist families regarding lactation and breastfeeding issues in both inpatient and outpatient settings while simultaneously teaching essential practical skills to Program participants.

In addition to the core and adjunct faculties, Wellstart has an outstanding and skilled staff which provides full support for both the educational program and the administrative needs of the organization.

Resources

A. Facilities

Wellstart occupies five buildings (4,250 square feet) in the Hillcrest area of San Diego. Three major activities are carried out in these facilities:

- The Learning Center provides a classroom capacity of 35 to 40, breakout rooms for small group discussions, a library, and an audiovisual review area.
- The Lactation Management Teaching Clinic includes a waiting and reception area, consultation rooms, and a nutrition counseling area.

- Administrative and Program Support Areas provide well equipped offices and work areas for all support staff.

Wellstart is located within a short walking distance of the UCSD Medical Center which provides the inpatient teaching component of the model program. Additionally, a comfortable, moderately priced apartment-hotel where LME Program participants and Wellstart guests can stay is within a few minutes walk of Wellstart.

B. Text and Audiovisual Library

Wellstart maintains an extensive professional and patient education library. The collection currently contains over 800 books and booklets on breastfeeding, maternal and infant nutrition, parenting, and related topics, and an extensive reprint collection of over 7,000 catalogued articles. Wellstart subscribes to 26 maternal and child health related journals and to fourteen newsletters. Each month, approximately 100 reprint articles are reviewed and selected by Wellstart faculty for addition to the library.

Wellstart has an extensive inventory of specialized teaching supplies and audio-visual aids, including several thousand slides, 80 English-language and 15 Spanish-language video tapes, and several slide tape sets. In addition, Wellstart has a comprehensive collection of teaching aids such as breast pumps, infant feeding devices, and dolls. Wellstart also maintains a Spanish-language library of text and audiovisual teaching materials.

As the library has grown, several of the collections have been specially catalogued and automated for ease of access. The library now utilizes:

- An automated reprint collection using ProCite, a reprint management software package;
- A comprehensive thesaurus of subject headings for the reprint library; and
- Formalized systems for cataloging teaching slides and video tapes.

The Wellstart library also informally networks with the American Public Health Association's Clearinghouse on Infant Feeding and Maternal Nutrition. This allows sharing of new acquisitions and expertise.

C. Institutional Affiliations

Wellstart has developed and maintained relationships with several organizations which enhance its abilities to successfully operate the LME Program. Examples include:

- Academy for Educational Development (AED)
- American Public Health Association Clearinghouse on Infant Feeding and Maternal Nutrition
- Bureau of Maternal and Child Health and Resources Development, Federal Department of Health and Human Services
- Children's Nutrition Research Center, Houston, Texas
- Institute for International Studies in Natural Family Planning (IISNFP)
- ISSSTECALI Hospital, Tijuana, Mexico
- Partners for International Education and Training (PIET)
- PERINASIA, The Indonesian Society of Perinatology, Jakarta, Indonesia

- Population Council
- UCSD Medical Center, San Diego, California
- UNICEF
- World Health Organization

In addition, Wellstart faculty and staff, or the organization as a whole, are members of the following relevant organizations:

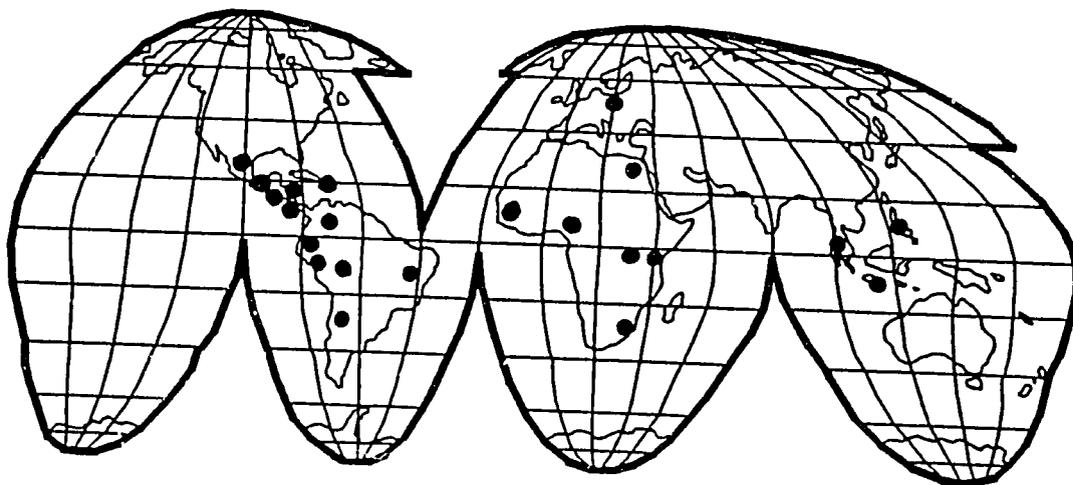
- National Council for International Health (Organization membership – Supporting Category)
- American Public Health Association (Member Breastfeeding Committee, International MCH Committee)
- La Leche League International (Health Advisory Council Member)
- American Academy of Pediatrics
- Ambulatory Pediatric Association
- International Society for Research in Human Milk and Lactation (Executive Committee Member)
- Association of Teachers in Maternal and Child Health
- Healthy Mothers, Healthy Babies Coalition
- National Association of Perinatal Nurses and Practitioners

IV. PROGRAMMATIC CAPABILITIES

Wellstart has vast experience in providing LME for multidisciplinary health professionals from developed as well as developing countries. The full Program (all seven components as described above) are available in both English and Spanish. French language capability is being explored.

To date fourteen English-language and five Spanish-language courses have been provided for 250 multidisciplinary health professionals from twenty-two countries. Numerous additional courses have been provided for health professionals from the United States and its associated territories.

The twenty-two countries currently participating in Wellstart's LME Program are: Bolivia, Peru, Ecuador, Chile, Costa Rica, Mexico, Guatemala, Poland, Indonesia, Thailand, Philippines, Sierra Leone, Kenya, Uganda, Swaziland, Nigeria, Brazil, Dominican Republic, Egypt, El Salvador, Honduras, and Colombia.



In addition to its extensive work in providing LME courses at its headquarters in San Diego, Wellstart has experience in providing:

- technical assistance in the areas of lactation management education, breastfeeding promotion, policy change, and lactation center development at the institutional and national levels;
- presentations on a variety of subjects related to LME including: AIDS and breastfeeding, breastfeeding and child survival, and formula marketing and the WHO Code;
- two-month Advanced Study Fellowships for participants in the international LME Program;
- lactation management workshops and conferences at other sites, coordinating with local agencies on actual implementation;
- technical assistance in operations and basic science research;
- technical review and comment for documents which include any discussion of the clinical aspects of breastfeeding;
- reconnaissance and assessment visits to countries or institutions considering development of a breastfeeding program; and
- guidance in curriculum review and design.

V. WELLSTART'S INTERNATIONAL NETWORK OF HEALTH PROFESSIONALS WITH LACTATION MANAGEMENT EXPERTISE

By virtue of the fact that Wellstart's approach to LME involves entering participant teams into a program of ongoing communication, follow-up, and continuing education, any discussion of the LME Program's capabilities must include the capabilities of its expanding multidisciplinary network of health professional participants.

Fifty-five teaching hospitals from 21 countries are now participating in this ongoing, multicomponent program and are working on developing teaching, service, research, and promotional programs for breastfeeding that are culturally appropriate, language-specific, and institutionalized with built-in spread capabilities. Wellstart's LME model is now being adapted and modified by several of the most successful teams into national, in-country lactation management training centers.

Specific capabilities of this network of participants include:

- development of lactation clinics
- changes in hospital policies and procedures
- implementation of research and evaluation studies
- medical and nursing school curriculum changes
- development of LME programs

- promotion through the media
- establishment of mother-to-mother support groups
- establishment of volunteer provider networks
- provision of technical assistance in a variety of settings
- influencing public policy
- assisting with the development of national codes of marketing of breastmilk substitutes

For further information on the services Wellstart can offer, contact:

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