Evaluation of the Application of Law 295 in
Matagalpa and Jinotega, Nicaragua

MERYL GOODWIN
GLOBAL HEALTH DEPARTMENT
ROLLINS SCHOOL OF PUBLIC HEALTH
# INTRODUCTION

# BACKGROUND

# SIGNIFICANCE

# DESIGN

# OBJECTIVES

# RESULTS

## SUMMARY

**Exclusive Breastfeeding Promotion**

**Regulation**

**Infractions**

**What MINSA Needs**

**Mothers in Intervention Communities**

**Current Practices**

**Barriers to Exclusive Breastfeeding**

**What Information do They Receive About Exclusive Breastfeeding?**

**What Information do They Receive About Formula?**

# RECOMMENDATIONS

# APPENDIX I: FORMULA LABELS

# APPENDIX II: PICTURES OF ADVERTISEMENTS IN MATAGALPA, NICARAGUA

# APPENDIX III: LAW 295

# APPENDIX IV: INTERVIEW GUIDES

**Brigadistas (Community Healthcare Workers)**

**MINSA**

**Mothers**

**Nestle**

# WORKS CITED
Introduction

Over 10 million children under five die each year in developing countries, and the majority of these deaths are attributable to malnutrition. It is estimated that 1.4 million of these deaths could be averted annually if every mother breastfed exclusively until 6 months of age, which makes protecting a woman’s right to breastfeed the first point of intervention in reducing global childhood mortality.

Breastfeeding is inexpensive, has a high cost effectiveness, and is the best way of nourishing children and protecting the health status of the entire population. For example, breast milk contains immunological and anti-infective properties that help protect a child from infections such as diarrhea, pneumonia, ear infection, flu, and meningitis as well as provides critical nutrients and proteins. Infants who are breastfed are also less likely to develop allergies, type I diabetes, Crohn’s disease, cardiovascular disease, high blood pressure, and obesity as adults. Finally, breastfeeding lowers a mother’s risk of postpartum hemorrhage, breast and ovarian cancer, as well as increases lean muscle composition in the body and delays early return of fertility.

While exclusive breastfeeding offers nutritional and protective benefits, breast milk substitutes increase negative health outcomes such as bacterial infections which can lead to malnutrition and death. Milk substitutes require clean water, the ability of the caregiver to read and comply with mixing instructions, and a standard of overall household hygiene. These factors are often either non-existent or compromised in developing countries which leads to a high risk of formula contamination and subsequent disease and death. In countries with a moderate to high infant mortality rate, bottle fed babies are 14 times as likely to die from diarrhea and 4 times as likely to die from pneumonia as are breastfed babies. Even in countries with low infant mortality rates, bottle fed infants are 5 times as likely to require hospital treatment.

Global breastfeeding rates began to decline in the middle of the 20th century and this decline is largely attributable to unethical and aggressive marketing of baby formula. Currently, poor breastfeeding practices are widespread across the globe with only about 39% of all infants being exclusively breast fed until four months of age. The international community began paying attention to the practices of baby formula companies in the 1970s, when in 1974 a Swiss NGO published a paper called Nestle Kills Babies. A few years later in 1976, a group of nuns filed suit against Bristol-Myers for their marketing practices. The company later settled the case out of court and agreed to stop all direct consumer marketing of milk substitutes.

Perhaps the most well known publicity brought to the issue of formula marketing was the boycott against Nestle which began in the United States in 1977. Consumer rights groups accused the company of using unethical marketing practices to promote the use of breast-milk substitutes in less economically developed countries, and as a result
causing unnecessary suffering and death of babies. For example, Nestle was accused of distributing free powdered formula to hospitals and maternity wards. Mothers would then use the formula in the hospital, which interfered with natural lactation and therefore when mothers left the hospital they were unable to breastfeed and were forced to buy formula. Nestle was also accused of disbursing free formula under the guise of humanitarian aid in order to expand their market, not using culturally appropriate labels, and offering gifts to influence health workers into promoting their products. The publicity resulting in the boycott led to similar boycotts all over Europe, Australia, and Canada. As of 2009, the boycott against Nestle is still in effect under the coordination of the International Nestle Boycott Committee, which consists of more than 200 groups in over 100 countries.

Decreased prevalence of breastfeeding around the world as well as the attention drawn to marketing practices culminated in the 1979 international meeting hosted by WHO and UNICEF. This meeting resulted in the formulation of the International Code of Breast-milk Substitutes. The goal of the Code is to “contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.” The Code is a set of recommendations to regulate the marketing of breast-milk substitutes, feeding bottles, and teats and applies to their quality and availability as well as to information concerning their use. It covers several areas including information and educational materials, advertising and marketing practices, health care workers, promotional materials, and labeling. Upon its passing in 1981, the WHO called upon governments to adopt the Code into official policies and legislation.

Code compliance varies by country. A study completed by the University of Puerto Rico in 2008 found that out of 34 breast-milk substitute labels examined, 100% violated the Code in at least one way. The most common violations were: labels were not written in the local language, Spanish, (100%), text which idealized the use of infant formula or discouraged breastfeeding (97.1%) and that the label lacked a statement indicating that breastfeeding is superior (73.5%). Similarly, a report entitled Cracking the Code by the Interagency Group on Breastfeeding Monitoring (which includes UNICEF, Save the Children, and Voluntary Services Overseas) concluded that many infant formula manufacturers continue to blatantly violate the Code. Among the chief violators were Nestle, Gerber, Mead-Johnson, Wyeth, and Nutricia. Some of the violations found were women receiving information within the healthcare system that was donated by manufacturers, receiving free samples of products, contact between manufacturer staff and pregnant women, and incorrect product labeling that idealized the use of breast-milk substitutes and that failed to warn mothers of the dangers. Because of limited adoption and implementation of the Code, it has had little impact on curbing negative marketing practices. In 1983 the global market for milk substitutes was valued at $3.3 billion and grew to over $6 billion by 1991. Although 60 countries now have laws officially recognizing the Code, the application of these laws is often in question.

---

**Background**

Though it got off to a slow start, Nicaragua is one of the few countries to put forth great effort in promoting exclusive breastfeeding. In 1993 the Ministry of Health
(MINSA) started the Mother-Baby-Friendly Hospital Imitative (MBFHI). This program certifies hospitals based on their compliance to the Code and so far 10 of the country’s 19 hospitals are certified. When the initiative passed, 53% of infants in hospitals were bottle fed, while now fewer than 5% are in certified hospitals.

Several years later on June 16, 1999, the government officially adopted the Code when it passed Law 295, entitled “Law of Promotion, Protection and Continuance of Breast Feeding and the Regulation of the Breast Milk Substitute Commercialization.” The law contains three chapters, which refer primarily to regulating the marketing practices of formula companies and to ensuring exclusive breastfeeding promotion within the health care system.

Nicaragua’s Ministry of Health (MINSA) has also been working with several NGOs in the country, such as CARE, to train physicians, nurses, and midwives as well as community volunteers on the importance of breastfeeding. “Window of Opportunity,” which began in 2008, is the current program implemented by CARE related to breastfeeding. The Project’s goal is to improve the nutritional status of 15,000 children under the age of 5 and 2,500 pregnant women in poor and extremely poor communities of the municipalities of Waslala and Rancho Grande (Departament of Matagalpa) and of El Cuá and San José de Bocay (Department of Jinotega) by the year 2011. Part of the project includes increasing the number of women who breastfeed, and therefore the program trains pregnant women about the best maternal and child nutrition practices, distributes breastfeeding materials, and monitoring infractions to breast milk substitute distribution and promotion.

Significance

In spite of efforts made over the past several decades, malnutrition remains to be a huge barrier to the improved health status of children under 2 in Nicaragua. Although malnutrition in this country decreased from 45% in 1967 to 17% in 2007, the decrease is not uniform across the country. The North-Central zone of Nicaragua, which includes the districts of Matagalpa and Jinotega, has only been reduced to 26% and 33% respectively. The municipalities of El Cúa, San José de Bocay, Waslala and Rancho Grande in the country’s central rural zone are within the poorest quintile in Nicaragua, where chronic malnutrition is stable at 35.3%. This represents a major barrier in achieving Millennium Development Goal 5: “to reduce poverty and hunger by half” by 2015.

The promotion of exclusive breastfeeding is a sustainable, long term, and cost effective intervention strategy to combat Nicaragua’s child nutrition challenges. One of the major barriers to the success of CARE Nicaragua’s “Window of Opportunity” program is the low percentage of women in the intervention communities who exclusively breastfeed. One proposed explanation is that there is a lack of enforcement of Law 295 and therefore the continued promotion and distribution of breast-milk substitutes in these municipalities. In order to develop intervention strategies, CARE
must first understand if there are violations of Law 295 and, if so, on what level they reach and affect breastfeeding women in the intervention communities.

My project is significant in the public health context because nobody has done a study on the enforcement of Law 295 in Nicaragua. It is critical to determine how much progress health facilities have made in the elimination of formula promotion, the current availability and marketing of formula, and what messages about breastfeeding and formula use women are receiving.

**Design**

**Key Informant Interviews:** I conducted 35 Key Informant Interviews in order to understand knowledge and beliefs of community members as well as practices, knowledge and adherence to Law 295 of health care workers. Key Informant Interviews were chosen as the appropriate qualitative research tool because a) women from the rural communities proved to be very timid and un-talkative and therefore this type of interview provided more in depth answers than the focus group dynamic where women were less willing to talk, and b) health care workers could remain anonymous and were able to talk freely about sensitive topics such as legal violations.

**Informant criteria:** 1) NGO staff involved with child nutrition in Matagalpa or Jinotega districts, and 2) Nicaraguan community health workers (brigadistas), and 3) Senior MINSA staff at 4 Centro de Salud locations (Waslala, Rancho Grande, El Bocay, and El Cua), 2 SILAIS locations (Matagalpa and Jinotaga), and 1 national MINSA representative (Managua), 4) breastfeeding women living in intervention communities, 5) marketing representatives from formula companies.

**Recruitment:** I worked with CARE Nicaragua staff in order to establish contacts in Nicaragua with whom I interviewed. CARE Nicaragua set up all my contacts with MINSA. The brigadistas I interviewed were in attendance at the breastfeeding trainings held by CARE. The women I interviewed were in two rural intervention communities. For the other two towns were we could not go into a rural community, I interviewed women at the Casa Materna’s (maternal waiting homes), some of which had already given birth to their baby.

**Survey Instrument:** Survey questionnaires were developed in collaboration with an Emory advisor, Dr. Karen Andes. They were then translated by a certified translator from English into Spanish to ensure accuracy. The questionnaires were modified after feedback from CARE Nicaragua staff and then again after use in the field.

**Objectives**

*Host Organization’s Overall Objective*
• Improve the nutritional status of 15,000 children under the age of 5 and 2,500 pregnant women in poor and extremely poor communities by 2011.

• Help poor families and communities increase the number of mothers who exclusively breastfeed by 10%.

**My Project’s Overall Objective:**

• Assess the enforcement of Law 295 in order to make an official recommendation to Nicaragua CARE staff about current adherence, infractions, and possible points of intervention.

**Specific Objectives:**

• Interview Ministry of Health officials at all three levels (community – Centro de Salud, district – SILAIS, and national) in order to assess government health care workers’ compliance in terms of formula distribution, promotion, and information.

• Interview breastfeeding mothers in the intervention communities in order to understand what messages about breastfeeding and formula are being given to women as well as their current practices and barriers to exclusive breastfeeding.

• Interview brigadistas (community health care workers) about what information they give to breastfeeding mothers and what they view as the main barriers to exclusive breastfeeding.

• Perform a market assessment of community stores and identify infractions of Law 295.

• Interview formula company representatives about their knowledge of Law 295 as well as their company’s adherence to the Law.

**Results**

**Summary**

Since Law 295 was passed in 1999, the Ministry of Health (MINSA) has done an excellent job of implementing the promotion of exclusive breastfeeding in its health units however has done little to no regulation of infant formula companies. MINSA has modified the law in its implementation based on what it views as most important:

“The strategy isn’t designed how the law says. We try and modify it in order to most effectively serve the population. The best way of supporting Law 295 is with counseling and lecturing mothers on the techniques that best help them.”

–Rancho Grande, MINSA

MINSA has yet to fully implement the regulation part of Law 295 as a result of perceived ambiguity of the law, lack of resources, and other priorities.
I. Promoting a culture of exclusive breastfeeding

MINSA has achieved a ‘culture of exclusive breastfeeding’ in all government health centers through their adoption of the Baby Friendly Hospital Initiative (BFHI) in 1993. The Baby Friendly Hospital Initiative (BFHI) is the world’s largest accreditation program and has standards such as staff training, mother training, early initiation of breastfeeding, all of which have been shown to promote proper breastfeeding, child health and survival. Nicaragua took the initiative a step further by changing the name to “Mother and Baby Friendly Hospital (MBFH),” in order to encompass the mother child pair. The MBFH includes primary care units in addition to maternal and neonatal units and applies to all personnel in contact with mothers or infants.

All health centers and hospitals in Matagalpa and Jinotega at the SILAIS and Centro level are MBFH certified. After observing patient/doctor consultations and facility environments, I concluded that these health units do in fact follow the guidelines though the promotion of exclusive breastfeeding and the absence of formula distribution, promotion, or doctor incentives. Interviews with MINSA personnel confirmed these observations and elaborated on the ways MINSA meets the MBFH guidelines:

“We do murals and put up posters and if we can obtain pamphlets we hand them out to the mothers that know how to read.”
– El Bocay, MINSA

“We are talking about the Health Centers and the Mother and Baby Friendly Hospitals because we don’t allow teets or bottles to enter in the first place in the health units. We stop them at the door.”
– Rancho Grande, MINSA

“This hospital was declared as breastfeeding friendly, right, because here….here we do a lot of campaigns about breastfeeding.”
– Waslala, Nurse, MINSA

“We have done a lot of lectures about breastfeeding. Um…because this hospital, right, is a Mother and Baby Friendly Hospital, and therefore we don’t give out bottles, rather we only allow exclusive breastfeeding.”
– Waslala, Nurse, MINSA

Although Health Centers still have large murals, posters, and displays (see photos in appendix I) and promote exclusive breastfeeding through consultations and lectures, one health worker voiced concern that the momentum behind the MBFH has waned over the past few years:
“There was a period in which Nicaragua pushed this “Mother and Baby Friendly Hospital” initiative, and yes there is a plaque there in the Health Center, but in some moment it was lost…it was forgotten. Today it doesn’t look the same.”
– Doctor, El Cua

This comment reflects a well documented problem with the BFHI. For example, a report published by USAID in 2006 found that hospitals that once met certification standards no longer do so because well trained staff move on and hospitals lose their initial enthusiasm and commitment.\textsuperscript{xxvi} Although the study later found Nicaragua to be an exception to this rule as the initiative in this country continues to have an impact, the lowering in momentum cited by the doctor in El Cua may tie into the low priority exclusive breastfeeding has relative to other more pressing health issues, which is discussed more in depth in the ‘regulation’ section.

II. \textit{Publication and circulation of materials about Law 295 and exclusive breastfeeding promotion.}

MINSA has complied with this aspect of the law by creating and circulating internal documents for all health workers to read:

“This is called…this breastfeeding manual is a manual about how we have to behave and the things that we have to teach in the form of patient counseling.”
– Doctor, Rancho Grande, MINSA

As a result of these materials and trainings, every MINSA official I interviewed could tell me the main point of Law 295, although they did not go into specific details:

“The one that protects, promotes, and teaches about breastfeeding.”
– SILAIS Jinotega

“A law that protects children and promotes breastfeeding.”
– El Cua, MINSA

“The sale, you know that it is the sale of formula, those artificial milks, right, that they have out there.”
– Waslala, Nurse, MINSA

“It has to do with…the people that sell other types that aren’t milk, formula they call them.”
– El Bocay, MINSA

“Law 295 specifically is about the promotion of breastfeeding…the law also has to do with the sale and distribution of breastmilk substitutes.”
– Rancho Grande, MINSA
III. Lectures for pregnant women and new mothers on exclusive breastfeeding.

MINSA does an excellent job of taking advantage of the limited time they have with mothers to lecture on exclusive breastfeeding. This includes capitalizing on the time women are in waiting rooms, during appointments, post-delivery ward, while pregnant women wait at the Casa Materna, and during pre-natal and post-partum visits:

“In the post-delivery ward we give educational lectures about the importance of breastmilk….women learn about the benefits, right, the cost that… that… that breastmilk is free, that it is a way to protect their children…. when the mother returns we give her lectures again about breastfeeding, during her post partum follow ups.”
– SILAIS, Matagalpa

“Educational lectures right there in the waiting room while they are waiting to be seen. Also when the mothers come to do their pre-natal controls… we promote and continue advancing every time that she comes… we promote breastfeeding and at the hour that she comes here to the health unit to have her baby, we continue. It is a tireless fight.”
– Rancho Grande, MINSA

In addition to providing counseling in the post delivery ward, MINSA starts messaging early on in pregnancy as well as makes an effort to reach women who do not come to health facilities through radio programs:

“We are always doing lectures through radio programs for the women that we never see and also through on a one by one basis when they come to the health unit for their prenatal visits.”
– SILIAS Jinotega

**Regulation**

MINSA has limited power over formula companies and has not given any fines or punishment for violations, though they are cognizant that violations exist. Some formula companies, such as Nestle, have made changes to their marketing practices which is mainly due to pressure from advocacy organizations such as IBFAM who have called international attention to their marketing practices. The most significant change has been in labeling and advertising. Now products destined for infants less than 6 months comply to a certain extent with labeling requirements and there is less advertising to the general public, with the exception of in store sales and promotions. Because these changes have not come out of MINSA, this section focuses on why MINSA has been unable to perform their regulating activities.

I. Ambiguous Law
Part of the reason regulation has not been implemented is because it is not clear under the law which level of MINSA is responsible for enforcement activities. Through interviews with MINSA at the national, regional, and community level, it emerged that each branch of MINSA was counting on a different branch for enforcement activities.

Starting at the top, MINSA National felt that they were the only ones putting forth an effort and that it was up to the SILAIS level to discipline formula companies and enforce regulation:

“We are at the national level. But also the SILAIS ought to be giving fines and doing regulation exercises because they are the ones at the department level.”

Representatives from the SILAIS level pointed back at MINSA National and also down to the Health Centers:

“We empower women by means of lectures…we empower health personnel so that they know and value this right and this duty through the power of the law, right? We make sure that they know the law well and that they themselves, right, are the ones that are empowered to apply it.”

-SILAIS, Matagalpa

“The Ministry of Health at the national level has a component that is called ‘Regulation’ where they are working with every establishment that attends to the population so that they comply in accordance to the rules and laws established by the Ministry of Health.”

-SILAIS, Jinotega

While Law 295 holds MINSA responsible for enforcement and giving fines, it also stipulates that companies must regulate their own marketing practices. Nestle, who has a strong presence in Nicaragua, stated that they comply with the law 100% and pointed to other entities as failing to uphold their end of regulation practices. The company also absolved itself from any responsibility for a mother’s feeding practices and said it was the responsibility of doctors to ensure that their patients only used formula in the appropriate circumstances:

“Nestle is a company that is a signatory of the Code…we don’t do promotions, we don’t give sales incentives, we don’t do any type of promotion that would promote infant formula. The other companies are the ones that ought to respect the Code as well…it has been only our fight. And the practices that patients have on the street… that no longer has anything to do with us, right? The person that decides to prescribe infant formula is the doctor…he is the only one capable of deciding what type of formula to give to his patient and nobody else.”
II. Loopholes in law

Formula companies have found loopholes in the law which allow them to continue some of their harmful promotion and marketing practices.

One of the main loopholes I found through my market assessment and community observation was that Nestle strongly promotes its powdered milk for babies 12 months and older, Nido, throughout the country. There are murals, billboards, promotions, and publicity campaigns (see Appendix II). Nestle’s infant formula for babies under 6 months is called NAN, which is product with a similar name and from the same company. This may have the effect of creating confusion among mothers who may not pick up on the subtle difference between a powdered milk for a baby of 12 months and a powdered infant formula for a baby under 6 months. Furthermore, aggressive promotion and advertising may establish brand loyalty to Nestle products and so in promoting Nido, Nestle may be creating a preference for NAN as well. Nestle explained this type of promotion is legal by saying:

“Nido isn’t a breastmilk substitute. The breastmilk substitutes are infant formulas, and therefore they are in different categories.”

Another loophole Nestle has discovered is passing off responsibility of promotions of Nestle infant formula products. When confronted with pictures of Nestle formula displays and a sales promotion in the main supermarket in Matagalpa, Nestle told me that that is the practice of the supermarket and independent of the Nestle Corporation. While they are not responsible for this promotion, Nestle said that if they became aware of such practices, they would take action:

“In these cases of infant formula, um… if Nestle verifies that a supermarket is doing some type of promotion with infant formula, what is done is that we stop selling it there.”

Formula companies also muddle their messaging by paying lip service to the superiority of breastmilk while implying that their product is equivalent, often invoking scientific advances and studies on nutrition. As the program director for Save the Children explained:

“It is like the case of cigarettes, is it not? They put the message ‘smoking can cause cancer,’ and in the same way they do formula promotion by saying ‘the best nutrition is breastmilk,’ but if not, Nido is a great option, this and that are great options… if you can’t breastfeed, if you work, if this and that, you can use other things.”

MINSA has not modified Law 295 since its passing in 1999 and therefore has not kept up with these adaptations. Many formula companies are transnational organizations with
unlimited resources and MINSA has been unable to put monetary and personnel resources into closing these loopholes.

III. Lack of resources

MINSA has severe financial restrictions and therefore lacks resources in which to regulate companies and enforce Law 295. Most money that MINSA has to spend comes from overseas donations and goes to specific expenditures:

“The vast percentage of our operating budget comes from donations. It is this that supports the state, the government, the payment of salaries, the purchase of medicines and equipment, and that’s it. That’s it…after that there are no more resources.”
- MINSA National.

Because MINSA has insufficient financial resources, it must prioritize health issues and what areas of the law to implement.

i. Prioritization of Health Issues

Maternal mortality, infant mortality, infectious diseases, teen pregnancy, family planning (quantity and spacing), and high risk pregnancies were all cited as issues with higher priority than exclusive breastfeeding. A nurse working at a Health Center in Rancho Grande explained the issue by saying:

“Sometimes we aren’t working on breastfeeding like we ought to. Right at this time we are working more on maternal mortality and neonatal and infant mortality. The guidelines are there but sometimes with so much work and little personnel…and we can’t establish a strategy for just breastfeeding. We can’t do it…the majority of the pregnancies we have here are women between thirteen and fourteen and fifteen years. They are high risk pregnancies. And if a woman has already given birth, we have to talk about her post partum care, infant care, and vaccinations.”

Furthermore, while maternal and infant mortality are visible and pressing issues, breastfeeding and regulation of formula companies are not and therefore easy to push to the side:

“If somebody calls MINSA they… they say that women are dying out there and they don’t call and say ‘look, there are women…there are a lot of women leaving without breastfeeding their infant,’ or they don’t call and say ‘they put up a billboard on the highway with a picture of infant formula.’ The thing that we work on, the thing that costs us most is this… this… attention to the woman.”
“Sometimes there are just so many things that we have to get to the people and we are always leaving to the side… it’s that the people already understand that breastmilk is the best nutrition for their infant, and so we do less promotion… the demand is very high from the population and so we are left with little time to do patient counseling.”
– El Bocay, MINSA

When MINSA is able to implement aspects of Law 295, it is the promotion of exclusive breastfeeding, and then usually within the context of reducing maternal and infant mortality:

“Activities have priority. In this case two components exist, maternal and infant… on those two components there are strategic strategies that we use each time that we go to a municipality. Our duty and our law is to promote exclusive breastfeeding.”
- SILAIS, Matagalpa

ii. Prioritization of Implementation

MINSA must also decide which activities it is able to undertake due to limited personnel. Regulating formula companies would require employees specifically for that task, unlike breastfeeding promotion which can utilize existing health care workers. While MINSA has plans and strategies for regulation, there is no man power to carry out the activities:

“Right now… because our funds come from UNICEF and for some administrative problem they haven’t…they haven’t come through but we have a work plan. If we had the resources back in April, we would already have had the team put together.”
- MINSA National

The utilization of existing health care workers for breastfeeding promotion is complicated by more pressing health issues but also by geographical challenges. Due to the mountainous topography and the constant natural disasters that plague Central America including earthquakes and hurricanes, Nicaragua has a very poor transportation infrastructure. Just 2,299 of the 19,036 kilometers of the country’s roads are paved and most of these roads are in the Western, urban part of the country surrounding the capital of Managua. 43% of Nicaraguans live in rural areas, and all of CARE’s intervention areas in the districts of Matagalpa and Jinotega are rural. One woman I interviewed at a Casa Materna said the following about her community’s location relative to the Health Center:

“From here to Bocay it takes us five hours walking by foot because there is no road.”
– Pregnant woman, El Bocay
This presents a great challenge in the implementation of Law 295 in rural communities because they are not easily accessed and therefore it is hard for MINSA to regulate commercial activities and it is hard for health care workers to reach patients in order to promote exclusive breastfeeding. As a MINSA representative explained:

“Jinotega and Matagalpa are the most rural districts...they correspond to the most distant places in the country, distant, and with a... a... a topography that makes it the most difficult to access and get there. And so... it is where there is more... um... it takes more effort... and we don’t have the capacity to attend to the mediums of communication or what industries are doing out there.”
- MINSA National

Furthermore, the migratory status of women in intervention communities makes outreach costly and time consuming:

“The population is largely migratory and right now we are in winter and as you know Jinotega is a coffee growing zone and so the people migrate to the different farms and it is there that we lose contact.”
- SILAIS Jinotega

**Infractions**

**I. Health Care System: MINSA**

Although MINSA struggles with regulating commercial industries, it has made great strides in breaking ties with formula companies. MINSA health care workers no longer receive incentives from formula companies and all promotion of formula within health units has ceased. The biggest change has been the cessation of free formula sample distribution. Health care workers all promoted exclusive breastfeeding and there was never any talk of formula use. This was concluded after observation in health units, interviews with MINSA staff, and then confirmed through reports by new mothers and pregnant women with exposure to these health facilities.

**II. Formula Companies**

Formula companies have found loopholes in the law (discussed in depth in ‘regulation’ section). The most important infractions found were messaging to the general public and labeling.

i. *Messaging to General Public*
There were no commercials for infant formula that I saw on TV, nor billboards in the community specifically for infant formula products. However, there were promotional displays and sales in supermarkets in Matagalpa.

ii. Labeling

The table below contains articles from Chapter 10 of Law 295 that apply to formula labels. The label analyzed is NAN, Nestle’s infant formula. A scan of this label as well as the highlighted violations can be found in Appendix I.

<table>
<thead>
<tr>
<th>(Article)</th>
<th>Stipulation</th>
<th>Does label comply?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(30)</td>
<td>Labels should be concise in order to facilitate all information about the adequate use of the product in order that it does not induce the stoppage of breastfeeding.</td>
<td>Yes</td>
</tr>
<tr>
<td>(31)</td>
<td>Formula label should comply with the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Ingredients used</td>
<td>a) Yes</td>
</tr>
<tr>
<td></td>
<td>b) Nutritional composition of product</td>
<td>b) Yes</td>
</tr>
<tr>
<td></td>
<td>c) Conditions required for proper use</td>
<td>c) Yes</td>
</tr>
<tr>
<td></td>
<td>d) Serial number and expiration date</td>
<td>d) No- Serial number but no expiration date</td>
</tr>
<tr>
<td></td>
<td>e) Preparation instructions and hygienic requirements</td>
<td>e) Yes</td>
</tr>
<tr>
<td></td>
<td>f) Age for which the product is intended</td>
<td>f) Yes</td>
</tr>
<tr>
<td></td>
<td>g) A declaration about the superiority of breastmilk, stated on the front “Breastmilk is the best nutrition for infants,” printed visibly in color and in letters no smaller than 3mm</td>
<td>g) Yes</td>
</tr>
<tr>
<td></td>
<td>h) Products covered by this law that do not satisfy the standards established for infant requirements and needs but can be modified to this effect, will have on the label an announcement that the product should not be used as the only source of nutrition for the infant.</td>
<td>h) N/A</td>
</tr>
<tr>
<td>(32)</td>
<td>Product labels should not contain</td>
<td></td>
</tr>
</tbody>
</table>
information that could be used to stimulate use of bottles, such as:

a) Images of infants or others that could idealize the use of bottles.

b) Legends, drawings, or illustrations that could directly or indirectly create the idea that the substitute is equivalent or superior to breastmilk.

c) The phrase: “Breastmilk, human milk, like breastmilk,” or anything similar should not be used on bottles or labels of products covered by this law.

a) Yes

b) No

i. On the front of the label there is an image of a bird feeding her chicks. This could indirectly contribute to the idea that formula use is natural and a comparable source of nutrition.

ii. On the back of the label is a diagram entitled “Nestle Nutrition Research.”

c) Yes

What MINSA needs

There are large gaps between Law 295 as it is written and Law 295 as it is applied in Nicaragua. When asked what is needed to close these gaps, MINSA officials identified money as the number one need and after that, more help from NGOs.

I. Monetary resources

MINSA has done a great job of publicizing the law, they have the plans and teams formed, however they lack operative funds to hire personnel and carry out activities:

“Basically, we need to look for the mechanisms for how to make the people that already know about Law 295 apply it. We need to apply it. To enforce compliance.”

II. Alliances with NGOs

The NGO I interviewed, Save the Children, as well as officials from MINSA both agreed that the promotion of exclusive breastfeeding and the regulation of corporations is too much work for MINSA alone and that it needs support from outside organizations working on childhood nutrition:

“The best thing would be support from NGOs that already have strategies, because with so little personnel we can’t even leave the health units and go to
the communities. The health centers fills up and we can’t leave the people here and go out.”
– Rancho Grande, Doctor

“It shouldn’t be only an effort by the Ministry of Health but it ought to be an effort not only by the state but the different powers, the civil society, um… to leave it to MINSA… the enforcement of this law when we have so few economic resources in play would be… I don’t see it as being very realistic.”
– Save the Children

Mothers in Intervention Communities

Current practices

There is no official statistic for EBF in the intervention communities, however officials working with rural women estimated between 50 to 60% EBF with the remaining using other sources which include cow milk, local foods such as rice and corn puddings, and to a lesser extent, powdered milk:

“The prevalence of exclusive breastfeeding is about 60%. Many times in practice women give coffee, right, coffee in the bottle, honey, things like that. We work in rural communities and so infant formula isn’t the problem.”
– Save the Children

“I think the percentage of the population that uses cow milk or gives a mixture of breastmilk and cow milk has reached more than 50%. One of the customs is to give cow milk. We have almost no problem with the sale of formula because it isn’t sold here. They are very expensive products that the people aren’t familiar with. And I think that with the pharmacy that is half complete anyway, I don’t think that they even sell formula. One has to go to Matagalpa to buy it.”
– Rancho Grande, MINSA

“There is a huge portion that use bottles to give cow milk or powdered milk.”
– El Bocay, MINSA

My interviews with mothers supported these claims to a great extent. Many mothers claimed to practice EBF, but knew of other women in their community using alternative foods, most often cow milk or locally grown produce:

“For me personally, I am accustomed to breastfeeding, breastmilk and nothing more. That is the custom.”
– Mother, Rancho Grande
“For me at least, I am accustomed to breastfeeding my children, breastmilk and nothing more. And when they are old enough to eat food, I give them tortillas with cheese, beans, rice. That is the custom.”
–Mother, El Bocay

“I breastfeed but there are others that bottle feed because their breasts aren’t full.”
–Mother, El Colectivo

“Beans, eggs, cheese, vegetables, whatever is around.”
–Mother, El Bocay

“Yes, there are some that buy powdered milk but not all, just some. Yes it is rare those that give powdered milk to their kids, more common is cow milk.”
–Mother, El Colectivo

The most common alternative food cited was cow milk, which changes in concentration as the baby grows:

“At the beginning when they give cow milk, they give half cow milk and half water. And when the baby starts to tolerate it, the increase the quantity of milk until it is pure.”
–SILIAS, Jinotega

Infant formula is not commonly used in the rural communities primarily because the expense (150 cordobas for a can which is equal to $7.50 USD) puts it out of reach for most families. When powdered milk is used, it is not infant formula but rather generic powdered milk (Anchor and Lechera were the two brands cited most) and Nido, which is a powdered milk for older babies and children. Infant formula was not sold in any of the intervention communities. This means that even if a woman could afford to buy infant formula, she would have to walk or travel to the nearest town, which is often hours away.

“We don’t have money to buy it right now because powdered milk is very expensive and so as one is poor, they go buy the cheapest thing.”
–Mother, El Colectivo

“We don’t have money, very little, it is very difficult for women to buy powdered milk.”
–Mother, Rancho Grande

“Those that have money to buy things give their baby cow milk or they buy the powdered milk…Nido, the growth milk. But as we are poor here, we can’t buy it.”
–Mother, Waslala

“Look, of course powdered milk is the best thing for the girl. But as one can’t…we don’t have anything to buy it with.”
–Mother, El Colectivo
Women in rural communities are not exposed to formula promotion, cannot afford to buy it, and do not have access to it. Therefore, infant formula is not a significant barrier to EBF in the rural communities. This point was summarized by a doctor working in El Bocay:

“It is just that here one doesn’t see that, it’s that we are way in the background. You see that more in the city where there is greater promotion. But here, it is less so because people have great difficulty because they don’t have a way to buy it.”
– El Bocay, MINSA

Instead of infant formula, the primary barriers to EBF are poverty, breastfeeding complications, and cultural practices.

I. Poverty

Due to the low economic situation in communities, many women work outside the home in agricultural jobs. This often takes them far away from the home and even out of the country, and thus away from their infants:

“Fundamentally, it has to do with people that have family outside of Nicaragua or children that…children of mothers that leave to work in Costa Rica or that migrate to other places for work.”
– Save the Children

“The women have to go to work to support the whole family because many are single mothers, right, the husband just has the children and leaves them with the partner, right, the women have to integrate work in order to support the family…and due to the economic conditions even if both work, right, they say that they barely make enough for food.”
– SILIAS JINOTEGA

“Only breastmilk and sometimes bottles when they go out to work.”
– Mother, Waslala

“Sometimes we work, we can’t be in the house because as we don’t have anybody to help us, we have to go out and look for work… the work that I have is far away and so…because of that I can’t always breastfeed.”
–Mother, El Bocay
“As you know I am poor and I have a lot of kids and so I work in the field and I plant corn, harvest beans, and right now I have this kid…but at 8 in the morning I leave.”
– Mother, Waslala

“Sometimes…because I don’t…I don’t have a husband, um, so I have to go out to the field…because of that it is very hard.”
–Mother, Rancho Grande

“There are women that go out to work and so they give their kid bottles.”
–Mother, Rancho Grande

II. Breastfeeding complications

Many women and health care workers interviewed stated that mothers begin using alternative milks because they have to work outside the home, but also because they can no longer breastfeed due to complications. When asked what complications mothers have with breastfeeding, the most commonly cited were lack of milk, a baby who will not suckle, painful breasts, and feeling like the baby was not getting enough to eat:

“Because I don’t have enough milk.”
–Mother, Waslala

“In my case I have a lot of difficulty because as I was telling you I am poor and so I am dry of milk and so to maintain the child it is very difficult.”
–Mother, Waslala

“Some don’t have milk, they don’t have enough to fill the child.”
–Mother, Rancho Grande

“With the girl, my breasts hurt, and with the boy as well.”
–Mother, El Bocay

“Some mothers are dry of milk and others leave the house and so they leave bottles.”
–Mother, El Bocay

“From that point they being to give powdered milk, those mothers that say ‘my milk is not coming down’ but it is because they don’t put them to the breast right or because their breasts hurt when the baby sucks.”
– SILAIS Jinotega

“Because it my baby isn’t being fed well.”
–Mother, Rancho Grande
III. Behavioral practices

Mothers that do have access to their infants and choose not to breastfeed often do so because of negative associations with body image as a result of breastfeeding:

“It is something that we haven’t been able to get rid of, perhaps because of custom, right, but perhaps because of culture.”
– SILAIS Jinotega

“Several women have come that haven’t wanted to breastfeeding. It is that they don’t want to, it is that they don’t want to. They don’t want to breastfeed because they don’t want to get soft, they don’t want their breasts to droop, that. Yes. They don’t want to breastfeed because they don’t want their figure to change.”
– Waslala, Nurse, MINSA

Another practice that is a barrier to EBF is leaving a child at home when one travels outside the community. Due to the rurality of the communities, many find it difficult to carry an infant long distances, so they have to leave them at home:

“The majority capture the message, the advantages that breastfeeding has. Some, because they work, the reality is that they don’t want to take the kid, they want to go out free, so they leave their kid and they leave a bottle. Because of the distance of the roads, for example, to come here to the Center, there are communities that are three or four hours away and women can’t carry their children and so they leave them at home with something, and that something is a bottle.”
– El Bocay, MINSA

What information do they receive about exclusive breastfeeding?

Every single woman interviewed told me that a mother should practice EBF for the first six months of a child’s life. When asked why that is, most women could not elaborate on the benefits of EBF other than that is what their doctor had told them. The few that could cite reasons said that it helped their child grow better and have less cases of diarrhea:

“They told me to give her breastmilk.”
– Mother, Waslala

“That during the first months of life we can’t give them water or any other liquid because the breastmilk is…is…is what the baby prefers.”
– Mother, El Bocay

“That breastmilk only until six months of age because it causes less diarrhea.”
– Mother, Rancho Grande
“The baby will be prettier and grow better.”
–Mother, Rancho Grande

“Supposedly they have explained to us that if one doesn’t breastfeed their baby it will end up with a lot of diarrhea and that…well… it will end up malnourished… and that it will end up with a lot of diseases.”
– El Cua, mother

“They tell us, those that give the lectures, they tell us how to feed our babies, how to attach him, how to put him to the breast, all of that they give during the lectures… they always tell us to breastfeed so that the baby grows better, healthier, that they don’t get diarrhea.”
–Mother, El Bocay

**What information do they receive about formula?**

When asked if they received any information about formula use from their health care worker, every single woman said no. This means that whatever information they are receiving about the benefits and dangers of formula are coming other sources, which might include biased sources such as the information printed on the formula labels. This is illustrated by one pregnant woman interviewed at the Casa Materna in El Bocay who thought that cow milk was worse than formula because it gave children parasites:

“It is cheaper but it is worse for the child because it gives him parasites. But, the mothers that are poor can’t pay 300 pesos to buy powdered milk.”
–Pregnant woman, Casa Materna, El Bocay

The implication here is that women don’t know that formula use, because it is mixed with water, can also give their children parasites. There also might be undue feelings of guilt because they are unable to buy formula.

“They say that bottles have a lot of diseases.”
–Mother, Waslala

“It is bad to give them a bottle, they told me that at the Health Center, that I shouldn’t give a bottle only the breast.”
–Mother, Rancho Grande

“They have told us that powdered milk is bad.”
–Mother, Rancho Grande

“Some say it is bad, some in the Health Center prohibit us from giving cow milk because of the parasites. There are a lot of parasites.”
–Mother, El Bocay
Recommendations

I. Address the needs of working mothers

The main barrier to breastfeeding in intervention communities is the demand on mothers to leave the home to work in agricultural jobs. Communities lack tangible ways to help working mothers breastfeed and past attempts at having nurseries on the farms have not been successful because women would have to carry their children there plus a farm is a poor environment for a daycare:

“I think that promoting, in a given moment, because in the fields the conditions aren’t there to have a … a nursery for those children, it is very difficult.”
– El Cua, MINSA

CARE Nicaragua needs move beyond lectures on EBF and empower women with the actual tools to do it. Suggestions include improving on past attempts to establish daycares on farms, working with owners of farms to establish breaks for lactating women to return home, or provide training on milk expression.

II. Encourage open communication and counseling between mothers and doctors so that women feel comfortable addressing problems and barriers to breastfeeding.

Health care workers err on the side of being militant rather than being lax when it comes to breastfeeding promotion. For example, some health officials stated that Law 295 applies to all children 2 and under, another said that stores who sell formula are in violation because a doctor has to prescribe the formula, and another said that under no circumstance can a health facility allow a mother to bottle feed in the hospital. Most doctors at the SILAIS and Health Center level do not counsel on anything other than EBF.

“Cow milk is very dangerous for children, as you know. And the Nido milk, well… as that doesn’t enter in our program, which is breastfeeding, we say to a mother that… that she express her milk and we teach her to put it in a little cup, in other things, but… at least in my case I have never suggested artificial milk.”
– Waslala, Nurse, MINSA

When confronted with the question of what advice to give a woman who works outside the home and therefore is not breastfeeding, responses were mixed but the primary answer was to promote the use of cow milk:

“Right now cow milk is being promoted…because there are a lot of people that can’t buy powdered milk because it is too expensive and it is consumed too fast while a cow can continue to help out because it is permanent and it doesn’t cost money.”
- Health Center, El Cua

**III. Breastfeeding support groups in the communities**

Although promotion in prenatal and immediate post delivery visits is strong, MINSA is deficient in follow up support for breastfeeding mothers and are not best suited for that type of work:

“We aren’t in the house, we are here. What we do is we do here is we have the mother breastfeed for ten, fifteen minutes in the morning, right, and after that until she leaves.”
–Waslala, Nurse, MINSA

“You go to whichever health unit and you can interview a mom and you can ask the mom ‘what is the best food for your baby?’ And she will tell you breastmilk. That is the first step. What is lacking is to deepen certain aspects. For example, the support that the mother ought to receive…support groups…when a mother says to another mother ‘I had this difficulty that you are having now and to resolve it this is what I did.’ That is more efficient than if a somebody here says ‘do this, this and this.’”

**IV. Find ways to limit the effects of exposure to formula advertisements without relying the implementation of Law 295.**

Although most women in the intervention communities do not have sufficient funds to buy formula, they do go into towns and buy powdered milk of other kinds, most often Nestle. Preference for Nestle could be due to Nestle’s intense advertising in the region, which suggests women are exposed to media on some level. The regulation arm of Law 295 is years from being implemented, so CARE Nicaragua needs to find a way to talk to women and health workers about what advertisements are out there and about the products. One way could be through radio programs:

“They could support us with radio time. That way we could enter more communities and it is what the patients that are here have in their communities, they are the people that listen to the radio the most. For example, the Yes station, La Dalia, the radio Waslala, Stereo Musun Rio Blanco, those reach out there.”
–Rancho Grande, Nurse

One woman I interviewed at the Casa Materna in El Bocay had to travel five hours on foot because there was no main road into town. Because she rarely made this journey, she received most of her health information from the radio:

“We listen to health talks from the radio. The doctors give lectures about what age you can begin to give your child food. The radio from El Cua, Pena Blanca. On those stations they give lectures.”
–Pregnant woman, Casa Materna, El Bocay
V. Educate health care workers and mothers about the sources of nutrition for infants six months and under currently in practice.

Women need to be empowered with knowledge about the dangers of cow milk and formula as well as how to mitigate the harmful effects that it may have on their infants. This may include pasteurization techniques, ways to store milk, how to prepare formula, and the differences between powdered milk for children that most are currently buying and infant formula.

VI. Incorporate technical breastfeeding skills into exclusive breastfeeding promotion.

Though women know to exclusively breastfeed, many have not been taught how. For example, it was common in communities for women to claim that their milk was dry, that the baby was not attaching to the nipple, that their breasts were not large enough. Education on the actual activity of breastfeeding needs to occur. It will also be beneficial to counter perceived negative outcomes such as sagging breasts with benefits such as weight loss, delayed return of fertility and as a mother en El Cua noted, convenience:

“For me at least, when I go to El Cua, I only take my child and I just put him to the breast to feed. If I give him a bottle I have to carry the bottle, the milk, and…and that takes more time.”

“It is just easier to breastfeed. You don’t have to cook the milk, bring a bottle, buy the milk, boil the water…and so the breast is more…there are less diseases.”
–Mother, El Bocay

“I don’t give that, no.”
–Mother, El Bocay
Appendix I: Formula Labels

NAN label. Arrows contain the relevant article number and section.
Anchor and La Lechera (next page) were the two powdered milks that women cited using most because NAN was cost prohibitive. Neither the Anchor nor the La Lechera labels have as much details as NAN as far as how to prepare the milk and the required hygienic conditions. Powdered milk may not have the necessary nutrients for infants less than 6 months of age. All of these factors further complicate the use of artificial milk.
La Lechera®
Leche entera en polvo con toda su crema

Peso neto: 120 g

La leche materna es el mejor alimento para el lactante

Hierro
Ácido Fólico
Vitaminas A y D

ES BUENO SABER
La Leche LA LECHERA® es rica en proteínas y en calcio, es ideal durante el período de crecimiento en los niños. Contiene la cantidad suficiente de calcio que se necesita para un desarrollo óseo saludable. Los niños también necesitan vitamina D para la absorción de calcio para formar huesos fuertes.

Contactenos

SERVICES AL CONSUMIDOR NESTLÉ
NICARAGUA 1-800-6000
www.nestle-nicaragua.com
www.nestle-mercenaries.com

Modo de Preparación

Para preparar un vaso, agregue 3 cucharaditas rasas (10 g) de LA LECHERA® a un vaso de agua con hielo y mezcle durante un segundo.

Rinde 1 taza.
Appendix II: Pictures of Advertisements in Matagalpa, Nicaragua

Promotions and sales of food destined for infants under 2 years is prohibited under Law 295. This “special offer” of gerber in a Matagalpa supermarket is therefore a violation.

Advertisement for Nido, hung right over the display for NAN.
Appendix III: Law 295

Normas Jurídicas de Nicaragua
Materia: Mercantil
Rango: Leyes

LEY DE PROMOCION, PROTECCION Y MANTENIMIENTO DE LA LACTANCIA MATERNA Y
REGULACION DE LA COMERCIALIZACION DE SUCEDANEOS DE LA LECHE MATERNA

LEY No 295, Aprobada el 10 de Junio de 1999

Publicada en la Gaceta No. 122 del 28 de Junio de 1999

EL PRESIDENTE DE LA REPUBLICA DE NICARAGUA

Hace saber al pueblo nicaragüense que:

LA ASAMBLEA NACIONAL DE LA REPUBLICA DE NICARAGUA

CONSIDERANDO

I

Que la Lactancia Materna es un medio inigualable que proporciona el alimento ideal para el sano crecimiento y desarrollo del lactante constituyendo la base biológica, psicológica y fisiológica o al desarrollo normal de los niños y niñas.

II

Que el fomento, la protección y mantenimiento de la lactancia materna son elementos importantes de las medidas de salud y de nutrición, así como de las demás medidas de índole social, que garantizan un desarrollo integral del lactante.

III

Que la práctica de la lactancia materna se ha reducido significativamente producto del tradicional auge comercial de los sucedáneos de la leche materna, haciendo necesaria la promoción del hábito de amamantar y la regulación de la comercialización, propaganda y distribución de sucedáneos o suplementos de la misma, que inciten a su utilización en detrimento de una adecuada y eficiente lactancia materna.

IV
Que la Asamblea Mundial de la salud, de la cual Nicaragua es miembro permanente, ha recomendado la adopción de normas que tiendan a proteger la lactancia materna, regulando la comercialización de los sucedáneos de la leche materna, razón por la cual es procedente emitir en tal sentido la correspondiente disposición legal, así como la realización, por parte del estado, la Sociedad Civil y Organismos No Gubernamentales, de esfuerzos y medidas que promuevan, protejan y mantengan la lactancia materna.

En uso de sus facultades;

HA DICTADO

La siguiente
LEY DE PROMOCION, PROTECCION Y MANTENIMIENTO DE LA LACTANCIA MATERNA Y
REGULACION DE LA COMERCIALIZACION DE SUCEDANEOS DE LA LECHE MATERNA

CAPITULO I
De la Definición, Objeto y alcance

Artículo 1.- La presente Ley constituye un conjunto de conceptos doctrinarios y procedimentarios, con fines de proteger, promover y mantener la lactancia materna, así como regular el uso correcto de los sucedáneos de la leche madre en los lactantes.

Artículo 2.- La presente Ley tiene por objeto establecer las medidas necesarias para proteger, promover y mantener la lactancia natural que ayude al mejoramiento del estado nutricional de los lactantes, asegurando el uso adecuado de los sucedáneos de la leche materna, sobre la base de una información apropiada, cuando estos fueran 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 lácteos, incluidos los alimentos complementarios, cuando estén comercializados como sucedáneos de la leche materna o cuando de otro modo se indique que pueden emplearse, con o sin modificación, para sustituir parcial o totalmente a la leche materna; además incluye la regulación de la comercialización de los biberones, y disponibilidad de los productos relacionados y a la información sobre su utilización.

CAPITULO II
Generalidades

Artículo 3.- Definiciones. Para los efectos de la presente ley, los términos contenidos en la misma, se entenderán de la manera siguiente:

a) Leche Materna: Es un fluido secretado por las glándulas mamarias de la mujer que contiene las sustancias necesarias para la protección psico-affectiva, el sano crecimiento y desarrollo integral de los niños y niñas.

b) Lactante: Es toda niña o niño hasta la edad de dos años cumplidos.
c) Alimento Complementario: Es todo producto alimenticio procesado, manufacturado o industrializado local o internacionalmente, incluida la pasteurización y preparación casera, destinados a complementar la alimentación de niñas y niños mayores de seis meses y que sean administrados después del amamantamiento.

d) Servicio de Salud: Es toda Institución u organización gubernamental o no gubernamental privada dedicada a prestar servicios de salud directa o indirectamente con énfasis en la salud de la mujer gestante, madre lactante y de las niñas y niños menores de dos años de edad incluyendo los de desarrollo infantil y cualquier otro que brinde este tipo de servicio.

e) Profesional y Agente de Salud: Son Profesionales de la salud, los médicos, enfermeras, nutricionistas, trabajadores sociales, administradores de servicios de salud o cualquier otro profesional que realice acciones de promoción, protección, prevención, curación, y rehabilitación de salud. Son agentes de salud las personas que trabajan en un servicio de salud, ya sea profesional o no, incluyendo trabajadores voluntarios.

f) Información Científica: Información actual basada en datos confirmados, en referencia a estudios realizados.

g) Sucedáneos de la leche materna: Es todo alimento comercializado, presentado u ofertado explícitamente o que induzca a su utilización como sustituto parcial o total de la leche materna, sea o no adecuado para este fin.

h) Alimento de fórmula para lactantes: Son aquellos productos de origen animal o vegetal que sean materia de cualquier procesamiento, transformación o adición, incluso la pasteurización, de conformidad con el Codex-Alimentarius, que por su composición tenga por objeto suplicar parcial o totalmente la función de la leche materna en niñas y niños menores de dos años.

i) Fabricante: Es toda persona natural o jurídica del sector público o privado que se dedique al negocio, o desempeñe la función directamente o por medio de un agente de una entidad controlados por ella o vinculada a ella en virtud de un contrato escrito o verbal, de fabricar algunos de los productos comprendidos en las disposiciones de la presente Ley.

j) Comercialización: Es toda actividad de promoción, publicidad, venta, distribución, servicios de información y relaciones públicas relativas a los productos comprendidos en la presente Ley. Se considerará comercialización de los sucedáneos de la leche materna, cuando las actividades de comercialización induzcan a sustituir la leche materna.

k) Personal de Comercialización: Es toda persona natural o jurídica cuyas funciones incluye la promoción, publicidad, venta, distribución, servicio de información y relaciones públicas relativas los productos comprendidos en la presente Ley.
l) Expendedor: Es toda persona natural o jurídica que, en el sector público o privado se dedique directa o indirectamente a la comercialización al por mayor o al detalle de los productos comprendidos en las disposiciones de la presente Ley.

m) Distribuidor: Es toda persona natural o jurídica que, en sector público o privado se dedique al almacenamiento, comercialización y distribución al por mayor o al detalle de los productos comprendidos en la presente Ley.

n) Suministro: Son las cantidades de un producto facilitadas para su utilización, gratuitamente o a bajo precio, incluidas las que se proporcionan a familias de escasos recursos económicos.

o) Muestras: Es una unidad o pequeñas cantidades de un producto que se facilite gratuitamente.

p) Etiquetado: Es todo rótulo, marbete, símbolo, marca, imagen u otra materia descriptiva, escrita o gráfica, impresa, esparcida o marcada en alto o bajo relieve, fijada en un envase de cualquiera de los productos comprendidos en la presente Ley.

q) Envase: Es toda forma de embalaje de los productos para su venta por unidades.

CAPITULO III
De la Comisión

Artículo 4.- Créase la comisión Nacional de Lactancia Materna como entidad administrativa adscrita al Ministerio de salud, que en el texto de la presente Ley se denominará simplemente "la Comisión", con el objetivo de servir de órganos de consulta, apoyo y coordinación interinstitucional y foro de discusión multidisciplinario para la promoción y mantenimiento de la lactancia materna.

Artículo 5.- La Comisión estará integrada por los siguientes miembros:

a) Un Delegado del Ministerio de Salud quien la presidirá.

b) Un Delegado del Ministerio de Educación.

c) Un Delegado del Ministerio del Trabajo.

d) Un Delegado del Ministerio de Economía y Desarrollo.

e) Un Delegado del Instituto Nicaragüense de Seguridad Social.

f) Un Delegado del Instituto Nicaragüense de la Mujer.

g) Un Delegado por las Organizaciones no Gubernamentales.

h) Un Delegado por las Instituciones de Educación Superior.

i) Un Delegado por las asociaciones de Profesionales.

Artículo 6.- La Comisión tendrá las siguientes funciones:

a) Promover la práctica de la lactancia materna a través de un trabajo educativo, coherente y sistemático de carácter intersectorial e interdisciplinario.
b) Reforzar la cultura del amamantamiento y la confianza de la mujer en su capacidad de amamantar, propiciando un ambiente general de apoyo a la lactancia materna mediante la divulgación y propagandización sistemática y continua de su práctica.

c) Impulsar un proceso que genere información sobre la situación de la lactancia materna y las acciones que se desarrollen alrededor de la misma en todos los niveles.

d) Formular, coordinar, dar seguimiento y evaluar las actividades relacionadas con la promoción y mantenimiento de la lactancia materna.

e) Promover proyectos de reglamentos y reformas a las leyes existentes relacionadas con la promoción y mantenimiento de la lactancia materna.

f) Cualquier otra función que le sea asignada.

Artículo 7.- El Ministerio de salud, a través de la Comisión Nacional de Lactancia Materna, será el encargado de planificar, regular y controlar la promoción, protección y mantenimiento de la lactancia materna; así como normar y cautelar el apropiado uso y consumo de los sucedáneos de la leche materna y de los alimentos complementarios.

Artículo 8.- Toda persona natural o jurídica que directa o indirectamente se relacione o intervenga en la comercialización de los productos comprendidos en la presente Ley, estará sujeta a lo dispuesto en la misma.

CAPITULO IV
De la Promoción

Artículo 9.- El organismo ejecutor de la presente Ley promoverá la sana costumbre de alimentar exclusivamente con el pecho al lactante hasta los seis meses de edad. Así mismo, deberá estimular a las madres a continuar alimentando a la niña y niño con el pecho, por lo menos hasta los dos años de edad, aún después de la introducción de alimentos complementarios a partir de los seis meses de edad.

Artículo 10.- El Gobierno de la República de Nicaragua, por intermedio del Ministerio de Salud y con la cooperación de otras instituciones y organismos no gubernamentales, tiene la responsabilidad de implementar y consolidar iniciativas públicas y privadas con el fin de promover, proteger y mantener la lactancia materna como un medio eficaz para salvaguardar la vida de niñas, niños y mujeres.

CAPITULO V
Comercialización del la Información y Educación

Artículo 11.- El Gobierno de la República de Nicaragua, por intermedio del Ministerio de Salud, con la cooperación de otras instituciones públicas y privadas y organismos no gubernamentales, tienen la responsabilidad de garantizar que se facilite a los padres,
madres y público en general, una información objetiva y coherente sobre la alimentación del lactante.

Artículo 12.- Los materiales informativos, educativos y promocionales, sean impresos, auditivos, visuales o de otra índole, así como materiales y equipos relacionados a los sucedáneos de la leche materna u otros productos comercializados como tales, destinados a las mujeres embarazadas y a la madre de niñas y niños lactantes, deberán estar basados en información científica y contener entre otros aspectos:

a) Ventajas y superioridad de la lactancia materna.

b) Los riesgos para la salud causados por el uso del biberón y por el uso incorrecto o innecesario de alimentos complementarios y otros sucedáneos de la leche materna.

c) Instrucciones para la alimentación con taza y cuchara de los productos comprendidos en la presente Ley.

d) Información del uso de alimento complementarios hechos en casa.

e) Incluir información sobre la importancia de las prácticas de higiene general y en la preparación de los alimentos, así como la importancia de la higiene de la persona responsable de su preparación.

f) Estos materiales no deberán contener imágenes, pinturas ni dibujos de lactantes que reciban alimentos por medio de un biberón.

g) Los mensajes deben estar escritos en idioma nacional y otros dialectos y lenguas.

Artículo 13.- Los profesionales y agentes de salud no podrán hacer demostraciones, charlas, consejos y prácticas sobre la alimentación infantil en los servicios de salud que vayan en detrimento de la lactancia materna.

Artículo 14.- Los Fabricantes y/o expendedores y distribuidores solo podrán hacer donativos de equipos o material informativo o educativo referente a los productos objeto de la presente Ley, a petición del interesado y con la autorización escrita de la autoridad competente.

Artículo 15.- Corresponde al Gobierno de la República de Nicaragua a través de los Ministerios de Educación, Salud, y Familia, la promoción, protección y mantenimiento de la lactancia materna.

CAPITULO VI
Al Público en General y las Madres

Artículo 16.- La publicidad de los sucedáneos de la leche materna y el uso del biberón no deberá inducir a la sustitución de esta.
Artículo 17.- Los promotores de sucedáneos de la leche materna y biberones no podrán utilizar la publicidad engañosa; para los efectos de la presente Ley, se entenderá que se ha utilizado publicidad engañosa, cuando no se advierta a las madres y en general a los consumidores, de los inconvenientes que para la salud de los lactantes puede ocasionar el consumo o uso de dichos productos.

Artículo 18.- Solo se podrá obsequiar sucedáneos de la leche materna a madres con hijos de dos años.

CAPITULO VII
Sistema de Atención en Salud

Artículo 19.- El Ministerio de Salud de la República de Nicaragua a través de la Comisión Nacional de Lactancia Materna, fomentará, protegerá y mantendrá la lactancia materna y cautelará la aplicación de la presente Ley, facilitando a la vez la información y orientación a los profesionales y agentes de salud en cuanto respecta a sus obligaciones.

Artículo 20.- No podrá utilizarse ningún servicio de salud que tenga programas de atención a niñas, niños y madres para la promoción de sucedáneos de la leche materna o de otros productos comprendidos en la presente Ley.

Artículo 21.- No deberá permitirse en los servicios de salud del país, el empleo de personal facilitado o remunerado por los fabricantes o distribuidores de los sucedáneos de la leche materna para la comercialización de estos productos.

Artículo 22.- Los donativos o venta a precio reducido de los productos comprendidos en la presente Ley, solo podrán hacerse a los servicios de salud, previa autorización de la autoridad competente.

Artículo 23.- Los equipos o materiales donados a un servicio de salud, previamente autorizado por la autoridad competente, pueden llevar el nombre o símbolo de la empresa donante, pero no debe referirse publicitariamente a ningún producto comercial comprendido en las disposiciones de la presente Ley.

CAPITULO VIII
De los Profesionales y Agentes de Salud

Artículo 24.- La información facilitada por los fabricantes, expendedores, distribuidores y personal de comercialización a los profesionales y agentes de salud acerca de los productos comprendidos en las disposiciones de la presente Ley, debe limitarse a datos científicos y objetivos y no llevará implícita o incitar a la creencia que la alimentación con sucedáneos es equivalente o superior a la lactancia materna. Dicha información debe incluir asimismo los datos especificados en el Artículo 12 de la presente Ley.
Artículo 25.- Los profesionales y agentes de salud no deberán aceptar ni recibir, incentivos financieros o materiales de parte de los fabricantes, expendedores y distribuidores con el fin de promover los productos comprendidos en la presente Ley.

Artículo 26.- Los profesionales y agentes de salud no deben dar muestras y/o originales de los productos comprendidos en la presente Ley, a mujeres embarazadas, madres de niñas y niños, ni a los miembros de su familia.

Artículo 27.- Los fabricantes, expendedores y distribuidores de los productos contemplados en la presente Ley, podrán entregar contribuciones financieras, becas, viajes de estudio, subvenciones para investigaciones, gastos de asistencia a conferencia profesionales y demás actividades de índole similar, siempre que no estén condicionadas a la realización de actividades de comercialización de los sucedáneos de la leche materna o de otros productos sujetos a la presente Ley.

CAPITULO IX
De los Empleados de los Fabricantes, Expendedores y Distribuidores

Artículo 28.- El personal empleado en la comercialización de los productos comprendidos en la presente Ley no deben, en el ejercicio de su profesión desempeñar funciones educativas en relación con las mujeres embarazadas o las madres de niños y niñas lactantes. Ello no debe interpretarse como un impedimento para que dicho personal sea utilizado en otras funciones por el sistema de atención en salud, a petición y con la aprobación escrita de la autoridad competente.

Artículo 29.- Los fabricantes expendedores y distribuidores deberán guardar registros de todos los productos comprendidos en la presente Ley que hayan sido distribuidos por ellos, hasta un mínimo de seis meses después de la fecha de caducidad de los mismos. Tal registro se pondrán a disposición del Ministerio de salud o de cualquier otra institución u organismo competente cuando sea necesario.

CAPITULO X
Etiquetado

Artículo 30.- Las etiquetas deberán concebirse para facilitar todo la información indispensable acerca del uso adecuado del producto, de modo que no induzca a desistir de la lactancia materna.

Artículo 31.- El etiquetado de los sucedáneos de la leche materna y de los productos contemplados en la presente Ley deberán contener la siguiente información:

a) Los ingredientes utilizados.

b) Composición análisis del producto.

c) Condiciones requeridas para su almacenamiento y empleo adecuado.
d) Número de serie y fecha límite para consumo del producto.

e) Instrucciones sobre la preparación y las medidas higiénicas.

f) La edad para la cual está indicado su uso.

g) Una declaración de la superioridad de la alimentación con el pecho, objetivada en la leyenda; "LA LECHE MATERNA ES EL MEJOR ALIMENTO PARA EL LACTANTE", impresa en tipo visible, de color y letras de altura no menor de 3 mm.

h) Los productos comprendidos en la presente Ley que no satisfagan los estándares establecidos para cubrir requerimientos y necesidades del lactante pero que puedan ser modificadas, a ese efecto, llevarán en la etiqueta un aviso en el que conste que el producto no debe utilizarse como única fuente de alimentación del lactante.

Artículo 32.- El etiquetado de los productos comprendidos en la presente Ley no deberá contener información que pudiera estimular el uso del biberón, tales como:

a) Imágenes de lactantes u otros que puedan idealizar el empleo del biberón.

b) Leyendas, dibujos o alusiones que directa o indirectamente tiendan a crear la convicción de que el alimento sustituto es equivalente o superior a la leche materna.

c) La frase: "Leche maternizada, leche humanizada, semejante a la leche materna", o cualquier similar, no deben figurar como avisos en los envases y etiquetas de los productos comprendidos en la presente Ley.

Artículo 33.- Las etiquetas de biberones, mamaderas, chupeta o consoladoras deberán incluir:

a) Una firmación de la superioridad de la leche materna para alimentar al lactante.

b) Una declaración de que alimentar con taza y cuchara es más seguro que usar un biberón.

c) Una advertencia sobre los posibles riesgos para la salud y para las prácticas de la lactancia materna cuando se usa un biberón.

Artículo 34.- Los fabricantes expendedores y distribuidores de los productos comprendidos en la presente Ley deberán velar porque se imprima en cada envase una etiqueta que no pueda despegarse fácilmente del mismo, una inscripción clara, visible y de lectura y comprensión fácil en el idioma español que incluya los puntos siguientes:

a) Las palabras "aviso importante" o su equivalente.

b) Una afirmación de la superioridad de la leche materna.
c) Instrucciones para la preparación apropiada con indicación de los riesgos que una preparación apropiada puede acarrear para la salud.

d) No debe llevar ninguna fotografía, diseño u otra presentación básica salvo los gráficos para ilustrar el método de preparación del producto.

e) Las etiquetas de la leche entera, condensada, azucarada, evaporada, descremada y semidescremada y fórmulas denominadas de seguimiento deberán contener una advertencia clara y visible que no deben ser utilizadas para alimentar a las niñas y niños lactantes.

f) No llevará o presentará imágenes de profesionales y agentes de salud, o cualquier otro signo convencional que sugiera que estos productos son recomendados por la autoridad de salud.

g) No debe utilizar imágenes o textos que puedan idealizar el uso de productos comerciales comprendidos en las disposiciones de la presente Ley, imágenes que puedan suscitar ansiedad o duda en cuanto a la lactancia materna o al uso de alimentos complementarios caseros.

CAPITULO XI
De la Calidad

Artículo 35.- Los productos alimentarios comprendidos en la disposiciones de la presente Ley destinados a la venta o a cualquier otra forma de distribución deben satisfacer las normas recomendadas por la Comisión del Codex Alimentarius.

Artículo 36.- No se podrá importar para uso en este país, un alimento o producto comprendido en la presente Ley, que no satisfaga las normas de calidad y seguridad en su país de origen.

Artículo 37.- Cualquier producto alimentario comprendido en la presente Ley deberá ser vendido en su embalaje original y no se podrá re-embalar para venta al detalle.

CAPITULO XII
De la Aplicación y Vigilancia

Artículo 38.- La aplicación de la presente Ley corresponde al Ministerio de Salud. Los fabricantes expendedores y distribuidores y cualquier otro organismo gubernamental o no gubernamental deben cumplir con la presente Ley.

Artículo 39.- El Ministerio de Salud a través de la Comisión Nacional de Lactancia Maternal debe:
a) Revisar el material educativo e informativo, escrito o audiovisual, destinado al público en general, a las madres y padres, a instituciones de enseñanza y a los profesionales o agentes de salud, acerca de la alimentación del lactante.

b) Exigir la corrección o el retiro de todo material que se contravenga con los objetivos de la presente Ley.

c) Retirar cualquier producto del comercio que viole las disposiciones de la presente Ley.

Artículo 40.- Independientemente de cualquier otra medida adoptada para la aplicación de la presente Ley, los fabricantes expendedores y distribuidores de los productos comprendidos en la presente Ley, deberán considerarse obligados a vigilar sus prácticas de comercialización y a adoptar medidas para asegurar que su conducta en todos los planos resulten a los principios y objetivos de la presente Ley.

CAPITULO XIII
Sanciones

Artículo 41.- La violación a las disposiciones de la presente Ley por una persona natural o jurídica, será sancionada por los organismos responsables de la aplicación y vigilancia de la presente Ley.

Las sanciones se aplicarán en forma progresiva, según la gravedad y frecuencia de las violaciones, de la siguiente manera:

a) Llamado de atención escrito.

b) Multa de un mil a veinte mil córdobas.

c) Suspensión temporal de la comercialización del producto o productos sujetos a la infracción.

d) Suspensión definitiva de la comercialización del producto o productos sujetos a la infracción.

e) Cancelación del registro sanitario.

Artículo 42.- Sin perjuicio de la sanción que en cada caso se imponga, la autoridad sanitaria correspondiente podrá decomisar los sucedáneos de la leche materna y los productores comprendidos en la presente Ley que considere inadecuados para el consumo, pudiendo proceder a la destrucción o incineración de los mismos, auxiliándose de la fuerza pública en los casos que fuere necesario.

Artículo 43.- Cuando se demuestre que un agente o profesional de la salud ha violado una disposición de la presente Ley, el Ministerio de Salud aplicará las sanciones progresivas en el siguiente orden:

a) Amonestación verbal.

b) Llamado de atención por escrito.

c) Multa de cincuenta a mil córdobas.
Artículo 44.- La Comisión Nacional de Lactancia Materna por medio de resolución, impondrá las sanciones previstas en la presente Ley, a las personas naturales o jurídicas que la infrinjan, previa audiencia al supuesto infractor, quien dispondrá del término de 6 días para contestar lo que tenga a bien y presentar las pruebas de descargo.

Artículo 45.- Contra la resolución que impone una sanción cabrá el Recurso de Reposición ante la Comisión Nacional de Lactancia Materna en el término de cuarenta y ocho horas después de notificado. La Comisión resolverá en un plazo de 5 días.

Artículo 46.- Si la resolución anterior no le favorece, el sancionado podrá interponer Recurso de Apelación ante el Ministerio de Salud en un plazo de setenta y dos horas después de la notificación respectiva. El Ministerio de Salud dispondrá de 10 días para resolver el recurso.

Artículo 47.- En el escrito de interposición de estos recursos se deberán expresar los agravios que procedan. Si el sancionado no utilizara ninguno de los recursos previstos en la Ley, la resolución quedará firme, con lo cual se agotará la vía administrativa y se procederá a la ejecución de la sanción.

CAPITULO XIV
Disposiciones Finales y Derogatorias


Artículo 49.- La presente Ley entrará en vigencia a partir de la fecha de su publicación en cualquier medio de comunicación social escrito, sin perjuicio de su posterior publicación en La Gaceta Diario Oficial.

La presente Ley de Promoción, Protección y Mantenimiento de la Lactancia Materna y Regulación de la Comercialización de Sucedáneos de la Leche Materna, aprobada por la Asamblea Nacional el dieciocho de Junio de mil novecientos noventa y ocho contiene el Veto Parcial del Presidente de la República, aceptado en la Tercera Sesión Ordinaria de la Décima Quinta Legislatura.

Dada en la ciudad de Managua, en la Sala de Sesiones de la Asamblea Nacional, a los diez días del mes de Junio de mil novecientos noventa y nueve. IVAN ESCOBAR FORNOS, Presidente de la Asamblea Nacional. VICTOR MANUEL TALAVERA HUETE, Secretario de la Asamblea Nacional.

Por tanto: Téngase como Ley de la República, Publíquese y Ejecútense, Managua, dieciséis de Junio de mil novecientos noventa y nueve. ARNOLDO ALEMAN LACAYO, Presidente de la República de Nicaragua.
Appendix IV: Interview Guides

Brigadistas (Community Healthcare Workers)

I. Basic Situation

1. How old are you?
2. How long have you been practicing medicine?
3. Which municipality do you work in?
4. How many patients do you see each month?
5. Who is your typical patient? Education, economical situation, marital status, number of children
6. How many times do you see a woman before she gives birth? After she gives birth?
7. How long do you spend with each woman on her visits?
8. What does a typical visit consist of?

II. Breastfeeding and Supplementation – Knowledge and attitudes

1. In your opinion, what do you think is the ideal form of feeding a baby?
2. What are some of the problems women have with breastfeeding?
3. When do you first start talking to a mother about breastfeeding? What are some of the topics you discuss?
4. When a mother has a problem with breastfeeding, what do doctors in this hospital do? Give formula?
5. Do most women continue breastfeeding after they leave the hospital?
6. Do most women buy formula (where do they get it?)? Does the hospital help if a woman has problems affording formula?
7. What advice would you give a new mother who wanted to breastfeed?

III. Code and Law 295

1. I am learning about the International Code of Marketing Breastmilk Substitutes. What do you know about the Code?
2. Tell me about breastfeeding in Nicaragua. Has it changed over the past decades? Why?
3. Tell me about the use of supplements in Nicaragua. Has it changed over the past decades? Where do supplements come from? Why do some women use them?
4. Does Nicaragua have any official policy about the distribution of breastmilk substitutes? What does it say? When was it passed?

**MINSA**

1. What is your role in the Ministry of Health?
2. How long have you worked for the Ministry of Health?
3. What is being done in Nicaragua to enforce and protect the culture of breastfeeding and a woman’s confidence in breastfeeding? Can women breastfeed at work?
4. How has your department promoted breastfeeding through the distribution of information and publicity?
5. What do you know about Law 295?
6. What is being done to implement Law 295?
7. Who is involved in the National Commission of Breastfeeding?
8. What kinds of coordination and evaluation activities exist?
9. Has the application of the law ever been evaluated? Has it ever been revised?
10. What do you understand your branch’s role to be in the application of Law 295?
11. Who else is responsible for implementing Law 295?
12. What has changed to protect and promote breastfeeding since 1999 when the law was passed?
13. How have marketing practices changed? What does the government do to ensure that marketing practices are being followed?
14. Has MINSA ever sanctioned or fined an entity or business found to be violating the law?
15. Does the Ministry of Health receive sufficient cooperation from other public and private institutions?
16. What process is in place to facilitate revision of educational material about infant feeding that is given to the general public, to moms and dads, or to teaching institutions?
17. Who is in charge of correcting or deleting from circulation, material that conflicts with the law?
18. What kind of sanctions can be taken against those who break the law?
19. What do you think needs to happen so that Law 295 is fully enforced?

**Mothers**

1. **Basic Information**
   1. How old are you?
   2. Where do you live?
3. How old is your baby?
4. Are you married, living with your partner, or a single mother?
5. How old were you during your first pregnancy?
6. Where did you have your baby?
7. How many children do you have? How old are they? Do you have boys, girls, or both?

II. Access to Medical Services

8. Can you tell me about how you prepared to give birth to your baby?
9. Did you receive prenatal care? How many times and how often?
10. Did you know before you had your baby if it was a girl or a boy?
11. What did you learn about breastfeeding before your baby was born?
12. Who explained it to you?
13. Did they ask you how you wanted to feed your baby? What did you say?
14. How does breast milk help a baby?
15. How did you prepare to breastfeed your baby? Did you seek advice from a doctor, a community health care worker, or your family?
16. What did you understand or find out about breastfeeding from (answer from question 15).
17. In your opinion, what is the best way to feed your baby?
18. Where did you learn about breastfeeding? Where did you learn about feeding your baby with formula?

III. Hospital Feeding

19. Did you receive formula in the hospital for free? Did you receive formula for free from another source?
20. Please describe to me how you fed your baby in the hospital.
21. At what moment did you breastfeed your baby for the first time?
22. Who taught you about breastfeeding in the hospital?
23. Did you need help to breastfeed? Did you ask for help? Did you feel comfortable asking for help?
24. If you had a problem breastfeeding, what did the doctor say? Did they give you formula or suggest that you buy formula?
25. Have you received support for breastfeeding from community health workers?
26. What kind of support? How many times did you seek medical care because of a problem with breastfeeding? Did they answer your questions? What did they tell you?

IV. Feeding in the home

27. Tell me about how you feed your baby in the house. Is it how you planned on feeding your baby?
28. How do you feel about the method that you currently use to feed your baby?
29. Is it differently than how you fed your baby in the hospital?
30. How long did you want to breastfeed your baby?
31. Are they times when you give your baby food other than breastmilk?
32. Where do women in your community buy formula?
33. What are the brands that you like and why?
34. Have you seen advertisements or promotions for formula?

V. Breastfeeding

35. What are some of the reasons why a mom decides to breastfeed?
36. How do you feed your baby? Do you bottle feed, breastfeed, or both?
37. Have you only given your baby breastmilk? Have you ever breastfed?
38. What do you think about if a mother breastfeeds or not?
39. Please tell me about the people in your family and community who help you or give you advice about breastfeeding.
40. Did you have any problems breastfeeding? What was the problem and what did you do?
41. What are some of the problems that women in your community have when they breastfeed?
42. Do you buy formula? Where do you buy it?
43. How does your family pay for formula? Do you have enough money?
44. Has there ever been a time when you have had a problem with paying for formula?
45. What does your community do to help a mother if she does not have enough money to buy formula?

Nestle

Interviewee: Solangel Gutierrez
Title: Managua – Field Operations Manager – Nutrición
Telephone: 280 9212 (office) 846 5437, 883 7343 (cell)
Location: Nestle Nicaragua, Managua

Good afternoon. I am a student in public health. I am studying breastfeeding and Law 295 in Nicaragua. The goal of my interview with you is to understand Nestle’s practices in the area of infant nutrition.

1. What is your role at Nestle?
2. How long have you worked for Nestle?
3. Our knowledge of nutrition has advanced thanks to research and today formula contains a lot of nutrients. I would like to know more about the benefits of this product for babies under six months of age.
4. In your opinion, in which situations should formula be given to babies under six months of age?
5. Is Nestle going to participate in World Breastfeeding Week?
6. Have you heard of Law 295? What is your opinion of the law?
7. What is Nestle’s role in the application of the law?
8. What is Nestle’s relationship with the Ministry of Health like? Who is responsible to give fines to companies that violate the law? Does communication between you about promotion rules exist? How does Nestle decide on how to promote their products?
9. What is the relationship like between Nestle and the health system? How has it changed in the past 10 years?
10. Can you describe the promotion activities that Nestle does?
11. Some of the key rules are that companies cannot promote their products to the general public, they have to include information about the benefits and superiority of breastmilk, and they cannot distribute their products for free. In your opinion, does Nestle follow these rules?
12. How has international pressure affected Nestle’s marketing practices? (demonstrations, boycotts, bad press)
13. What does Nestle do to ensure that the law is not violated?
14. In your opinion, has Nestle’s marketing practices changed since the law was passed? How?
15. In your opinion, what does Nestle still need to do in order to comply with the law 100%?

Works Cited


“Ley de Promocion, proteccion, y mantenimiento de la lactancia maternal y regulacion de la comercializacion de sucedaneos de la leche maternal.” Ley no 295, aprobada el 10 de Junio de 1999. Republica de Nicaragua.

