

5-2013

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Tailored Breastfeeding Intervention for Hispanic Mothers

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Funding by Briton Research Grant

Abstract

A retrospective chart review was done using a sample of breastfeeding Hispanic mothers recruited from a large pediatric clinic in Northwest Arkansas in order to examine the impact of a tailored breastfeeding intervention and to identify factors associated with discontinuation of breastfeeding before four months of age. It was hypothesized that Hispanic women who participated in the study would increase their breastfeeding rates compared to Hispanic women who received no intervention. Breastfeeding rates at four months were assessed via self-report in the electronic medical record. Variables within the sample population that were measured include maternal age, maternal education, primary language spoken, return to work within four months, and type of insurance. Data analysis was done using descriptive statistics and appropriate hypothesis testing was carried out. Although data from this study was limited, trends and correlations were identified that maintain similar reports of social support as a method of increasing breastfeeding rates in Hispanic mothers and offer suggestions for management strategies of breastfeeding support.

Keywords: Hispanic, breastfeeding, breastfeeding education

Introduction

For centuries, breastfeeding was the primary mode of nourishment for infants. In the United States, it has been surpassed by formula feeding, especially among the immigrant population who consider bottle-feeding the “American way” (Faraz, 2010). Breastfeeding reached its lowest level in 1971 with only 24.7% of mothers breastfeeding, but efforts have been made by public health and medical professionals, especially in recent years, to increase awareness of and promotion for breastfeeding (Ryan, Wenjun, & Acosta, 2002). The American Academy of Pediatrics coined the phrase “Breast is Best” and recommends breastfeeding exclusively for about six months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for one year or longer as desired by mother and infant (Eidelman & Schanler, 2012). The World Health Organization and the Institute of Medicine concurs with this recommendation.

The United States *Healthy People 2020* goals are to increase breastfeeding in the early postpartum period to 75%, to 50% at six months, and to 25% at one year (Ruowei & Grummer-Strawn, 2010). These increased rates are important because of the associated benefits with breastfeeding. According to the American Academy of Pediatrics, breastfeeding reduces the risk of respiratory tract infections, otitis media, nonspecific gastrointestinal tract infections, pneumonia, necrotizing enterocolitis, sudden infant death syndrome (SIDS), clinical asthma, atopic dermatitis, celiac disease, inflammatory bowel disease, and leukemia, among many other infections and diseases (Eidelman & Schanler, 2012).

Benefits of breastfeeding also increase as the duration of breastfeeding increases. For example, breastfeeding for any period of time will reduce the incidence of otitis media by 23% but exclusively breastfeeding for more than 3 months reduces the risk of otitis media by 50% (Eidelman & Schanler, 2012). By decreasing the risk of disease, the infant mortality rate in the United States is dramatically reduced. According to the European Childhood Obesity Trial Study Group, the obesity risk at school age was reduced by 15-25% with early breastfeeding compared with formula feeding (Koletzki et al., 2009). Faraz agrees, stating there is an inverse relationship between breastfeeding and overweight children, and adds there is even some evidence that type 1 and type 2 diabetes mellitus are less prevalent among breastfed children (2010).

The benefits are psychosocial and intellectual as well. Research shows enhanced mother-infant bonding and higher intelligent quotient scores for infants who were breastfed (Purdy, 2010; Faraz, 2010). There is great potential economic benefit as well, shown by a report by the Agency for Healthcare Research and Quality concluded that if 90% of US mothers would comply with the recommendation to breastfeed exclusively for six months, there would be a savings of \$13 billion per year (Eidelman & Schanler, 2012). In contrast to the physical, psychological, intellectual and economical benefits associated with breastfeeding, consequences of not breastfeeding include increased infant morbidity and mortality rates and health care costs linked to illnesses related to bottle-feeding (Mann et al., 2003).

For the purpose of this study, it is important to understand the scope of the breastfeeding problem in the United States, especially among the Hispanic population. One in five children in the United States now lives in an immigrant family, and more than 60%

of these children are of Hispanic origin (Hopkinson & Gallagher, 2009). With such statistics it is clear that efforts to increase breastfeeding rates in the United States need to address immigrant populations. In regards to the *Healthy People 2020*, none of the subgroups have reached their targets. Only 13% of the United States population breastfeeds exclusively for six months (Eidelman & Schanler, 2012), compared to 11.6% of Hispanic women (Faraz, 2010). Studies show the likelihood of breastfeeding initiation is inversely associated with level of acculturation (Anderson et al., 2004). What occurs during a Hispanic woman's acculturation into the US population remains unknown and further research is recommended. Other variables associated with lower breastfeeding levels include younger maternal age, lower educational level, lower socioeconomic status, lack of support from both immediate and external family and friends (Anderson et al., 2004), being employed, and participating in the Supplemental Nutrition Program for Women, Infants, and Children (WIC) (Ryan, Wenjun, & Acosta, 2002).

Studies show that social support seems to be the most influential for immigrant women in making the decision to breastfeed (Faraz, 2010). While it is impossible to control many of the factors that affect breastfeeding, it is proposed that interventions to increase social support, specifically within the clinical setting, will increase the breastfeeding rates of Hispanic women. Social support in this study is in the form of tailored breastfeeding education by a certified lactation professional and follow-up care between hospital discharge and the two-week visit, the period when there is typically a gap in breastfeeding support (Hopkinson & Gallagher, 2009).

The purpose of this study was to answer the question, "What is the impact of a tailored breastfeeding intervention on breastfeeding rates of four-month-old infants among

breastfeeding Hispanics?” It was hypothesized that Hispanic women who participated in the study would increase their breastfeeding rates compared to Hispanic women who did not receive intervention.

The independent variable was breastfeeding intervention and the dependent variable was breastfeeding rates at four months of age. The intervention was operated according to the treatment outline (see appendix) and success was measured at four months postpartum via maternal self-report. This study used the Health Promotion Model as a theoretical framework for health-promoting interactions among the Hispanic mothers with four month old infants. The results contribute to literature supporting social support to increase breastfeeding rates, especially within the Hispanic population.

Methods

The proposed study was submitted to the University of Arkansas International Review Board and was approved in March 2013. The investigator completed Collaborative Institutional Training Initiative (CITI) training in the spring of 2012.

This study was conducted as a retrospective medical record review. It occurred August 2012 through February 2013 at the largest pediatric clinic serving Northwest Arkansas and data collection took place in March 2013. The clinic’s advanced practice nurse (APN), who is also an International Board Certified Lactation Consultant (IBCLC), provided the breastfeeding intervention.

Participants:

Sample size included 5 participants in the intervention group, and 10 in the control group. Only declared breast feeders of Hispanic ethnicity were considered for participation. The control group received no specific breastfeeding education and members were seen by any

of the eighteen attending pediatricians at the clinic. Exclusion was warranted for gestation less than 37 week, NICU stay in the hospital, illness that contraindicated breastfeeding, hyperbilirubinemia treatment, and supplemental formula feeding in the early postnatal period. Newborns must have had their first well-visit within 7 days of hospital discharge to be eligible.

Control Group:

Routine care included establishment of the birth history and newborn milestones by the patient care assistant, asked from a closed-ended question template created by the pediatric clinic and consistently used for each patient. The assistant also measured the height, head circumference, and weight of each patient, plotting results on a growth chart. The clinician performed a physical examination and reviewed vital signs, eating and digestion, and safety of the newborn, as well as answered any questions the parents had. Patients received feeding assessment and education that complied with clinic protocol but did not meet with the APN who is trained in lactation or receive specific education regarding the benefits of exclusive breastfeeding. They could, however, have accessed the APN upon request for feeding difficulty. Mother-newborn pairs returned to the clinic at two weeks, two months, and four months and the visits were performed as before, with the exception of the birth history, which is established only once. An interpreter was provided at every visit as needed.

Intervention Group:

Routine care as described for the control group was given at each visit in addition to a tailored intervention session performed by the APN at the first newborn visit. The APN performed a lactation consult and provided informational handouts in the patient's

preferred language. All written materials were translated to Spanish by a certified interpreter and verified by a trained professional. The APN presented specific information concerning the benefits of breastfeeding with specific emphasis on the inverse relationship of exclusive breastfeeding and childhood obesity. See appendix for intervention outline.

The APN also assisted the mother with any breastfeeding issues she had. At the two-week visit the APN provided reinforcement of previous teaching as well as information on protective benefits of exclusive breastfeeding (see appendix). One follow-up phone call between the two-week and two-month visit provided additional support for the mother-child dyad. At the two-month visit the APN provided information on introduction of solids and the reasons to delay, as well as information on returning to work (see appendix).

Mother provided self-report at the four-month visit of continuation of exclusive breastfeeding.

Data Collection:

Data collection was done electronically using a template created by the APN prior to the study. Variables that affect intervention success were retrieved from the electronic medical records (EMR) after the final data was collected. The primary outcome measured was the number of Hispanic women who exclusively breastfed at four months of age within the control and intervention groups. Primary language spoken and need for a translator represented the level of acculturation. Education of mother was measured by >12 or <12 grade. Return to work within four months, previous breastfeeding experience, type of delivery, type of insurance, smoking during pregnancy, and maternal age are also variables that have been shown to affect breastfeeding and were analyzed within the contents of this study.

Patient information was stored as EMR that were accessed by password. The study received approval from the International Review Board before beginning data collection. No coding of data occurred, ensuring confidentiality during analysis, reporting, and potential publication. The Health Information Accountability and Portability (HIPPA) guidelines were strictly followed.

Statistical Analysis:

Data collection was performed via self-report by the parent at the four-month appointment. Pertinent data included whether exclusive breastfeeding was still performed at four months and associated independent variables. These include maternal education level (<12 years or >12 years), maternal age (in n years), delivery type (vaginal or cesarean), previous breastfeeding experience (yes or no), level of acculturation (primary language spoken), type of insurance (private or state), return to employment before the infant reached four months of age, breastfeeding education received (yes or no), and smoking during pregnancy (yes or no).

Statistical analysis was used to calculate the number and percentage for each categorical variable. The number of exclusive breastfed infants that received exclusive breastfeeding education at two weeks, two months, and four months were compared with the control group that did not receive the newly implemented exclusive breastfeeding education. All analysis tables are shown below.

Data

Table 1: Breastfeeding Education Data Collection Template: Initial Visit

Maternal Education level	Maternal Age.	Delivery Type V= vaginal C= Cesarean	Previous BF Experience Y=yes N=no	English Primary Language Y= yes N=no	BF education Received Y= yes N= no (control)	Smoking 1=yes 2=no
1= < 12 years						
2= > 12 years						
1	19	C	Y	N	Y	2
1	37	V	Y	N	Y	2
2	26	V	N	Y	Y	2
1	41	V	Y	N	Y	2
2	-	C	Y	N	Y	2

Table 2: Breastfeeding Education Data Collection - Visits 2 weeks, 2mo., 4 mos.

Well Visit # 2= 2weeks 3= 2mo. 4= 4mo	Return to Employment before Infant Reached Four Months Y= yes N= no	BF Education by LC/APN Received Y= yes N= NO (control)	Current feeding Y = exclusive Breastfeeding C= complementary or non-exclusive BF N= no breastfeeding	Phone follow Up Done Y=yes N=no	Length of BF in months Post-delivery
2 3 4	N	Y Y Y	N N N	Y	0.25
2 3 4	N	N N N	C C N	N	2
2 3 4	N	Y Y Y	Y Y Y	Y	4
2 3 4	N	Y Y Y	C C C	Y	4
2 3 4	N	Y N -	C N -	N	0.5

Tables 1 and 2 represent the raw data from the intervention group. Five mother-baby dyads took part in the intervention, with data collection beginning before the fifth participant's four-month visit.

Table 3: Participants receiving Quality Control Improvement

Patient characteristics	Yes (%)	No(%)
Education level <12 years = no >12 years = yes	40%	60%
Delivery type- vaginal	60%	40%
Previous breastfeeding experience	80%	20%
Return to work<4 mo.	0	100%
Maternal smoking	0	100%

Table 4: Participants NOT receiving Quality Control Improvement

Patient characteristics	Yes (%)	No(%)
Education level <12 years = no >12 years = yes	45.5%	54.5%
Delivery type- vaginal	72.7%	27.3%

Previous breastfeeding experience	45.5%	54.5%
Return to work < 4 mo.	18.2%	81.8%
Maternal smoking	9.1%	90.9%

Table 5: Comparison of Control and Intervention Groups

	Control	Intervention
Maternal Education		
<12 years	54.5%	60%
>12 years	45.5%	40%
Maternal Age		
Range	19-42	19-41
Average Years	29.9	30.2
Delivery		
Vaginal	72.7%	60%
Cesarean	27.3%	40%
Previous BF Experience		
Yes	45.5%	80%
No	54.5%	20%

Primary Language Spoken		
Spanish	83.3%	80%
English	16.7%	20%
Insurance		
Private	0	0
State	100%	100%
Smoking during Pregnancy		
Yes	9.1%	0
No	90.9%	100%

Table 6: Comparison of education received and breastfeeding rates

Breastfeeding Education Received	Average Length of Exclusive BF in months	Average Length of Any BF in months
Yes	1	2.25
No	1.3	3.2

Results

The data collected shows trends in the Hispanic breastfeeding population in Northwest Arkansas. This serves as an excellent pilot study that encourages further research in this specific population. Table 5 offers a side-by-side analysis of the independent variables of both the intervention and control group. The majority of both the control and intervention did not seek education past high school (54.5% and 60% respectively), had vaginal deliveries (72.7% and 60%), spoke primarily Spanish (83.3% and 80%), did not smoke during the pregnancy (90.9% and 100%), and were not employed

within four months of the birth (81.8% and 100%). The age ranges were also similar within the two groups, 19-42 for the control and 19-41 for the intervention. The average age of the control was 29.9 years and the average age of the study participant was 30.2 years. All the participants, control and intervention, were on state insurance (Medicaid). Where the two groups were not similar was previous breastfeeding experience – 54.5% of the control group had not had previous experience where 80% of the intervention group had experience.

The five intervention participants were all breastfeeding at the initial well-baby visit, which was scheduled at least seven days postpartum. Four of five participants (80%) were still breastfeeding, although only one was exclusive, at the two-week visit. Three of five participants (60%) were still breastfeeding, again only one was exclusive, at the two-month visit. Two of five participants (40%) were breastfeeding at the four-month visit, with only one participant exclusively breastfeeding throughout the four month study.

The average length of any breastfeeding for the intervention group was 2.25 months and the average length of exclusive breastfeeding was one month.

Discussion

This is the first study on intervention-influenced exclusive breastfeeding rates among Hispanic women in Northwest Arkansas. The study has limitations due to the small sample used. It is therefore important to stress that the results cannot be generalized and further research is recommended to obtain statistically significant evidence to support interventions that can be implemented to increase exclusive breastfeeding. Although data from this study is limited, trends and correlations exist that support similar studies and offer suggestions for management strategies of breastfeeding support.

The average length of any breastfeeding for the study population was 2.25 months, while the average length of exclusive breastfeeding was one month. This data suggests Hispanic women are more likely to complimentary feed (provide breast milk and formula) for a longer period of time than exclusively breastfeed their baby. This widespread incidence of early mixed feeding has been termed the “las dos cosas” phenomenon and can be attributed to many factors, including the fact that many immigrants to the United States consider bottle-feeding to be the “American way” (Faraz, 2010). Furthermore, studies show that those who receive WIC assistance (all of the study participants are eligible for WIC considering their Medicaid status) are less likely to breastfeed and breastfeed less than the recommended eight to twelve times a day (Mann, Reifsnider, Gill, & Ritsema, 2003).

Of the many factors that have been shown to negatively influence breastfeeding, three were present in the study population - 60% received an education of 12 years or less, 80% claimed Spanish as their primary language, and 100% received state insurance. According to a study by Man, Reifsnider, Gill, & Ritsema (2003), factors of women less likely to breastfeed include grade school education, Hispanic ethnic origin, and income of less than \$10,000 a year. Also the likelihood of breastfeeding is inversely associated with level of acculturation (Anderson et al., 2004), which was measured in this study by primary language spoken.

While the average length of exclusive breastfeeding did not increase significantly after intervention, there were several strengths identified within the study population that can be used for future research and breastfeeding promotion. Previous studies show that the highest rates of breastfeeding occur among women who are not first time mothers,

older than 30 years of age, and who are not employed outside of the home (Mann, Reifsnider, Gill, & Ritsema, 2003). The factors specific to the Northwest Arkansas Hispanic population identified in this study include previous breastfeeding experience (80%), maternal age (30.2 years average), and not being employed outside of the home (100%). Therefore this study provides evidence to support comprehensive breastfeeding education utilizing these specific strengths for NWA breastfeeding Hispanic mothers.

Clinical Recommendations

Evidence-based strategies for increasing exclusive breastfeeding rates promote social support, both in the clinic and community settings. Skilled professionals contribute to a comprehensive support network complimented by peer groups of women with similar cultures, traditions, and life experiences.

Historically, women who decided during or late in their pregnancy to breastfeed were less likely to breastfeed. According to a study conducted by Balcazar, Trier, & Cobas (1995), "advice to breastfeed at prenatal care was the strongest predictor of intentions in Mexican-American women." Therefore targeted educational programs about breastfeeding should begin preconception or early in the prenatal phase. The pregnant mother's family and/or partner should be involved as family approval can influence a mother's decision to breastfeed.

Studies show postpartum interventions that improve breastfeeding durations include serial, face-to-face breastfeeding counseling episodes with skilled professionals (Hopkinson & Gallagher, 2009). These skilled professionals can be lactation specialists, health care providers, nurses, or peer counselors. The episodes can be part of the well visits, as demonstrated in this study, support groups, or breastfeeding group classes. A

study reported by Faraz (2009) found “interactive breastfeeding classes were well received by Hispanic women, as were personalized breastfeeding plans, which could be realistically implemented and integrated into women’s lives.”

A key finding in a community-based approach to increase breastfeeding rates among Hispanic women was that among those who named a peer counselor as a source of support, 50% continued to breastfeed for at least six months compared to more than half of those without a peer counselor who discontinued breastfeeding by two months postpartum (Faraz, 2009). La Leche League International (LLL) is a resource designed specifically for Hispanic mothers and provides mothers with a bilingual personal advocate or coach. The program includes training and education on breastfeeding management, child development, parenting, communication skills, and supporting and counseling mothers (Faraz, 2009).

Continuing staff education is equally as important, as new recommendations and support mechanisms are constantly introduced. One particular program, The Breastfeeding Research and Training Working Group, demonstrated benefits of providing an educational intervention for health care workers by increasing their knowledge and compliance with breastfeeding guidelines (Purdy, 2010). Nurses are in a unique position to inform and encourage mothers about the numerous benefits of breastfeeding. Their patient interaction allows them to establish a working relationship with mothers and provide personalized assistance. Nurses can promote breastfeeding in hospitals and clinics, serve as counselors in support groups, become lactation consultants and even become active in advocacy groups to initiate policy change.

These clinical guidelines incorporate current evidence-based literature to provide recommendations for supporting breastfeeding in Hispanic women in Northwest Arkansas. While further research is recommended, this pilot study indicates that progress can be made on the issue. With the proven benefits to the infant, mother, and society as a whole, infant feeding should not be considered a lifestyle choice but rather a basic health issue.

Acknowledgements

The author would like to thank the Briton Research Grant for funding on this honors thesis work.

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Appendix

Treatment Outline

I. Relationship between exclusive breastfeeding and positive outcomes

- A. Lower childhood obesity
- B. Decreased acute illness, allergies, and possibly asthma

II. Counseling regarding feeding practices

- A. Nonverbal cues of infants
- B. Satiation cues

III. Introduction of solids after four months

- A. Reasons to delay
- B. Breast milk = complete food

IV. Social support resources

- A. Well clinic numbers
- B. La Leche League contact

V. Returning to work

- A. Pumping and storage options

VI. Phone follow-up by APN between four and six weeks of age



ILCA's INSIDE TRACK

a resource for breastfeeding mothers

A Publication of the International
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Lactancia exclusiva: ¿Es “amamantar un poco” suficiente?

Por Jane Heinig, PhD, IBCLC, y Kara Ishii, MSW

Traducido por Helen Mashie, estudiante de enfermería en la Universidad de Arkansas

¡Felicidades que Ud. esté escogiendo amamantar a su bebé! Muchos de los beneficios de lactancia duran toda la vida. Quizás ha escuchado que organizaciones de salud, incluyendo la Organización Mundial de la Salud, recomiendan lactancia *exclusiva* por los primeros 6 meses de vida. Ud. puede preguntarse si lactancia exclusiva es importante o si lactancia mezclado con la alimentación de biberón es suficiente para Ud. y su bebé.

Lactancia exclusiva significa su bebé recibe sólo su leche materna y nada más. Muchas mujeres amamantan un corto periodo de tiempo. Es decepcionante porque la lactancia exclusiva puede hacer la diferencia.

¿Por qué recomiendan la lactancia exclusiva los expertos?

La leche materna es diseñada perfectamente para ser la única alimentación de su bebé. Contiene los nutrientes que necesitan los infantes para crecer y los anticuerpos y factores inmunológicos que mantienen sano a su bebé. La leche materna cubre al intestino para que no entren al cuerpo las bacterias y los virus. Entonces los bebés que son amamantados exclusivamente son mas saludables, más que los niños quienes reciben los dos, fórmula y leche materna.

Las madres quienes amamantan exclusivamente lo hacen más tiempo. Muchos de los beneficios se ven cuando las madres amamantan un mínimo de 3 meses. Para las madres, la lactancia exclusiva por los primeros 6 meses significa el uso de más calorías para hacer la leche materna (entonces se pierde el peso más rápido y eso es importante para la salud). También a las madres quienes amamantan exclusivamente usualmente les faltan sus períodos 9 meses después del nacimiento de sus bebés. La lactancia exclusiva que dura más tiempo también es relacionada con una mayor protección contra el cáncer de mama.

¿Por qué piensan que no tienen bastante leche algunas madres?

Cuando nacen los bebés los cuerpos no saben cuánta leche materna será necesaria. Entonces muchas madres producen bastante leche materna en los primeros 7-10 días. Cuando se mejora la lactancia, el cuerpo empieza a producir la misma cantidad de leche que toma el bebé. Las mamas no parecerán tan llenas y quizás se preocupe la madre que no tenga bastante leche. A veces lloran los bebés y las madres pueden creer que tengan hambre aunque están creciendo y están desarrollándose bien. Si piensa que no tiene bastante leche materna, hable con el doctor o especialista de lactación antes de darle la fórmula al bebé.

¿Y si tengo que dejar a mi bebé?

Aunque tenga que dejar a su bebé con alguna persona durante la hora de amamantar, puede dar su leche materna en vez de fórmula. Pregúntele a la especialista de lactación cómo sale la leche materna. Puede usar las manos o los sacaleches. Ella le puede ayudar si lo que necesita es usar los sacaleches y cuál tipo es mejor. No se desanime si la calidad no parece bastante; mientras su cuerpo se vaya acostumbrando, saldrá más leche materna.

¿Y si tengo que darle fórmula a mi bebé?

Es muy importante que Ud. exclusivamente solo amamante, especialmente cuando su bebé está recién nacido. Cuando recibe otro alimento, su bebé necesitará menos leche de usted, y el cuerpo producirá menos leche. Afortunadamente si regresa a la lactancia exclusiva su producción de leche aumentará para satisfacer la necesidad de su bebé.

Fórmula puede cambiar la bacteria en el intestino del bebé y no proporciona protección inmune al bebé, pero si regresa a amamantar el intestino volverá a la normalidad. Entonces, si absolutamente necesita darle fórmula al bebé, regrese a lactancia exclusiva cuando pueda. Si tiene alguna problema ¡la especialista de lactación puede ayudarle!

¿Sabe que?

Solamente la leche materna contiene...

- **más de 190 ácidos grasos**, no sólo DHA (ácido docosahexaenoico) y ARA (ácido araquidónico).
- **factores inmunológicos** que le ayuda al sistema inmune.
- **enzimas** que le ayudan a digerir la leche a su bebé
- **factores de crecimiento y hormonas** que ayudan a su bebé a crecer y desarrollarse
- **anticuerpos específicos** contra los gérmenes de que Ud. ha estado expuesto, para que esté protegido su bebé

¿Cómo puedo asegurarme que tengo bastante leche?

- El aumento de peso es el mejor indicador que recibe bastante leche. Vaya a todas las citas que recomienda el doctor.
- Debe tener frecuentes pañales sucios y mojados.
- Debe tener períodos calmos durante el día y no debe ser difícil despertarlo para alimentarlo.
- Debe tener piel suave que rebote cuando se presiona.

Recuerde –

- Las razones por las cuales lloran o se despiertan los bebés pueden ser diversas. Llorar y despertarse no son signos definitivos de hambre.
- Llame a la especialista de lactación o al doctor si tiene preocupaciones sobre su bebé. No se olvide – ¡Ud. es la experta sobre su bebé!





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Lactation Consultant Association 

Lo que Ud. debe saber sobre la alimentación y su bebé

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¡Felicidades! Ahora su bebé tiene unos meses y está creciendo rápido. Ud. puede pensar en darle comida. Quiere lo que es mejor para su bebé, pero es desconcertador saber cuándo y cómo empezar. Aquí hay unos consejos buenos sobre la alimentación de su bebé.

Lo Que Necesita Su Bebé: Nacimiento Hasta 6 Meses

La lactancia exclusiva le proporciona todos los nutrientes que necesita durante los primeros meses. Pero como su bebé crece, necesita más calorías que las que tiene la leche materna. También cambian la boca y tracto digestivo. Estos cambios le preparan a su bebé para comer comida. La introducción de comida, junto con la leche materna, es importante para el desarrollo. Debe empezar la comida a las 6 meses. Pero los bebés se desarrollan diferentemente y tienen necesidades diferentes. **Hable con su médico antes de darle comida a su bebé.**

Lo Que Necesita Su Bebé: 6-12 Meses

Hay que comenzar a ofrecerle comida al bebé poco a poco y con paciencia. Necesita tiempo para acostumbrarse a los sabores y las texturas diferentes. Continúe amamantando.

Hay **consejos** para cuándo pueden comer cuáles tipos de alimento.

- **Nacimiento hasta 6 meses:** La leche materna sola
- **6-7 meses:** Cereales de bebés que son fortificados con hierro
- **6-8 meses:** Verduras coladas o trituradas, frutas, y carnes; jugo en vasito; y la leche materna
- **7-10 meses:** Comida que puede comer con las manos (cereales secos, galletas, tortillas, verduras cocinadas, frutas blandas), y leche materna
- **8-12 meses:** Comida triturada o cortada de la mesa familiar (carne molida o cortada finamente, pescado, o pollo; requesón), y leche materna.

No se atre si no come la comida inmediatamente. Recuerde que es un tiempo para aprender. Tiene que *aprender* a comer la comida. Como se vaya acostumbrando a la nueva, Ud. debe ofrecerle otros tipos.

El nombre de la especialista de lactancia es **ALLISON SCOTT**

Mitos y La Verdad

Mito #1 : Se introduce la comida cuando come con más frecuencia que cada 3 horas.

Los bebés tienen estómagos y costumbres de comer diferentes. Algunos bebés necesitan comer cada 5 horas. Otros necesitan comer cada 2 horas. Calculando las horas entre las comidas no significa que esté listo para comer.

Mito #2 : Si no empieza la comida temprano su bebé la rechazará.

Antes de que tenga 6 meses su bebé no necesita la comida. No hay prueba de rechazar si Ud. espera hasta 6 meses. La leche materna tiene muchos sabores. Los bebés que son amamantados prueban más alimentos diferentes.

Mito #3 : Los cereales les ayudan a los bebés a dormir por la noche.

Cereales son comidas sólidas. Ofreciendo el alimento demasiado temprano no es saludable para su bebé. También el estómago solamente es el tamaño del puño. No puedo contener mucha comida. Por esto necesita comer con más frecuencia. Como su bebé crece, va a dormir más tiempo.

Comida que nunca debe comer su bebé:

- Soda
- Dulces
- Palomitas
- Uvas pasas
- Perritos calientes
- Papas y patatas fritas
- Nueces
- Leche de vaca (antes de un año)
- Sal, azúcar, ni especias añadidos
- Uvas enteras

Hable con el médico sobre lo que puede comer su bebé si tiene historia familiar de alergias.

Las mejores maneras de introducirle la comida a su bebé

- Amamante y después se lo ofrezca un poco de cereal. Esto mantiene el suministro de leche materna.
- Mantenga el horario de lactancia mientras añade la comida.
- Ofrezca la comida a su bebé cuando hay pocas distracciones.
- Nunca dé cereales u otro tipo de comida por el biberón.
- Empieza con comida lisa y sin grumos. Será más fácil para tragar. Añada textura lentamente como se vaya acostumbrándose.
- Ofrezca la comida del plato o tazón, no le de un tarro. La comida que queda en el tarro estropeará rápidamente a causa de la saliva.
- Dé la comida a su bebé cuando come la familia. Por eso probará comida nueva.
- No le fuerce a comer a su bebé. Comerá si no está forzado.
- Dé sola 2-4 onzas de jugo al día. Demasiado jugo es malo.
- Ofrezca una comida nueva cada unos días. Por eso puede notar si tiene alergias a una comida particular.

Una publicación de la Asociación Internacional Consultora de la Lactancia



LA LACTANCIA EXCLUSIVA... LA LECHE MATERNA = NIÑO SALUDABLE

¿Qué es “lactancia exclusiva”? Cuando amamanta exclusivamente su bebé... no tome nada de agua, fórmula ni jugo.

Los beneficios de la lactancia exclusiva: Menor riesgo de infecciones del oído, infecciones pulmonares, problemas de la piel, enfermedades estomacales, y el síndrome de la muerte súbita en lactantes (SMSL). También los estudios muestran que los bebés quienes son amamantados exclusivamente tienen menor riesgo de la obesidad infantil y tener sobrepeso.

Mientras Ud. amamanta **MÁS TIEMPO** su bebé recibe más protección contra el sobrepeso.

Muchos estudios muestran que la protección contra el sobrepeso dura por la edad adulta. Los estudios más recientes muestran que la probabilidad de tener sobrepeso es 15% hasta 30% menos si el bebé amamanta exclusivamente.

¿Sabe que la flora del estómago (bacteria normal) es diferente entre el bebé quien amamanta exclusivamente y el bebé quien recibe alguna o toda fórmula? Sólo los bebés quienes amamantan pueden recibir IgA – una inmunoglobulina que protege al estómago y tracto intestinal.

¿Dónde puede recibir información sobre la lactancia exclusiva o ayuda si tiene preguntas o problemas con la lactancia?

La Clínica Pediátrica de Arkansas del Noroeste (NWAPC):
Consultora de Lactación/APN: Allison Scott **479-442-7322**; elija la lactancia materna y deje un mensaje.

Departamento de Salud de Arkansas; Línea de la Lactancia Materna: **1-800-445-6175**;
8:00-4:30 Lunes-Viernes

La Liga Internacional de La Leche: **1-800-525-3243**; <http://www.lalecheleague.org>

La Oficina de WIC de Washington County: **479-927-3667**

El Hospital de Willow Creek: **479-684-3000**

Departamento de Salud y Servicios Humanos; La Oficina de La Lactancia Materna: **1-800-994-WOMAN** o <http://www.4woman.gov/Breastfeeding/index.htm>

Centro de Recurso de Lactancia Materna de Bright Future, Ltd: <http://www.bflrc.info>