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Sustainability

THE STATE OF
BREASTFEEDING IN THE
DOMINICAN REPUBLIC:
*PRACTICES AND
PROMOTION*

Final Report

May 1992

Prepared for the
U. S. Agency for International Development
by MotherCare, John Snow, Inc./Manoff Group
and LAC Health and Nutrition Sustainability, ISTI/URC

**THE STATE OF BREASTFEEDING
IN THE DOMINICAN REPUBLIC:
PRACTICES AND PROMOTION**

prepared by

Marijke Velzeboer, Dr.P.H.
Josefina Coën, M.D.
Argentina Alas de Chavez, M.D.
Magdalena Fischer, M.S.

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- Marijke Velzeboer

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LIST OF ACRONYMS

ADD	Acute Diarrheal Disease
ADDC	Acute Diarrheal Disease Control
ADOPLAFAM	Asociación Dominicana de Planificación Familiar
AED	Academy for Educational Development
AHLACMA	Asociación Hondureña de Lactancia Materna
A.I.D.	Agency for International Development
ANEP	Applied Nutrition Education Program
ARAF	Asociación de Representantes y Agencias de Productos Farmaceuticos
ARI	Acute Respiratory Infection
CARITAS	local arm of Catholic Relief Services
CDC	Center for Disease Control
CE MUJER	Centro de Educacion de la Mujer
CEDOIS	Centro Dominicano de Organización de Interés Social
CELADE	Centro Latino Americano de Demografía
CENISMI	Centro Nacional de Investigaciones en Salud Materno Infantil
CIF	Centro de Integración Familiar
CIPAF	Centro de Investigación para la Acción Femenina
CONAPOFA	Comité Nacional de Población y Familia
CONAMUCA	Consejo Nacional de Mujeres Campesinas
CRS	Catholic Relief Services
CSP	Child Survival Program (Programa de Supervivencia Infantil, PSI)
CTU	Confederación de Trabajadores Unitarios
DF	Dueños de Farmacias (pharmacy owners)
DHS	Demographic Health Survey
FHI	Family Health International
IDDI	Instituto Dominicana de Desarrollo Integral
IDSS	Instituto Dominicano de Seguridad Social
IEM	Intituto de Mercado
IEPD	Instituto de Estudios de Población y Desarrollo
INCAP	Nutrition Institute of Central America and Panama
INESPRE	Instituto de Estabilización de Precios
INFACF	Infant Formula Aciton Committee
INFADOM	Industrias Farmaceuticas Dominicana
LBW	low birth weight
MCH	Maternal Child Health
MEPES	Monitoreo de Efectos de las Politicas Económicas y Sociales en el Bienestar Infantil
MUDE	Mujeres para el Desarrollo
NCHS	National Center for Health Statistics
NGO	Non-governmental organization
NNS	National Nutrition Survey
ONAPLAN	Oficina Nacional de Planificación
ONE	Oficina Nacional de Estadística
ORT	oral rehydration therapy

**List of Acronyms
(continued)**

PAHO PL-480	Pan American Health Organization Public Law-480
PLANSI	Plan Nacional de Supervivencia Infantil (National Child Survival Program of SESPAS)
PRITECH	Technologies for Primary Health Care
PROFAMILIA	Asociación Probienstar de la Familia
SESPAS	Secretaria de Estado de Salud Publica y Asistencia Social
SDD	Sociedad Dominicana de Pediatrica
STC	Save the Children
TBC	Tuberculosis
UASD	Universidad Autonoma de Sto. Domingo
UNAMUT	Unión Nacional de Mujeres de Trabajadores
UNICEF	United Nations Children's Fund
URC	University Research Corporation
USAID	United States Agency for International Development
WHO	World Health Organization
ZF	Zonas Francas

EXECUTIVE SUMMARY

Breastfeeding has been identified as a priority in child survival programs of the public and private sector of the Dominican Republic (DR). In order to plan a comprehensive strategy for promoting and supporting breastfeeding, MotherCare and the Latin America/Caribbean Health and Nutrition Sustainability Project were asked to assess the breastfeeding situation in the DR.

The assessment was carried out by a team of four consultants: Marijke Velzeboer, Dr. P.H., team leader; Josefina Coën, M.D., Child Survival Coordinator for the Sociedad Dominicana de Pediatría; Argentina Alas de Chavez, M.D., Director of the Asociación Hondureña de Lactancia Materna; and Magdalena Fischer, M.S., Nutrition Institute of Central American and Panama (INCAP). The assessment followed the *Guide for a Preliminary Country Analysis of the Activities and Practices Supporting Breastfeeding*. Extensive documentation was reviewed prior to beginning the interviewing. Representatives from international and non-governmental organizations (NGOs), as well as from the public and private sectors, were interviewed. Field visits were made to child survival promoters and mothers, to hospitals and clinics. Inventories of infant formulas were taken at different commercial outlets. Due to a strike by public sector doctors, the ongoing work of the Secretaria de Estado de Salud Pública y Asistencia Social (SESPAS) could not be observed. Recommendations were defined with health officers from USAID and representatives of UNICEF and the USAID-assisted Child Survival Program (URC/CSP).

The detailed findings are organized by activity area as they are ordered in the *Guide*. For a concise overview of the results, see the Breastfeeding Score Sheet following this summary.

Conclusions

A deteriorating economic and public service situation in the Dominican Republic makes breastfeeding promotion an obvious choice for improving the chances of survival for Dominican children. Studies have shown that Dominican children, when breastfed, grow taller, are healthier and have lower mortality.

In keeping with internationally established recommendations, most mothers (90-98%) do initiate breastfeeding but, contrary to recommendations, only a few (10%) breastfeed exclusively during the first three months and virtually none breastfeed exclusively during months four to six. It is this period of the first four to six months when breast milk provides optimum protection against disease, malnutrition and death. Bottles are introduced during the first month and water and teas are customarily given

to infants from birth. Mothers are well informed about the health advantages of breast milk for their babies, but do not practice optimal breastfeeding to make use of breastfeeding's health benefits. Though most mothers (84%) believe that babies should be breastfed for the recommended one year or more, few do so (18%). In fact, one-third have stopped breastfeeding by three months. The gap between knowledge and practice is wide.

There is little knowledge among mothers about how to begin giving complementary foods. Liquids and solid foods are introduced at the mother's own discretion, rather than according to sound advice or the recommended scheme. Only about one-third of the mothers introduce foods at the appropriate time.

Dominican mothers have many beliefs about when breastfeeding must be stopped or at least supplemented. They believe babies should not be nursed when mothers have fever, hepatitis, anemia, or when they are malnourished or pregnant, or are hot and sweaty. Most nursing mothers believe that certain foods should be avoided, that their milk is at times salty and should be discarded, and that they do not/cannot produce a sufficient quantity of milk for their baby. Also alarming are the many mothers (40 percent) who withhold breast milk when their babies have diarrhea and vomit, thereby depriving them of the immunologic and nutrition protection they need from breast milk. Mothers need more knowledge about breastfeeding techniques to breastfeed optimally.

Though little information exists on the relationship between lactation and the fertility of Dominican women, the effect of breastfeeding on amenorrhea is minimal because so little time is spent breastfeeding exclusively. There is no family planning policy for nursing mothers and recommended low dose estrogen and progestin-only pills are not readily accessible, making it difficult to practice family planning and breastfeed.

There is no difference in initiation rates between women who work outside the home and those who do not. However, those who work outside the home stop breastfeeding earlier (6.4 versus 9.4 months). Though mothers rarely identify work as a reason for discontinuing breastfeeding, the reality is that they lack support to continue breastfeeding, especially those in the service sector and in the free trade zones.

Ironically, Dominican law is supportive of breastfeeding. The Labor Law (Codigo de Trabajo) assures 12 weeks of paid maternity leave, three 25-minute breastfeeding breaks for eight months, and nurseries for work places with over 30 employees. In reality, only maternity leave is granted; few Dominicans are even aware of the other provisions. A major exception to supportive legislation is that the law does not protect mothers from potentially unethical practices of infant formula companies. In

1984, the Asociación de Lactancia Materna worked for passage of the Law of the Commercialization of Breast Milk Substitutes. The law was not passed. However, in spite of its absence, most formula distributors abide by the International Code passed by the World Health Organization. Doctors, though, readily prescribe formulas and solicit them for private hospitals where rooming-in and breastfeeding are the exception, and Caesareans and formula feeding are the norm. Private medical facilities require extensive orientations on breastfeeding promotion.

In the public sector there is a breastfeeding policy although, with the exception of hospitals, it is not applied. In SESPAS hospitals babies are placed with their mothers immediately upon normal delivery, though no support or follow-up is provided. Formulas are restricted to special cases, though the criteria for contraindicating breast milk are incorrect (in mothers: Caesarean births, toxemia and infection; in babies: low birth weight, infections, and cleft palate). Through the Asociación de Lactancia Materna, ten breast milk banks were established in hospitals, but only three are functioning now.

A Breastfeeding Program exists as part of the Plan Nacional de Supervivencia Infantil (PLANSI) which was recently incorporated into the Maternal Child Health Division of SESPAS. The Program's policy is contained in the PLANSI Manual of Norms which was distributed without training and therefore has had limited implementation. The policy has many organizational and technical shortcomings. It is not surprising, then, that breastfeeding is not promoted during prenatal care, delivery, and postnatal care in health services. This is an unfortunate missed opportunity because over 90% of all Dominican women obtain prenatal care and give birth in formal sector health facilities.

Medical personnel receive little, if any, in-depth training concerning breastfeeding. Physicians and nurses are taught the physiology and advantages of breastfeeding, but not its technical and clinical management. They are apt to recommend formula under any unusual circumstance. The Sociedad Dominicana de Pediatría has tried to improve this situation through one-day seminars on breastfeeding for more than 2,000 doctors and nurses.

Auxiliary health personnel, especially promoters from NGOs, have received some training. Of 5,000 SESPAS promoters, 800 have been trained in 33 health interventions, including breastfeeding. No information exists about their effectiveness, though their work seems to be limited to vaccination campaigns. NGO promoters have received more consistent training and use breastfeeding materials provided as part of the USAID-funded Child Survival Program (URC/CSP). CARE and Caritas promoters also actively promote breastfeeding in their respective communities. The NGOs provide their promoters with accurate information, moral support, and financial assistance so that they can work closely with mothers.

Current activities carried out to promote breastfeeding are based with private organizations. At the moment, the public sector is inactive. Specifically, the "voluntary" organizations are active, receiving funding from many sources, but primarily from USAID through the URC/CSP. UNICEF continues to be the leading supporter of SESPAS' Child Survival/Breastfeeding Program. Given the current priority assigned to breastfeeding by USAID, UNICEF and PAHO, continued assistance is likely. Though past lack of coordination between these primary funders has resulted in a duplication of efforts and resources, UNICEF and USAID/CSP are currently collaborating on a breastfeeding education and media campaign.

Recommendations

Health professional training for hospital-based breastfeeding promotion.

Since 90% of all births in the DR are institutional, half being public, breastfeeding promotion in hospitals would be an effective way to stimulate mothers to breastfeed correctly. The following strategies are proposed:

1. Train medical teams (one pediatrician, one obstetrician and one nurse) from the four largest, urban maternity hospitals (40+ births a day) in clinical management of breastfeeding per the WELLSTART model.
2. Train two nurses to be "Consejeras de Lactancia Materna", in each of these large urban hospitals. Their training would focus on breastfeeding support techniques per the model of AHLACMA, Public Maternity Hospital, Honduras
3. Set up a selection and monitoring team to assure appropriate selection and post-training implementation.
4. Upon their return to the DR, the trainees will reform the lactation management practices in their respective hospitals in compliance with WHO/UNICEF "Ten Steps to Successful Breastfeeding" (1989). A specific example of needed reforms would be to insure that low birth weight and new born infants with infections are fed their mother's breast milk.
5. After training, candidates will form teams of master trainers including the Consejeras, to provide the breastfeeding component of child survival training and follow up to other, smaller hospitals and clinics. It will be critical to work with private hospitals and clinics in this effort.

Revision of medical training and education.

At this time the medical curriculum for the Universidad Autónoma de Santo Domingo is being revised, providing an opportunity to strengthen the clinical management of the breastfeeding component, as well as the technical information available to medical and nursing students and other health personnel. The continued support of a PAHO/WELLSTART consultant is required in design, initial testing and revision of the curriculum.

Reinforce CSP/SESPAS/NGO breastfeeding promotion activities for community promotion.

1. Ensure that quality formative research is available on motivations for women to exclusively breastfeed and to stop using bottles.
2. Strengthen existing materials to emphasize exclusive breastfeeding for the first 4-6 months, the relationship between the number of feeds and successful lactation, and appropriate introduction of semi-solids. Correct all misinformation.
3. Assure the distribution of existing CSP materials to community NGO and SESPAS locations and provide interim training and follow up to promoters in their use, while URC/CSP revises and completes its IEC strategy. All promotor training should emphasize management of common complications.
4. Coordinate IEC efforts with UNICEF, PAHO, NGOs, SDP, SESPAS and other related agencies to assure harmony of message and acceptance as a national program and to prevent duplication of resources.
5. Collaborate with other NGOs (CEDOIS), especially women's organizations, in promoting breastfeeding as part of the important health role women play in their families and communities. Also work to build women's confidence in their abilities to breastfeed successfully.
6. Include mass media promotion of breastfeeding in the broad IEC breastfeeding strategy.

marginalized urban areas. Prenatal care should cover breastfeeding counselling and a breast examination.

Breastfeeding can be promoted for child spacing and should be considered for contraceptive users with respect to recommended and contraindicated methods. Currently unavailable low dose contraceptive pills and progestin-only pills should be marketed as an alternative to the contraindicated estrogen pills for nursing mothers.

Identify a SESPAS breastfeeding program coordinator/leader and strengthen SESPAS activities in breastfeeding for nationwide breastfeeding promotion.

At this time, SESPAS child survival activities have not been implemented due to a complex of problems. The first recommendation is critical and should be applied when these problems are addressed.

1. The lack of leadership for breastfeeding activities in SESPAS is a crucial issue and needs closer examination by national leaders in the health sector. A home must be found for breastfeeding with an individual responsible for coordination and execution. Because of a lack of a MOH/PLANSI Breastfeeding Program Coordinator, the team has not defined how and where these recommendations should be coordinated.
2. Revise, reorganize and correct PLANSI's Manual of Norms; design training and monitoring strategies with the trained hospital teams to implement norms at the operational level.
3. With URC/CSP revise the Health Promoter Manual: Limit areas of responsibility, improve organization, simplify, and correct errors. Emphasize proper breastfeeding, weaning, the importance of breastfeeding during diarrhea and management and motivation techniques.

Coordinate activities among international donors.

Coordination should be established thorough regular exchanges and/or joint efforts (C.4) in the design and implementation of IEC for community promoters and mothers, and health personnel, to assure consistency and optimum use of resources.

BREASTFEEDING SCORE SHEET

SECTION I: COUNTRY SOCIO-ECONOMIC AND HEALTH STATUS

	Poor		Optimal
A. Socio-demographic profile - no score			
B. Malnutrition & morbidity/mortality	1	2	3 4 5
C. Contraceptive prevalence	1	2	3 4 5

SECTION II: NATURE & MAGNITUDE OF SUBOPTIMAL BREASTFEEDING PRACTICES

		not supportive at all		very supportive
A. Breastfeeding practices	1	2	3	4 5
B. Mothers' KAP	1	2	3	4 5
C. Household and community members' KAP	1	2	3	4 5

SECTION III: POLICY, LEGAL AND FINANCIAL ENVIRONMENT

		not supportive at all		very supportive
A. Breastfeeding policy	1	2	3	4 5
B. Breast milk substitute/infant foods	1	2	3	4 5
C. Women's work and maternity leave	1	2	3	4 5
D. Local financing and donor assistance	1	2	3	4 5

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SECTION IV: FORMAL AND TRADITIONAL HEALTH SERVICES

FORMAL HEALTH SERVICES	not supportive at all	2	3	4	very supportive 5
A. Prenatal care	<input type="text" value="1"/>				
B. Hospital/clinic deliveries	<input type="text" value="1"/>				
C. Immediate postpartum and infant care	1	<input type="text" value="2"/>			
D. Health staff's KAP	<input type="text" value="1"/>				
E. Integration of breastfeeding promotion in health programs	<input type="text" value="1"/>				
 TRADITIONAL HEALTH SERVICES	 not applicable				

SECTION V: TRAINING PROGRAMS FOR HEALTH CARE PROVIDERS

	not well developed	2	3	4	very well developed 5
A. Formal public health care providers	<input type="text" value="1"/>				
B. Private health care providers	<input type="text" value="1"/>				
C. Traditional practitioners	not applicable				

SECTION VI: WOMEN'S WORK AND SUPPORT SYSTEMS

A. Description (do not score)

	not supportive at all				very supportive
B. National policy (no score if completed in Section III) (Maternity leave)	1	<input type="checkbox"/> 2	3	4	5
C. Wage earning environment	<input type="checkbox"/> 1	2	3	4	5
D. Agriculture and non-formal section environment	<input type="checkbox"/> 1	2	3	4	5
E. Women's group	1	2	3	<input type="checkbox"/> 4	5

**SECTION VII: MARKETING OF BREAST MILK SUBSTITUTES AND SUPPLEMENTS,
BOTTLES AND BOTTLES AND TEATS**

	not well developed				very well developed
A. National policy (no score if completed Section III)	<input type="checkbox"/> 1	2	3	4	5
B. Regulation of distribution	<input type="checkbox"/> 1	2	3	4	5
C. Regulation of promotion activities	<input type="checkbox"/> 1	2	3	4	5
D. Marketing of bottles, nipples & infant cereals	<input type="checkbox"/> 1	2	3	4	5

SECTION VIII: STATUS OF IEC ACTIVITIES

A. Overall effort	1	<input type="checkbox"/> 2	3	4	5
B. Available resources	<input type="checkbox"/> 1	2	3	4	5

- C'

		not well developed				very well developed
C. Specific Activities	Mass Media	1	2	3	4	5
	Interpersonal (NGOs)	1	2	3	4	5
	Clearinghouse	1	2	3	4	5
TOTAL:	ALL SECTIONS	54 / 145				

[Handwritten mark]

INTRODUCTION AND METHODOLOGY

Appropriate breastfeeding has been recognized as one of the most effective and cost-efficient means of ensuring child survival. The nutritional benefit and health protection, especially from diarrhea and respiratory diseases, that breast milk provides for young children has been universally documented (USAID, UNICEF, Anderson). In addition, breastfeeding favors mothers' health by reducing the risk of postpartum bleeding and subsequent iron loss, and reducing the risk of breast cancer. For both the child's and mother's health, exclusive and frequent breastfeeding has an impact on fertility by delaying ovulation, thereby increasing birth intervals.

Unfortunately, optimal breastfeeding practices are not uniformly practiced in many countries, including the Dominican Republic (DR). Although always listed as one of the child survival strategies, breastfeeding has not been the major focus in international or local health programming.

Recently UNICEF, PAHO/WHO, and A.I.D. have given priority to breastfeeding in their child survival programs. In a recent (June 1991) Regional Meeting for Latin America, the Executive Director of UNICEF, Dr. James Grant, declared breastfeeding and assisting hospitals to support breastfeeding as UNICEF's programming priority. A.I.D., in its Breastfeeding for Child Survival Strategy of 1990, pledges to strengthen and focus on breastfeeding promotion within its child survival, health, population and nutrition programs.

Common goals are to increase the number of infants who are breastfed immediately and exclusively from birth until four to six months of age; who are consuming appropriate complementary foods, in addition to breast milk, by the end of six months; and who are breastfed for one year or more.

Given the deteriorating economic situation of the Dominican Republic and the decreasing quality and availability of health services, breastfeeding promotion becomes extremely urgent. In response, UNICEF and the USAID-funded URC/Child Survival Program (CSP) are in the process of launching a large scale education campaign to promote breastfeeding. USAID also has included breastfeeding as a major component of five strategies for the DR outlined in the large scale Family Health Project to be started in 1992.

The first action listed in the A.I.D. international breastfeeding promotion and support strategy is to "assess the breastfeeding situation in assisted countries". The assessment is to form the basis for country-specific program planning, actions and monitoring. For this purpose MotherCare, (a centrally-funded A.I.D. project to assist work on improving maternal and neonatal health and nutrition) in close collaboration with A.I.D.,

developed the Guide for Preliminary Country Analysis of Activities and Practices Supporting Breastfeeding (1991). This guide served as the basis for the field visits and interviews and provided the structure for this report.

The Dominican Republic is the first country where the Guide for a Preliminary Country Analysis of Activities and Practices Supporting Breastfeeding was applied. A local team consisting of team leader, Dr. Marijke Velzeboer, an independent consultant, and Dr. Josefina Coën, Child Survival Coordinator for the Sociedad Dominicana de Pediatría, gathered relevant materials and research and contacted primary sources prior to the arrival of other team members. With international consultants, Dr. Argentina Alas de Chavez, Director of the Asociación Hondureña de Lactancia Materna (AHLACMA), and Magdalena Fischer, Director of Information, Education and Communication at the Nutrition Institute of Central America and Panama, (INCAP), extensive documentation was reviewed (See the Bibliography) and interviews with representatives of international, non-governmental organizations (NGOs), public and private health institutions were held (Annex I). Field visits were made to child survival promoters of five different NGOs and to a regional hospital and clinics in Regions IV and VI. In Santo Domingo, a maternity hospital, a private clinic and a NGO nutrition project in a poor barrio were visited. Pharmacies, one rural and one urban, a Santo Domingo supermarket and a rural restaurant and eatery were inventoried for infant formula.

Normal procedures in establishments of the Secretaria de Estado de Salud Publica y Asistencia Social (SESPAS) could not be observed because a national strike by public sector doctors, which had begun in May, 1991, was still ongoing at the time of the assessment.

After information was gathered and assembled, recommendations were defined with health officers from USAID, and representatives of UNICEF and the URC/Child Survival Project.

The assessment took five weeks, with the team leader working full-time, the Dominican advisor for three weeks and the international advisors for two weeks each. Time was equally divided among gathering information, interviewing, field visits and writing.

SECTION I

COUNTRY SOCIO-ECONOMIC AND HEALTH STATUS

The effects of suboptimal breastfeeding practice on the health of infants have been extensively documented (A.I.D., Breastfeeding for Child Survival Strategy, UNICEF State of the World's Children, 1991). In countries such as the Dominican Republic (DR), where the number of people who live below the poverty level grows yearly, it becomes more difficult to protect the health of children.

The worsening economic situation has had a direct effect on the nutritional status, morbidity and mortality of this most vulnerable group of Dominicans. In this section, the context in which to view current breastfeeding practices is put forth. In addition, particularly vulnerable groups are identified.

A. SOCIO-DEMOGRAPHIC PROFILE

1. Demographic Factors

The Dominican Republic shares the second largest island in the Caribbean, Hispaniola, with Haiti. In 1990 its estimated population was 7,169,850, with the majority living in urban areas (59%). The male to female ratio is fairly equal (103:100), with men outnumbering women in rural areas (112:100), the opposite being true in cities (97.4:100). Literacy rates for the DR are relatively high (80%) with men (82%) being slightly more literate than women (79%). The Dominican government does not publish ethnic or religious data. Most Dominicans are Catholic, though many adhere to folk rituals and beliefs.

2. Economic Factors

Economic factors have contributed to a reduction in the quality of life for much of the Dominican population, especially the poor.

The average per capita income for 1989 was RD\$508 per month with 39% of the population earning below the minimum wage (RD\$532.50 = US\$81.00) (CENISMI, MEPES). With almost 20% unemployment and under-employment gestimated at 40%, it is not surprising that 43% of rural and 45% of urban dwellers live below the poverty level (UNICEF, 1991). A recent USAID working paper placed this rate at 85% for Santo Domingo (USAID, Family Health).

Inflation was between 44.6% and 50% for 1989 and the consumer price index increased 41.2% from the previous year (U.S. Embassy Report 04). It is not surprising that the cost of the family

food basket, which increased 29%, to RD\$1000 (CENISMI, MEPES), outstrips the family's earnings, which decreased 19% during that period, leaving 80% of families unable to obtain even a minimal level of nutrition. This deteriorating situation is also reflected at the macro-level, showing a 43% decrease in trade balance, from -18 million US dollars in 1988 to -1,024.06 million US dollars in 1989. For this same period foreign debt increased almost 10%, to US\$4,216 million, with 37% of export earnings in 1988 allocated towards paying off the debt.

In 1989 the government of the DR increased the proportion of its GNP spent on health from 7% in 1985, to 7.6%, though in monetary value there was a decrease of 13%. While overhead expenditures were increased (rural clinics by 7.5%, and salaries of doctors by 3.8% and nurses by 28%), overall primary level care was decreased (popular pharmacies by 25%, external consultancies by 21%). Moreover, decreased resources are secondary to structural inefficiencies within SESPAS. The USAID/Family Health Project Paper (1991) describes the highly politicized and chaotic nature of health policy making and health care delivery. Coupled with the limited resources and overwhelming health needs, this situation has resulted in "a vacuum" in policy making and technical leadership at the national level and inefficiencies throughout the health sector.

3. Migration Patterns

Because of the worsening economic crisis, there is an increasing stream of Dominicans leaving rural areas for the cities and abroad. The emigration rate is difficult to quantify since many leave illegally. Based on the number of visas issued between 1970 and 1989, the US consulate alone gives out over 15,000 visas a year. Immigration of primarily poor Haitian sugar workers is also mostly illegal, and is estimated at 13,000/year, with 200,000 Haitians residing permanently in mostly rural southeastern areas (60%) in the DR (USAID, Health Assessment, 1990).

The overall migration rate is -2.3%, which has remained the same since 1980 (ONE, 1990). Internal migration rates reflect the migration to cities which grew 9/1,000/year from 1980-85, while rural areas lost 20/1,000/year (ONAPLAN, 1990).

4. Transportation and Communication

An extensive network of roads exists in the DR, though many areas, especially in the northwest, are difficult to reach. The majority of Dominican homes (95%) can be reached by radio. There are 200 stations, 87 in Santo Domingo alone. More than six religious stations broadcast regular education programs.

Television, considered to be the most effective medium by the private sector, has an overall penetration of 40% with most of the audiences in urban areas, where 55% of residents own a set. In Santo Domingo this number is 83%, with 74% of low income families owning a television. (See Section IX.)

The DR circulates six newspapers to predominantly urban and middle to upper class readers. The List in Diario and Nacional are the most widely read.

B. NUTRITIONAL STATUS AND MORBIDITY AND MORTALITY

1. Nutritional Status

Table I.1, based on 1986 DHS data, illustrates the malnutrition rate among Dominican children 6-36 months old, as defined by the percentage of children below 2 standard deviations (SD) of the NCHS/WHO/CDC Standard. Table I.2, based on CENISMI/MEPES data, includes rates defined by the same standard for children 3 months to 1 year of age in Regions O, IV and V. Although malnutrition is high by weight/age and especially height/age standards, the actual percentages of acute malnutrition (wasting) as reflected by weight/height are low. These figures indicate that Dominican children are chronically undernourished, this showing most in stunted heights (height/age), especially after one year of age and in rural areas. However, because both weight and height gains are less than expected, these children are small but not necessarily thin, hence the low rates of acute malnutrition. The nutritional differences as defined by weight/age in rural (17%) and urban (10%) areas are not apparent for weight/height (2.5% and 2.2%). It remains alarming that stunting affects over 20% of the 6-36 month population and that its effects increase drastically after one year of age when nutrients and antibodies provided by breast milk are minimal. At this time, it can only be hypothesized that the stunting begins in the first months as breast milk is replaced with other liquids. Figure I.1 (NNS, 1987) highlights the nutritional advantage breastfed infants have over mixed and bottle-fed babies, an advantage that lasts well into the ninth month of life.

TABLE I.1

MALNUTRITION RATE
% OF CHILDREN 6 TO 36 MONTHS
<-2SD WEIGHT/AGE, WEIGHT/HEIGHT AND HEIGHT/AGE
BY SEX, AGE, ZONE AND REGION
DOMINICAN REPUBLIC, 1986

	WEIGHT/AGE % <-2SD	WEIGHT/HEIGHT % <-2SD	HEIGHT/AGE % < -2SD
TOTAL	12.5	2.3	20.8
SEX			
Male	14.0	3.6	24.5
Female	11.1	1.2	17.2
AGE			
6 - 11 Months	6.7	3.2	9.6
12 - 23 Months	12.7	2.9	21.8
24 - 36 Months	15.3	1.3	25.6
ZONE			
Urban	9.6	2.2	15.1
Rural	16.6	2.5	28.8
REGION			
0	9.7	2.7	16.2
I	8.4	2.1	22.7
II	10.9	1.4	19.7
III	17.2	3.9	25.3
IV	19.6	2.1	28.0
V	12.4	1.5	18.8
VI	18.5	2.7	31.1
VII	10.1	1.0	18.0

Source: Demographic and Health Survey, 1986.

TABLE I.2

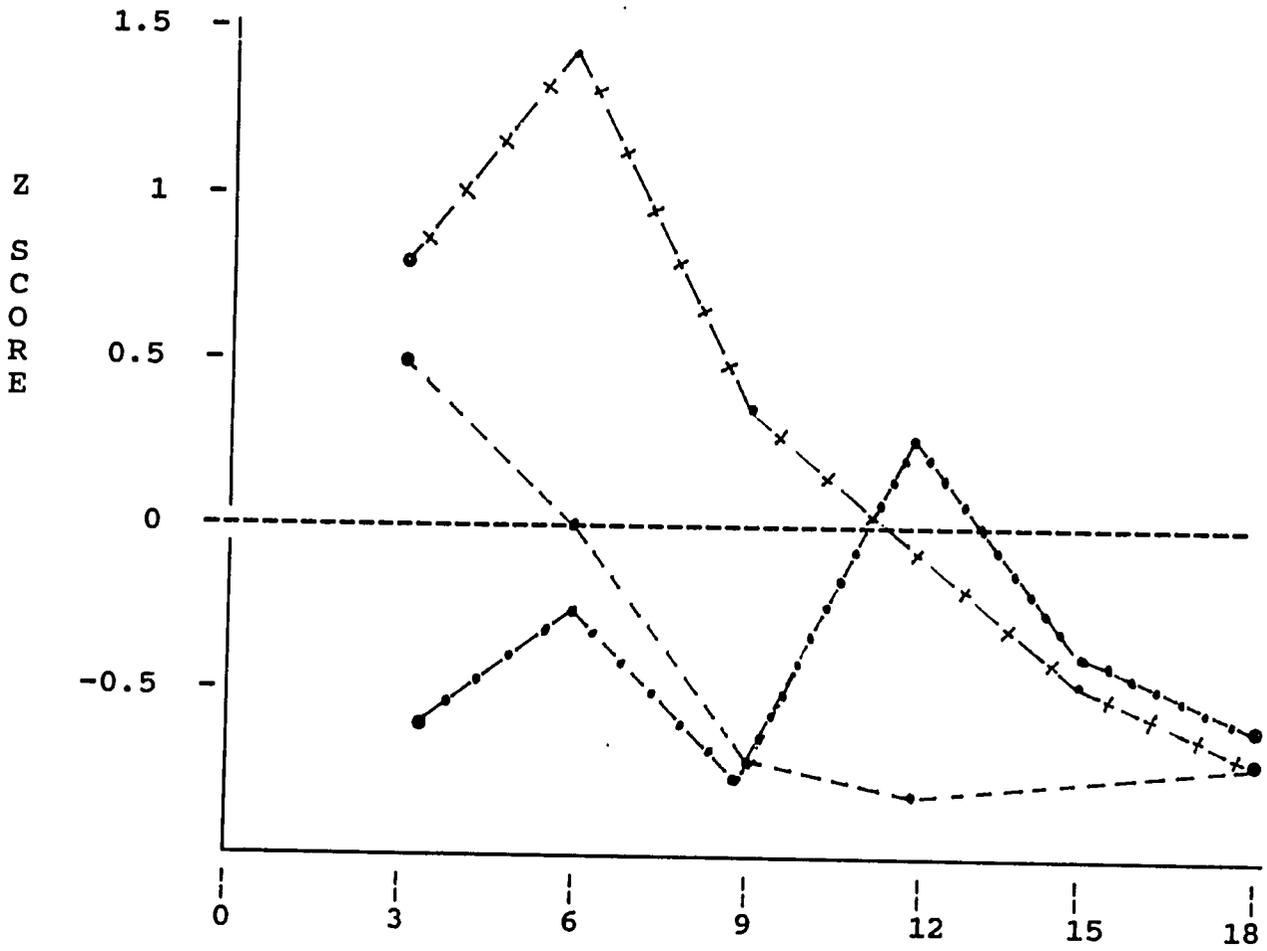
MALNUTRITION RATE
WEIGHT/AGE < -2SD
FOR CHILDREN 3 MONTHS TO 1 YEAR
IN REGIONS O, IV AND VI, BY SEX
DOMINICAN REPUBLIC, 1988-1989

AGE	3 MONTHS % < -2SD	6 MONTHS % < -2SD	1 YEAR % < 2SD
MALE	1.5	3.9	16.4
FEMALE	2.8	2.5	12.2

CENISMI/MEPES, 1990

FIGURE I.1

WEIGHT-FOR-HEIGHT
FOR BREASTFED AND BOTTLEFED INFANTS
IN THE DOMINICAN REPUBLIC, 1987



LEGEND: ●+--+Breast Milk Only
 ●---Breast & Bottle
 ●-●-Bottle Only

N = 281
p = 0.05

Source: USAID/Tufts Univ. National Nutrition Survey, 1987.

2. Morbidity and Mortality

Infant mortality in the Dominican Republic has decreased from 79.6 (per 1000 live births) in 1971-1975 to 65 in 1985. In rural areas, the decrease has been more marked (88 to 65.8), and is now lower than in urban areas (65.8 vs. 69.2) (DHS, 1986). According to SESPAS and confirmed in the 1991 DHS, respiratory illness and diarrhea are the two main causes of infant mortality apart from congenital abnormality.

Morbidity continues to be high with a recent CENISMI study (Mendoza, vol. 4, #2) in eight urban areas finding 59% of infants ill at the time of the survey. Extrapolating from this finding, Dominican children spend 15% of the year ill. Ninety-four percent of the illnesses are either diarrhea or respiratory diseases.

Diarrhea makes up 59% of illness, with a higher prevalence in urban (68%) than rural areas (49%) (Mendoza, vol. 4, #2). Various studies show the prevalence of diarrhea in the DR to be high, with episodes ranging from five to over seven days (Table I.3). Prevalence is higher for infants 6-11 months when breast milk provides less immunological protection and babies are more exposed to contamination and poor complementary foods (Table I.4). SESPAS estimates infant mortality due to diarrhea to be 12.6 with a range of 11.2 (Region 0) to 38 (Region IV), though other studies and sources (Table I.3) estimate this rate to be much higher. Diarrhea kills more infants than it does children between 1-4 years of age.

More children suffer from acute respiratory infections (ARI) than from diarrhea, though fewer die from ARI (Tables I.4 through I.6). Unlike diarrhea, morbidity rates for ARI do not change dramatically for infant age groups. In a 1987 hospital-based study Mendoza, *et al.* (CENISMI, 1987) found ARI to be the cause of 22% of childhood deaths, 26% for infants and 15% for 1-5 year olds.

Just as breastfeeding has a positive effect on the nutritional status of infants, it has a corresponding effect on illness (Figure I.2). Children included in the 1987 NNS had a significantly lower incidence of illness when breastfed through their second year of life, with the most marked difference before one year (76.9% of non-breastfeeders vs. 57.6% of breastfed infants were ill in the past year.) The higher incidence of illness at three years may be attributed to a negative income effect, i.e. mothers who prolonged breastfeeding may have lower incomes than those who weaned earlier.

The most dramatic effect of breastfeeding is shown in Table I.6. Here the morbidity of slightly malnourished infants (<-1SD, NCHS) and infant mortality is compared by risk factor. Morbidity rates are most affected by low birthweight, lack of breastfeeding and diarrhea.

TABLE I.3

DIARRHEA MORBIDITY AND MORTALITY
AMONG INFANTS IN THE
DOMINICAN REPUBLIC

YEAR	STUDY	AGE OF CHILD	PREVA- LENCE	AVERAGE DURATION/ EPISODE	MORTALITY
1986	DHS, National (last 2 wks)	< 6 months	25 %		12.6/1,000
			27.3%		
		6-11 months	41.3%		
1986	SESPAS, National Region 0 Region IV				12.6,1,000
					11.2/1,000
					38/1,000
1987	Mendoza, Vol 4 #2, Sto. Domingo	< 1 year	35 %	5.3 days	19/1,000
		1-4 years			5/1,000
1987	Mendoza 8 Urban Areas	< 1 year	23 %	5.0 days	
1987	CENISMI/MEPES Region 0, IV	< 1 year	40 %	7.3 days	26/1,000
1991	DHS, National	0-4 years	17 % (2 wks)		21.2/1,000
		< 6 mos	15.7%		
		6-11 mos	33.8%		
		12-23 mos	24.3%		
		29-36 mos	11.3%		

TABLE I.4

**MORBIDITY BY CAUSE AND
AGE GROUP OF INFANTS
IN REGIONS 0, IV, VI,
DOMINICAN REPUBLIC (PER 1,000 LIVE BIRTHS)**

CAUSE	< 3 MONTHS	6 MONTHS	1 YEAR
Diarrheal Disease	357.6	427.9	440.1
Acute Respiratory Infections	840.5	806.4	810.9

Source: CENISMI/MEPES, 1988-1989.

TABLE I.5

ACUTE RESPIRATORY INFECTION MORBIDITY
AND MORTALITY FOR CHILDREN IN THE DOMINICAN REPUBLIC

YEAR	STUDY	PREVAL	EPISODES/YR	MORTALITY (Per 1,000)
1986	SESPAS			7.6
1987	Mendoza, Ureña Hospital	20%	5 ep.	
1987	Mendoza	40%	10 (7 day duration)	3
1988- 89	CENISMI/MEPES	81% <1yr		
1991	DHS			8.0

TABLE I.6

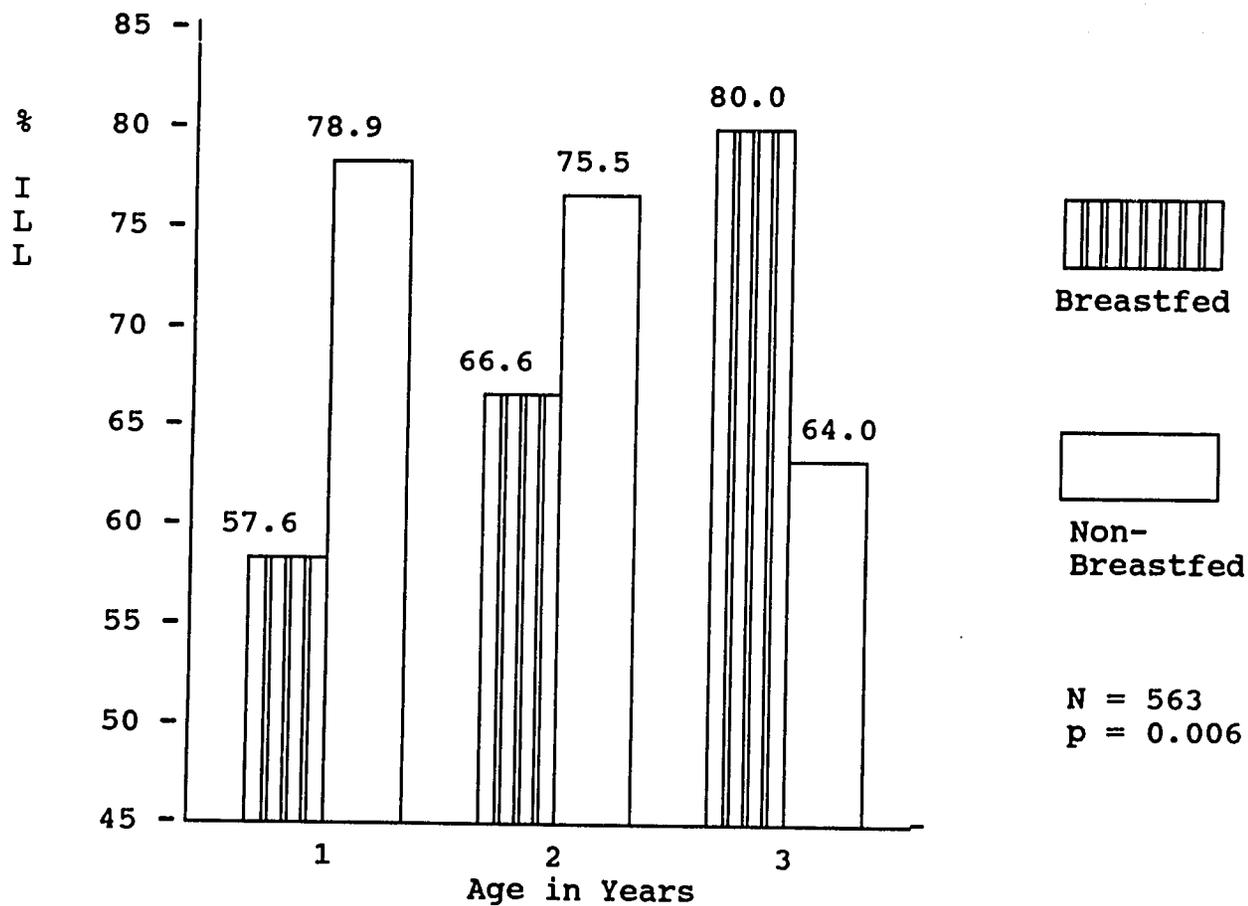
RISK FACTORS FOR MORBIDITY IN SLIGHTLY MALNOURISHED CHILDREN (< 1 SD. WT/AGE) AND FOR MORTALITY AT ONE YEAR OF AGE. DOMINICAN REPUBLIC REGIONS O, IV, VI.

Risk Factor for Children < 1 yr.		Morbidity Rate (%) of children < 1 SD main. wt/age	Mortality Rate per 1,000 child.
INCOME			
< 1,000 Pesos		46.8	----
> 1,000 Pesos		37.4	----
< 600 Pesos		----	31.2
> 600 Pesos		----	8.8
With previous episodes of diarrhea		52.4	30.7
Without diarrhea		40.0	14.0
With Previous ARI		46.2	24.6
Without ARI		42.3	7.5
With previous ARI and diarrhea		----	34.6
Without		----	----
Low birth weight		64.5 %	333.3
No low birth weight		43.3 %	40.7
Breastfed		42.4 %	36.1
Never breastfed		58.8 %	684.9
Malnourished <-2SD		----	34.6
Not malnourished		----	19.6
Mother	Adolescent/Not		114.2 / 58.1
	Illiterate/Not		203.9 / 63.1

Source: CENISMI/MEPES, 1990.

FIGURE I.2

COMPARISON OF ILLNESS INCIDENCE
BETWEEN BREASTFED AND NON-BREASTFED CHILDREN
IN THE DOMINICAN REPUBLIC, 1987



Source: USAID/Tufts University Natural Nutrition Survey, DR, 1987.

The difference made by breastfeeding is much more dramatic for mortality rates. Here, lack of breastfeeding standing out as the most significant risk factor. The risk of death for non-breastfed 1-year olds (684.9/1,000) is almost twenty times that of their breastfed cohort (36.1). The second risk factor, low birthweight, is eight times more likely to result in death.

C. FERTILITY AND CONTRACEPTION

The fertility rate for the DR 1988-1991 was 3.3 (DHS 1991), a decline from 3.7 in 1983-1986 and from 4.7 in 1975-1979 and 7.1 in 1965-69. In 1988-1991, fertility was 2.8 in urban and 4.4 in rural areas. The desired birth interval of mothers with one or two children was 23-25 months, which is lower for childless mothers and for those with more than two children (DHS, 1986).

Mean duration of lactational amenorrhea among Dominican women is five months and the median duration is even lower, 2.2 months (Table I.7). At three months, almost half the new mothers are fertile (DHS, 1986).

The 1991 DHS found that 56.4% of fertile age women in unions use some kind of contraceptive method (an increase from 50% in 1986), with the following distribution:

Pill	9.8%
IUD	1.8%
Condom or other vaginal methods	insignificant
Sterilization	38.5%
Traditional methods	4.7%

In 1986, oral contraceptives were used more by younger women (15-19 years, 18.2% ; 20-24 years, 16.4%), dropping to less than 5% use by older age groups. Overall, use of IUDs is low, and sterilization is the most popular contraceptive method for women 25 to 49 years, ranging from 29% for ages 25-29, to 57% for ages 35-39.

In 1991, 64.7% of family planning acceptors obtained their "modern method" from a private sector establishment: 76% of pills, 51% of condoms; 62% of sterilizations and 63% of IUDs were obtained through the private sector (DHS, 1991). Some SESPAS promoters distribute pills (44%) and condoms (29%). Private organizations (PROFAMILIA and ADOPLAFAM) also distribute temporary methods through their local distribution centers and trained promoters. Progestin-only pills, the oral contraceptive recommended for lactating mothers can be obtained only at a few

pharmacies at high cost. Norplant is available through PROFAMILIA's social marketing program, but is not affordable for poor women. Breastfeeding is not actively promoted or considered in service delivery of public or private family planning organizations.

TABLE I.7
BREASTFEEDING, LACTATIONAL AMENORRHEA
AND ABSTINENCE OF WOMEN BY AGE OF CHILD
DOMINICAN REPUBLIC, 1986

MONTHS SINCE BIRTH	NUMBER OF BIRTHS	PERCENT BREAST FED	PERCENT AMENORRHEA	PERCENT ABSTINENCE
0-1	138	85.1	83.6	79.6
2-3	134	71.9	55.1	25.9
4-5	139	67.3	35.1	12.1
6-7	153	52.8	20.6	13.9
8-9	146	42.1	19.2	14.5
10-11	168	29.5	11.9	9.8
12-13	165	24.0	5.4	7.1
14-15	153	19.8	5.2	6.3
16-17	157	22.2	6.4	8.0
18-19	138	14.3	5.8	8.5
20-21	166	13.1	1.4	6.6
22-23	152	6.2	0.9	9.8
24-25	137	6.7	1.6	4.8
26-27	149	4.5	1.2	3.8
28-29	120	3.5	0.0	4.5
30-31	121	1.6	0.0	0.4
32-33	133	0.8	0.0	3.3
34-35	178	2.6	0.0	1.6
TOTAL	2667	26.1	13.9	12.1
MEDIAN		7.0	3.0	1.7
MEAN		9.3	4.9	4.3

Source: Demographic Health Survey, 1986.

D. CONCLUSIONS

Breastfeeding is critical to child survival in the Dominican Republic. It should be an integral part of all health and family planning programs. Various studies in the DR have demonstrated breastfeeding's positive effect on child nutritional status and its positive influence on morbidity and mortality (NNS, 1987). Although the DR has made strides in reducing infant mortality, there is still much more that can be done. Promoting optimal breastfeeding practices is a critical next step.

With an average of five months of amenorrhoea for nursing mothers, breastfeeding is clearly not having its full impact on fertility. Breastfeeding should be promoted for child spacing and low dose estrogen pills or progestin-only pills should be available for nursing mothers.

Both the mortality/morbidity and fertility pictures lead to one conclusion: suboptimal breastfeeding practices. The major problem is the lack of exclusive breastfeeding. It will be important to review this situation more thoroughly and to promote optimal practices--not just the concept of breastfeeding.

SECTION II

THE NATURE AND MAGNITUDE OF SUBOPTIMAL BREASTFEEDING PRACTICES

Almost all mothers in the Dominican Republic breastfeed their babies, and they do so for an average of 9.4 months (mean rate) but this is not the complete story. Unfortunately, very few breastfeed optimally to assure the health and survival of their infants. An understanding of Dominican mothers' breastfeeding behavior and the attitudes behind them will help identify promotion priorities and strategies, and will provide information on problems that training, education and communication activities should attempt to resolve.

A. BREASTFEEDING SITUATION

In the DR, the incidence of breastfeeding is high (Table II.1). According to the National Nutrition Survey of 1987 (NNS), 93% of all children under five years of age had been breastfed time (USAID/Tufts, 1987). The Centro Nacional de Investigaciones en Salud Materno Infantil (CENISMI, 1990) found that in Health Regions 0, IV and V, 97% of infants less than six months of age had been breastfed. Although procedures vary between studies, they show a decrease of initiation among urban poor, while more middle and upper class mothers breastfeed. A comparison of World Fertility Study (1978) and DHS (1986) results show that the proportion of children ever breastfed increased from 87% to 92% of all children born.

Although the percentage of mothers initiating breastfeeding is high, it diminishes quickly as the infant gets older. Beginning with the youngest age group, 0-3 month olds, the 1991 DHS shows that slightly more than 80% were being breastfed but that this falls to only 30% among infants 10-12 months old.

Table II.2 illustrates that for 18% to 58% of infants 0-3 months, breastfeeding has been stopped. With the exception of the NNS and the DHS, data displayed in this table were collected in hospitals in Santo Domingo. Here the percentage of weaned infants 0-3 months is much higher than at the national level. Although procedures and figures vary greatly, there seems to be an improvement in breastfeeding duration in public hospitals since rooming-in was institutionalized in 1986. It remains alarming, however, that a large proportion of infants stop breastfeeding during these critical early months.

TABLE II.1
PERCENT EVER BREASTFED
BY ZONE AND INCOME LEVEL

YEAR	INVESTIGATOR	ZONE				
		<u>NATIONAL</u>	<u>RURAL</u>	LOW	<u>URBAN</u> MED	HIGH
1964*	Suero et al		100%			
1971*	Mendoza et al			100%	20%	4%
1977*	Rondon et al			90%	63%	4%
1981*	Tavarez et al				63%	
1983*	Tavarez & Rondon		93%			
1983*	Rondón et al			86%		
1986**	Gómez et al		100%	60%	83%	90%
1986	Demographic Health Survey	92%				
1987	National Nutrition Survey	93%				
1988 1990	CENISMI/MEPES	97%				

* Hospital-based studies in Santo Domingo area from CENISMI, Current breastfeeding status in the Dominican Republic, 1987.

** A survey of urban and rural marginal areas of Santo Domingo described in above named publication.

TABLE II.2

PERCENT OF INFANTS BY AGE WHO HAVE STOPPED BREASTFEEDING:
DOMINICAN REPUBLIC

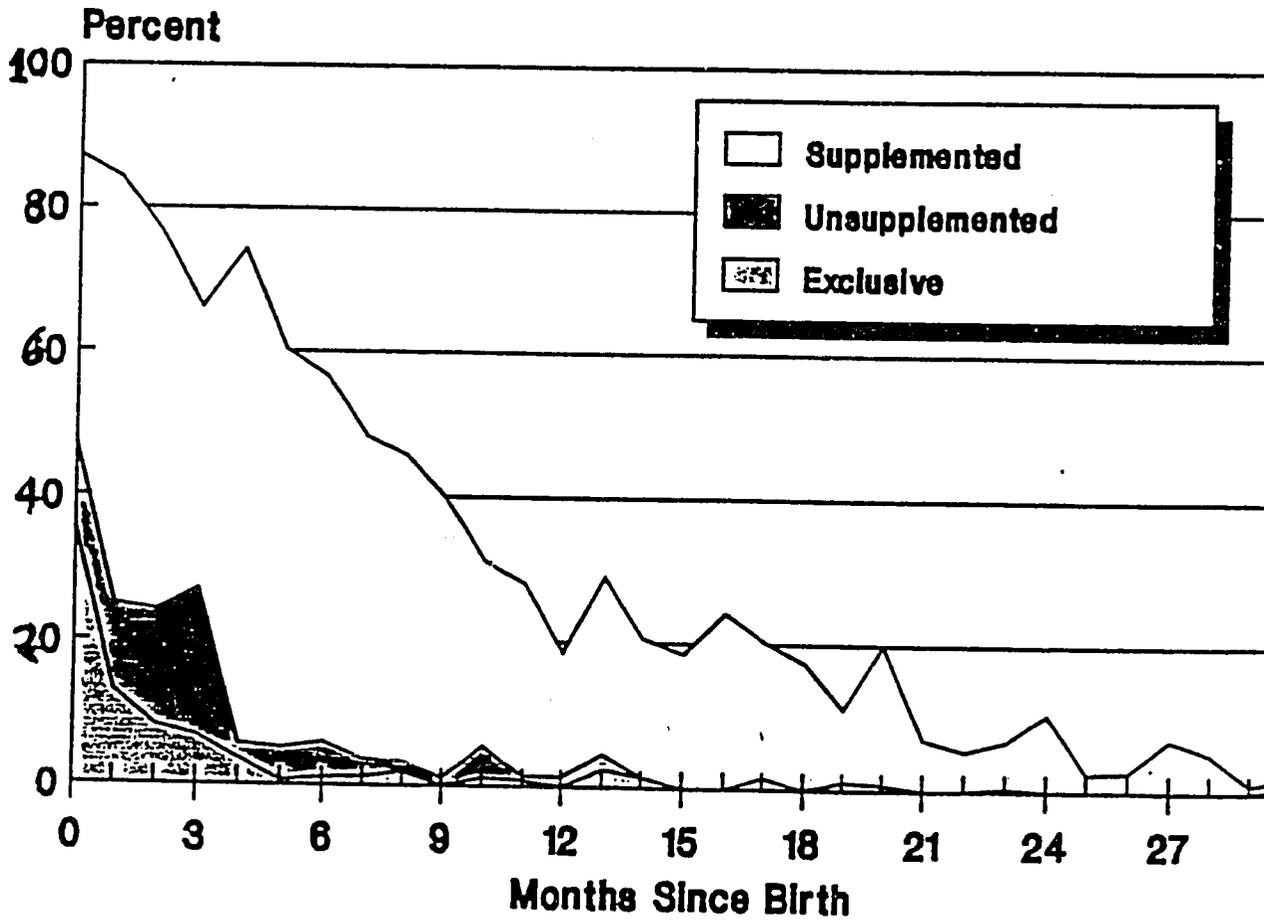
	AGE IN MONTHS			
	0-1	0-3	4-6	6-12
Mendoza, H., 1970		57%	15%	21%
Div. of Nutrition, SESPAS, 1983 2 Hospitals, Sto. Dgo. (n=298)				
Public Health Centers		34%	14%	37%
Private Health Centers		33%	4%	0%
CENISMI/UASD 1986				
Hospitals				
Public		20%	18%	56%
Private		40%	21%	16%
Gómez <i>et al.</i> , 1986 Survey of Marginal Areas, Sto. Dgo.	18%	58%	75%	11%
Tufts/USAID National Nutrition Survey (1987)		30%	50%	75%
CENISMI/MEPES 1988-91 Health Regions O,IV,VI		23%	19%	62%
DHS 1986		18%		
Preliminary Results, DHS, 1991		19%	44%	60% 69%
				(7-9) (10-12)

A most important point among these breastfeeding statistics is that although an impressive percentage of mothers initiate breastfeeding, very few do so exclusively. The 1987 NNS found that 90% of all mothers also bottlefed their babies, with early introduction of the bottle (1.1 months) being the norm. Of 0-4 month old infants included in the 1986 DHS who were breastfed, only 13% were breastfed exclusively, with 13% receiving water and 56% being supplemented with other foods (see Figure II.1). This situation seems to be deteriorating: In 1991, only 10% of the infants 0-3 months were breastfed exclusively and after three months, all children received some type of supplements. In the 4-6 month old range, 2% were breastfed and received water only, 33% were breastfed and received other liquids while 21% were breastfed and received semi-solid or solid foods (the rest of the infants were not breastfed) (DHS 1991). In Santo Domingo and its surrounding areas, Gómez *et al.* found that while only 3% of mothers with infants 0-1 months introduced liquids or other foods, 76% of infants 0-4 months had been supplemented. Milk, other than breast milk, was fed to 3% of infants by the first day and to 20% by the first month; by four months, 62% of babies had been fed other milk (CSP/KAP). There is no doubt that the high use of supplementation during the first three months of life contributes to the high rate of breastfeeding cessation during that period. These studies also show that infants who breastfeed exclusively or breastfeed at all beyond three months are more likely to continue beyond six months.

As implied above, the problem of early supplementation is strongly linked with use of the bottle. In 1991, 65% of the infants 0-3 months were breastfed and given a bottle (DHS 1991). Of mothers included in the CSP/KAP study, 42% had introduced bottles on the first day and 61% had done so by the third day. Of the 600 women from six regions who participated in the CARITAS/ANEP (1987) evaluation, over 60% introduced bottles during the first month. Moreover, early bottle feeding did not differ greatly for mothers who breastfed (42%) and those who did not (55%) (CSP/KAP).

Breast milk is not sufficient to sustain the growth of a child beyond the age of six months; the introduction of solid foods is necessary along with continued breastfeeding. However, 1986 DHS data show that only 11% of children 7-11 months comply with this recommendation to continue breastfeeding along with solid food. Other infants either receive no solids (16%) or have discontinued breastfeeding (5%) or both. According to the NNS, the mean age at which solids were introduced was 6.9 months at the national level, but with variations between 5.0 (Region I) and 8+ (Region O, Region III, Region V) months at the regional level. The first solid and semi-solid foods given are potatoes and soup for 50% or more of infants surveyed (NNS, 1987).

Figure II.1
PERCENT STILL BREASTFEEDING BY
SUPPLEMENTATION AND AGE OF CHILD
DOMINICAN REPUBLIC



DHS 1986: Nutritional Status and Graphs.

Even though breastfeeding is encouraged for two years or more, only 26% of 12-14 month old children continue to breastfeed (DHS, NNS). In Regions O, IV, and VI, CENISMI, (1990) this rate was 38%, with 58% of 1-year olds having been weaned. The mean duration of breastfeeding is 9.4 months according to the 1986 DHS, and 8-9 months, according to the 1987 NNS. Between the 1978 World Fertility Study and the 1986 DHS, median duration actually declined from 8.8 months to 7.5 months (Sharma). Rural mothers breastfeed longer (10.7 months) than their urban counterparts (8.4 months). Although maternal age does not affect duration, working status does, with working mothers nursing three months less (6.4 months) than mothers who do not work outside the home. Infants of uneducated mothers breastfeed longer (12.7 months) than do those of mothers who have received primary (10 months), secondary (7.2 months) or university educations (6.2 months).

B. MOTHERS' KNOWLEDGE, ATTITUDES AND PRACTICES (KAP)

Of more than 1,000 mothers interviewed in the Child Survival Program (CSP/KAP, 1990) study in Region O, IV, V, 99% believed breast milk to be the best milk for their newborns. CARE obtained the same results when interviewing 600 mothers in Region IV for a Baseline Study (CARE, 1990). On a national basis, 91% of mothers believe breast milk to be the superior milk for their children (NNS, 1987).

Overall, mothers are well aware of the advantages of breastfeeding. Table II.3 lists reasons mothers give for breastfeeding. Most mothers breastfeed to benefit the health of their babies, whereas few do it for ease, affection or economical reasons.

In a focus group exercise preceding the CSP/KAP, mothers said doctors placed their babies at the breast to start nursing as long and frequently as demanded. Although almost all mothers believed breast milk to be the best for their newborns, only 72% thought colostrum was good, because it cleanses their baby's system, aids digestion (hacer estómago) and prevents diarrhea. Seventeen percent of mothers said colostrum was bad milk; 2% thought it was old milk.

In the CARE study, 76% of mothers believed it was possible to breastfeed exclusively for the first four months, yet 87% of the mothers interviewed introduced bottles during this period. Smaller and more qualitative studies support the trend. CENISMI/MEPES (1990) found that in Regions O, IV, and VI only 13% of mothers breastfed exclusively. Introduction to other liquids is started almost immediately after birth. Because babies are believed to be thirsty, water and teas are given from the first days of life, followed by juices and milks to make babies strong. All but 5% of mothers boil water, though after a year, many (42%)

TABLE II.3

REASONS FOR BREASTFEEDING
DOMINICAN REPUBLIC, 1991

REASON	Sto. Domingo Area 1987/(1) %	CSP/KAP 1990 (2) %
More nutritious	27	20
Reduce infant deaths	15	
Protect child	11	42
Mother/child relations	6	2
Grow more		8
Develop better		8
Grow fatter		11
Grow stronger		8
Don't have to prepare	3	
More economical	1	

Sources:

- (1) Gómez, E., Montano, R. and Canario, M. Patrones de Lactancia en el Distrito Nacional de la Rep. Dom., UASD, CENISMI, 1987.
- (2) Child Survival Program/KAP Study for Mothers in Regions 0, IV and VI. DR, 1990.

believed children should get used to local water. Herb teas are used widely to cleanse the newborn's system (meconium), to aid in digestion (hacer estómago), and to prevent diarrhea and other ills.

In the CSP/KAP study (1990), the majority of mothers believed babies should be breastfed for one year or more, with only 6% supporting stopping before six months. Most (76%) believed weaning should be gradual, rather than abrupt (24%). However, 25% stopped breastfeeding their last child before four months, another 39% between five months and a year and only 18% nursed beyond a year. Younger women were more likely to stop breastfeeding their babies before six months.

Reasons for stopping breastfeeding are numerous. Table II.4 lists reasons as derived from a national study and a Santo Domingo hospital-based study. Most infants were weaned because mothers believed they did not have sufficient milk or because babies rejected the breast, both complications of the early introduction of supplements. A significant proportion stopped breastfeeding because they felt their child was too old. Unfortunately, no age was specified. There is a gap between mothers' belief in prolonged breastfeeding and actual weaning behavior. Aside from pregnancy, maternal health, nutritional, or work status had little influence on women's decisions to stop breastfeeding their babies.

Mothers participating in CSP/Focus Groups (1989) said they suspended nursing when they were ill with fever, hepatitis, anemia or malnutrition; when they were hot and sweaty; when walking; when their babies were ill with diarrhea and vomiting; or when the infants rejected their milk because it was "salty". In the KAP study (CSP/KAP, 1990), 85% of mothers believed in the existence of "salty" milk, of which 60% indicated as being harmful to the baby. In addition, 36% believed the milk of pregnant mothers to be harmful. Thirty-seven percent of mothers withheld breast milk to babies sick with diarrhea and vomiting, giving them instead juices, rice water and cornstarch (maizena).

Gómez et al. (1986) found no difference in the incidence of breastfeeding by working and non-working mothers in the Santo Domingo area. The CSP/KAP study showed that mothers' attitudes toward breastfeeding did not differ much by working status, though 15% of working mothers versus 9% of non-working mothers introduced other milks before one month. Introduction of other foods was similar. As mentioned previously, working was rarely identified as a reason for weaning.

TABLE II.4
REASONS FOR STOPPING BREASFEEDING
IN THE DOMINICAN REPUBLIC

	Santo Domingo 1983 (1) %	NNS 1987 (2) %
Milk Salty	1.8	
Milk ceased /insufficient	38.7	29.4
Motner refused		2.1
-- pregnant	12.8	
-- ill	6.0	3.9
-- malnourished	3.9	
-- working	3.5	2.5
-- using antibiotics	0.7	
Baby Refused	14.2	13.5
-- too old	12.8	29.2
-- sick	4.6	
-- absent	1.1	
Medical Advice		0.5

Sources:

- (1) Rondón, H., et al. Situación de la Lactancia Materna en la Población Urbana de Dos Maternidades de Santo Domingo, CONAPOFA, 1983.
- (2) A.I.D./Tufts University, National Nutrition Survey, 1987.

Mothers do not define an age at which the child can eat a full diet. They introduce solids gradually. Mothers are concerned with food preparation because they know that badly prepared foods are a primary cause of diarrhea. Eleven percent of babies were fed semi-solid and solid foods before 1 month of age and 58% before 4 months; only 31% received foods between 4-6 months and 7% after 7 months (CSP/KAP, 1990). In the CARITAS/ANEP (1987) study, more children were found receiving solids late: 21% of children over 7 months had not received solids and half of them were over 12 months. Most commonly introduced foods were crema de habichuela (bean broth) (32%), purees (20%), soups (16%) and maizena (5%), (CSP/KAP, 1990; ANEP/CARITAS; NNS, 1987). Focus group participants listed foods low in fat, such as: root staples (potato, cassava, sweet potato), plátanos (plantains), and crema de habichuelas (bean soup), and sometimes carrots, as suitable baby foods. Other vegetables and fruits were not mentioned.

There is a belief that certain foods consumed by nursing mothers will harm babies and, therefore, should not be eaten. These include greasy (pork 14%, avocado 18%) and spicy foods, as well as eggs (20%) and guanabana (CSP/KAP, 1990). These beliefs are held with little variation in urban and rural areas. A minority (39%) of women felt that mothers could eat all foods while breastfeeding.

Doctors are most commonly consulted on breastfeeding matters (81%), and it is they (42%) who most often recommend that mothers give other milks (CSP/KAP, 1990). Yet, when asked if they would listen to a doctor who advised against the intake of water if a baby was breastfed, 56% of mothers (65% in Santo Domingo; 50% in IV, VI), said that they would not, although 98% would seek a doctor's advice on diarrhea and child health.

Mothers are unlikely to seek medical advice for breast problems. While 62% have experienced pain when breastfeeding, the most common solution is to continue breastfeeding (39%). The use of soap or alcohol for washing nipples (done by 45% of women) may contribute to these problems. Thirty-three percent of mothers wash with water only, as recommended.

C. COMMUNITY AND HOUSEHOLD MEMBERS' KAP

In the Dominican family structure the father traditionally is the authority figure, an authority which is, at times, overstepped. Recent economic, social, and cultural changes have affected many families and have brought with them stress, alcoholism and breakups. However, family support for the nursing woman is important. Focus group (CSP, 1989) participants felt that fathers supported breastfeeding, though they had known men (not theirs) who thought breastfeeding affected women's hygiene and appearance. Even though men may support breastfeeding, they may

also be the purchasers of milks. The well-known Law 2402 requires an absent parent to pay for food for his/her children, though it is many times ignored by absent fathers. Unfortunately, when fathers comply, they often buy expensive milk rations for their babies (thus the popular name of Law 2402 is the Milk Law).

When mothers go out, they tend not to leave their children with fathers. Since Dominican mothers rarely take their babies out, except to visit doctors, they leave them with older siblings, female relatives or neighbors, who they sometimes pay. According to interviews with promoters and mothers, this care is not optimum and has been associated with malnutrition and diarrhea in children. The children, neighbors, female friends and relatives are unlikely to encourage expressing breast milk and feeding it to their infant charge from a cup. However, they are considered strong supporters for breastfeeding, though physicians are definitely the choice for advice about breastfeeding.

D. CONCLUSION

Almost all Dominican mothers start out breastfeeding their babies and do so for an average of almost ten months. In spite of this positive beginning, very few mothers breastfeed optimally. There exists a discrepancy between mothers' knowledge and attitudes about the health benefits of breastfeeding, and what they actually practice. This gap must be closed. For example:

(1) even though exclusive breastfeeding is the optimal practice only a few women exclusively breastfeed (10% of children 0-3 months old), even though most are aware of the nutritional and health advantages their milk provides for their babies. In fact, Dominican mothers say they nurse their infants for health reasons rather than for affection, economics, or ease. Interfering with exclusive breastfeeding are teas and water, customarily given immediately after birth, most likely with a bottle.

(2) Mothers believe that breastfeeding is important for a year or more, but about one-third of infants are taken off the breast before three months and two-thirds half have stopped by a year (DHS, 1991).

Reasons for beginning supplementation and then for discontinuing breastfeeding are related to complications caused by early supplementation: insufficient milk and baby rejecting the breast. Supplementation interferes with milk production and confuses the young infant who may opt for the more easily obtained milk from an artificial nipple. Neither mothers, nor their doctors understand this and therefore readily resort to supplementing the infant or to discontinuing breastfeeding rather than increasing breast feeds to stimulate mother's milk production. Although

female family members do influence mothers' decision to breastfeed, doctors are by far more influential and are identified as the primary source for recommending early supplementation. Proper breastfeeding techniques and how to handle complications should become a routine part of breastfeeding promotion.

Many Dominican mothers live in poverty. The accompanying unhygienic conditions substantially increase the health risks of bottle feeding to babies whose immunological systems can not yet defend them. Mothers and doctors need to understand the critical importance of exclusive breastfeeding during the first four months, if the baby is to have any chance of survival under these conditions. They should also understand that early supplementation interferes with lactation and that breastfed babies do not need teas or water, or any other supplements for the first four to six months of life. The ingestion of these liquids actually increases the risk of infection. The biggest challenge is to motivate women to breastfeed exclusively, a practice that to-date has not received major attention. Likewise, the proper introduction of semi-solids and solids by six months along with continued breastfeeding requires emphasis. Here, there have been some positive experiences in the DR that can offer a guide to improving this aspect of young child feeding practices.

SECTION III

POLICY, LEGAL AND FINANCIAL ENVIRONMENT

In the following section the policy, legal, and financial environment in the Dominican Republic (DR) will be assessed, as it relates to protecting, promoting and supporting breastfeeding practices. An understanding of this environment will result in a clearer idea of the impact that national policies and legislation and support from donor agencies, could have on the breastfeeding practices of Dominican mothers.

A. BREASTFEEDING POLICY

1. Current Norms

Since 1988, the National Breastfeeding Program was incorporated in the Plan Nacional de Supervivencia Infantil (PLANSI) of SESPAS. In 1991, PLANSI became a program of the Maternal Child Health (MCH) Division. The breastfeeding policy of the MCH Division has been defined in the PLANSI Norms. To date, the Norms have been distributed to Directors of SESPAS hospitals, health centers and sub-centers, but lack of accompanying training and monitoring has meant that the majority of the Norms are not applied.

The Norms do not clearly address the following "**optimal breastfeeding behaviors**" as defined in A.I.D.'s 1990 Breastfeeding Strategy Paper.

Breastfeeding within one hour of delivery.

The Norms state that breastfeeding should begin immediately after normal delivery and that neonatal procedures be implemented afterwards. They emphasize rooming-in and demand-feeding. However, breastfeeding is incorrectly contraindicated for infants who are premature, have cleft palates and infections, and for mothers who have tuberculosis and birth complications (Caesarean, toxemia, infections).

Exclusive breastfeeding from birth through 4 to 6 months.

The importance and meaning of exclusive breastfeeding is not emphasized in the Norms, and supplementation was only mentioned for 6-month old infants.

Feed appropriate complementary foods, in addition to breast milk, by the end of 6 months of age.

In the section on weaning in the Norms (C.2.p.49), the title states "From 6 months to Weaning". The text, however, indicates that introduction of others foods should happen at 4 to 6 months. No nutritional guidelines are given for introducing semi-solid foods.

Breastfeeding for one year or longer.

No mention is made about prolonged breastfeeding in the norms.

Although the 1990 program plan for breastfeeding does include training of 100% of promoters and 60% of medical personnel in the content of the Norms, these objectives were not accomplished. The installation of milk banks in 100% of hospitals remains a high priority (SESPAS/PLANSI, Programa: Lactancia Materna. Esquema Logístico del Proyecto 1990).

Likewise, SESPAS/MCH policies do not comply with the UNICEF/WHO-recommended "ten steps" to support breastfeeding (See Table III.1). As mentioned, the written breastfeeding policy (Norms) has not been communicated to all health care staff (step #1). Only 16% of promoters have been trained in implementing this policy, though their responsibilities are too numerous and their support structures too weak to do so effectively (step #2). Most breastfeeding materials, including the Norms and the Promotor Manual, emphasize the benefits of breastfeeding, though information on management is neither consistent nor complete (step #3). Even though immediate (step #4) and on-demand (step #8) breastfeeding is a policy, medical personnel do not show mothers how to breastfeed. Formula is advised when medical conditions warrant infants to be separated from their mothers (step #5). Exclusive breastfeeding is not emphasized, (step #6), but no teats or pacifier are provided (step #9). In public hospitals rooming-in is a standard procedure for normal deliveries, though mothers are discharged too soon (6 to 12 hours) after delivery to optimize this benefit (step #7). Support groups are not considered in PLANSI Norms, manuals or strategies (step #10), and, with the exception of La Leche League in Santiago, do not exist.

The policy of the National Program for Acute Diarrheal Disease Control (ADDC) is included in the PLANSI Norms. In the ADDC Norms, breastfeeding is mentioned for rehydrating babies with acute diarrheal disease (ADD) and is encouraged when vomiting accompanies ADD, though its overall importance is not stressed. The role of exclusive breastfeeding in preventing ADD in infants under 4-6 months is not mentioned.

Breastfeeding practices during oral rehydration therapy (ORT) are not defined with regard to separating the ill child from its mother, the use of bottles and ORT interference with exclusive breastfeeding. During therapy, normal food intake is encouraged, but breastfeeding is not included.

TABLE III.1

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. Practice rooming-in: allowing mothers and infants to remain together, 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Source: WHO/UNICEF. Protecting, Promoting and Supporting Breastfeeding in Maternity Services, 1989.

Of the three forms promoters are expected to fill out for diarrhea cases, none of them--not even the personal history--contains information about breastfeeding.

Breastfeeding is not promoted in the SESPAS family planning program (CONAPOFA) which has limited coverage, nor is it in any of the non-government family planning organizations. No policy exists concerning the use of family planning methods for breastfeeding mothers. Likewise, no policy exists for breastfeeding HIV+ mothers. Lacking a national policy, health facilities and milk banks follow WHO guidelines.

2. Information Systems

Given the inconsistent breastfeeding policy, the lack of dissemination and overall non-compliance, it would be difficult to collect information to demonstrate to policy makers the benefits of breastfeeding promotion. In reality, SESPAS collects no breastfeeding information, though a space is provided on the family health records (ficha familiar) maintained by promoters. In coordination with SESPAS, the Child Survival Program has designed the community level part of an information system, as well as an implementation strategy and procedures to be used by SESPAS and NGO community promoters. This effort, which is to be part of a single national information system, collects data on exclusive and prolonged breastfeeding, as well as on other child survival practices (CSP/STL. Para que Nuestros Hijos Crezcan Sanos y Fuertes, 1990).

Most of the existing information on breastfeeding in the DR is obtained from national studies and surveys (DHS, NNS, local or hospital surveys and CSP/KAP studies). The ongoing CENISMI/MEPES studies provide information to policy makers on the global health of young children, of which breastfeeding is a part. The USAID-URC/CSP, PAHO and UNICEF, all have budget items for operations research and special studies, so more information on breastfeeding may be forthcoming.

Although there are Dominican studies showing the physiological advantages of breast milk (CENISMI: Polanco et al., 1984; Payano et al., 1988; Sanchez Martinez et al., 1985; Rondón et al., 1988), there are no cost-effectiveness studies to convince policy makers of the economic value and cost savings of breastfeeding.

3. Coordination of National Breastfeeding Policy

In 1984 the Comisión Nacional de la Lactancia Materna was formed, consisting of nine members of the private and public sector. The Commission was formed to promote legalization of the Ley de la Comercialización de las Sucedeas de la Lactancia Materna (Annex

3) and to set up milk banks in maternity hospitals. It ceased to function when the then-First Lady formed the Comisión Nacional de la Madre y el Niño and took over the task of implementing milk banks. The Code, which was modeled after the WHO International Code and was presented in 1986, lost its support.

4. Policy Implementation

As mentioned above, breastfeeding policy was developed but not implemented. Although central level policy makers and donors attended a seminar in 1989 to introduce PLANSI Norms, training never reached operational levels.

B. POLICIES RELATED TO MARKETING AND PROMOTION OF BREASTFEEDING SUBSTITUTES AND INFANT FOODS

Although the Ley de Comercialización de Sucedaneos de la Leche Materna (Annex 3) has not become law, most formula distributors do abide by the WHO International Code of Marketing Breast Milk Substitutes. A more detailed discussion concerning their marketing policies follows in Section VIII.

C. WOMEN'S WORK AND MATERNITY LEAVE POLICY

Although legislation exists in the Código de Trabajo favoring breastfeeding for working women, with the exception of the Maternal Leave Article, these laws are not enforced. A more complete discussion on this topic follows in Section VII.

D. MAGNITUDE OF LOCAL FINANCING AND DONOR ASSISTANCE

According to the program plan for the Programa de Lactancia Materna (SESPAS/PLANSI) for 1990, there was RD\$1,268,719 programmed for breastfeeding, 55% was to be provided by the government of the DR, 39% by UNICEF, 2% by PAHO/WHO and 3% by PL-480 funds.

Private funding for breastfeeding promotion has until now been limited to the Pediatrics Society and Nestlé, even though the philanthropic community among commercial businesses is large.

E. CONCLUSIONS

Policy in the DR for protecting, promoting and supporting breastfeeding is poorly defined and generally not applied. Even though a National Breastfeeding Program was established within SESPAS in 1988, its activities have been limited to defining a

policy as part of the PLANSI Child Survival Norms. These Norms, though published, are not specific and contain many errors. They have been distributed, but there is little evidence of their application. They should be revised.

The Norms reinforce rooming-in and breastfeeding immediately after birth. However, they incorrectly contraindicate breastfeeding for babies with low birth weight and infections and from deliveries with complications. Other critical oversights in the Norms that must be addressed include the lack of priority given to (1) the promotion of exclusive breastfeeding during the first four to six months of life; (2) prolonged breastfeeding beyond two years; (3) guidelines on the introduction of semi-solids and solid foods; (4) the importance of breast milk for babies with illness or diarrhea.

At the legislative level breastfeeding receives no attention. Ley de Comercialización de Sucedaneos de la Leche Materna, drafted in 1985, has still not become law),

Donor agencies have identified breastfeeding as a priority health intervention and are committed to supporting breastfeeding activities and research. However, this will be difficult to do without a well defined policy that addresses the breastfeeding problems and needs of the DR and a commitment to enact it.

SECTION IV

FORMAL AND TRADITIONAL HEALTH SERVICES

This section aims to assess the availability, content and accessibility of breastfeeding support services provided by the formal and traditional health sectors of the Dominican Republic. These services will be described with respect to prenatal, maternity and postpartum and infant health care, in order to identify action, policy and research needs aimed at improving breastfeeding practices within these services.

A. FORMAL HEALTH SECTOR

1. Overview

The health sector in the Dominican Republic is composed of public and private services. The public sector includes the Secretariat for Public Health and Social Welfare (SESPAS), the Dominican Institute of Social Security (IDSS), the Armed Forces and Police Security Institute (ISSFAPOL), and the State Sugar Council (CEA). Private services are provided by physicians through clinics. Medical Contracts are private prepaid medical plans that offer health services in urban areas. Some 19 Medical Contracts control 75% of the private medical insurance market in the country. Thirty-two private medical insurance groups offer health services to private sector workers and their dependents. Many of the over 400 non-governmental organizations (NGOs) provide health services in rural and urban areas, although their capacity is limited.

The Household Survey of 1987 collected data on the use of formal health services. The survey found that approximately 11% of the population use prepaid private medical insurance services, 5.9% is covered by IDSS and 4% by ISSFAPOL, which leaves 76% of the population to be covered by SESPAS. This survey also showed that private medical services are used for 50% of all outpatient medical visits and 46% of hospitalizations of the non-insured population. In reality, SESPAS covered 42% of outpatient visits and 46% of hospitalizations of the non-insured population.

Theoretically, SESPAS is the major provider of health services, although exact coverage is not known and estimates fluctuate between 40% and 60%. During the last 15 years SESPAS has developed an ample infrastructure of formal health services. At present it has 527 rural clinics, 113 area hospitals and health subcenters that provide maternal and child health services, and 47 urban hospitals. The system employs 2,740 physicians, 420 registered nurses, 4,000 nursing aids and approximately 6,000 community health promoters and supervisors.

The country is divided into eight health regions. Each region has a director and regional team composed of one epidemiologist, one maternal-child nurse, one nutritionist and a medical statistician; they are responsible for the execution, monitoring and evaluation of health programs and for a network of area hospitals, health subcenters and rural clinics. Hospitals and subcenters provide services with specialized medical personnel in pediatrics, gynecology and obstetrics.

Each rural clinic is headed by a recently graduated physician known as "Assistant Physician". S/he works with a nursing aid to provide primary health care services to the community, with the help of health promoters and their supervisors. In theory, each supervisor is responsible for 8 to 10 promoters and each promoter, in turn, is responsible for 60 to 80 families.

Under the Basic Health Services system established in the early 1980s, approximately 6,000 promoters were trained in primary health care. After a change in government, almost all of these trained promoters were replaced. To date, only 850 of the new promoters have received training in child survival activities based on the recently produced Manual de Promoter.

There has been a general deterioration of SESPAS infrastructure and services. Use of its services has decreased significantly since 1987 due to the lack of equipment, materials, drugs and administrative support. As a result, there has been an increase in the use of private health care. Likewise, NGOs are providing more care to the poor population in rural areas and in urban communities.

2. Prenatal Care

a. Coverage

The Demographic Health Survey (DHS, 1986) showed that the Dominican Republic has high prenatal coverage (94.8%). In 66.4% of pregnancies, prenatal care is provided by a physician, and in 0.6% by a midwife. Only 4.4% of pregnancies do not receive any type of prenatal care. Table IV.1 shows prenatal care coverage according to mother's age, educational level, urban/rural area, and health region. Rates do not differ much by geographic area or age of mother, but are somewhat lower among women with no education (84%).

Public sector prenatal care is provided through SESPAS hospitals, subcenters and rural clinics and covers 60% of pregnancies in rural areas and 30% in urban areas (Household Survey, 1987). Private prenatal services are used more in urban areas and have had a rapid growth in the last years in the largest cities of the country. Private family planning organizations such as PROFAMILIA and ADOPLAFAM operate more than 200 clinics that offer

prenatal care, primarily in poor, urban areas.

TABLE IV.1

DISTRIBUTION OF BIRTHS IN THE LAST FIVE YEARS
IN WHICH MOTHERS RECEIVED PROFESSIONAL CARE DURING THE
PREGNANCY, ACCORDING TO THE MOTHER'S AGE AND EDUCATION, AREA AND
HEALTH REGION

Variable and Category	% Receiving Prenatal Care
MOTHER'S AGE	
Less than 30 years	95.6
30 years or older	92.9
EDUCATION	
No education	83.6
Elementary School	94.3
High School	98.9
University	100.0
AREA	
Urban	95.9
Rural	93.3
REGION	
0 (National District)	94.5
I	96.8
II	96.7
III	96.7
IV	92.6
V	93.6
VI	89.3
VII	97.9
TOTAL	94.8

Source: DHS, 1986

b. Number of Prenatal Care Visits

There are no available statistics about the number of prenatal visits women make, but from interviews and CSP/KAP information (1990), it is estimated to be between four and seven per pregnancy. These numerous visits provide excellent opportunities for prenatal care providers to educate mothers on breastfeeding and maternal-child nutrition.

In a participative health survey by Mujeres Dominicanas para el Desarrollo (MUDE, 1990) more than 80% of member peasant women had six to seven prenatal visits. Women giving birth at a Santo Domingo maternal hospital also obtained prenatal care regularly, though 77% did so before the fifth month of pregnancy (Hay, 1990). Almost all (91%) thought prenatal care was important and 97% knew where to obtain it. Reasons for visits were for reassurance and out of obligation.

c. Quality of Prenatal Care: Breastfeeding Norms in Prenatal Visits

A recent CENISMI study (1990) established that the quality of prenatal care offered in the maternity wards in Santo Domingo is deficient. High prenatal coverage documented by many recent studies (DHS, 1986; CENISMI, 1988: "Epidemiology of Low Birth Weight") is contrasted with the high incidence of pregnancy problems, malnutrition during pregnancy, low birth weight and high maternal mortality. The CENISMI study estimates that 40% of prenatal care is inadequate in the public services and 15% of the private prenatal services.

As part of the National Health Policy for 1986-89, standards were prepared by SESPAS and included in the National Plan for Child Survival. These standards were distributed to hospital and health subcenter directors in all health regions. However, they were never implemented because no training concerning their contents accompanied their distribution.

The assessment team questioned mothers in maternity wards about information they received on breastfeeding during prenatal visits. Not one mother had received any advice or had her nipples examined. Unfortunately, due to the physicians' strike in hospitals and health subcenters, the team was unable to observe prenatal care and to assess compliance with the breastfeeding norms by regular health personnel.

At present there is no counseling on breastfeeding in the maternity wards nor are educational materials on breastfeeding distributed to pregnant women or new mothers. Fortunately, there is no promotion or distribution of infant formula to pregnant

mothers in the prenatal care provided by the public health services.

3. Standards for Delivery Care in Hospitals and Clinics

a. Summary of Statistical Indicators

Deliveries

Obstetric care is highly institutional: 90% of births are attended in hospitals and health subcenters by professional personnel. The DHS of 1986 found that 54.8% of the births were delivered by physicians and 36% by nurses. Only in predominantly rural areas were births delivered by midwives, who had not received training by the formal health services. Institutional coverage of deliveries is high in all the health regions; however, in two regions (IV and VI), more than 20% of the births were not assisted by qualified personnel (Table IV.2). Educated mothers were more likely to have an assisted delivery than mothers without education. This may be explained by better accessibility to health services, since educated women tend to live in urban areas.

Although the rate of institutional delivery is high, the quality has been questioned in the technical reports of CENISMI/MEPES (1990). These reports point out the high mortality of infants with low birth weight within the first 48 hours (17%) and seven days of life (18%), as well as the frequency of maternal infection.

Distribution of Births Public Sector Facilities

The crude birth rate for the Dominican Republic is estimated at 31.1 per 1,000 inhabitants. ONAPLAN/CELADE estimates that the annual average of live births for the period 1985-1995 is 213,000. Total live deliveries in public facilities were 110,883 in 1990, which means that approximately 51% of infants born were delivered in the SESPAS facilities. Health Regions 0 and II, containing the highest population, had the greatest proportion of these deliveries, with 23% and 25%, respectively, while sparsely populated Region VII had the lowest (5%).

TABLE IV.2

**DISTRIBUTION OF BIRTHS IN THE LAST FIVE YEARS
IN WHICH MOTHERS RECEIVED PROFESSIONAL CARE DURING CHILDBIRTH,
ACCORDING TO MOTHER'S AGE AND EDUCATION, AREA AND HEALTH REGION**

Variable	% of Childbirth Assistance
AGE	
Less than 30 years	91.7
30 years or older	85.5
EDUCATION	
No education	73.3
Elementary School	88.4
High School	97.6
University	98.6
AREA	
Urban	95.0
Rural	82.8
REGION	
0 (National District)	96.9
I	92.0
II	90.9
III	85.7
IV	79.9
V	86.7
VI	76.3
VII	87.9
TOTAL	89.7

Source: DHS, 1986.

Deliveries by Caesarean Section

Average rate for Caesarean sections at the SESPAS facilities is estimated to be 8%, with the highest rate in Region I (22.2%) and the lowest in Region V (2.5%). By all accounts, these rates are low. Data obtained from CENISMI/MEPES (1990), for example, found the rate of Caesarean sections in public hospitals to be at least

twice as high (15-30%) and in private hospitals to be an astonishing (90%). This report also raised concern about the high incidence of Caesarean complications in public hospitals and questioned the cost-benefit of this common practice in the private hospitals.

This very high rate of caesarian sections is alarming and has an effect on breastfeeding. As a rule in the DR, babies are separated from their mothers after Caesarean births and are fed formula.

Low Birth Weight

The average weight at birth is estimated at 2.987 ± 598 grams (CENISMI), or above the 2,500 gram cut-off for low birth weight (LBW). For full term babies (40 weeks), the average weight is 3.179 ± 594 grams. Although this average birth weight is relatively high, it was estimated that between 1981 and 1986, 15.8% of the children born in the largest maternity clinic in Santo Domingo were LBW. Of these, 54% were premature and 16% died.

The 1987 Nutrition Survey estimated that 10.2% of live births were low weight. Currently, the estimated prevalence ranges from 10% to 25% for LBW and from 0 to 2.5% for very low weight at birth (<1500 gm). According to CENISMI (1990), the national average of low birth weight is 14%, and one third of these babies are premature.

Breastfeeding Initiation Rates

No information was available on the rates of initiation of breastfeeding among the different types of health facilities. The data provided by CENISMI (Report No. 3, 1990) show that at the national level 93% of the Dominican mothers initiate breastfeeding and that there is little difference by area of residence, age, or educational level of the mother.

b. Breastfeeding Protocols or Standards at Delivery and Postpartum - Public Sector

Use of Oxytocin Before and After Birth

The labor-controlling medications, oxytocin and ergometrine (the breast milk suppressant), are not used on a routine basis in the labor and delivery rooms of SESPAS maternity wards. Oxytocin is used only if medical reason warrants induction and conduction of birth. As a rule, there is a scarcity of any medication in SESPAS hospitals, which may explain the almost complete lack of these medications used by doctors who are quick to interfere

medically in birthing, as attested by the high rates of caesarian sections in hospitals.

Labor/Delivery Rooms

The prenatal record is available if the mother has received prenatal care in the same health facility; if not, the information provided by the mother at the time of admission for delivery is recorded. The mother's wishes on the use of sedatives, analgesics, anaesthesia, or oxytocin during labor are not considered; and the provision of the same is based solely on the attending physician's judgement.

While observing in the labor room at a hospital in Barahona, the assessment team confirmed that mothers remain in bed, without being allowed to drink liquids or to have the company of family members for support. The Hospital Director explained that this was hospital regulation and added that if relatives were allowed the patient felt "overprotected and did not cooperate."

The administrators of the three hospitals visited by the team explained that each hospital had its own policy, though none could produce the policy. Many said they had heard of the PLANSI Norms but were not totally familiar with their breastfeeding contents. (Note: Provision of liquids to women during and immediately following labor is not mentioned in the PLANSI Norms.)

Rooming-In

The capacity of maternity wards ranges from 10 to 20 beds in the health subcenters to 60 or 70 beds in the Santo Domingo wards. Poor hygiene, lack of sheets for beds, and lack of gowns for the mothers (most of whom wear their own clothes) was observed in all except one area hospital.

Rooming-in and early breastfeeding are recommended in the PLANSI Norms. Rooming-in in public hospitals and subcenters is commonly exercised; however, it is unsupervised and not supported by institutional medical and nursing staff. One gets the feeling that these norms are adhered to because they are mandated rather than because of an interest in supporting breastfeeding. Lethargy among personnel seems to be standard.

Newborns of normal deliveries are taken to mothers within the first hour after birth (the medical staff said "immediately after birth" or "in the first hour after birth") so that breastfeeding can begin. It is unusual that newborns of mothers with normal deliveries are given glucose solutions or infant formula before breastfeeding, though it must be pointed out that infants are separated from their mothers under defined conditions and also when medical personnel consider it necessary. In these

situations, formula is given to babies in the nurseries, and no effort is made to promote breastfeeding.

Counselling

There is no counselling on breastfeeding in the public health facilities. The staff of maternity wards is not trained in breastfeeding or in supporting the breastfeeding pair. We observed indifference and apathy in the nursing staff toward providing support to mothers. Newborns "remain" with their mothers and depend on the mother's previous experience for adequate breastfeeding. No training is given to medical and support personnel about how to identify and prevent problems in breastfeeding. They are not aware of the importance of breast examinations to identify problem nipples, or of the different positions to prevent breastfeeding problems.

This lack of support negatively affects mothers who could not breastfeed their previous children or had difficulty doing so. Also, first-time mothers are not aware of the correct breastfeeding positions or have a series of taboos or beliefs against breastfeeding that prevent them from establishing optimal breastfeeding practices. They need simple, straightforward counsel.

In the labor and post-delivery rooms, there are no protocols for breastfeeding counselling. Mothers are "abandoned and alone," without any orientation on how to feed their newborns; of the benefits of colostrum; nor of the frequent sucking required to stimulate the lowering of transitional breast milk. They are left on their own to decide the feeding schedule of their newborn babies. The fact that mothers are dismissed within nine to twelve hours of delivery also inhibits follow-up and education. Though infant formulas are donated to nurseries, we found no evidence that they were directly distributed to mothers or given upon their discharge from the hospital.

Few private physicians promote breastfeeding or counsel their patients on breastfeeding techniques. On the contrary, whenever there is any difficulty with birthing or with breastfeeding, they readily prescribe infant formula to mothers.

Perinatology Units or Newborn Wards

The national PLANSI Norms and those of individual hospitals establish that newborns must be separated from their mothers when there are problems during pregnancy and delivery. Reasons for separation are:

- Low birth weight or prematurity
- Neonatal asphyxia
- Potentially septic babies

- Toxemic mothers
- Mothers with Caesarean sections
- Mothers with infections (see Section III)

These babies are placed in nursery units where they are fed infant formula "donated" by pharmaceutical companies through signed requests by the medical staff in charge of the units (see Section VIII). In these units, access by mothers to their babies is restricted, and breastfeeding is not promoted. The team observed that newborns placed in these units were fed with feeding bottles containing infant formula. Their ability to suck means that they could have been breastfed by their mothers. None of these units, however, had space or chairs where mothers could nurse their babies.

There are also no provisions or procedures for mothers to express their colostrum (versus using pooled milk from a milk bank, discussed later) so that it can be fed by a nasogastric tube or cup to very low birth weight babies until their sucking reflex is developed.

The "Kangaroo Mother" method of caring for LBW babies by skin-to-skin contact with mothers and frequent nursing, is not used in the Dominican Republic hospitals. A physician received training in this method in Colombia, but upon his return he never practiced it.

Both at the national normative level and at the hospital level, there are policies of mother-child separation under special circumstances. This has a negative impact on breastfeeding and on the survival of babies with low birth weight or perinatal problems. It is not surprising that in the maternity Hospital of Altagracia in Santo Domingo the team was informed by the neonatologist that the incidence of neonatal sepsis in newborns is common and that they have had cases of necrotizing enterocolitis and death of babies with these pathologies. The pediatric literature has various examples that illustrate that these fatal illnesses in newborns can be prevented with colostrum and breast milk from their own mothers.

Breast Milk Banks

During the period 1982-1985, after participating in the Seminar on Breastfeeding sponsored by INCAP in Contadora, Panama, the first breast milk banks were established in the Dominican Republic as part of a research project on breastfeeding. At one point, there were ten breast milk banks operating, but many were closed due to lack of support from the hospital authorities and SESPAS' Maternal and Child Health Division. Currently there are only three breast milk banks functioning, two in Santo Domingo hospitals and one in a Santiago hospital. They are operating because of the goodwill of the persons managing them. They do

not receive any support from the National Breastfeeding Program, nor from the hospital directors. There is no staff permanently assigned to the banks.

It is not surprising that these banks are marginally operational and store little milk. An example of their deterioration is the Las Minas Hospital in Santo Domingo in which 8,186 ounces of milk were collected in 1988, decreasing to 5,558 ounces in 1989 and to only 1,949 ounces in 1990.

The milk banks also have suffered due to the publication in international medical journals on the circumstantial evidence of HIV antibodies in human milk, causing fear that the AIDS virus could be transmitted through breast milk. Without further scientific medical justification, the breast milk banks were discouraged and began to disappear.

c. Breastfeeding Protocols or Standards at Delivery and Postpartum - Private Medical Sector

Few private physicians promote breastfeeding with their patients. On the contrary, whenever there is any difficulty with birthing or with breastfeeding, they readily prescribe infant formula to mothers.

In addition, most private hospitals and clinics do not practice rooming-in. Newborn babies are fed infant formulas donated by milk companies. Free infant formula samples are given to mothers upon leaving the hospital in an open promotion of artificial milk by pharmaceutical companies (see Section VIII). Some people interviewed referred to the private hospitals as "formula warehouses."

The CENISMI/MEPES (1989) report ratified that the negative aspects indicated in the 1988 INFACST study of breastfeeding promotion in the DR have not been overcome: (a) the donation of powdered milk from companies has continued in public and private hospitals; (b) promotion of breastfeeding has decreased; (c) except for one breast milk bank, official promotion is non-existent; (d) legislation on marketing of breast milk substitutes is still pending. The private sector is a major offender.

d. Existence of a Teaching Hospital or Model Maternity

There is no model or teaching hospital to promote breastfeeding at either the public or private level in the Dominican Republic. The team interviewed a pediatrician who is a strong proponent of breastfeeding and formed part of the Asociación de Lactancia Materna in the 1980s. She is still promoting rooming-in and breastfeeding at a private maternity unit in Santo Domingo.

However, the 13 other pediatricians working in the same medical facility promote infant formula. There is one pediatrician in the country who received lactation management training at Wellstart, but he has not applied or multiplied his knowledge at the operating level. Currently, he works in the Immunization Program at SESPAS.

4. Standards for Infant and Maternal Postpartum Care

a. Postpartum Care at the Delivery Site

No information was found on postpartum care, but according to all sources, postpartum care is poor. There is no effective reference system to refer new mothers to peripheral clinics. In some public hospitals, mothers are referred to the family planning clinics for postpartum care, but, the general impression is that they do not go. The private sector seems to have a better reference and perinatal follow-up system, but statistics are not available.

b. Visits to Children or Mothers during Postpartum

SESPAS' public services do not include home follow-up visits to mothers and babies in the postpartum period. Health promoters from NGOs associated with the URC Child Survival Program in Health Regions IV and VI visit mothers during the postpartum period and counsel them on breastfeeding, infant nutrition, immunizations, and family planning.

During visits for observations and interviews with NGO health promoters the team found that they visit mothers regularly and individually, and constantly reinforce the advantages of exclusively breastfeeding for the first four to six months. These promoters work with great enthusiasm and commitment, but there are some limitations:

- Their training doesn't include breast examinations in the prenatal or postpartum period to detect possible nipple problems.
- They are not taught technical counselling or breastfeeding management in case of problems experienced by the mother or the child.
- Promotion of exclusive breastfeeding during the first four months is not successful due to ingrained beliefs on the importance of water and herbal teas that the promoters are not equipped to counter.

c. Recommendations on the Use of Bottles or Powdered Milks

The immediate postpartum period is no different than what has been reported more generally about the use of bottles and other milks. Interviews, surveys and KAP studies all point to physicians most frequently recommending breast milk substitutes. This recommendation is the norm in private hospitals and supported for special conditions affecting the mother and/or baby in public hospitals. They also commonly contraindicate breastfeeding when mothers are ill, malnourished, or take oral contraceptives or antibiotics.

d. Infant Growth Monitoring

Although the Norms and programming of PLANSI/SESPAS include growth and development monitoring, this activity is not systematically executed. There is a growth and development graph in the child's health card, but it is not used consistently.

In the last few years many NGOs have developed growth monitoring programs for children under 5 years old. CARITAS has trained close to 200 health promoters that work in rural and poor urban areas in the ANEP program (see section VIII). The promoters weigh children every month to detect those that are not gaining weight adequately, with the intention of taking measures to prevent malnutrition. CARITAS has developed various educational materials for this program, such as the Community Graph and the Growth Monitoring Card that contains information on breastfeeding, child nutrition, and immunizations. The program has an educational component with counselling cards (laminas) on breastfeeding, weaning foods and child nutrition. The cards contain recommendations for changes in feeding practices when the child is not gaining weight according to his age. For those young infants not gaining weight, the recommendation is that the mother breastfeed more frequently and that she eat and drink more.

URC's Child Survival Program, in coordination with SESPAS, has trained promoters from the NGOs in weighing, monitoring and nutrition education and has designed and implemented a health card for this purpose. The information on growth and development is recorded in the daily book kept by the health promoter.

5. Knowledge and Attitudes of Health Personnel

a. Knowledge and Attitudes of Medical Personnel

Due to a four month national strike in the public health services, it was not possible to interview "regular" medical staff. However, military and civil physicians working in SESPAS hospitals and health subcenters were interviewed. During the

last five years, many physicians have received information on breastfeeding through short scientific seminars of eight hours duration, organized by the Dominican Pediatric Society (SDP). These courses have been coordinated by Dr. Josefina Garcia de Coën as an SDP continuing education program but it is not part of an organized program to promote breastfeeding.

Most of the doctors and nurses interviewed know about the advantages of breastfeeding for the child, the mother, and the family, indicating that "breastfed children are healthier," "suffer fewer illnesses such as diarrhea and malnutrition," and that "breast milk is more economical." We observed that there is an overall lack of knowledge with respect to clinical management of breastfeeding problems during the postpartum period: inverted or flat nipples; nipple or breast irritation or infection; Caesarean sections; toxemic mothers; premature or low birth weight babies; babies with sucking problems or with perinatal pathologies; or when the mother is sick or uses drugs. Lack of this knowledge easily leads physicians to recommend the use of breast milk substitutes, thus initiating or continuing the use of artificial milk.

In general health staff interviewed had a positive attitude toward breastfeeding, rooming-in, the benefit of colostrum, and early initiation of breastfeeding. However, lack of materials and of technical training prevents them from actively promoting breastfeeding. There is a large gap between knowledge and practice. The tendency is to let the mother and her relatives decide the type of feeding to be used, the breastfeeding schedule, the use of teas and water during the neonatal period, and the introduction of other types of milks or foods.

Nurses receive no training to provide adequate technical support to breastfeeding mothers in the prenatal, delivery and postpartum care. More importantly, the nurses' role in the Dominican Republic carries no status. It is easier, therefore, for them to adopt an air of indifference or apathy towards mothers, limiting themselves to routine hospital activities and avoiding direct interaction with the mothers on how they should feed their newborns.

b. Knowledge and Attitudes of the Administrative Staff

The administrative staff of the public services visited has not received any formal or informal training on breastfeeding. There was an intent to carry out this activity, but due to lack of support it was not undertaken.

6. Integration of Breastfeeding Promotion in Health Programs

As discussed in Section III, SESPAS/PLANSI breastfeeding policy does not address all of the UNICEF/WHO Ten Steps for Successful Breastfeeding. (See Table III.1). It is not surprising then that in the public health facilities visited in Santo Domingo and in Health Regions IV and VI do not uniformly integrate breastfeeding promotion into public health programming.

a. Integration of Breastfeeding in Diarrhea Control and Oral Rehydration Therapy Programs

Because of the physicians' strike, it was not possible to interview the "regular" health staff of the health facilities. The doctors and nurses, temporarily in these positions, espouse breastfeeding as a preventive measure against diarrhea in the child under one year of age and as a complement to oral rehydration therapy. The concept of "ideal breastfeeding practices" is not solidly held.

The NGO health promoters associated with the URC/Child Survival Program in the Health Regions IV and VI do integrate breastfeeding, diarrhea control and oral rehydration therapy concepts in the education they provide the mothers.

b. Integration of Breastfeeding in Family Planning Programs

Family planning promoters have received no information on breastfeeding in their training. As mentioned before, the private family planning organizations PROFAMILIA and ADOPLAFAM provide support to more than 200 maternal health clinics which provide prenatal care, but breastfeeding promotion is not included.

There is no counseling on breastfeeding in family planning programs, or vice versa. The use of recommended contraceptive methods is low. Among contraceptive users, there is only a 7% use of IUDs and 12% use of condoms and other modern contraceptive methods. The low-dose estrogen or progestin-only oral contraceptives are not readily available. Instead, contraceptive pills with normal doses of estrogen, which reduce breast milk production, are inappropriately taken by lactating women.

c. Integration of Breastfeeding in Nutrition Programs

Nutrition for many in the DR means feeding programs (CRS has been the long-standing exception to this.) Supplementary feeding is provided to pregnant and lactating mothers and small children in the health centers of SESPAS. This program does not function

well, but there are no operational guidelines relating to breastfeeding, even if it were functioning.

In the areas of the country where CARE promoters are involved in food distribution, breastfeeding and complementary nutrition concepts have been integrated in a strong educational component in the supplementary feeding programs for pregnant and nursing mothers. The programs are operated through CARE in coordination with SESPAS in rural clinics. At present, CARE is designing a new policy on complementary feeding and is planning to include breastfeeding promotion as a main activity at the community level. CARE participated in the preparation of the PLANSI/CSP/URC educational materials and is planning to use the flip chart on breastfeeding in the training of community and institutional staff of SESPAS rural clinics.

d. Integration of Breastfeeding Activities within the Ministry of Health Infrastructure

Breastfeeding is a program component of the Child Survival Plan (PLANSI) of the Secretariat of Health (SESPAS). In the last years, PLANSI has been managed in a "vertical" form but now is integrated within the Maternal and Child Division. Two previous coordinators of the Breastfeeding Program have resigned because of the lack of institutional support, the lack of funds for training public health staff, and the delay in printing of educational and training materials. To date, the only achievement of PLANSI has been the preparation of its Policy Manual that contains the Standards for the Breastfeeding Program. If PLANSI and its breastfeeding component began to function again, it would be desirable for them to adopt the URC/Child Survival breastfeeding materials for use nationally.

e. Supervision of Breastfeeding Activities in Health Services

During the team's visits to the various maternity wards in Santo Domingo and the hospitals in the Health Regions IV and VI, we observed the total lack of supervision guidelines for breastfeeding. The absence of supervision guidelines stems from the limited diffusion of the existing SESPAS/PLANSI Breastfeeding Policy that was prepared at the central level and distributed to the Regional Directors, but was never implemented.

B. TRADITIONAL HEALTH SECTOR

There is little information on traditional health providers because the country has developed an extensive infrastructure of formal health services. There are a few traditional midwives

that assist 7.2% of deliveries (DHS, 1986). When the team requested information about midwives, the formal sector health staff was negative about them and some medical professionals denied their existence.

Traditional midwives do not receive any type of training from either the formal health sector or from the institutions providing training to health practitioners. Their skills in delivery have been passed from generation to generation. According to women and promoters interviewed in villages of the Health Region IV in Barahona, traditional midwives assist deliveries when mothers cannot make it to the hospital or local health subcenter. There is no information on their provision of prenatal or postpartum care.

There is no political or official desire to recognize and train traditional midwives. Overall, there is strong opposition from physicians, especially from the gynecologists and obstetricians, who support the infrastructure developed in the country in the last decades and think working with midwives would be a step backwards.

Lic. Mireya Arias de Guerra, President of the Obstetric Nurses Association informed us that they are undertaking a study in the San Cristobal region, where there are 91 traditional midwives, 20% of whom work in the rural areas of Santo Domingo and 79% in the rural areas of San Cristobal. During January and November of 1990, these midwives attended 703 deliveries. The Association plans to obtain financing to train these traditional midwives to improve their knowledge and practices of delivery care in the rural areas.

C. CONCLUSIONS

Most maternal and child health services in the Dominican Republic are provided by the formal health sector. Over 90% of mothers seek institutional prenatal (more than four visits) and obstetric care. Even though the public sector operates an extensive network of hospitals and health centers, the continuing deterioration of its infrastructure has caused an increasing proportion of mothers to obtain services in the private sector. Based on findings of endemically high rates of low birth weight, neonatal and infant mortality, and maternal and infant infections, CENISMI has concluded that most public prenatal and delivery care is inadequate and they question many procedures used in private facilities.

With such a high concentration of centralized MCH services, it is most unfortunate that breastfeeding promotion and management are rarely, if ever, applied. The principal providers are physicians and to a lesser extent nurses. Most medical professionals are

aware of the advantages of breastfeeding, but they know little about optimum breastfeeding practices or the management of problems or just common concerns. While they may tell mothers about breastfeeding advantages, there is no effort to actively promote breastfeeding.

The gap between word and practice is wide. In maternity hospitals medication is rarely applied during delivery and rooming-in is a practiced policy, but these favorable policies are adhered to more due to apathy and economy than out of a commitment to promoting breastfeeding, as attested by the complete lack of support mothers receive during labor and in maternity wards. Incorrect and harmful contraindications for breastfeeding (low birth weight, infant and maternal infection, Caesarean delivery) are written policy and are not contested. Given the high incidence of complications, many infants are needlessly deprived of the health advantages provided by their mothers' milk. The problem is most acute in private facilities but there is also a large gap in public institutions.

More opportunities for promoting successful breastfeeding are missed during postnatal, well-baby and family planning follow up. Though these services are not as well established, especially in the public sector, and are therefore less utilized, many of their providers offer a variety of services which could easily incorporate the promotion of breastfeeding.

NGOs have taken the lead in promoting breastfeeding, which they include in all their child survival activities carried out by trained promoters. Training modules and strategies, as well as educational materials for mothers, have been developed as a coordinated effort under the Child Survival Program.

The traditional health sector is made up of midwives, who deliver less than 10% of babies, but whose existence and contributions are denied by the medical community. Little effort has, therefore, been made to quantify their numbers and activities. Many NGO and health workers feel that these midwives are more numerous and active than believed, and that given the economic and public health sector situation of the DR, their numbers are more likely to increase. Providing midwives with maternal child health training, which includes breastfeeding promotion and management, could be an opportune and effective way of reaching and following up at risk mothers and children in marginal rural and urban areas.

SECTION V

TRAINING PROGRAMS FOR HEALTH CARE PROVIDERS

This section identifies and describes the existing training programs in breastfeeding for key health care providers in the public, private and traditional sector of the Dominican Republic (DR). This assessment is necessary to identify strengths and weaknesses of existing training in order to improve the design of future training programs and materials in breastfeeding.

A. FORMAL HEALTH CARE PROVIDER TRAINING

In the DR there are thirteen medical schools, five nursing schools, and three nutrition schools. Most of these universities are private, though the public Autonomous University of Santo Domingo (UASD) graduates the largest number of doctors and nurses. The medical curricula of these universities vary and currently do not cover community health, in general, or breastfeeding, in particular. The subject of breastfeeding is touched upon in classes on pediatrics and consists mostly of a few hours of theory. Nursing schools dedicate two hours of instruction to breastfeeding in each of four classes: pediatrics, community health IV and V, and obstetrics-gynecology. Courses cover the physiology and anatomy of lactation, child nutrition, and the benefits of breastfeeding, with emphasis on immunological and bonding aspects. Currently, the medical department of the UASD is coordinating an effort with other medical schools to revise and standardize the curricula for medicine and nursing and to incorporate primary health care contents. At this time only the Universidad de Pontificia Madre y Maestra in Santiago and INTEC (Technological Institute of Santo Domingo) have community medicine practicums.

The Human Resources Division of SESPAS offers continuing education for SESPAS personnel but it does not include breastfeeding or any other child survival intervention. Until recently, the Child Survival Plan (PLANSI) of SESPAS was a vertical program, responsible for its own training, materials and norms. In 1990, PLANSI was integrated into the Maternal Child Health Division. Before this happened, PLANSI developed a promoter training manual (Manual del Promotor de Salud) and trained 800 out of 6,000 SESPAS promoters, mostly in the remaining health regions not covered by the University Research Center/Child Survival Program (URC/CSP). Breastfeeding is a part of this health promoter training.

The Manual is a well illustrated document that covers breastfeeding along with 32 other health interventions- too many for promoters who traditionally limit their health promotion responsibilities to vaccination campaigns. As is the case with

the PLANSI Norms, the Manual del Promotor is not well organized and contains some errors. It does support the importance of exclusive breastfeeding for the first four months of an infant's life, and the continued breastfeeding of the child during illness and diarrhea. Supplementation recommendations are clearly illustrated and are based on locally available and used foods. Again, much space is given to the generally known advantages of breastfeeding, while no mention is made of measures recommended for successful breastfeeding: e.g. frequent and on-demand feedings, correct positions and managing problems.

Practically no breastfeeding training is carried out in public or private hospitals for staff attending maternity or new born wards. Hospitals have their own policy which does not include breastfeeding promotion or management by personnel. As mentioned earlier, in public hospitals normal delivery newborns are placed with their mothers, without any support for breastfeeding.

The most widely recognized and substantial breastfeeding training for doctors and nurses is provided by the Dominican Pediatrics Society (SDP) through its eight hour workshops that are held on an irregular basis, as part of a voluntary continuing education program. From 1985 to 1990 the SDP gave 50 such courses and provided training to medical and nursing students and promoters, as well. During this period the following health workers received SDP breastfeeding training:

Teaching Physicians (Pediatrics and ObGyn)	58
Pediatricians, General Practitioners, Interns	8,215
Medical Students	2,389
Teaching Nurses	281
Professional Nurses	514
Auxiliary Nurses	1,474
Promoters	263
TOTAL	13,194

In addition, the SDP trained 445 community volunteers and 8,215 mothers in its collaboration with several NGOs.

In the DR medical professionals are not required to take courses for maintaining certification, so that attendance is low and demand is not spontaneous. Materials for these courses consist of a collection of well selected articles from 1984 or before, compiled by INCAP and augmented with Dominican studies by SDP and the Centro Nacional de Investigación de Salud Materno Infantil (CENISMI), and a breastfeeding pamphlet based on a scientific review of the advantages of breastfeeding compiled in 1982. Course contents also emphasize the advantages of breastfeeding, without going into technical or clinical management details. UNICEF has assisted the SDP by sponsoring the pamphlet and courses, as it does the technical meetings organized by CENISMI.

Mostly high level medical professionals regularly attend these meetings where CENISMI research findings concerning the health of Dominican children are discussed.

Technical references to support training are limited and generally outdated. A search of the scientific-technical information available at the library of the (UASD) consisted of only 13 articles, of which 12 were by national authors, published during 1980-90. PAHO is in the process of linking the major Dominican medical and nursing schools up with a computerized information service to provide access to the latest health related publications.

Though there are many dedicated people involved in the training and promotion of breastfeeding and breast milk banks, most of them are self taught, have taken an occasional course, or have attended conferences on breastfeeding, most significantly the Contadora Breastfeeding Conference in Panama, 1982. Their enthusiasm has resulted in practically all the breastfeeding support and activities existing in the DR today. Only one professional has received intensive training from Wellstart in 1985. This doctor's only contribution to the promotion of breastfeeding has been his participation in a training session on clinical management of lactation organized by his Nutrition Division of SESPAS, with support from INCAP. As a result of this training, SESPAS established milk banks in its largest maternity hospitals, and instituted rooming-in and early breastfeeding in all its hospitals. In 1991, after many years as the Director of the Nutrition Division, the only trained breastfeeding expert in the DR became the Director of the Immunization Program of PLANSI, where the multiplier effect of his training is limited.

Breastfeeding courses and training for formal health personnel are not designed and implemented based on any kind of needs assessment, though plenty of information exists to estimate these needs. Most courses result primarily from the efforts of a few dedicated individuals such as those in the SDP and with the financial backing of Nestle, SDP, and UNICEF. With the general agreement between donor agencies on the importance of breastfeeding in assuring the survival of Dominican children, technical support and operational funds should be available for improving the training of those practitioners who examine pregnant mothers, who are at hand when babies first nurse and who are the mothers' preferred source of advice on breastfeeding.

B. PRIVATE SECTOR TRAINING

In the area of training in breastfeeding, health personnel of NGOs have faired much better than these in the public or university sector. In large part this can be attributed to the USAID supported URC/CSP which provides technical and financial

support to the child survival activities carried out by participating NGOs and SESPAS in their target Health Regions 0, IV and VI. However, the independent efforts in breastfeeding promotion and training recently launched by CARE and carried out for nearly a decade by CRS/Caritas, as well as those of non-participating NGOs, cannot be ignored. In fact, many NGOs still use the training materials and techniques developed by Caritas for their widely acclaimed Applied Nutrition Education Program (ANEP).

Under the direction of Save the Children, the initial USAID/CSP, with full participation of affiliate NGOs and SESPAS representatives, developed training modules for trainers and supervisors of promoters, and flip charts for community education, for each of the child survival components, as well as a simple pamphlet on breastfeeding for mothers. The training modules are currently being revised by URC, the new contractor managing the CSP. Flip charts were distributed to NGO field teams, but a lack of accompanying training and follow up has resulted in limited use.

The assessment team interviewed a number of promoters working with NGOs affiliated with URC/ CSP and found that all actively promoted breastfeeding within their communities. Since these visits took place prior to the termination and distribution of the flip charts and modules, we found that each NGO trained their promoters according to its own procedures. In Region IV (Barahona) there had been successful regionally coordinated training and technical assistance. Some NGOs had developed their own materials, while others used those developed by other URC/CSP affiliates or by other organizations. Promoters were well informed on the advantages of breastfeeding and understood the importance of exclusive nursing during the first four months of life, though very few had success in convincing mothers to do so. Promoters did not know how to manage or prevent complications.

C. TRADITIONAL SECTOR TRAINING

As mentioned in Section IV, the existence of traditional midwives is not recognized by the formal sector and therefore there are no training programs for them. The Association of Obstetric and Gynecology Nurses has made the first attempt to identify traditional birth attendants in the San Cristobal area for eventual training. PAHO has shown interest in a national survey. These efforts, however, remain in the planning stages.

D. CONCLUSIONS

In the DR the training of health practitioners in breastfeeding is minimal beginning with their preservice preparation,

inconsistent and does not address priorities. It is not surprising, therefore, that graduates do not promote breastfeeding in their practices, that they establish and comply with incorrect and harmful norms, and that they are the main source of incorrect advice about breastfeeding and infant feeding for mothers.

In-service training is also limited as well as resources for in-service training if a group desired to conduct training. Though much research and information exists, it is not easily accessible. The need for training in the area of breastfeeding for health professionals is urgent and opportune, given the interest of the donor community in supporting breastfeeding, and current efforts to revise and standardize university curricula. A core of well-trained local professionals (master trainers) would be a key to a successful national training effort.

Training of NGO personnel at the community level in breastfeeding has been more serious and is coordinated and supported by the URC/CSP. This effort has resulted in some active support work by a large number of promoters in their target communities. Based on the experience of some very active and informed rural promoters, the most difficult challenge remains to convince Dominican mothers to exclusively breastfeed their infants during the first four months of life. For this, promoters will need training in motivational techniques.

Traditional midwives are not recognized by the medical community in the DR although it is believed that their contribution is more extensive than officially admitted and that it may be increasing. It would be wise to consider orienting them to proper breastfeeding initiation.

SECTION VI

WOMEN'S STATUS: THEIR WORK AND SUPPORT SYSTEMS

As a result of the worsening economic conditions and their increased educational level, more and more women are joining the labor force. The low status of their employment and the lack of support systems have made it difficult for them to optimally care for their children.

It is important, therefore, to identify those areas for potential policy change aimed at improving institutional, community, and peer support and guidance for breastfeeding mothers in different working environments.

A. WOMEN'S WORK

In 1981, 29% of women over 15 years old were economically active, an increase of 18% from 1960 (IEPD, 1990). According to the 1987 NNS, 21% worked outside the home, increasing dramatically with income level: 15% in the lowest and 38% in the highest quartile. In urban areas where women outnumber men, around 40% of women work outside the home (CIPAF, 1991).

In 1983, one-third of employed women were domestic employees, 29% worked in the formal and 22% in the informal sector (IEPD, 1990). A 1989 study of eight urban areas (Table VI.1) found that women make up the majority of employees in offices (64%) and services (62%); half of professional and technical employees are also women, as reinforced by their strong presence in the tertiary sector (48%) (Table VI.2). Table VI.3 illustrates that the majority (63%) of women earn low wages (less than RD\$900 = US\$138), though of high wage earners, 43% were women.

The Zonas Francas (ZF) or Free Trade Zones are among the fastest growing sectors of Dominican economy. Since the first zone was constructed in 1968, they have expanded to 30 nationwide, mostly near small towns with ready labor supplies. From 1987 to 1990 the number of employees in ZFs increased from 48,600 to 120,000. Seventy percent to 80% of this labor force are women, who work mostly in textile manufacturing which makes up 60% of the zones. In a study of three zones, CIPAF (1987) found that 76% of women workers came from areas outside of the area where the ZF is located, that 58% were between the ages of 22 and 34, 65% had children and that 51% worked to maintain those children. Ninety percent regularly worked overtime, with 23% working 9 hours and 64% working more than 10 hours a day without extra pay. Working conditions are not optimal and lunch room and toilet facilities are often insufficient. Health care is provided by the Instituto

Dominicano de Seguridad Social (IDSS) after three months of employment, but irregular payment on the part of the employer, and minimal services, cause many women to take time off to seek health care in time-consuming public hospitals or in costly private clinics.

TABLE VI.1
ECONOMICALLY ACTIVE POPULATION
BY SEX AND PROFESSION
IN EIGHT URBAN AREAS OF THE DOMINICAN REPUBLIC, 1989

Profession	Women	Men	Percent Women by Profession
TOTAL	100.0	100.0	42.6
Professional and Technical	13.3	9.6	50.7
Managerial and Administrative	0.9	2.0	25.0
Mid-level Management	3.2	4.4	35.0
Office Employees	11.4	4.7	64.5
Sales	27.1	20.3	49.7
Agricultural Workers	1.1	6.7	11.2
Drivers	0.2	7.4	2.4
Crafts	16.1	30.7	28.0
Domestic Service	25.4	11.4	62.2
Others	0.9	2.2	23.6
Non-specified activities	0.3	0.6	27.3

Source: CIPAF. Encuesta Mujeres Urbanas 1989.
 Quehaceres, Feb., 1991.

TABLE VI.2
ECONOMICALLY ACTIVE POPULATION
BY SEX AND ECONOMIC ACTIVITY
IN EIGHT URBAN AREAS OF THE DOMINICAN REPUBLIC, 1989

Sector of Activity	Women%	Men%	Percent Women
TOTAL	100.00	100.0	41.9
Primary	1.2	6.8	11.1
Secondary	22.2	33.1	32.6
Tertiary	76.6	60.1	47.9

Source: CIPAF. Encuesta Mujeres Urbanas 1989.
 Quehaceres, Feb., 1991.

TABLE VI.3
MONTHLY INCOME BY SEX
IN EIGHT URBAN AREAS OF THE DOMINICAN REPUBLIC, 1989
(US\$1.00 = RD\$6.50)

Income Scale	Men%	Women%	Percent Women
Total	100.0	100.0	43.4
Less than 450	19.4	31.1	55.2
450 - 899	35.0	32.3	41.4
900 - 1349	13.5	9.4	34.8
1350 - 1799	4.9	3.4	34.6
1800 - 2249	5.6	2.9	28.3
2250 or more	21.5	20.9	42.7

Source: CIPAF. Encuesta Mujeres Urbanas 1989.

No concrete data were found on work and rural women. Experience with organized rural groups shows that the majority spend most of their time on domestic support activities, with an occasional venture into an income generating activity, such as raffles. Mujeres en Desarrollo Dominicana (MUDE) promotes agricultural income generating projects with rural women but found that over 80% of women do not have access to land. Also, when women buy cows or plant staple or cash crops, their husbands still do most of the work. When profitable, they hire help and occasionally, especially during the harvest, they work on the land themselves. However, in the rural areas of San Jose de Ocoa, URC/CSP promoters attributed the high prevalence of malnutrition to mothers leaving the feeding of their children to siblings or other caretakers while they worked the fields. Rather than agricultural labor, rural women wanting to earn incomes go to the cities as domestics or to the ZFs.

B. LABOR LAWS RELATED TO BREASTFEEDING

Even though the Ministry of Labor monitors working conditions in the ZFs, there are only three inspectors. The Dominican Labor Law was composed in 1954 under the late dictator Trujillo (1932-1964). The need for its revision is generally recognized, but the Code does provide some basic conditions for working women. Article 227 guarantees maternity leave for three months - six weeks before and six weeks after giving birth - with guaranteed pay and position upon return. Article 229 calls for businesses with more than 30 employees to have nurseries to facilitate breastfeeding. A mother has the right to nurse for 25 minutes, three times a day, until her child is eight months old.

Maternity leave is granted by all public institutions and most businesses, although women in the service and informal sector enjoy no such privilege. Some ZFs still evade this law by the once widely-held practice of firing women before completing three months, when social benefits take effect (trimestrismo), and then rehiring them for the next three-month period. Most public and private enterprises are unaware of the nursery/breastfeeding article, which is not implemented. There is a law on the books for all ZFs and industries to include nurseries, which has passed Congress in March, 1991, but has been held up in the Senate. The IDSS has signed an agreement with the ZF of Puerto Plata to provide a nursery, which has been constructed and furnished, but lacks funds for operation. Although some ZFs have dispensaries, there are no known health clinics within the zones.

C. ORGANIZED SUPPORT FOR WORKING WOMEN

1. Labor Unions

In spite of the marginal labor status of women, there are few women's labor groups and though many women are members of large labor unions, women's issues are rarely a priority. The Unión Nacional de Mujeres Trabajadores (UNAMUT), for example, which forms part of the Confederación Autónoma del Sindicato Clasista (CASC), organizes women and promotes the ideologies of the CASC. The Tribunal para la Defensa de la Mujer y el Menor of the Ministry of Labor was established to defend the fundamental rights of women and children. Other organizations working with women are listed in the Directorio de Organismos Gubernamentales y No Gubernamentales que Trabajan con Mujeres by Clara Baez (UNICEF, 1989).

In the ZFs, labor organizations are in their infancy. Due to an agreement between the ZFs and the Government, labor-organizing in the zones has been systematically discouraged. Although officers are regularly fired, unions are establishing a presence in the zones and women play an important role in their formation and leadership. In Haina and Itabo, women make up at least half of the Westinghouse and Sylvana Unions. In San Pedro de Macoris, the Undergarment Fashion Union's and la Borinqueña C.A.s membership is 95% women and both are headed by women. In both unions two previous directorates were fired. The Sociedad Anonima is all-women. The Confederación de Trabajadores Unitarios (CTU) is in the process of organizing eight to ten unions. These unions claim their right to organize, to be recognized and to bargain collectively.

Management representatives of various industries and ZFs, when interviewed for the upcoming USAID Family Health Project, were open to providing improved health care for their employees. The agreement between IDSS and the Puerto Plata ZF to set up a day care center is a positive step. These business leaders believe that improved human support structures will positively affect production by decreasing sick days and time taken off to care for children.

2. Women's Groups

Part of the USAID's URC/CSP involves promoting and monitoring exclusive and prolonged breastfeeding through home visits and mothers' groups. Health promoters actively involve mothers in monitoring their children's nutritional status and train them to prepare ORT. The formation of mothers' groups has been slow.

Breastfeeding support groups are scarce. In Santiago, a La Leche League group provides breastfeeding support to members, mothers in some hospitals and in some of the surrounding rural areas. The

Centro de Integración Familiar (CIF) at one time provided a support telephone network and still does promote breastfeeding in marginal areas in Santo Domingo.

Women's organizations such as CE MUJER, MUDE (Mujeres para el Desarrollo), Tu Mujer, CIPAF, as well as women's labor and peasant unions (CONAMUCA) can and have played an important role in assuring that existing laws protecting women and their rights are applied. More importantly, they instill in their members self confidence as women, as caretakers and as active members in the development of their communities. The work of their promoters, as well as research and educational materials cover health issues which affect women and their families.

D. BREASTFEEDING AND WORKING MOTHERS

The 1987 NNS shows that the incidence of breastfeeding is about the same for working (91%) and non-working women (94%). Babies of employed mothers do have bottles introduced earlier (1 week) and stop breastfeeding sooner (6.4 vs. 9 months) (Table VI.4). This difference was most marked between mothers in the lowest income quartiles. Although these differences are significant, the nutritional status of their children was not adversely affected. It may be that increased income compensated for the loss of the advantages of breastfeeding.

As mentioned before (Section II), Dominican women rarely carry their infants with them. When mothers are working or commuting, infants are left with siblings or neighbors. A rural NGO supervisor attributes the high rate of malnutrition in her productive Region IV to mothers leaving their babies after the "riesgo" period (six weeks) to work on their "conucos" (farming plots) to support the family. The quality of this proxy care has not been studied, but observations by health and community workers indicate that it is sub-optimal. With the exception of community-based nutrition recuperation centers, no ongoing low-cost child care models seem to be in operation.

TABLE VI.4
COMPARISON OF WEANING BEHAVIORS
BETWEEN WORKING AND NON-WORKING MOTHERS
BY INCOME QUARTILE IN THE DOMINICAN REPUBLIC, 1987
N=888; p=0.00

	INCOME QUARTILE				TOTAL POP.
	LOWEST QUARTILE	QUARTILE 2	QUARTILE 3	HIGHEST QUARTILE	
BEGIN BOTTLEFEEDING					
(Months)					
Working	1.7	.2	1.7	.7	.98
Non-Working	1.1	1.4	0.8	1.3	1.14
BREASTFEEDING					
Working	100.0%	87.7%	92.8%	90.0%	91.0%
Non-Working	94.3%	95.7%	95.7%	90.5%	93.6%
BOTTLEFEEDING					
Working	100.0%	100.0%	89.4%	94.6%	94.6%
Non-Working	88.2%	84.7%	90.1%	94.9%	89.2%
AGE OF CESSATION OF BREASTFEEDING (Months)					
Working	6.6	7.0	7.8	5.0	6.4
Non-Working	8.9	9.4	9.3	8.3	9.0

Source: USAID/Tufts Univ. National Nutrition Survey, 1987.

E. CONCLUSIONS

While an increasing number of women are joining the labor force, most do so at low levels, with low pay, and no rights to contest their working conditions. In the DR there are some progressive laws protecting women as nurturers, but they are rarely applied. The lack of support for working women is causing an earlier use of bottle and earlier cessation of breastfeeding.

Newly formed labor unions are concerned with working conditions of women and could be sensitized to the importance of breastfeeding small children. They could then press for the application of existing laws that require nurseries in work places of 30 or more employees, and the three 25 minute break periods for nursing or expressing breast milk. However, women will need to feel that this nursery environment is better for their child than their home environment and that transporting the child does not pose a harmful situation or they will be unused.

In addition to labor unions, the women's groups and the organizations that work through women in the community could do more to support breastfeeding among working women. In addition to promoting activities directly linked to breastfeeding management, the work of these groups to enhance women's self-confidence will be critical to the overall breastfeeding effort. Attention to this type of outreach should have high payoff.

SECTION VII

MARKETING OF BREAST MILK SUBSTITUTES, WEANING FOODS AND BOTTLES

Aggressive marketing by infant formula companies has been internationally recognized as a negative influence on breastfeeding. The WHO International Code of Marketing of Breast Milk Substitutes (signed by the DR) offers regulations on the marketing of formulas and other breast milk substitutes. However, in the Dominican Republic companies are marketing breast milk substitutes, supplements and weaning foods, and they are having an effect on breastfeeding. In this section, the magnitude of these commercial efforts and their effect on breastfeeding practice is assessed. This knowledge should serve as the basis for designing measures to counteract the negative influence of these companies' sales techniques.

A. NATIONAL BREASTFEEDING POLICY AND GENERAL SITUATION

As discussed in Section III the "Ley de Comercialización de los Sucedaneos de Leche Materna" (Annex 3) has been on the books in Congress since 1986, when it was presented by the Comisión Dominicana de Lactancia Materna. To this day, the law has not been passed, but most pharmaceutical companies abide by the WHO Code. However, medical personnel, particularly doctors, do not comply and provide an easy vehicle for formula companies to reach Dominican babies early in life.

All infant formulas are imported. Nestlé produces its whole milk in-country, but imports its formulas. Many best selling formulas are distributed through multinational pharmaceutical companies (Abbot, Mead Johnson, Wyeth) where their sales make up 40%-50% of their market (41% for Mead Johnson) and merit separate divisions. Others (Milex, Nutricia, Moringa), are marketed through wholesale merchants who are able to circumvent the legal money market to purchase products at lower prices than the established pharmaceutical companies and Nestlé. In the unstable economy of the DR, this gives them a competitive edge, because of lower prices. In 1990 pharmaceutical companies spent US\$ 4 to 5 million on importing nearly 2.5 million cans of formula. According to a Nestlé representative, Abbot leads the market with about 50% of sales, followed by Nestlé with 20% to 25% and Mead Johnson with 5%. For Mead Johnson, this market has remained stable, and for Nestlé, it has been decreasing. No such data were available for the import of breast milk substitutes by independent wholesalers.

B. REGULATIONS IN PRODUCT DISTRIBUTION

Infant formula is predominantly sold to pharmacies (40% Mead Johnson; 95% Nestlé), followed by supermarkets (20% Mead Johnson; 5% for Nestlé) and then by independent wholesalers (20% Mead Johnson) who distribute the product through a network of small shops (colmados) and food outlets (eateries). According to the Federación Panamericana de Farmacéuticos y Bioquímicos, 30% to 50% of all pharmacy sales are formula and powdered whole milk, which along with aspirin, are among the three top sellers.

Although a wide range of infant formulas were found by the assessment team at both the rural and the urban pharmacies, supermarkets and eating places (Table VII.1), none were found in colmados, where only condensed and powdered whole milk were sold. According to interviews with three international distributors (Mead Johnson, Abbot, Nestlé), mark-up on formula is fixed at 25% to retail outlets and 20% to consumers. Inventories at different outlets confirmed this policy (Table VII.1).

Because of inflation, the already high price of formula has increased 20% to 50% in the last two years, making it unaffordable for most Dominican mothers. Table VII.2 lists the approximate price per day to feed babies 2-4 months old. Powdered formula ranges between 8-20 pesos for regular, low iron or fortified; and 20-25 pesos for soy-based. Liquid formula is more expensive. As interviews from the 1987 NNS and CSP/KAP studies (Section II) attest, most poor mothers do not give their babies formula. In rural areas, mothers give cows' milk and in urban areas they are more likely to use powdered whole milk after their infants reach three months. In accordance, colmados, where most of these women purchase their staples, do not usually carry formula. N

Formula is not distributed, as a rule, in public hospitals to healthy, normal-delivery babies. Reports from hospital directors and hospital visits supported this. But, interviews with poor urban mothers and with promoters revealed that formula distribution, to mothers with Caesareans and LBW babies, is common (Section IV).

In private hospitals, from clinics catering to the well-to-do, to small clinics in lower-middle class neighborhoods, prescribing formula to newborns is the norm rather than the exception. Here very high Caesarean rates (70%-90%) and general lack of support and technical knowledge about breastfeeding result in this condition. With each pharmaceutical company employing formula saleswomen who visit pediatricians, it is not surprising that physicians are often identified by mothers and promoters as the primary obstacle to exclusive breastfeeding. Formula samples with bottles are distributed in these private hospitals; Abbot and Mead Johnson claim that hospitals and doctors solicit these products and that they are not provided directly to mothers by company promoters.

TABLE VII.1

AVAILABILITY AND PRICE OF BABY FORMULA
 IN AN URBAN AREA PHARMACY (UP), URBAN SUPERMARKET (USM),
 RURAL PHARMACY (RP), RURAL RESTAURANT (RR) AND RURAL BAKERY (RB)*
 DOMINICAN REPUBLIC, 1990

Manufacturer	Name	Wt.	Type	UP	USM	RP	RR	RB
Abbot	Similac	450g.	Inf.pwd		78.55	71.00		
	Similac	450g.	Inf.pwd		78.55			
	Similac	6/8oz.	Liq.	113.25				
	Similac	6/4oz.	Liq./ Low Iron		84.30			
	Similac	1qt.	Liq.	36.20				
	Similac	13oz.	Liq./Con.		26.25			
	Similac	32oz.	Liq.		54.00			
	Alimentum	32oz.	Liq.		21.00			
	Alimentum	8oz.	Liq.					
Nestle	Nan1/0-6m.	1lb. 3lb.	Inf.pwd Inf.pwd		81.40	56.40		
	Nan2/6-12m	1lb.	Inf.pwd			56.40		
		3lb.	Inf.pwd					
		5lb.	Inf.pwd			142.60		
	Nestogeno1	1lb.	Inf.pwd			38.75	40.00	
		3lb.	Inf.pwd			81.40		
	Nestogeno2	1lb.	Inf.pwd		38.75			
		3lb.	Inf.pwd			38.75		
	Alsoy	400g.	Soy/pwd	78.00		81.50		
	Alprem	400g.	Prem/pwd			71.00		
Pelargon								
Mead Johnson	Prosobee	400g.	Soy/pwd	80.0	80.47			
	Enfamil	450g.	Inf.pwd		71.00	71.00		71.00
	Enfamil	450g.	Inf./Iron		71.00			
	Enfamil20	40oz.	Liq.		18.00			
	Isomil Con.	13oz.	Conc. 1/1		26.25			
	Isomil	400g.	Inf.pwd		83.49	83.50		
	Isomil	400g.	Soy/pwd	83.75				

Manufacturer	Name	Wt.	Type	UP	USM	RP	RR	RB
Milex Nutricia	Baby Milex	400g.	Inf.pwd	45.00				45.00
	Nenatal	400g.	Neonat.pwd	27.70				
	Almiron	400g.	Lowfat.pwd	62.10				
	Nutrilon	400g.	Inf.pwd	59.40				
	Nutrisoya	400g.	Soy.pwd	80.40		80.00		
Wyeth	Nursoy	400g.	Inf./Iron	93.30				
	S - 26 Promil >26	454g.	Soy.pwd	74.26				
Morinaga Milupa	Milupa	450g.	Inf.f.	60.00			60.00	
		250g.	Diar.pwd	100.75			100.75	

Rural denotes rural town.

TABLE VII.2

INFANT FORMULAS SOLD IN THE DOMINICAN REPUBLIC

PRODUCER	FORMULA NAME	AMOUNT PER CAN	TYPE	INSTRUCTIONS AND LABEL	WARNING	PRICE PESOS/DAY FOR BABY 2-4 mos
ABBOT LABORATORIES (Produced in Holland)	ISOMIL	400g.	Infant Soy Protein Powder	-Bear and bottle on can. -Instructions in pictures very clear. Includes time for boiling (10 min).	-Breastmilk (BM) is best but under special conditions recommend ISOMIL, by med. prescription. -Warning about dilution and concentration.	21 pesos
ROSS / ABBOT (USA)	SIMILAC	6 bottles 8 fl oz.	Ready fed liquid bottles. Low iron	-Bear and bottle on package. -Instructions, clear.	-No warning -Only BM better throughout first year of life -Physician rec. -Not dilute -Emphasizes ease	47 - 50 20 oz/day
	SIMILAC 8 fl oz. 32 oz/1qt.	32 oz/1qt.	Ready to use liquid Low iron	-Bear and bottle on package. -Instructions, clear.	-No warning -Only BM better throughout first year of life -Physician rec. -Not dilute -Emphasizes ease	27 - 28 20 oz/day
	SIMILAC	450g	1) Inf. p. 2) Inf. p. w. iron	-Bear, bottle and cup on can -Instructions very small letters illustration	-when not possible to give baby BM--- (very small letters) -Med advice -No warning dil/conc	15 - 20
	ALIMENTUM	32 fl.oz/ 1qt.	Hypoall. Ready liquid	Not clear No quantity No pictures	-BM is best & rec. for as long as possible during infancy, except where special med. cond. exist -Warning about dil—	54.00
NESTLE (SWITZERLAND)	NESTOGENO	450g. 1 kg.	Inf. p.	-Instructions clear -No boiling clock -No illustrations on can label	-BM best 1st mos. of life -Med. adv. before use -Warning dil/conc	9 - 12
	1. 0-6 mths 2. 6-12 mths					
	NAN	450g. 1 kg.	Inf. p.	-Instructions clear -No boiling clock -No illustrations on can label	-BM best 1st. mos. of life -Med. adv. before use -Warning conc./dil	8 - 10
	1. 0-6 mths 2. 6-12 mths					
PELARGON	450g.	Acidified Inf. Powder		-BM best 1st. mos. of life -Med. adv. before use -Warning dil/conc	10 - 12	
AL 110	400g.	Low lactose Inf. powder		-Hold baby in arms when feeding -BF best 1st mos. of life -Med. advice -For regurgit., colic, diar	20	

PRODUCER	FORMULA NAME	AMOUNT PER CAN	TYPE	INSTRUCTIONS AND LABEL	WARNING	PRICE PESOS/DAY FOR BABY 2-4 mos.
MEAD, JOHNSON (USA)	PRO SOBEE	400 g.	Soy free Inf. p.	-Very small instructions	-Warning: in most cases BM best. Sometimes med. decides not so. (lact. int.) allergies, common food probs. excess. regurgit. colic, eczema, excessive diarrhea. -Only med. advice -Warning dil/conc	20 - 22
	ENFAMIL 1) With iron 2) Without iron	450g.	Inf. p.	-No picture on label -For first 12 months	-Warning: in most cases BM best. Sometimes med. decides not so. (lact. int.) allergies, common food probs. excessive regurgitation, colic, eczema, excessive diarrhea. -Only med. advice -Warning dil/conc -Enfamil is a good substitute for mothers who decide not to BF	14 - 17
	ENFAMIL 20	4 oz.	Low iron liq. form	-Clear	-No BM mentioned -For hospital use only	
	ISOMIL	13 oz. (1/1 prepare)	Concentrate Soy protein with iron	-Not show bottle washing -Shows kettle for boiling water	-BM rec. as long as possible except when med. advises -Dil/conc -Hot state quantity	26
	ISOMIL	400 g.	Inf. p.	-Bear bottle and cup on label	-BM rec. as long as possible -Warning dil/conc	20
	ISOMIL	400 g.	Soy based Protein	-Bear bottle and cup on label	-BM rec. as long as possible -Warning dil/conc	20
	NATAMIGEN	425 g.	Hypoall protein allergy	-Does not show bottle washing -No age for doses	-Phys. advice -Warning dil/conc -No BM mention	
MILEX (DENMARK)	BABY MILEX	400 g.	Inf. p.			11
NUTRICIA (HOLLAND)	NUTRILON	400 g.	Inf. p.	-Bear/bottle -Clear directions	-Important: BM best -Only med. adv. -When mother supplements	14 - 16
	ALMIRON	400 g.	Low lactose Inf. powder	-Bear/bottle -Clear directions	-Important: BM best -Only med. adv. -When mother supplements	15 - 17
	NUTRISOYCE	400 g.	Soy protein powder	-Bear/bottle -Clear directions	-Important: BM best -Only med. adv. -When mother supplements	20-27
	NENATAL	400 g.	LBW infant powder	-Baby with nasaldrip -and bottle on front	-Nasaldrip <2000 gms. -No BM	

PRODUCER	FORMULA NAME	AMOUNT PER CAN	TYPE	INSTRUCTIONS AND LABEL	WARNING	PRICE PESOS/DAY FOR BABY 2-4 mos.
WYETH (USA)	NURSOY	400 g.	Soy based Iron fort. Inf. powder	-Spec. boiling time for water incl.	-BM BEST -for lact. intolerance -Med. advice -warning dil/conc	23 - 25
	S-26	454 g.	Iron fort. Inf. powder	-Spec. boiling time for water incl.	-BM BEST -Replace or complement when impossible or insuf. -Med. advice -Most like BM -Warning dil/conc	16 - 18
	PROMIL	400 g.	> 6 months Inf. powder	-Spec. boiling time for water incl.	-No mention BF	
MILUPA (Germany)	MILUPA	250 g.	Diarrhea Supplement powder for Infants - adults	-Show bottle	-As electrolyte, in case of acute diarrhea -No mention BF -No dose by age	
MORINAGA (Japan)	MORINAGA BF	450 g.	Infant powder	-Cow in front -Not show boiling water	-BF best 1st mos. -Rec. med. advice. For mothers who need to supplement	13 - 15

C. REGULATION OF PROMOTION ACTIVITIES

According to Nestlé and the pharmaceutical companies interviewed, their Head Office and the Asociación de Representantes y Agencias de Productos Farmaceuticos (ARAF), comply rigidly with the WHO International Code of Marketing Breast Milk Substitutes, by prohibiting the direct contact of their representatives with pregnant or lactating mothers and the promotion of products for health care within health care facilities or through the media.

Table VII.2 illustrates that no formula container idealizes artificial feeding, that almost all state that breast milk is best and that formula should only be given under medical advice. They, however, do point out when formula should be given, and do not promote exclusive breastfeeding for the first 4-6 months, or prolonged breastfeeding. Wyeth states that S-26 is most like breast milk.

In accordance to an agreement made with formula distributors, 1/2% of formula import costs is donated to the Asociación Dominicana de Medicos. The companies interviewed collaborate closely with the Asociación Dominicana de Pediatría in their efforts to educate medical and health personnel about breastfeeding. Nestlé has supported the installation and operation of milk banks, contributed to the UNICEF/CENISMI/MEPES studies and set up libraries within hospitals to which they have donated a series of their highly-respected, technical MCH discussion papers. Also, Nestlé is one of the original members of the Comisión Nacional de Lactancia Materna.

Both Mead Johnson and Nestlé have shown interest in supporting and participating in any future effort promoting breastfeeding. The Federación Panamericana de Farmaceuticos y Bioquímicos has also offered support in distributing information and education through the existing networks of their member organizations (Dueños de Farmacias (DF), Industrias Farmaceuticas Dominicana (INFADOM)).

Although various sources indicated that Infant Formula Action Coalition (INFACT) representatives regularly monitor the infant formula marketing and distribution situation the DR, no report was located.

D. MARKETING OF BOTTLES, NIPPLES AND INFANT CEREALS

Bottles and nipples are imported by private wholesalers but figures on their foreign exchange value were not located for this assessment. These baby products are imported primarily from the U.S. (Evenflo) and Brazil and come in a wide range of models and prices (4 to 8 models, ranging from RD\$10 to RD\$236). Nipples

range from RD\$5 for ready-to-use formula bottles to RD\$10-RD\$15 for regular nipples.

Bottle feeding is highly prevalent in the DR (Section I) but poor mothers usually have only one bottle and nipple. With high fuel costs and limited time, this bottle is seldom sterilized, if at all.

The 1987 NNS showed that poor infants were supplemented by bottle with mostly low-cost liquids (Section I and II) made from a powder other than powdered milk and formula. Informal interviews revealed that infants often consume the locally and readily-available Negrito Cereal (Cream of Wheat) which sells for RD\$ 10-15/400g. Imported cereals such as Nestum, Cerelac (Nestlé), Gerber and Nutriben (Spain) were not commonly found in bottles. These are sold in pharmacies and supermarkets and range from RD\$25-RD\$35 for eight ounces of Gerber cereal, to RD\$45-RD\$50 for 400g of Nutriben. According to Nestlé, it is the largest importer of infant cereals. These are Nestum and Cerelac, which it promotes as a supplement after six months of age. Nutriben, on the other hand, is marketed as a weaning food for babies at four months. The development of a low cost, local weaning food has been underway for several years in the Barahona area.

E. CONCLUSIONS

Even though the International Code for the Marketing of Breast Milk Substitutes is not law in the DR, pharmaceutical and food importers do seem to comply with many of its provisions. However, problems remain:

- (1) Although formula distribution in public hospitals is restricted, infants with LBW or other complications are still fed formula, as are babies of mothers who have Caesareans.
- (2) Formula use is rampant in private hospitals where rooming-in and early breastfeeding is uncommon; Caesarean births are the norm, and hospital/doctors regularly prescribe and donate formula to new mothers.

These problems point to non-compliance with the Code by local doctors. It is their practices that need examination and change.

Among poorer segments of the population, formula is not so much an issue as in bottle feeding and the use of non-nutritive substitutes. The use of substitutes and bottles needs to be tackled together.

On the bright side, many multinational companies have supported breastfeeding activities and are willing to continue to do so and can provide valuable skills and resources in the promotion of breastfeeding in the Dominican Republic.

SECTION VIII

PROMOTION OF BREASTFEEDING AND WEANING THROUGH INFORMATION, EDUCATION AND COMMUNICATION (IEC) ACTIVITIES

In order to understand the influence and potential of information, education and communication (IEC) activities on promoting breastfeeding in the DR, it is necessary to identify and describe the successes and failures of the existing IEC activities. Such knowledge is vital for designing and targetting future IEC strategies to improve breastfeeding behavior.

A. OVERALL BREASTFEEDING COMMUNICATION EFFORT

There is no overall breastfeeding communication program in the DR. The non-operational Breastfeeding Program of PLANSI/SESPAS developed an integrated IEC plan, which included a training component for promoters and community groups, the dissemination of education and informational materials to mothers, and a mass media campaign. Nothing of this plan has been implemented.

Materials developed by NGOs are available but lack careful pretesting and a place in a broader strategy. The few efforts that are ongoing are the following:

- (1) The Sociedad Dominicana de Pediatría (SDP) with UNICEF developed one of the more commonly encountered breastfeeding pamphlets, Las Ventajas y Técnicas de la Lactancia Materna. This pamphlet, based on a lecture presented by Dra. Ligia Fernandez Reid to APEC in 1982, consists of an extensive scientific review of the advantages of breastfeeding, as well as a short discussion of techniques. Many organizations have it on their shelves, but because of its complexity, few use it and it is not appropriate for mass distribution. As mentioned earlier, this pamphlet provides a take-home review of key principles for participants of the SDP breastfeeding workshops.
- (2) TU Mujer has developed a mimeographed pamphlet to be used by mothers. It is complete, but has some mistakes, is long and has only a few small illustrations. Therefore, it may be more appropriate for trainers, than for community members and mothers who often have limited literacy skills.
- (3) The Dominican Institute for Integrated Development (IDDI) has developed a short pamphlet that can also be used as a poster. Its information is based on SESPAS' Manual del Promotor de Salud and is well illustrated and simple. The pamphlet is widely distributed among mothers involved in IDDI's marginal urban target area. Like most existing IEC materials, the IDDI pamphlet emphasizes the advantages of

breastfeeding and also illustrates a schedule for the introduction of foods, but it barely touches on appropriate breastfeeding techniques.

- (4) The Center for Cultural Research and Action (CIAC) has an integrated IEC program based on popular non-formal education strategies. It distributes a wide range of short, simple comic books with a number of health related and other community-interest themes, including breastfeeding. CIAC operates a number of documentation centers and reinforces its messages with popular education programs, aired on the very popular, local Catholic radio stations.

Two broader efforts that include breastfeeding are:

- (1) The A.I.D.-supported IEC efforts of the Caritas/CRS's Applied Nutrition Education Program (ANEP) was launched in 1983 in six regions with technical assistance from Manoff International. ANEP combined the training of promoters and education of mothers through face-to-face counselling and group education sessions. These messages and materials, which include the widely used counselling cards for mothers, flip charts and cassettes, were developed based on sound formative research and were carefully pretested. The effect of the program on mothers' child feeding (including breastfeeding) behaviors was evaluated after three years of operation (Caritas/CRS ANEP, 1988). When the behaviors of 500 mothers were compared with those not in the program, it was found that there were many significant changes in child feeding practices but few of the breastfeeding behaviors were changed significantly. More program mothers did believe their babies only needed breast milk for the first four months (76% vs. 65%). On-demand feeding was better among program mothers (63% vs. 35%); however, bottle feeding did not vary (75% vs. 78%). The introduction of other foods remained common before four months of age although was lower among the program group (37% vs. 44%); and, more program mothers were introducing other foods between four to six months, showing some delay in introduction (45% vs. 35%). Though the ANEP is internationally recognized as a successful IEC effort, it does illustrate the existing, serious difficulty of changing mothers' behavior regarding use of bottles and exclusive breastfeeding before four months of age. The counselling materials in ANEP merit consideration under any new IEC strategy.
- (6) At this time, the USAID-funded Child Survival Program, under the recent administration of University Research Corporation (URC), is designing an integrated IEC program for all child survival activities of its 15 NGO affiliates and SESPAS in its three target regions: Health Regions 0, IV and VI. Representatives of NGOs, SESPAS, SDP, UNICEF and PAHO

participate in all parts of this process. The program: (a) plans to use existing pamphlets for mothers and flip charts developed under CSP/Save the Children (see description below); (b) is in the process of developing training manuals for trainers and supervisors of NGO and SESPAS promoters; and, (c) in coordination with UNICEF, is designing a media campaign aimed at improving specific behaviors of mothers. With assistance from URC/CSP the Academy for Education Development (AED), the URC/CSP will undertake additional preliminary KAP studies for mothers, NGO promoters, and medical personnel; as well as the design, validation, implementation and evaluation of the IEC activities.

To date, the URC/CSP has distributed the pamphlet for mothers and the five child survival flip charts to the field offices of the participating NGOs and the three SESPAS regions. Unfortunately, the lack of an applied training and education strategy means that these materials are not used. Following is a critique of the materials. The pamphlet, "La Lactancia Materna: un Regalo para Toda la Vida" is a lavishly illustrated 12-page booklet for semi or illiterate mothers. It covers advantages, erroneous beliefs, techniques, recommended food intakes for mothers and supplementation schedules for infants. Its major weakness is that it does not emphasize the importance of exclusive breastfeeding for the first four months of a baby's life. This concept is mentioned only on the last page, as part of the graph on the introduction of foods.

As the most widely available material, the CSP/Save the Children flip charts warrant analysis. Made from durable cloth to be rolled up and carried with a shoulder strap, these materials are ideal for enduring the tough conditions of the field. Information is provided by simple, colored drawings on one side of the page accompanied by brief, clear explanations on its reverse side. A different chart summarizes the points for each of the child survival strategies: growth and development, low birth weight, birth spacing, diarrhea, and breastfeeding. The breastfeeding flip chart contains 10 pages with information on colostrum, exclusive breastfeeding (to four months), the introduction of foods (after four months), prevention and management of breastfeeding problems, mother's diet and contraindications (cigarettes and alcohol). Breastfeeding is mentioned in the other flip charts:

- (a) Growth and development: Breastfeeding is related to health, and exclusive nursing is stressed for the first four months of life.
- (b) Low birth weight: The warmth and affection provided during nursing is pictured; also shown is the feeding of mother's

milk with a spoon to premature babies who are not yet able to suck.

- (c) Diarrhea and ORT: Bottles are rightly blamed for causing diarrhea, while exclusive breastfeeding for the first four months of life and the importance of continued nursing during illness is emphasized; however, oral rehydration is recommended before giving the breast for babies with dehydration.
- (d) Birth spacing: Unfortunately breastfeeding for birth spacing and with respect to recommended and contraindicated contraceptive methods was not mentioned.

Though the planned IEC activities of the URC/CSP are aimed at their three program regions, the hope is that its strategies will be used on the national level by SESPAS and other related government agencies, and by all NGOs. Much effort is made by CSP to include all these groups, as well as UNICEF and PAHO, who traditionally work closely with the public sector, to assure harmony of messages and strategies between different organizations, as well as across the different child survival components.

Common criticism of this plan consists of URC/CSP not having provided interim follow up and training in the use of existing materials, recently developed under the previous administration of the CSP, and for not using and improving the Manual del Promotor de Salud as part of their IEC system.

At this time the URC/CSP has been assured USAID funding through 1992, with child survival, and specifically breastfeeding, allocated a priority position in USAID's next health project, which is currently being designed. Breastfeeding is also a priority for both UNICEF and PAHO who coordinate their efforts with the URC/CSP. The consistent local initiatives (SDP) and support (Nestle), and possible interest of private industry (pharmaceutical, rum industry), in addition to the wealth of communication expertise and channels in the DR, assures that efforts can be sustained.

B. COMMUNICATION RESOURCES AND LIMITATION

There are over 200 radio stations and seven national television channels in the Dominican Republic (Table XIII.1). The broadcasters with the largest national audiences are Radio Mil, Radio Popular and Radio Central. In provinces the popular education programs of the Catholic radio channels play to large audiences. Channel 6 - Color Vision- is the most viewed TV channel from Monday through Friday for all social classes. Prime TV time is from 12:00 pm to 2:00 pm, when most Dominicans go home

for lunch, and from 6:00 pm to 11:00 pm. In 1990, 30 seconds of radio time cost RD\$ 125, while a prime time television announcement can cost up to RD\$ 3,200 (US\$1.00 = RD\$12.30 in 1991).

TABLE XIII.1
TELEVISION AND RADIO COVERAGE

MEDIUM	PENETRATION	STATIONS	SOCIAL CLASS
Television	40% nationally 56% urban areas 83% Santo Domingo	6 private 1 state 30 cable channels	Santo Domingo 98%--upper class 89%--middle class 74%--lower class
Radio	99% households	Santo Domingo 45 AM stations 42 FM stations 113--interior 6 chains	Radio programs: 2 government 6 cultural-religious 12 "novelas" 30 sports 180 news

Regulation 824 of Law 1951, published in 1949 regulates the operations of the showing of films and theater works, as well as radio and television, publicity, and promotion programs using mass media. The law prohibits the exposure of breasts in public media, during daytime hours. However, according to a representative of the National Commission on Public Events and Radio Programs, this law would not apply to the promotion of breastfeeding.

There is no established procedure for giving free air time for public service messages, though non-prime time is often donated when prime time spots are purchased. Because radio is considerably cheaper, it is easier to obtain donated radio spots than TV spots. Private industry also regularly sponsors public service messages.

C. OTHER IEC ACTIVITIES

With the exception of some isolated broadcasts, there has been no consistent use of the media for the promotion of breastfeeding. As described above, the specific IEC activities related to breastfeeding in the DR are limited and are carried out mostly by the private sector. Outside these efforts little or no attention is paid to breastfeeding. The portrayal of happy motherhood and

infancy in the DR continues to include a baby bottle to complete the triangle, while nursing in public is increasingly frowned upon.

Successful health IEC programs have been carried out in the DR by UNICEF for immunization and AIDSCOM [the AIDS Communication Project coordinated by AED and Family Health International (FHI)]. UNICEF has facilitated the efforts of a local staff and a national communications firm to repeatedly remind Dominican families about the urgency to vaccinate their children. UNICEF-supported national vaccination campaigns were promoted by pamphlets, posters, training of SESPAS personnel at all levels, and clever, donated radio and TV spots narrated by Dominican celebrities. Though formative research and materials pretesting were not done, vaccination data show the campaign to have had positive effects on vaccination rates.

The USAID-funded AIDSCOM project has effectively used print materials, billboards, theatre and festivals, as well as the media to educate the Dominican public, with a focus on the at-risk groups, about the disease. The project's successful and innovative promotion of condom use among sexually active men and prostitutes is recognized internationally as one of the best in the AIDS field.

Concerning breastfeeding, however most of the communication has been interpersonal. As pointed out repeatedly, there is rarely any communication between medical personnel and mothers. At the community level NGO promoters educate mothers mostly through face-to-face encounters, and sometimes in group sessions. The communication is usually one way, with the promoter providing information.

The information systems in place for breastfeeding are limited. This year PAHO signed an agreement to create a National Network of Health Information to: (a) study the availability and quality of scientific-technical information in health (library and human resources); (b) improve quality of nationally produced materials, and (c) promote the exchange of publications at the national and international levels. The coordinating center will have the necessary technology to access international databases such as MEDLINE and POPLINE. This system should vastly improve the current scarcity of literature on breastfeeding. For example, the library of the largest university in the DR, the Autonomous University of Santo Domingo, has only 12 articles on breastfeeding, all published prior to 1985. The only available journals are Salud Publica, Revista Medica Dominicana, Archivos Dominicanos de Pediatria, and Acta Medica Dominicana.

The URC/CSP has recently collected information on all child survival components to which NGOs have ready access. Its documentation on breastfeeding, however, is limited to policy

papers and its own materials. The CSP centers and NGO offices visited in Regions IV and VI had very little information on breastfeeding. Some did receive the newsletter Mothers and Children.

D. CONCLUSIONS

There is no national IEC program for the promotion of breastfeeding in the DR. The only strategy that exists is the one being developed under the USAID-assisted child survival plan. However, there have been a few limited efforts such as the CARITAS/CRS ANEP program that have many constructive lessons to offer.

NGO promoters are committed to teaching mothers about breastfeeding and often do so without materials. Generally, they stress the advantages of breastfeeding and, to some extent, the importance of exclusive nursing before four months of age. However, they seldom touch on successful ways to overcome problems. The ANEP evaluation and promoter experience confirms how difficult it is to teach mothers not to introduce bottles, teas and water before their baby is four months old. Most of the existing education is face-to-face, with promoters providing all the information rather than the counselling. Group meetings, where mothers could exchange knowledge and experiences and form support groups, are rare.

The use of radio and television in promoting breastfeeding has been limited, in spite of the extensive broadcasting networks, the popularity of radio and its relatively inexpensive costs. While television has a high penetration in urban areas, even among the poor, its high cost has limited its use in promoting health behaviors. Only a few NGOs have successfully used local radio for their breastfeeding messages.

There are currently some very successful IEC projects to promote immunization and AIDS prevention. These efforts have broad communication strategies that include multiple media. Though their financing is assured by international donors, their activities have been carried out by local talent with predominantly national resources. The USAID-funded URC/CSP is currently designing an IEC program for all of the child survival strategies. With lessons from these existing programs and with the participation of a broad range of private, public and international health sector representatives, they aim for this IEC program to be applied at the national level and at least by all NGOs.

One activity not contemplated in any plan is IEC for health providers (distinct from training). The breastfeeding knowledge and attitudes of doctors, nurses and promoters surveyed is

incomplete. Again, all are familiar with the advantages of breast milk, but few are aware of the importance of exclusive nursing during the first four months of life. Various studies show that doctors' recommendations are among the main causes for early supplementation and weaning. The participation of health personnel in breastfeeding promotion during prenatal, delivery and newborn care is nonexistent. Given the already deficient training of this personnel and the limited availability of recent publications on breastfeeding, it is imperative that IEC activities include health personnel. Because the IEC project of the URC/CSP is not directed to health institutions and their personnel, other groups should be identified for this task and their work linked closely with URC/CSP.

SECTION IX

RECOMMENDATIONS

A. OVERVIEW

In the Dominican Republic there is a complete lack of support for breastfeeding in health institutions and by medical personnel, particularly in the private sector. In fact, doctors are likely to interfere with optimal breastfeeding practices, by separating newborns from mothers for unnecessary and, at times, harmful reasons, and by regularly recommending early supplementation, when breastfeeding should be exclusive. Given this situation and the fact that little is being done to improve it, the assessment team feels strongly that breastfeeding promotion strategies must first target medical personnel and their education and training programs.

Breastfeeding promotion within service delivery protocols requires strengthening. SESPAS' breastfeeding policy, as expressed in its policy manual, should be revised and distributed with training and monitoring. Both public and private clinics offering prenatal and/or family planning services require strong breastfeeding promotion programs, as do the more obvious maternity wards of hospitals or birthing centers in private clinics. Training of health providers should focus on the management of breastfeeding problems, not just the current contents on the advantages of breastfeeding.

Ongoing efforts of the URC/Child Survival Program include an integrated IEC strategy for breastfeeding targetted for community promoters of NGOs and community members in three SESPAS regions. These activities should be reinforced and their messages should be harmonized with the information and education program provided for health personnel by SESPAS and through other donors (USAID/CSP, UNICEF, PAHO).

B. HEALTH PROFESSIONAL TRAINING FOR HOSPITAL-BASED BREASTFEEDING PROMOTION

Since 90% of all births in the DR are institutional, half being public, breastfeeding promotion in hospitals would be an effective way to stimulate mothers to breastfeed correctly. The following strategies are proposed:

1. Train medical teams (one pediatrician, one obstetrician and one nurse) from the four largest, urban maternity hospitals (40+ births a day) in clinical management of breastfeeding per the WELLSTART model.

2. Train two nurses to be "Consejeras de Lactancia Materna", in each of these large urban hospitals. Their training would focus on breastfeeding support techniques per the model of AHLACMA, Public Maternity Hospital, Honduras
3. Set up a selection and monitoring team to assure appropriate selection and post-training implementation.
4. Upon their return to the DR, the trainees will reform the lactation management practices in their respective hospitals in compliance with WHO/UNICEF "Ten Steps to Successful Breastfeeding" (1989). A specific example of needed reforms would be to insure that low birth weight and new born infants with infections are fed their mother's breast milk.
5. After training, candidates will form teams of master trainers including the Consejeras, to provide the breastfeeding component of child survival training and follow up to other, smaller hospitals and clinics. It will be critical to work with private hospitals and clinics in this effort.

C. REVISION OF MEDICAL TRAINING AND EDUCATION

At this time the medical curriculum for the Universidad Autónoma de Santo Domingo is being revised, providing an opportunity to strengthen the clinical management of the breastfeeding component, as well as the technical information available to medical and nursing students and other health personnel. The continued support of a PAHO/WELLSTART consultant is required in design, initial testing and revision of the curriculum.

D. REINFORCE CSP/SESPAS/NGO BREASTFEEDING PROMOTION ACTIVITIES FOR COMMUNITY PROMOTION

1. Ensure that quality formative research is available on motivations for women to exclusively breastfed and to stop using bottles.
2. Strengthen existing materials to emphasize exclusive breastfeeding for the first 4-6 months, the relationship between the number of feeds and successful lactation, and appropriate introduction of semi-solids. Correct all misinformation.
3. Assure the distribution of existing CSP materials to community NGO and SESPAS locations and provide interim training and follow up to promoters in their use, while URC/CSP revises and completes its IEC strategy. All

promotor training should emphasize management of common complications.

4. Coordinate IEC efforts with UNICEF, PAHO, NGOs, SDP, SESPAS and other related agencies to assure harmony of message and acceptance as a national program and to prevent duplication of resources.
5. Collaborate with other NGOs (CEDOIS), especially women's organizations, in promoting breastfeeding as part of the important health role women play in their families and communities. Also work to build women's confidence in their abilities to breastfeed successfully.
6. Include mass media promotion of breastfeeding in the broad IEC breastfeeding strategy.

E. INCORPORATE BREASTFEEDING PROMOTION IN PRENATAL CARE AND FAMILY PLANNING COUNSELLING PROVIDED BY FAMILY PLANNING CLINICS TO STRENGTHEN PRIVATE SECTOR BREASTFEEDING PROMOTION

Private family planning organizations provide low-cost prenatal care to women in 200 clinics located in predominantly marginalized urban areas. Prenatal care should cover breastfeeding counselling and a breast examination.

Breastfeeding can be promoted for child spacing and should be considered for contraceptive users with respect to recommended and contraindicated methods. Currently unavailable low dose contraceptive pills and progestin-only pills should be marketed as an alternative to the contraindicated estrogen pills for nursing mothers.

F. IDENTIFY A SESPAS BREASTFEEDING PROGRAM COORDINATOR LEADER AND STRENGTHEN SESPAS ACTIVITIES IN BREASTFEEDING FOR NATIONWIDE BREASTFEEDING PROMOTION

At this time, SESPAS child survival activities have not been implemented due to a complex of problems. The first recommendation is critical and should be applied when these problems are addressed.

1. The lack of leadership for breastfeeding activities in SESPAS is a crucial issue and needs closer examination by national leaders in the health sector. A home must be found for breastfeeding with an individual responsible for coordination and execution. Because of a lack of a MOH/PLANSI Breastfeeding Program

Coordinator, the team has not defined how and where these recommendations should be coordinated.

2. Revise, reorganize and correct PLANSI's Manual de Normas; design training and monitoring strategies with trained hospital teams (B.4) to implement norms at the operational level.
3. With CSP revise the Manual del Promotor de Salud: Limit areas of responsibility, improve organization, simplify, and correct errors. Emphasize proper breastfeeding, weaning, the importance of breastfeeding during diarrhea and management and motivation techniques.

G. COORDINATE ACTIVITIES AMONG INTERNATIONAL DONORS

Coordination should be established thorough regular exchanges and/or joint efforts (C.4) in the design and implementation of IEC for community promoters and mothers, and health personnel, to assure consistency and optimum use of resources.

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ANNEX 1

Persons Interviewed by Breastfeeding Assessment Team Dominican Republic, 1991

Hospitals/Doctors

1. Sto. Domingo

Dra. Mayra Mora, Jefe de Enseñanza, Hospital Maternidad Nuestra Señora de la Altagracia, SESPAS.

Dr. Acacia Mercedes, Pediatra, Jefe del Banco de Leche Materna y Encargada de Clínica de Alto Riesgo del Hospital Maternidad Nuestra Señora de la Altagracia. Futura Presidenta de la Asociación Dominicana de Pediatría, SESPAS.

Dra. Juana Montaña, Jefe del Banco de Leche, Hospita. San Lorenzo de los Minas, SESPAS.

Dra. Rosa Amador, Médico Interno de Hospital S.L. de los Minas, Directora Sub-Centro Villa Duarte, SESPAS.

Lic. Mireya Arias de Guerta, Responsable Cátedra Enfermería Obstétrica y Comunitaria. Universidad Autónoma de Sto. Domingo, Presidenta de la Sociedad de Enfermas Obstetras, SESPAS.

Dra. Ligia Reid, Pediatra, Clínica Gomez Patiño (privada). Miembro original del grupo de investigadores sobre la Lactancia Materna.

2. Barahona, Region VI

Dr. José Antonia Abreu, Director Interino, Hospital Regional Jaime Mota, SESPAS.

3. Elias Piña, Region IV

Dr. José Alcantara Rua, Director Interino del Hospital Elias Piña, SESPAS.

4. Tamayo, Region VI

Equipo del subcentro de salud, SESPAS, Secretaría de Estado de Salud Pública

SESPAS y Asistencia Social Nivel Central, Santo Domingo

Dra. Donastrog, Jefe de Información

Dra. Jefe de Medicamentos

IDSS, Instituto Dominicano de Seguro Social

Cristina Diaz, Encargada del Programa Guarderías IDSS. y Ex Coordinadora del Programa de Lactancia Materna/SESPAS/PLANSI. 1987-1990.

INESPRE, Sto. Domingo

Marianela Boden, Directora de Depto. Agroindustrial

CENISMI (Centro Nacional de Investigación de Salud Materno Infantil), Santo Domingo

Dr. Hugo Mendoza, Pediatra, Director, CENISMI

Cuerpo de Paz

Miguel León, Gerente de Salud.

Sector Privado

Dra. Josefina Coen, Pediatra Coordinadora de Supervivencia Infantil de la Sociedad Dominicana de Pediatría; y parte del equipo del Diagnóstico de la Lactancia Materna en la RD.

Milgueya Partes, Presidenta Federación Pan Americana de Farmacéuticos y Bioquímicos, Santo Domingo, Vice Presidenta, MUDE.

Maritza de Achecar, Gerente de Ventas de Productos Dietéticos, Bristol Myers/Mead Johnson.

Delio Antonio Picharaod, Jefe Dept. Productos Infantiles y Servicios de Marketing, Nestlé, encargado de Mercadeo, Abbot Laboratories.

Programa de Supervivencia Infantil/University Research Corporation (PSI/URC)

Mary Ann Abeyta Behnke, Directora

Dr. Angel Luiz Alvarez, Sub-Director; ex-Director de Programa Enfermedades Inmunoprevenibles, SESPAS.

Dr. Johny Rivas, Coordinador de la Region 0 (Sto. Domingo); ex-Director de PLANSI/SESPAS.

Dr. Frank Renandez, Coordinador de la Region VI (Barahona); ex-Director de Enfermedades Diarreicas; SESPAS.

Isabel Mantilla, Coordinadora Asistente, Region IV (San Juan de la Maguana).

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Dr. Marino Miniño, ex-Coordinador de Capacitación de PSI/Save the Children.

Lic. Denise Ureña, ex-Coordinadora Producción de Materiales Educativos, PSI/Save the Children. Consultora PSI/URC.

Non-Governmental Organizations (NGOs)

Centro Dominicano de Organizaciones de Interés Social, CEDOIS, Sto. Domingo.

Carlos Pimentel, Director.

CARE Dominicana, Sto. Domingo

Hilary Cottams, Sub Directora

Edith Rodriguez, Enfermera, Gerente de Capacitación

Dra. Cecilia Corpóran, Capacitadora

CARITAS, Sto. Domingo

Juana Maria Mendez, Directora y Presidenta Enfermería Socio-Comunitaria.

Fundación Centro el Hambre, Elias Piña, Region IV

Josefina Heredia Mercedes, Coordinadora

Fidelina Alcántara, Promotora

Fundación de Desarrollo Comunitario (FUDECO), Elias Piña, Region IV.

Centro de Capacitación

Servicio Social de Iglesias, Barahona

Glenys Obispo, Supervisora.

Milagros, Promotora, Batey #5

Instituto Dominicano para el Desarrollo Integral. IDDI, Sto. Domingo

Ramon Seiffe, Responsable Sistema Información

Liliana Rocha, Encargada Programa Salud

Isidora Abú, Supervisora de Promotoras en la Zurza.

Laundes Pedana, Encargada de Centro Recuperación Nutricional en la Zurza.

Dolores Mantero, Promotora en la Zurza.

Centro de Investigaciones y Apoyo Cultural (CIAC), Region VI.

Carlos Terreno, Encargado del Centro

Centro de Investigacion para Asuntos Femeninos, CIPAF, Sto. Domingo

Mujeres para el Desarrollo, MUDE, Sto. Domingo.

Rosarito Alvarez, Directora.

Tu Mujer, Sto. Domingo.

Cristina de Seiffe, Directora

Donor Agencies

A.I.D., Sto. Domingo

Paul Struharik, Jefe de Recursos Humanos.

Jack Thomas, Encargado de Salud.

Tim Truitt, Encargado de Supervivencia Infantil.

Sara George, Encargada de Nutrición.

Ann Lion, Directora Development Associates que provea asesoría técnica y administrativa en planificación familiar a PROFAMILIA y ADOPLAFAM.

UNICEF, Sto. Domingo

Michael McCabe, Sub Director

Ilsa Nina, Coordinadora de Supervivencia Infantil y Desarrollo.

Sara Menendez, Encargada de Nutrición.

PAHO, Sto. Domingo

Dra. Mirta Roses, Representante.

Lcda. Miriam Riaño, Consultora Materno Infantil

Lcda. Rosa María Borel, Representante PASCAP

Nelly Piña, Consultora Recursos Humanos

Lcda. Rosario Guzmán, Resp. Biblioteca.

Lcda. Yma Sánchez, Educadora para la Salud.

ANNEX 2

(Retyped from photocopy of Spanish original, obtained from the
Centro de Documentación OPS/OMS in Santo Domingo)

**SECRETARIA DE ESTADO DE SALUD PUBLICA Y
ASISTENCIA SOCIAL**

**PLAN NACIONAL DE SUPERVIVENCIA
PLANSI**

PROGRAMA DE PROMOCION DE LA LACTANCIA MATERNA

SANTO DOMINGO, DOM. REP.

PROPOSITO

El Programa se propone contribuir a la disminución de la morbilidad de los niños menores de 1 año mediante la promoción de las ventajas de Lactancia Materna, la provisión de leche humana a los recién nacidos de alto riesgo y de alimentación a las embarazadas y madres que lactan, en el cuatrenio 1988-1991.

OBJETIVOS GENERAL

Disminuir la morbimortalidad infantil de los lactantes y los costos de alimentación infantil.

OBJETIVOS ESPECIFICOS:

Revisar y establecer normas de atención maternoinfantil con prácticas asistenciales que favorezcan la lactancia materna (examen de mamas, divulgación de ventajas, lactancia inmediata, alojamiento conjunto, madre acompañada y distribución leche humana)

Suministrar alimentación complementaria a madres embarazadas y lactantes con riesgo de desnutrición a nivel local.

Incrementar y asesorar bancos de leche humana, en hospitales del país.

Capacitar los recursos humanos institucionales del sector salud, de entidades no gubernamentales y de la comunidad en normas y técnicas que favorezcan la lactancia materna.

Modificar, preparar y divulgar aspectos de la Legislación Nacional que favorezcan la práctica y promoción de la lactancia materna.

Propiciar la introducción de contenido relativos a la nutrición y lactancia materna en la curricula de la enseñanza pre-escolar, primaria, secundaria y universitaria, así como en los programas de la educación no formal.

Incentivar y orientar a las instituciones públicas y privadas relacionadas con acciones de salud para que ejecuten actividades de promoción de lactancia materna.

Promover entre las madres la práctica de la lactancia materna como la mejor forma de alimentar a sus hijos.

Apoyar el cumplimiento del código de prohibición de comercialización de sucedaneos de leche.

Difundir a todos los niveles los beneficios de la lactancia materna utilizando para ello los medios masivos de comunicación.

Promover el desarrollo de estudios e investigaciones relacionadas con la alimentación materna y del lactante para promover el conocimiento en este campo.

POBLACION OBJETIVO

Ochenta por ciento (80%) de embarazadas y población materno infantil lactante que asisten a establecimientos de salud de SESPAS. Poblacion en general.

METAS

Lograr que el 100% de las madres que asisten a control prenatal de SESPAS reciban orientación y asistencia que favorezcan con su posterior inicio en la lactancia.

Elevar de un ? a un 90% los establecimientos de SESPAS que ofrezcan examen de mamas, orientación psicoprofiláctica. Lactancia inmediata, alojamiento conjunto y leche humana a recién nacidos internados.

Eliminar la práctica de distribución de leches y productos maternizados en los establecimeintos que aún lo realizan.

Elevar de un 20% a un 70% el número de niños alimentados con lactancia exclusiva hasta el 4to. mes.

Proporcionar alimentación complementaria al 100% de las embarazadas y madres lactantes con riesgo de desnutrición que acudan a las clínicas rurales y otros establecimientos de SESPAS.

Instalar cinco (5) bancos de leche materna en igual número de hospitales del país.

Capacitar al 90% del personal de todos los niveles del sistema de salud SESPAS, relacionados con la práctica y divulgación de la lactancia materna en el país.

Lograr acuerdo con las instituciones que realizan acciones de promociones de la lactancia materna, que permitan divulgación y aplicación de normas y leyes nacionales que la favorezcan.

AREAS DE ACCION

I. PRACTICAS ASISTENCIALES

Se normalizará para la ejecución de las siguientes acciones:

- I. a) Examen de mamas en consulta prenatal.
- I. b) Orientación sobre preparación de pezones y motivación y técnicas de lactancia a las madres que asisten a control prenatal.
- I. c) Se donará alimentación complementaria a las madres indentificadas de alto riesgo para desnutrición en período de gestación y lactancia.
- I. d) Se promoverá y capacitará en principios básicos de psicoprofiláxis para el parto en los establecimientos de salud.
- I. e) Se promoverá el sistema de lactancia inmediata a los recién nacidos de establecimientos de salud.
- I. f) Se favorecerá el sistema de alojamiento conjunto y sistema de madre acompañante en los centros asistenciales que ejecuten partos de la SESPAS.
- I. g) Se completará la instalación de bancos de leche humana en todos los hospitales regionales del país.

FORMACION Y CAPACITACION DE RECURSOS HUMANOS

- II. a) Se elaborará material didáctico que permita la capacitación y actualización en técnicas y ventajas de la lactancia materna al personal de salud de diferentes niveles del sector salud.
- II. b) Se efectuarán cursos, charlas y talleres para dicho personal así como el personal que opera en los bancos de leche humana.
- II. c) Se coordinará y ejecutarán seminarios-talleres con organismos internacionales y no gubernamentales que favorezcan la capacitación y difusión de estrategias comunes para la promoción de la lactancia.
- II. d) Se propiciarán reuniones con representantes del Congreso de la Nación para la revisión y promulgación de leyes que favorezcan la lactancia materna en el país.

III.

EDUCACION A LA POBLACION

- III. a) Se revisarán acuerdos y promoverá la incursión de temas de lactancia materna a población escolarizada y universitaria del país.
- III. b) Se coordinará y apoyarán actividades educativas (charlas-talleres etc.) a población no escolarizada y grupos organizados de diferentes sectores del país.
- III. c) Se normalizará y promoverán actividades de orientación y motivación a la población de madres gestantes y lactantes que asisten a los establecimientos de salud de SESPAS y a la población general.
- III. d) Se organizarán encuentros con la comunidad donde se analice la importancia de las acciones propuestas por el programa y como influye en la salud del niño.

IV.

MEDIOS MASIVOS DE COMUNICACION

- IV. a) Se elaborará un diagnóstico y programación para la difusión por medios masivos de comunicación de las ventajas y técnicas de la lactancia materna.
- IV. b) Se elaborará material educativo para ser utilizado por medios comunitarios, prensa radial, escrita y televisión del país.
- IV. c) Se evaluará el impacto de la difusión masiva en la práctica de la lactancia materna y su duración.

V. COORDINACION ADMINISTRACION Y EVALUACION

- V. a) La coordinación del programa de lactancia materna será realizada por un coordinador nacional en la unidad ejecutora del PLAN NACIONAL DE SUPERVIVENCIA INFANTIL (PLANSI).
- V. b) La administración de los recursos para el programa recaerá en la Dirección de Servicios Básicos de Salud en coordinación de la coordinación técnica del PLANSI y de la coordinación nacional del programa de lactancia materna.
- V. c) La responsabilidad de la ejecución del programa recaerá en la Secretaría de Estado de Salud Pública y Asistencia Social (SESPAS), al igual que los demás componentes del PLANSI) a través de la Dirección general de Servicios Básicos de Salud, unidad de coordinación técnica del PLAN NACIONAL DE SUPERVIVENCIA INFANTIL. La coordinación del programación del programa y todos los niveles (regionales, de área y locales del sistema de salud).
- V. d) Se solicitarán recursos nacionales e internacionales a través de instituciones públicas y privadas para la ejecución y evaluación de las acciones programadas.
- V. e) Se coordinará la participación internacional, pública y privada nacional e internacional que favorezcan el intercambio de información y experiencias que favorezcan el logro de todos los objetivos del programa.
- V. f) Se coordinará y solicitarán consultorías técnicas con personal capacitado en el área de elaboración de material educativo y de promoción, revisión de leyes, evaluación de impacto e investigación del programa.
- V. g) Se realizará un diagnóstico inicial de la situación de la lactancia materna en las áreas de influencia de la SESPAS resaltando el cumplimiento de normas establecidas, prácticas asistenciales, duración promedio de la lactancia materna por áreas y regiones, así como morbilidad y mortalidad de población infantil lactante en las zonas a implementar el programa.
- V. h) Se propiciará y apoyará la realización de investigaciones locales y nacionales que aumenten el nivel de conocimiento de la lactancia materna en el país.
- V. i) Se supervisará, evaluará la existencia y cumplimiento de normas, la realización de actividades programadas, la disponibilidad, distribución y utilización de recursos, y el impacto en la morbilidad y desnutrición de la población objetivo.

**INDICADORES GENERALES DEL PROGRAMA DE
PROMOCION DE LA LACTANCIA MATERNA**

**INDICADORES DEL PROGRAMA DE PROMOCION
DE LA LACTANCIA MATERNA**

I - Prácticas Asistenciales

- I.1. Asistencia Prenatal
 - I.1.1. Examen de mamas
 - I.1.2. Alimentación complementaria
 - I.1.3. Psicoprofilaxis en atención al parto
- I.2. Atención del parto-lactancia inmediata
- I.3. Asistencia Post - Parto
 - I.3.1. Alojamiento conjunto
 - I.3.2. Bancos de leche

II - Formación y Desarrollo de Recursos Humanos

- II.1 Elaboración material didáctico
- II.2 Capacitación personal de Salud
- II.3 Capacitación personal organismos no gubernamentales
- II.4 Actualización curriculum enseñanza primaria-secundaria universitaria
- II.5 Actualización personal especializado
- II.6 Elaboración de material de apoyo para capacitación
- II.7 Concientización y motivación a nivel decisivo político (promulgación de leyes que favorezcan la lactancia materna)

III - Educación a la población

- III.1 Actividades educativas a nivel escolarizado
- III.2 Actividades educativas a niveles no escolarizados a grupos organizados existentes
- III.3 Actividades de orientación
 - III.3.1. Usuarios del servicio
 - III.3.2. Población blanco
 - III.3.3. Población general
- III.4 Actividades de información (investigación)

IV - Medios masivos de comunicación

- IV.1 Diagnóstico
 - IV.1.1. En población meta
 - IV.1.2. Multisectorial
- IV.2 Planificación o plan de acción
- IV.3 Difusión-evaluación
 - IV.3.1. Material escrito
 - IV.3.2. Material gráfico
 - IV.3.3. Radio
 - IV.3.4. T.V.
- IV.4 Capacitación de personal institucional
- IV.5 Participación comunal en el proceso
- IV.6 Evaluación de prácticas de lactancia en personas que la practican y duración

V - Planes Proyectos y Programas

- V.1 Otros proyectos del país, actividades que desarrollan y responsable de los mismos
- V.2 Mecanismos de coordinación
- V.3 Apoyo a los proyectos y/o programas
- V.4 Areas a evaluar e indicadores a usar
 - V.4.1. Objetivos globales y específicos
 - V.4.2. Metas
 - V.4.3. Recursos
 - V.4.4. Criterios
 - V.4.4.1 Productividad
 - V.4.4.2 Cobertura
 - V.4.4.3 Concentración
 - V.4.4.4 Eficacia
 - V.4.4.4 Impacto en enfermedades, morbilidad, mortalidad y desnutrición
- V.5. Indicadores
 - V.5.1. Desarrollo de actividad
 - V.5.2. Disponibilidad y distribución de recursos
 - V.5.3. Existencia y cumplimiento de normas

Artículo 9o - Protección especial. Los agentes de salud, instituciones o dependencias de servicios de atención de salud y personal de éstas, deberán estimular y proteger la lactancia natural, y los que se ocupen particularmente de la nutrición de la madre y del lactante, deben familiarizarse con las obligaciones que les incumben en virtud de la presente ley.

Artículo 10. Prohibición a incentivos. En ningún caso, los fabricantes o distribuidores ofrecerán, con el propósito de promover los productos comprendidos en las disposiciones de la presente ley, incentivos financieros o materiales al personal o los servicios de salud.

Artículo 11.- Declaración de beneficios. Los fabricantes y distribuidores de los productos relacionados en la presente ley, deberán declarar a la institución o dependencia a que pertenezca el empleado o funcionario respectivo, toda contribución hecha a favor de este, con el fin exclusivo de financiar becas, viajes de estudio, subvenciones para investigación, gastos de asistencia a conferencias profesionales y demás actividades de esa índole. El empleado o funcionario, previo a gozar de dicho beneficio, deberá contar con autorización extendida por la autoridad superior jerárquica del servicio a que pertenezca, y aprobación en su caso, del Ministerio de Salud Pública y Asistencia Social o del Instituto Dominicano de Seguros Sociales (IDSS). El personal de salud de instituciones o servicios privados, deberá contar con la aprobación de la Sociedad Dominicana de Pediatría, para aspirar a estos beneficios, previa solicitud de dicha Sociedad a los fabricantes o distribuidores.

Artículo 12. Muestras. En ningún caso, los fabricantes o distribuidores, por sí o por sus agentes o representantes, distribuirán muestras de los productos a que se refiere esta ley, ni materiales o utensilios que sirvan para su preparación o empleo, salvo cuando sea necesario para fines profesionales de evaluación o de investigación a nivel institucional o de información.

Artículo 13. Etiquetado. En las etiquetas de cualquier recipiente o en los envases de los productos comprendidos en las disposiciones de la presente ley, queda prohibida la impresión o utilización de las expresiones: "Leche humanizada", "leche maternizada", "equivalente de la leche materna" o cualquier otra expresión que induzca a error o a la creencia sobre las cualidades de dichos productos en relación a la leche materna. Se concede el plazo de tres meses contados a partir de la fecha de iniciación de la vigencia de este Decreto Ley, para el cumplimiento de los dispuestos en el presente artículo.

COMISION NACIONAL DE LACTANCIA
MATERNA
FUNDADA EL 21 DE NOVIEMBRE DE 1984
INSTITUCIONES REPRESENTADAS

- 1.- Secretaría de Estado de Salud Pública y Asistencia Social (SESPAS)
- 2.- Secretaría de Estado de Educación Bellas Artes y Cultos
- 3.- Secretaría de Trabajo
- 4.- Consejo Nacional de Población y Familia (CONAPOFA).
- 5.- PRO-FAMILIA
- 6.- Sociedad Dominicana de Pediatría
- 7.- Sociedad Dominicana de Ginecología y Obstetricia
- 8.- Centro de Integración Familiar (CIF)
- 9.- Dirección General de la Oficina de Promoción de la Mujer.



Ley

de Comercialización
de los Sucedáneos de
la Leche Materna



Una Ley que todo Dominicano
debe conocer... y hacer cumplir.

COMISION NACIONAL DE PROMOCION
DE LA LACTANCIA MATERNA.
REPUBLICA DOMINICANA
1986

**COMISION NACIONAL DE PROMOCION
DE LA LACTANCIA MATERNA
REPUBLICA DOMINICANA**

LA COMISION NACIONAL DE LACTANCIA MATERNA
SOLICITA QUE SE APRUEBE ESTE DECRETO DE LEY

CONSIDERANDO:

Que la maternidad y la niñez deben ser objeto de especial atención por parte del Estado, desarrollando a través de sus órganos, acciones de protección, promoción y las complementarias, a fin de procurar a la madre y al niño, el más completo bienestar físico, mental y social;

CONSIDERANDO:

Que la lactancia natural es un medio inigualado para proporcionar el alimento ideal para el sano crecimiento y desarrollo del lactante, constituyendo la base biológica y fisiológica para el desarrollo normal del niño;

CONSIDERANDO:

Que la Organización Mundial de la Salud, de la cual República Dominicana es miembro permanente, ha recomendado la adopción de normas que tiendan a proteger la lactancia natural regulando la comercialización de los sucedáneos de la leche materna, razón por la cual es procedente emitir en tal sentido la correspondiente disposición legal, solicitamos al Poder Ejecutivo promulgar éste decreto de ley.

**LEY DE COMERCIALIZACION DE LOS
SUCEDANEOS DE LA LECHE MATERNA**

Artículo 1o.— **Objetivos y alcances.** La presente ley tiene por objeto procurar el establecimiento de las medidas necesarias para proteger y promover la lactancia natural, asegurando el uso adecuado de los sucedáneos de la leche materna, sobre la base de una información apropiada, cuando éstos fueren necesarios, y las modalidades del comercio y distribución de los siguientes productos, sucedáneos de la leche materna, incluidas las preparaciones para lactantes, otros productos de origen lácteo, alimentos y bebidas, incluidos los alimentos complementarios administrados con biberón, cuando estén comercializados o cuando de otro modo se indique que pueden emplearse, con o sin modificación, para sustituir parcial o totalmente a la leche materna, se aplicara, asimismo, a la calidad y disponibilidad de los productos relacionados y a la información sobre su utilización.

Artículo 2o.— **Definiciones.** Para los efectos de la aplicación de la presente ley, los términos en ella usados, se entenderán de la manera siguiente:

- a) **Sucedáneos de la leche materna.** Todo alimento comercializado o presentado como sustitutivo parcial o total de la leche materna, sea o no adecuado para ese fin.
- b) **Alimento complementario.** Todo alimento, manufacturado o preparado localmente como complemento de la leche materna o de las preparaciones para lactantes cuando aquella o éstas resulten insuficientes para satisfacer las necesidades nutricionales del lactante.
- c) **Comercialización.** Las actividades de promoción, distribución, publicidad y servicios de información, relativas a un producto;
- d) **Distribuidor.** La persona individual o jurídica que directa o indirectamente se dedique a la comercialización de cualesquiera de los productos a que se refiere la presente ley;
- e) **Preparaciones para lactantes.** Todo sucedáneo de la leche materna preparado industrialmente de conformidad con las normas alimentarias aplicables, para satisfacer las necesidades nutricionales normales del lactante hasta la edad de 4 a 6 meses y adaptado a sus características fisiológicas;
- f) **Personal de salud.** Toda persona, profesional o no incluidos los agentes voluntarios no remunerados, que trabaje en un servicio que dependa de un sistema de atención de salud.

Artículo 3o.— **Material informativo.** Los materiales informativos y educativos, impresos, auditivos o visuales, relacionados con la alimentación de los lactantes y destinados a las mujeres embarazadas y a las madres de lactantes y niños de corta edad, deben incluir datos claramente presentados sobre los siguientes aspectos:

- a) Ventajas y superioridad de la lactancia natural;
- b) Nutrición materna y preparación para la lactancia natural y mantenimiento de ésta;
- c) Efectos negativos que ejerce sobre la lactancia natural la introducción parcial de la alimentación con biberón;
- d) Dificultad de revertir la decisión de suspender la lactancia natural, y
- e) Uso correcto, cuando así convenga, de preparaciones para lactantes.

Cuando dichos materiales contengan información relativa al empleo de preparaciones para lactantes, deberán señalar los riesgos que presentan para la salud los alimentos o los métodos de alimentación inadecuados y los riesgos que presentan para la salud el uso innecesario o incorrecto de preparaciones para lactantes y otros sucedáneos de la leche materna, con ese material no deberán utilizarse imágenes o textos que puedan idealizar el uso de sucedáneos de la leche materna.

Artículo 4o.— **Donativos.** Los fabricantes o los distribuidores de los productos a que se refiere esta ley, sólo podrán

hacer donativos de equipo o materiales informativos o educativos a petición de la entidad interesada y con la autorización escrita del Ministerio de Salud Pública y Asistencia Social o de los órganos directivos del Instituto Dominicano de Seguros Sociales en su caso, atendiendo las orientaciones que se hayan emitido con esa finalidad. El equipo o materiales donados podrán llevar el nombre o símbolo de la empresa donante, pero no deberá referirse a ninguno de los productos comerciales comprendidos en las disposiciones de la presente ley.

Artículo 5o.— **Distribución a las madres y público.** Los fabricantes y los distribuidores de los productos a que se refiere esta ley, no podrán facilitar, directa o indirectamente, a las mujeres embarazadas o a las madres, muestras de los productos comprendidos en las disposiciones de esta ley ni de artículos o utensilios que puedan fomentar la utilización de sucedáneos de la leche materna. Esta disposición no implica restricciones al establecimiento de políticas o prácticas de precios destinadas a facilitar los productos a bajo costo u otras operaciones. No deben ser tampoco objeto de publicidad destinada al público en general, los productos referidos en la presente ley.

Artículo 6o.— **Instalaciones de salud.** Ninguna instalación del sistema de atención de salud del Estado o de sus entidades autónomas, semiautónomas o descentralizadas, podrá ser utilizada para la promoción de preparaciones para lactantes u otros productos a los que se refiere esta ley. Igual prohibición tendrán los sanatorios, hospitales o instituciones privados. La información facilitada para los fabricantes y los distribuidores a los profesionales de salud, debe limitarse a datos científicos y objetivos y no llevará implícita ni suscitará la creencia de que la alimentación con biberón es equivalente o superior a la lactancia natural. Dicha información debe incluir también los datos especificados en el Artículo 3o.

Artículo 7o.— **Personal de empresas.** El personal de comercialización de las empresas no deberá tener, a título profesional, ningún contacto directo o indirecto con mujeres embarazadas o madres de lactantes o niños de corta edad.

No se permitirá en las instalaciones del sistema de atención de salud el empleo de representantes de servicios profesionales, de enfermeras de maternidad o personal análogo, facilitado o remunerado por los fabricantes o los distribuidores de los productos a que se refiere esta ley.

Artículo 8o.— **Personal de Salud.** Únicamente al personal de los centros de atención de salud les será permitido hacer demostraciones sobre alimentación con preparaciones para lactantes, fabricadas industrialmente o elaboradas en casa, y únicamente a las madres o a los miembros de las familias que necesiten utilizarlas; la información facilitada debe incluir una clara explicación de los riesgos que puede acarrear la utilización incorrecta de dichas preparaciones.