

BREASTFEEDING DECISIONS AMONG LOWER SOCIOECONOMIC HISPANIC WOMEN IN ANCHORAGE, ALASKA: THE NEED FOR A HOLISTIC PERSPECTIVE

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ABSTRACT

The purpose of this study was to answer the question: What are the factors that influence the initiation and maintenance of decision to breastfeed among lower socioeconomic level Hispanic women in Anchorage? Hispanic culture is rightly considered a breastfeeding culture. However, numerous researchers have shown that Hispanic women in the U.S. have different breastfeeding patterns compared to women in their home countries. This pilot study examines this complex issue among primarily immigrant Hispanic mothers in Anchorage. It attempts to understand the experiences of breastfeeding among a nonrandom sample of twenty Hispanic mothers via grounded theory. It argues that to successfully promote breastfeeding of infants among this population beyond six months requires education for health care professionals, for breastfeeding promotion organizations, and for Hispanic mothers. This education must holistically address the medical/biological, cultural, linguistic, socioeconomic, and emotional challenges of breastfeeding among this vulnerable group of Hispanic mothers.

KEYWORDS: infant nutrition, Hispanic mothers, Alaska

INTRODUCTION

The research question and findings of this pilot study regarding breastfeeding decisions among lower-income Hispanic mothers in Anchorage are first contextualized regarding breastfeeding data in the U.S. and Alaska.¹ Then a brief overview of the breastfeeding culture among Hispanic populations is presented. Finally, the findings are presented and recommendations provided regarding breastfeeding behaviors, issues, and problems among the study population.

A CRITICAL PERSPECTIVE: THE POLITICS OF BREASTFEEDING IN THE U.S.

It was only as recently as February 14, 2003, that the U.S. Senate passed Bill S.418 to amend the Civil Rights Act of 1964 to clearly define breastfeeding as “the feeding of a child directly from the breast or the expression of milk from the breast by a lactating woman.” The promotion of breastfeeding programs was authorized by Public Law 89-642, known as the Child Nutrition Act of 1966. Section

1. This paper is derived from the author's master's thesis, 2006, in the Department of Anthropology, University of Alaska Anchorage. An earlier version was presented at the meetings of the Society for Applied Anthropology, Vancouver, B.C., in 2006. The author also holds an M.D. degree from Colombia. The author wishes to thank the Anchorage Neighborhood Health Center and Providence Family Medical Center for allowing this study to occur with volunteer mothers from their programs. In addition, the author acknowledges the assistance of the faculty and her fellow graduate students in the Department of Anthropology at the University of Alaska Anchorage, particularly her thesis committee members: Professor Kerry Feldman (chair), Professor Stephen J. Langdon, and Professor David Yesner. The opinions expressed, however, are her own.

21 of this act states that the secretary of agriculture shall establish a breastfeeding promotion program to promote it as the best method of infant nutrition, foster wider public acceptance of breastfeeding in the U.S., and assist in the distribution of breastfeeding equipment to breastfeeding women. As part of the “war on poverty” of the 1960s, some programs such as food stamps were reoriented and new food assistance programs were developed. It is in this social and political context that the special Supplemental Nutrition for Women, Infants, and Children (WIC) program was created (Berry 1984; Fitchen 2000; Leonard 1994) in 1972 by the federal government. WIC’s mission is to safeguard the health of low-income women, infants, and children up to age five who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care. More information and critical analysis of the WIC program in Anchorage will be presented later.

During the 1970s and into the 1980s, when baby formula companies were losing markets in North America and Europe because mothers were shifting back to breastfeeding, they started promoting bottle-feeding and baby formula food in Africa, Latin America, and Southeast Asia. Companies were alleged to have used seductive advertising and promotional incentives to encourage doctors and departments of health to support the use of their products. The advertising associated this style of feeding with “modernity” and “prosperity,” thus inducing unsuspecting and illiterate impoverished mothers to associate their families’ well-being with the use of formula food. International protests against the Nestle company began in 1977. With help from the World Health Organization (WHO) and the United Nations International Children’s Education Fund (UNICEF), this effort culminated in a set of regulations ensuring the ethical promotion of such products. These regulations are known as the International Code of Marketing of Breast Milk Substitutes. All countries signed the convention except the U.S., which argued that deregulation would negatively affect American companies economically (Ervin 2000; International Baby Food Action Network 1999; Van Esterik 1997). The implementation and promotion of this code is through the International Baby Food Action Network (IBFAN) and it is the product of WHO and UNICEF working together on infant and young child feeding policies. The International Code aims to protect all mothers and babies from inappropriate company marketing practices. It bans all promotion of breast milk substitutes, bottles, and teats. It aims to ensure that

mothers receive accurate information from health workers. Subsequent resolutions of the World Health Assembly have clarified and amplified the International Code.

The U.S. recognized the importance of breastfeeding by signing the Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding which was adopted by WHO and UNICEF (U.S. Department of Health and Human Services 2000). As a result of national and international attention brought to this issue, the State of Alaska approved a law (Senate Bill 297) in 1998 stating that breastfeeding did not constitute “indecent exposure” or other similar offenses in any public or private location.

BREASTFEEDING IN ALASKA

Alaska has one of the highest breastfeeding rates in the nation. The states with the highest breastfeeding initiation rates are Oregon (88.6%), Alaska (88.5%), Utah (88.2%), and Washington (87.9%), and the states with the highest breastfeeding rates four weeks after birth are Utah (79%), Alaska (78%), and Washington (75%). However, the average duration of breastfeeding in Alaska was only 11.2 weeks, which falls very short of the 12 months recommended by the American Academy of Pediatrics. Moreover, the average infant’s age at first dietary supplementation was as early as six weeks (Carothers and Cox 2003; Perham-Hester 2003; U.S. Department of Health and Human Services 2000).

Alaska statistics (as of 1999) of breastfeeding initiation by ethnicity show that 95% of Hispanic mothers and 88% of non-Hispanic mothers initiate breastfeeding (Alaska Department of Health and Social Services Division of Public Health 2002). Breastfeeding initiation rates in both the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and general Alaska populations currently exceed the U.S. Healthy People 2010 targets. However, mothers in the U.S.-funded WIC program had duration rates at six months decreasing from 58.4% in 2001 to 48.3% in 2003, which is below the 50% target goal (WIC 2004).

Several reports have shown that even after the efforts of government programs such as WIC and of private pro-breastfeeding organizations such as the La Leche League (none of the mothers in this study consulted La Leche League), initiation breastfeeding rates have increased but do not have the expected results. One of the reasons for these results could be that the breastfeeding decision is not addressed as a complex process. The decision of whether

to bottle or breastfeed is often presented in the literature as being primarily based on nutritional and economic issues, and the breastfeeding promotion campaigns often focus on general education rather than including a cultural or ethnic focus (Dettwyler and Fishman 1992). This approach tends to ignore breastfeeding as more than a simple and natural process that flows from our human biological status as mammals. Breastfeeding is actually a highly culturized behavior that can be modified by cultural perception (De-Bocanegra 1998; Denman-Vitale and Krants-Murrillo 1999; Kannan et al. 1999; Libbus 2000; Rassin et al. 1994; Sweeney and Gulino 1987; Van Esterik 2002). Medical researchers have often or usually ignored the cultural and ethnic variation of humans in favor of an abstract "human being" experiencing a health challenge.

The factors influencing a woman's choice of feeding method are complex and varied. Factors in her home and family environment, social, cultural, and socioeconomic influences, her knowledge and educational background, and the quality of her contact with health professionals all contribute to the multidimensional nature of her infant feeding decision (Kannan et al. 1999; Rassin et al. 1994; Sweeney and Gulino 1987).

THE HISPANIC POPULATION IN ALASKA

According to the 2002 Alaska Department of Labor and Workforce Development, the Hispanic population in Alaska in the 1990 census was 17,803, which represented 3.2% of the Alaska population. In the 2000 census, it was 22,160, which represented 3.5%, and the 2002 estimate for the Hispanic population was 26,751, which represented 4.2 % of the Alaska population (Burnham 2004). As the numbers above indicate, the Hispanic population in Alaska was estimated to have increased by 8,948 (50.2%) in the twelve years between 1990 and 2002. This is an extraordinary growth rate.

Anchorage is home to more than half of the Hispanic population of Alaska. Over 75% of Hispanic persons living in Alaska are under forty years of age. According to the Alaska Bureau of Vital Statistics, there were 29,864 births to Alaskans for the three-year period of 1998 through 2000. Approximately 6% of these births were to Hispanic mothers, which is a higher rate than the percentage of the Alaska population comprised of Hispanics.

BREASTFEEDING AMONG HISPANIC POPULATIONS

Hispanic cultures are considered to be breastfeeding cultures. However, initiation and duration of breastfeeding rates can vary very widely by country of origin (Libbus 2000). Breastfeeding behaviors in these countries are influenced by the same factors described in other cultures such as education level, urban versus rural residence, economic status, and contact with modern health care systems (Pérez-Escamilla 1993). At present, breastfeeding is a general health concern in Latin American countries because breastfeeding initiation and maintenance rates have decreased. This situation has a major impact on child health due to the fact that developing countries sometimes have nonpotable water supplies and inadequate sewage systems and waste treatment facilities. The risk of gastrointestinal and infectious diseases increases, and they are the major causes of mortality in infants and children. Statistics published by UNICEF in Latin America show that in general breastfeeding initiation is about 95% after giving birth and continues to six months at a 50% rate (www.unicef.org/infobycountry/latinamerica.html).

There are two important values in the UNICEF information:

1. the duration of the breastfeeding can range from six months in Brazil or Paraguay, twelve months in Colombia and Mexico, to twenty-four months in Bolivia and Peru; and
2. the weaning process is very early, around four months. Therefore, exclusive breastfeeding could be considered short in duration. However, the duration of breastfeeding is about one year.

There are several studies (Espinoza 2002; González et al. 2002; González-Méndez and Pileta-Romero 2002; Pérez-Escamilla 1993; Pérez-Escamilla et al. 1993) that show the following factors as important in the breastfeeding decision among Hispanic women in their countries:

- the economic advantages of breastfeeding;
- women who live in a home where the head of household is her partner tend to breastfeed less than women living in a home where the head of household is another woman or the mother; and
- girls seem to be favored by a longer period of breastfeeding. "This has been suggested to reflect the belief that a male child's growing process demands more food" (Espinoza 2002).

Possible reasons for decreasing breastfeeding rates are the increasing number of women joining the labor force and heading households. There are also three cultural beliefs specific to Hispanic women and their breastfeeding practices (Weller and Dungy 1986):

1. Emotions from the mother are transmitted to the baby via breast milk such as anger and it can do damage to the baby;
2. the baby “eats” a part of the mother, and thus women “waste themselves” (deteriorate and age faster by breastfeeding); and
3. a pregnant woman must stop breastfeeding because her milk produces diarrhea in the baby.

BREASTFEEDING RATES IN THE U.S. AND ALASKA

Breastfeeding rates in the U.S. have increased; however, breastfeeding remains relatively low among certain ethnic populations and lower-income groups (Ahluwalia et al. 2005). The profile of mothers with low breastfeeding rates has been described as younger women, with limited socioeconomic resources, with a low education level, employed full-time, and with low self-esteem (Ahluwalia et al. 2005; Carothers and Cox 2003). Hispanic women have a good initiation rate in the U.S. but it declines before six months.

Table 1 below provides the initiation and duration rates of breastfeeding in Alaska, comparing all infants with WIC mothers' infants. Alaska has one of the highest rates of breastfeeding initiation (87.4%) (Abbott Laboratories Ross Products Division 2003). This percentage exceeds the Healthy People 2010 target, which is 75%.

The WIC population has a very good initiation rate. Breastfeeding rates at six months increased but in 2001 and

2002 this rate decreased. Breastfeeding at twelve months, as at six months, decreased. Surprisingly, breastfeeding rates, both initiation and continuation for at least four weeks postpartum, were lower among WIC and Medicaid mothers compared to non-WIC and non-Medicaid clients (Abbott Laboratories Ross Products Division 2003). This result seems counterintuitive: why do mothers in federal programs devoted to improved nutrition for mothers and infants from low economic households breastfeed less than other mothers? The research reported in this paper identifies the complex factors involved.

In terms of ethnic variation in breastfeeding initiation and duration in Alaska, White mothers are more likely to initiate and continue breastfeeding than Alaska Native mothers, and they continue breastfeeding for more than six months at a higher rate than Asian/Pacific Islander mothers. Black women have the lowest breastfeeding initiation rates, not only in Alaska but also in all of the U.S. What is of specific concern for my research is that Hispanic mothers have lower percentages than the combined non-Hispanic mothers. Only 80.6% of Hispanic mothers in Alaska initiate breastfeeding and only 71.4% continue it at four weeks postpartum, whereas 91.3% of non-Hispanic mothers initiate and 80.1% continue breastfeeding at four weeks (Perham-Hester et al. 2004).

RESEARCH METHODS FOR THIS PILOT STUDY

RESEARCH GOALS AND DESIGN

This research attempted to understand the experiences in breastfeeding among a specific group of Hispanic mothers in Anchorage and the implications of these experiences related to their decision to breastfeed their babies or not and how they maintained this decision throughout the first six months after the baby was born. It concerns the perceptions, thoughts, and feelings about the breastfeeding process among low-income Hispanic women participating in the WIC program. To accomplish the goal of the research, a descriptive nonrandomized study design was used, utilizing quantitative and qualitative data (however, with a sample of only twenty mothers, statistical arguments cannot be offered). The sample for this research was comprised of twenty Hispanic mothers, two physicians who provide service to these mothers, and three nutritionists from the WIC program. The mothers were divided into two groups, differing in regard to how long they breastfed

Table 1. Alaska breastfeeding rates at initiation and six months postpartum

	1993	2000	2001	2002
Initiation Rates				
All Infants: Alaska	76.7%	88.5%	88.3%	87.4%
WIC Infants: Alaska	49.7%	82.8%	84.6%	82.2%
At Six Months Postpartum				
All Infants: Alaska	31.3%	50.2%	50.8%	50.2%
WIC Infants: Alaska	23.1%	47.2%	46.2%	41.7%

Source: Mother Survey, Abbott Laboratories, Ross Products Division, 2003. http://www.ross.com/images/library/bf_trends_2002.pdf

their infants. Group A ($n = 10$) had these characteristics: Last child six to twenty-four months old; breastfed or has been breastfeeding the last child for six months or longer; a participant in the WIC program; a Hispanic mother; able to read Spanish or English; of age eighteen or older. Group B mothers ($n = 10$) were different only in that they breastfed their last child for three months or less (breastfeeding had already stopped). This study attempted to understand what might explain the differences between the breastfeeding durations of these two groups.

DEFINITIONS OF TERMS, RECRUITMENT, INFORMED CONSENT, AND INSTRUMENTS

A mother was considered Hispanic if she or her mother was born and raised in a Spanish-speaking country. This sample was not chosen at random because the expected population of immigrant Hispanic mothers available for the study is difficult to identify in terms of a numerical universe of possible subjects. The invitation to participate in the project depended on at which WIC office the mother was registered: Anchorage Neighborhood Health Center or Providence Family Medical Center. On a weekly basis the list of appointments was reviewed at one of these two local WIC programs. Mothers were selected who met the profile for the research project. A mother was then directly called (no messages were left on answering machines or with third persons) and asked if she was interested in participating in this project. The interview was scheduled immediately before or after her WIC appointment in order to avoid requiring the mother to make another visit to the WIC office. At the Providence Medical Center WIC office, the mothers were contacted through a posted flyer in which the project was explained. If the mother was interested in participating, she signed the consent form and then the researcher contacted her. All mothers received a fifteen-dollar thank you stipend after the interview.

A consent form for mothers was provided in Spanish or English; the mothers decided which language version to use. Participant confidentiality and voluntary participation was assured. This project received approval from two institutional review boards: from the University of Alaska Anchorage and Providence Health System. Other consent forms were given to health care or social service providers who participated.

Data were collected in three WIC offices. Providence Family Medical Center and Anchorage Neighborhood Health Center WIC offices were selected because their

Hispanic clients were significant, and the third was the Providence Hospital Medical Center WIC office because it had clients with different demographic profiles. The mothers were interviewed in two WIC offices: Anchorage Neighborhood Health Center and Providence Family Medical Center. The mothers from Providence Medical Center were interviewed in Providence Medical Center because there was no private place available for the interviews.

DATA COLLECTION INSTRUMENTS

The research included a written questionnaire and a personal interview focusing on the following question areas.

- How did these Hispanic women make their decisions about breastfeeding their babies?
- How was that decision maintained during their babies' first six months?
What kinds of supports did they receive from their social networks: primary social units (primary social units are based on kin ties and domestic groups), social units based on common residence (neighborhood), groups based on common culture of origin (Hispanic community), groups based on religious belief systems, and groups based on common work (employment supervisor and co-workers)?
- What kind of knowledge did the Hispanic women have about the benefits of breastfeeding?
- What were their perceptions of social norms about breastfeeding, including breastfeeding in public or in the workplace?
- What did they think was/were the purpose(s) of a woman's breasts?
- How did breastfeeding interfere with other aspects of their roles as women?

The health providers included a physician, two dietitians, one prenatal program assistant, one social worker, and one WIC coordinator. The interviews were made by the researcher and the mother in a closed room. Some mothers were accompanied by their partners and children. Sixteen questionnaires were completed in Spanish and four in English. Ten mothers were from Providence Family Medical Center, nine mothers from the Anchorage Neighborhood Health Center, and one mother from Providence Alaska Hospital Center.

Quantitative and qualitative analyses were applied to the research data. The questionnaire information was analyzed with descriptive statistics of demographic data, and a grounded theory analysis was applied to the qualitative

data (Bernard 2002; Kearney et al. 1994; Punch 1998, 2000). Due to limitations of space, this paper will describe the results of the study and direct the reader to the complete data summaries in my thesis (Marín Carrillo 2006), upon which the results presented here are based. Because this pilot study was aimed at a holistic understanding and identification of factors related to breastfeeding decisions, relying primarily on the self-reports of mothers, rather than on a statistical factor-analysis explanation, emphasis will be on statements from mothers and direct quotes that illustrate the mothers' views.

STUDY SAMPLE CHARACTERISTICS

The characteristics of the mothers in this study were the following.

- All were in the WIC program, which implies a low to very low household income.
- 75% (n = 15) did not have any medical insurance.
- 70% (n = 14) did not receive food stamps.
- 75% (n = 15) could not speak English.
- 80% (n = 16) did not have their extended family in Alaska.
- 60% (n = 14) did not have a formal job.
- 85% (n = 17) had early breastfeeding contact.
- 65% (n = 13) had some breastfeeding education.
- 65% (n = 13) had a normal delivery.
- 50% (n = 10) had medical conditions resulting from breastfeeding.

BREASTFEEDING AMONG HISPANIC MOTHERS IN ANCHORAGE

All of the mothers in this study planned on breastfeeding their babies in accord with traditional Hispanic cultural practice, but half of them breastfed less than six months due to biological/medical problems, social factors, and/or cultural beliefs. These are complex factors, often interconnected, and probably not even a very well-funded, comprehensive survey research project using factor analysis would be able to tease out the most meaningful hierarchy of problems/factors/cultural beliefs such that public health education of Hispanic mothers and health care or nutritional providers would know how or where to focus most attention. What will be argued in this paper is that individuals and agencies interested in improving the breastfeeding success of Hispanic mothers must be aware of all

of these factors, even though it is not possible at present to identify which among them is most important. That is, besides being "Hispanic," each mother is an individual, with her unique history, home and sociocultural environment. An emic understanding of cause/consequence and situation leads to an awareness that breastfeeding is not simply the decision of an individual mother. A holistic understanding of the local social context, of service agency culture and practice, and of healthcare provider maternal care assumptions and practices are also needed to improve the breastfeeding success rates among this group (and this is probably true, also, for other ethnic groups in Anchorage or elsewhere in the U.S.). A qualitative understanding of breastfeeding from the perspectives of the mothers provides the foundation for my conclusions.

INITIAL DECISION TO BREASTFEED

All mothers in this study initially made the decision to breastfeed their children. Fourteen mothers made the decision before getting pregnant and related the decision to previous experiences in their family and home countries. These participants found that witnessing other women breastfeeding made them feel comfortable and confident with the act of breastfeeding. One mother stated:

I always knew that I would like to breastfeed my babies. I wanted to breastfeed for at least one year. I breastfed my first baby for thirteen months and with my second baby, I have been breastfeeding for seven months so far.

Another participant related:

I really did not think whether or not I would breastfeed my baby; I knew I would do it because my mom, my aunts, my sisters, and other women in my family had breastfed their babies. I have always believed that breastfeeding is the normal way to feed babies; for me formula was not an option. Breastfeeding is normal and common in my home town and in my country. I remember in my hometown seeing women sitting on the steps of the church and breastfeed their children or in the farmer's market and nobody would stare at them. It was a very common event.

Seventy-five percent of the mothers of this study reported that their mothers were the most important person in their breastfeeding decision. For example:

For me, the most important support in breastfeeding has been my mother. She and I are very close,

and she always talked to me about how important breastfeeding was.

BIOLOGICAL/MEDICAL FACTORS

All mothers in this study believed that breastfeeding was superior to bottles and formula. However, some of the mothers did not know that breast milk contained antibodies and immunological substances to protect their babies against some illnesses and that breast milk is easily digested and nutritionally correct. Even the mothers that started formula before two weeks described the emotional feeling of connectedness as the best part of breastfeeding. Even the mother who breastfed for only one week stated:

There is nothing like holding the baby and having them looking up at you with those eyes. There is no bottle stuck to their mouth and you are like, yeah, it's cool, really cool.

When asked why she quit if breastfeeding was a very good emotional experience, she replied:

Because it was so painful for me; my sore nipples and bleeding nipples were very bad.

A significant biological factor referred to as the "let-down" reflex (Lawrence 1999) played a role in some of the discontinuance of breastfeeding due to pain experienced by the mother. This reflex is a neurohormonal response produced by stimulation of the nipple during breastfeeding, resulting in the flow of milk from milk-secreting cells in the breast tissue to the baby's mouth. It is considered to be a universal response, even if a woman is unaware of this occurrence. However, let-down is not governed by the hormonal response alone but is also affected by physiological factors. Women who chose to breastfeed may find themselves confronting a barrage of new sensations and emotions for which they are unprepared, such as the sensation in the let-down reflex. Some women find the let-down reflex very painful and describe red-hot wires brushing their nipples. This reflex not only is important in the first days after a baby is born but also during a breastfeeding because the let-down reflex always occurs when nursing the baby (Lawrence 1999). The let-down reflex is described by some mothers to be very painful, as in the case of this mother:

My milk was down three days after my baby was born, I had pain and a fever. It was terrible but after that, everything was okay.

However, let-down can be viewed by a mother as a normal event, as with this mother:

The breasts are there and they are not doing anything, while breastfeeding they are there and they have to work, so it is normal to have a little pain.

The let-down reflex is a very important issue in breastfeeding. It has been the reason why many mothers abandon breastfeeding: it is painful, it is unpredictable, and it can be present when the mother is not ready to breastfeed, causing an embarrassing situation. The let-down reflex has been related to the insufficient milk syndrome, which this study found to be the most common reason given for abandoning breastfeeding.

SOCIAL FACTORS RELATED TO BREASTFEEDING

There are many social factors that one should examine in relation to a Hispanic mother's breastfeeding decisions. These social factors include how long she has resided in Anchorage, her marital status and whether she is the head of a household, her income level, education profile, English speaking ability, age, employment status, whether she has health insurance or participates in federal/state programs for lower socioeconomic households, her legal status in the U.S. (which determines the federal or state programs for which she might be qualified), and her social networks—especially those with relatives and other women who might provide support needed in relation to breastfeeding. Also important is the mother's concern about social disapproval in the U.S. for public breastfeeding. Thirteen of the twenty mothers noted that they considered breastfeeding in public places as a major issue. One mother said:

My breastfeeding period was a short time; therefore, I did not have many opportunities to breastfeed in a public place. However, I was worried about it because I am very shy person.

Another mother explained:

To breastfeed in public places is very hard. People sometimes give me unfriendly looks, but I've got to feed my baby regardless.

In this sample of Hispanic mothers, there was little to no impact that could be identified regarding breastfeeding decisions influenced by friends, co-workers, and employers. However, mothers less than twenty-five years of age breastfed less than older mothers. Being employed

was not a noticeable factor in breastfeeding cessation decisions (at-home mothers breastfed even less than employed mothers), nor was the length of time mothers resided in Anchorage a distinguishing factor. I will not comment on the question of legal status of my sample because I did not ask about it, in that I thought it would be unethical to do so and would have precluded obtaining research volunteers from this at-risk population. The social networks of these mothers were quite limited. For some mothers the only family and social support was the baby's father. The baby's father support was ambiguous in terms of behaviors supporting breastfeeding for half of these mothers. More significantly, fourteen of the twenty mothers lacked fluency in speaking and understanding English, whether spoken or written. The mothers received little formal breastfeeding education from health care providers or agencies, and never in Spanish.² Six (30%) of the twenty mothers did not receive any education from WIC or healthcare providers about breastfeeding. This seems due to the lack of Spanish speaking personnel in doctor's offices, hospitals, federal, state or private agencies, and little awareness among the above of the importance of communicating in Spanish with immigrant Hispanic mothers who lack proficiency in English. Fourteen mothers did not have medical or dental insurance; they could have been eligible due to income level for Medicaid benefits, Denali KidCare program, help through the State Child Health Insurance Program (SCHIP) and food stamps but were not enrolled in the above programs (legal status concerns?). It is common for these immigrant parents not to apply for various aid programs because the lawyers working in their immigration process recommend that they not accept public aid that might be perceived as a burden on the state. This burden could be a negative factor when the parents' immigration status is determined. Regarding the variables of living with the baby's father, being the head of the house, and mother's marital status, a direct relation with breastfeeding was not found, even though other studies have found that married women tend to breastfeed and maintain breastfeeding for a longer time than single mothers and that the father's approval is a significant factor in the decision and maintenance of breastfeeding (Espinoza 2002; Korenman et al. 2002; Littman et al. 1994).

CULTURAL BELIEFS HINDERING BREASTFEEDING

Cultural beliefs among Hispanic cultures (Arguijo Martínez 1978) that hindered breastfeeding were expressed by some of the mothers related to becoming pregnant while nursing another child, multiple births (twins etc.), the belief that boys are stronger than girls, and premature births. One mother who became pregnant while nursing an infant stated:

My mom, who lives in Mexico, told me, because I was pregnant again, I had to stop breastfeeding. My milk would produce diarrhea to my baby.

Another mother who became pregnant while nursing said:

I stopped breastfeeding my first daughter because I was pregnant again. In my country it is said that the mother have to stop because her milk is not good anymore for the baby. But now I am pregnant again and WIC told me to continue breastfeeding since there is no problem for my second daughter.

Differences regarding perceptions of infant gender are illustrated by this mother who explained:

Some women told me that breastfeeding was painful; of course it was, but not too much. The breasts are there and they are not doing anything, while breastfeeding they have to work, so it is normal to have a little pain. With this baby, who is a boy, I feel more pain than with my daughter. This is because boys are stronger than girls.

A mother who stopped breastfeeding during the first month gave as a reason having had a set of premature twin babies. She stated:

My babies were born premature and they were in the NICU for two weeks. I tried to breastfeed them but it was very hard. Therefore, I decided to start formula when they were one month old.

Another mother who had a premature delivery continued offering breast milk to the baby until the infant began sucking. Breastfeeding twins and triplets has been documented and mothers can provide adequate nourishment for more than one infant (Lawrence 1999). The key in this case is education about how to do it.

In western societies, women's bodies are generally viewed as sexual objects. Breasts are viewed as objects of

2. In 2007 the WIC office at the Anchorage Neighborhood Health Center added a person in their education program who speaks Spanish.

sexual pleasure for men rather than organs to feed a baby (Beasley 1998; Dettwyler and Fishman 1992; Marchand-Lucas and Castro 2000). Marchand-Lucas and Castro (2000) stated that cross-culturally the duration of breastfeeding is inversely related to the strength of the breast as a sexual object. The image of the ultra-thin woman with attractive breasts has come to stand for beauty, sexiness, and success as women and this image has been considered to be a possible negative breastfeeding influence (Dettwyler and Fishman 1992). Six mothers in this sample showed concern with their weight, and they were very careful about their diets; one mother stated:

Yes, I am concerned about my weight. I like to look good. If a mother breastfeeds her baby and only eats nutritional food, she will have her normal weight.

Twelve mothers were overweight, and some of them were concerned about that. One said:

Yes, I am worried about my weight, because after my first baby I ended up fat, and right now, I am pregnant again. I do not know how I would control my overweight. No, my husband does not say anything about me being overweight, but I do not want to be fat.

Others were not worried about weight and one of them stated:

If I am overweight or my breasts sagged, it is no big deal for me. In addition, people always change with time, so what is the problem?

It should be noted that for some health care providers interviewed in this study, six months of breastfeeding meant a successful breastfeeding process. However, for the mothers the concept of success of their breastfeeding process is not related to time. On the contrary, in this study, 75% of the mothers (n = 15) felt that their breastfeeding process was successful because they were able to provide health and a stimulating connectedness to their children through the process of breastfeeding, independent of the temporal duration of breastfeeding over time.

ADDITIONAL ISSUES: USING WIC FOOD VOUCHERS

One might not consider that there could be negative experiences of the mothers using WIC vouchers, such as that reported below. One mother explained:

You know why some women feel embarrassed to use the WIC vouchers? Now I know why. Last week I was in a grocery store and the woman in front of me wanted to use a WIC voucher, but the cashier reprimanded her for mixing her own groceries with the WIC groceries. This woman did not speak English, so I talked to the cashier and the manager. I told them it was not this woman's fault that the cashier had to use two different systems for the WIC products. I told the mother that she should tell WIC about this because it was probably a common occurrence.

The ability of a woman to continue breastfeeding contrary to pressures from a coworker to discontinue the effort is revealed in the following mother's statement. She is the head of the household, with a low household income, low education level, and works full time. However, she is one of the mothers with the longest breastfeeding period (thirteen months). She stated:

I believe that breastfeeding is the normal way to feed babies. Yes, I do, I breastfeed my daughter. I have two daughters. I am practically alone since my partner (second partner) visits us once every two months for two or three days. I work full time, and my daughter is fed with breast milk and soup. I work in a restaurant; my boss supports me in my decision to breastfeed. Sometimes it is not possible to pump because the restaurant is full and I cannot be absent for fifteen minutes. I have one or two days off per week. When I am off from work, my daughter is sucking all the time. It is good for my milk production. One of my coworkers, who is American, asked me "Why do you breast feed your baby if there are so many good formulas?" My coworker also said "It is gross."

ANALYSIS AND DISCUSSION

Prior to my graduate studies in cultural (including medical anthropology), archaeological, and biological anthropology, I had been exposed almost exclusively, in relation to health issues, to the biomedical course work offered at a medical school in my home country of Colombia. I was not sufficiently aware of the class-based nature of pregnancy and birthing, of the cultural complexities surrounding this most fundamental human experience, and of the usefulness of a critical approach in assessing a nation's health care system. I focused on my patients as individuals, trying to motivate and educate them as individuals to take more

active roles in their own health care challenges. It is now clear to me that only a holistic approach to health issues, especially breastfeeding, can have a lasting and significant impact on creating more healthy populations. The factors influencing breastfeeding cessation in this study included medical, cultural, socioeconomic, and emotional factors.

A visual summary of the factors related to the decision to end breastfeeding is presented below in Figure 1. I included acculturation and depression as factors although considerations of space for this paper precluded further discussion of those two factors. Note that insufficient milk, or the perception of this syndrome by the mother, results from all lines of causation. If the mother perceived real or imagined insufficient breast milk for the baby, formula feeding commenced. Most of the factors are open to influence from a holistically envisioned program to improve breastfeeding duration among this population.

A holistic understanding of the above factors, which includes the systemic interactions of mothers with the medical-legal-service agencies related to breastfeeding, is provided in Figure 2 below. Note that I include baby formula companies because they are subject to review by the U.S. Department of Agriculture, and the latter has oversight of the WIC program. The most reliable and widely used statistics about breastfeeding in the U.S. are, interestingly, provided by a leading baby formula company.

EDUCATIONAL RECOMMENDATIONS

The mothers in this study desired to breast-feed their babies, but some of them quit early because of biological/medical problems, social issues, or cultural beliefs. These problems could be addressed and minimized through education programs. However, the education programs must be tailored to meet the needs of these mothers, not only about the art of breastfeeding, the scientific understanding of breast milk and a baby's nutritional needs, but also about resources that exist locally.

Education programs for nurses, doctors, and public health officials, as well as information made available to Hispanic mothers, must be focused on:

- the art of breastfeeding and the nutritional facts regarding breast milk and an infant's nutritional needs;
- how medical and social/bureaucratic phenomena "work" in the U.S. and Alaska and ways families might adapt/adjust to those new conditions;
- community services available to mothers;
- legislation related to breastfeeding, immigration, and labor; and
- because fathers have been identified as the main source of social and emotional support for many breastfeeding women in Anchorage, prenatal breastfeeding education must include the father of the baby. The fathers need the same basic breastfeeding information that their partners receive.

The challenges in implementing these recommendations are: Hispanic women are fearful regarding many things such as economic success of the family, unfamiliar social situations, legal immigration issues, and loss of self-esteem. All these factors make them vulnerable. As a result they do not trust others easily. Gaining their trust must be the first step.

Any breastfeeding campaign among Hispanic women in Anchorage (and maybe elsewhere in the U.S.) must address:

- How to mount a convincing educational effort among the fathers? They need to actively support their spouse's decision to breastfeed because Hispanic mothers are

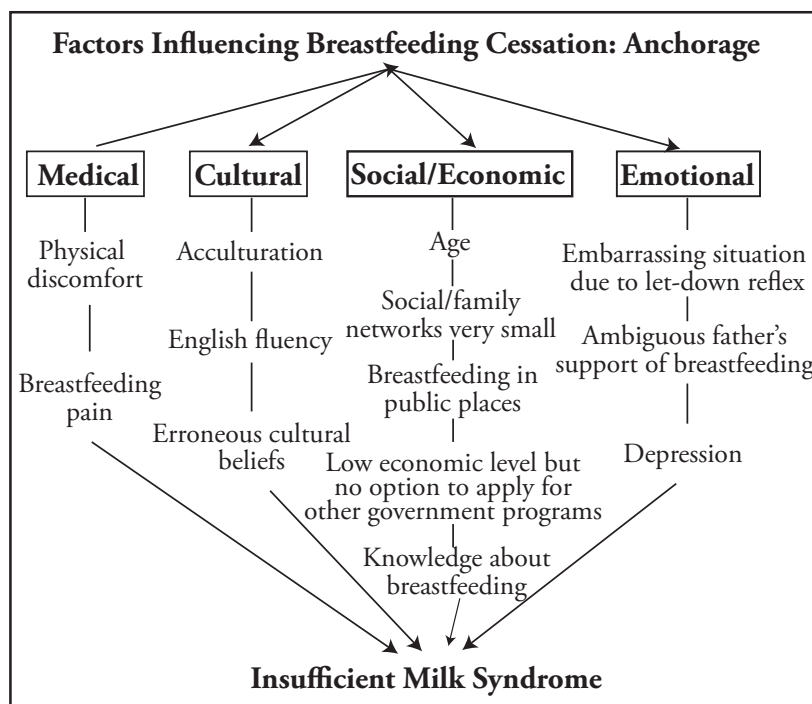


Figure 1. Factors influencing breastfeeding cessation

expected to take care of the babies while the fathers work outside of the home.

- The transportation problems that lower socioeconomic Hispanic women experience regarding attendance at any breastfeeding educational or related programs.
- Agencies such as WIC, whose goal is a nutritionally well-fed mother thus enabled to provide nutritious breast milk to an infant, must critically evaluate their process of educational interaction with Hispanic clients; professionally trained, Spanish-speaking nutritional advisors must be used for Hispanic mothers.
- A final recommendation, based on information from women in this study, is that any education program must be addressed within a Hispanic context and be provided in Spanish when requested by the mother.

CONCLUDING REMARKS

It was a privilege to work with this group of Hispanic mothers regarding breastfeeding issues and challenges in their lives. Likewise, I was privileged to work with the highly devoted and professional staff of the programs noted above. My suggestions for improving breastfeeding among Hispanic women should in no way lessen the appreciation for the exceptional health and social services they provide, day by day, to Hispanic and other low-income immigrant people who now call Anchorage home.

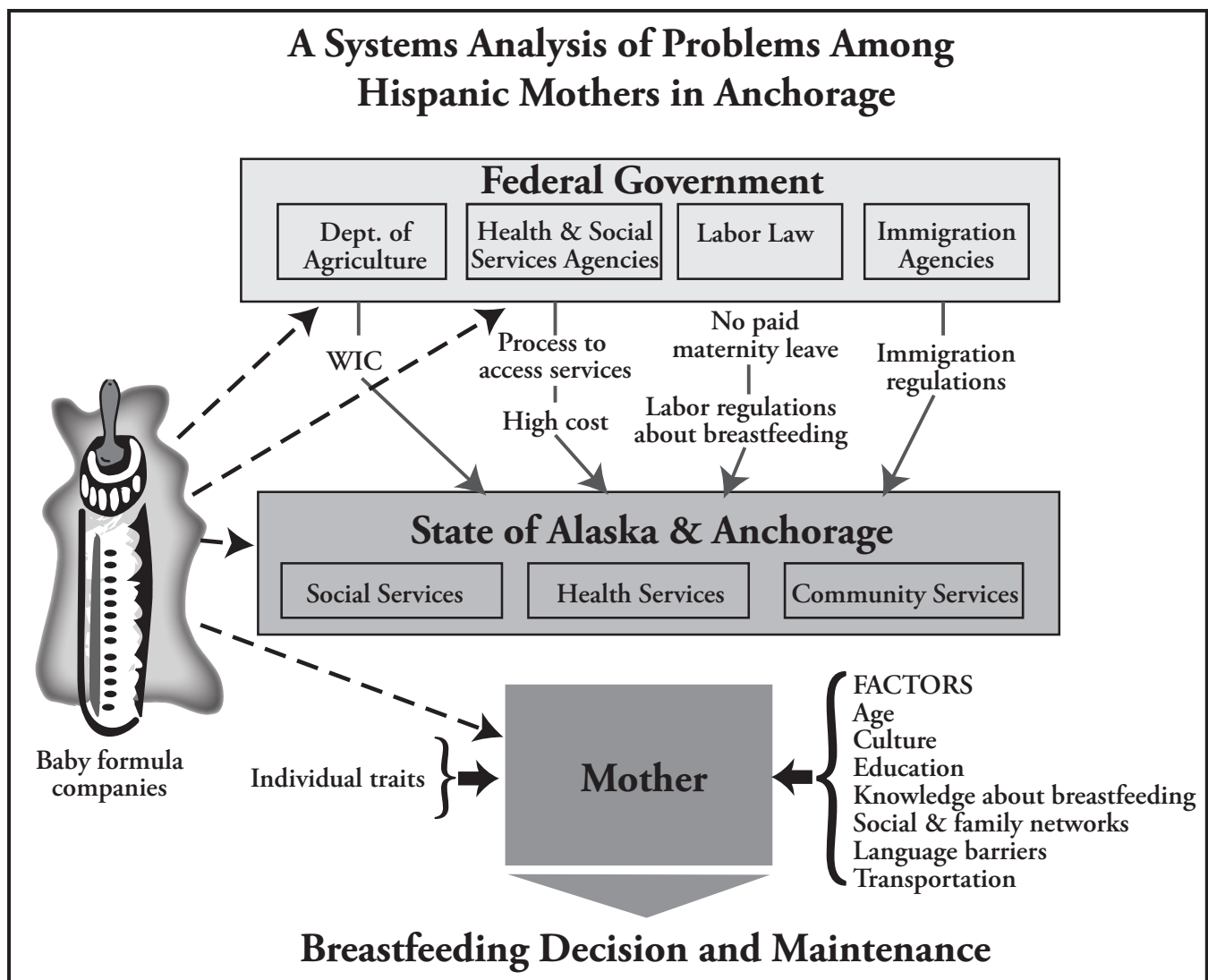


Figure 2. A systems overview of breastfeeding among Hispanic mothers in Anchorage

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