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Latinos and Hispanics in Dietetics and Nutrition

a member interest group of the Academy of Nutrition and Dietetics

Adelante LAHIDAN

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Greetings from Your Chair

Zachari Breeding, MS, RDN, LDN

Welcome to *Adelante*, the official publication of the Latinos and Hispanics in Dietetics and Nutrition (LAHIDAN) Member Interest Group from the Academy of Nutrition and Dietetics. We are very excited about this upcoming year. Lots of great information, resources, and networking opportunities are coming your way!

The mission of LAHIDAN is simple: empowering members to be the nation's food and nutrition leaders for Latinos and Hispanics. LAHIDAN is composed of male and female registered dietitian nutritionists (RDNs), nutrition and dietetic technicians, registered (NDTRs), other health professionals, and industry representatives committed to advancing awareness of Latino and Hispanic health issues, promoting cultural competency, and advancing nutrition and public practice. As we know, this population is at increased risk of nutrition-related health issues, so the work of our organization has never been more important!

The entire Executive Committee (EC) and I have been hard at work to bring you a variety of value-added services in the coming year:

- Three issues of *Adelante*
- Educational webinars
- Informative web-based e-blasts with up-to-date information on "what's happening" in our field
- Networking with fellow LAHIDAN members at the 2015 Food & Nutrition Conference & Expo™ (FNCE®)
- Updates on our website, eatrightlahidan.org
- Valuable mentor-mentee relationships with our new EC Mentorship Coordinator
- Volunteer opportunities within the organization

As always, feel free to reach out to us. Over time, LAHIDAN members become our family. We love when our members become involved because it eventually means better nutrition care to the Latino and Hispanic population. Whether you want to write an article for *Adelante*, develop culturally competent recipes, share an educational handout that can benefit other Registered Dietitians Nutritionists (RDNs), or just to learn how you can help, email us at lahidanec@gmail.com. We look forward to hearing from you!

LAHIDAN truly is a community, and we are so happy you are a part of it. So, get ready for all that is to come. I am very excited for this coming year, and hope you are too!

Saludos,

Letter from the Editor

Diana Romano, MS, RD, LD

Dear LAHIDAN members,

I'm excited to introduce the Fall 2015 issue of *Adelante*, which focuses on breastfeeding. We hope you enjoy this issue and gain some new information. As you can see in his greeting, our new Chair, Zach Breeding, MS, RDN, LDN, has many great ideas and is full of energy. He is a very interesting and busy person, juggling being a chef, an RDN, and the co-editor of *Adelante*. I am convinced that he will take LAHIDAN to a whole new level. As the current *Adelante* editor and chair-elect of LAHIDAN, I hope to learn a great deal this year to help me serve you better next year. In this issue, you also can read about your new Executive Committee (EC) members. Please let us know if you are interested in being part of the EC in the future.

We have several articles about breastfeeding written by wonderful volunteer members. Read about the history of breastfeeding in the United States as well as a literature review on benefits and barriers to breastfeeding in the Latino Community. In addition, two of our EC members write about their personal and professional experiences with breastfeeding. We hope you enjoy Chronicles of a Breastfeeding Latina and learn new methods of promoting breastfeeding in your community. Finally, we share a piece regarding the use of donor human milk, a practice being used in hospitals around the country.

As usual, we also highlight two Latin American countries and provide you with a delicious recipe.

We hope you are planning on attending the Academy of Nutrition and Dietetics FNCE® 2015 in Nashville, TN. As an enticement, check out some of the events in which LAHIDAN members are participating. We hope to network with you at the Joint Member Interest Group Reception or at our LAHIDAN booth.

Last but not least, at the end of the newsletter we provide more information about LAHIDAN, member benefits, and contact information.

Hope to see you all soon!!

Meet Our 2015-2016 Executive Committee

Chair
Zachari Breeding, MS, RDN, LDN

Zachari Breeding is a clinical dietitian with Drexel University College of Medicine in Philadelphia, PA, and is the Chair of LAHIDAN. He is a professional chef and earned his RDN credentials through completion of a dietetic internship at New York University Langone Medical Center. He earned a Bachelor of Science in Culinary Arts from The Restaurant School at Walnut Hill College and is completing a Master of Science degree from New York University. His previous roles include: nutritionist at Montefiore Hospital's South Bronx Health Center for Children and Families, nutrition educator for City Harvest, and assistant manager of patient food and nutrition services at NYU Langone Medical Center. He is also the owner and site manager for a food and nutrition website and the author of *The Slice Plan: An Integrative Approach to a Healthy Lifestyle and a Better You.*

Chair-Elect
Diana Romano, MS, RD, LD

Diana Romano works as an assistant state specialist with the Community Nutrition Education Programs at Oklahoma State University. Prior to this position, Diana worked as a family and consumer sciences educator at the same University for 6 years, where she taught community nutrition programs both in English and Spanish. She completed her dietetic internship and received her Master's in Nutritional Sciences from Oklahoma State University in 2008. Diana earned a Bachelor's in Nutrition and Dietetics from the Xaverian Pontificate University in Bogota, Colombia, in 1995. After graduation, she worked as a sales dietitian at Baxter Laboratories and then as a foodservice dietitian at San Ignacio Hospital. As part of her job teaching community nutrition, Diana has been interviewed by several newspapers and TV networks, both in English and Spanish. She loves being a dietitian and having a positive impact on people's lives. She is LAHIDAN's 2015-2016 Chair-Elect.

Past-Chair
Sylvia Klinger, MS, RD, LDN, CPT

Sylvia Klinger, registered dietitian and certified personal trainer, is founder of Hispanic Food Communications, Hinsdale, IL, a food communications and culinary consulting company. A Hispanic native who is a leading expert in cross-cultural Hispanic cuisine as it relates to nutrition and health, Sylvia has an impressive record and knowledge of Hispanic foods and culture. Using her in-depth foundation of culinary and cultural expertise as a base, she introduces new strategies to maximize exposure to the Hispanic population. Sylvia balances the tasteful Latin cuisine and lifestyle of health-conscious Hispanics with addressing the increasing health problems in this population today. She earned a Bachelor of Science in Dietetics and Nutrition from Loma Linda University in Loma Linda, CA, in 1984 and a Master of Science in Public Administration from DePaul University in Chicago, IL, in 1993. In 1994, the Chicago Dietetic Association presented her with the Recognized Young Dietitian of the Year award, and in 2009 she was awarded Outstanding Dietitian of the Year. In 2012, Sylvia was awarded the Loma Linda University Distinguished Alumna of the year and the 2012 Rincon service award.

Secretary
Christina McGeough, MPH, RD, CDN, CDE

Christina McGeough is a native New Yorker and proud Nuyorican. Since 2005, she has been a registered dietitian and became a certified diabetes educator in 2009. She earned her Bachelor's in Nutrition and Dietetics from New York University and Master's in Public Health from Hunter College. She has experience working in urban communities facilitating nutrition, health, wellness, and diabetes education in community, clinical, and business settings. Currently, she is Clinical Director of Diabetes, Nutrition & Wellness at the Institute for Family Health, which is a network of federally qualified health centers across New York City and the Mid-Hudson region of New York State. Some of Christina's extracurricular activities include practicing hot yoga and running.

Treasurer
Margaret Cook–Newell, PhD, RDN, LD, CDE, CN, MLDE

Margaret "Maggie" E. Cook-Newell has been practicing dietetics for more than 35 years. She has been active in the field of diabetes since 1981 and uses her role as faculty at Western Kentucky University to encourage students in all health care professions to attend or advocate for the Kentucky Diabetes Camp for Children "Camp Hendon," as a tool for learning how to manage life with diabetes. Maggie has been active in the Academy of Nutrition and Dietetics at the local and state level and is looking forward to more involvement at the

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national level. Her professional opportunities have been exciting and rewarding and still allow for future adventures in the field.

Nominating Chair
Marisol Avila, RD, CDE

Marisol Avila is a renal dietitian for a well-known dialysis company and owns her own consulting practice. She is fluent in English, Spanish, and Portuguese and has an impressive record as a bilingual educator in preventive health and chronic disease management. She has counseled thousands of clients in groups and individually in many areas, including weight control, maternal and child health, diabetes management, cardiovascular health, renal disease management, allergies, prenatal nutrition, and childhood nutrition. She began her career as a nutritionist for the Women, Infants and Children (WIC) supplemental feeding program. She moved on to Kaiser Permanente's Department of Preventative Medicine, where she obtained solid experience as a health educator, furthering her expertise in diabetes education and weight management.

Nominating Chair-Elect
Sandra J. Arévalo, MPH, RD, CDN, CDE

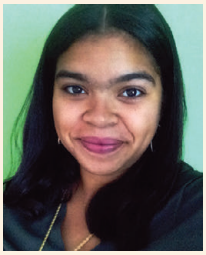
Sandra Arévalo is the director of Nutrition Services and co-director of The Starting Right Initiative and co-leader of the Diabetes Programs at Community Pediatrics, a program of the Montefiore Hospital and The Children's Health Fund that provides health care to the most underserved families in the Bronx, NY. She completed her dietetic internship and received her Master's in Public Health from Hunter College. She has served as chair of the NYC Nutrition Education Network, co-chair for the Cultural Foods Group of the Greater New York Dietetic Association, and on the Executive Committee of LAHIDAN for the past four years after volunteering for several different projects. Sandra received the Nutrition Education Program of The Year award from the Academy of Nutrition and Dietetics in 2012 for her work on obesity prevention with children in the South Bronx. She also received an Award of Excellence from the Hispanic Medical Association for her work helping to advance Latinos in the nutrition profession.

Mentoring Coordinator
Julie Plasencia, MS, RD

Julie Plasencia received a Master of Science in Human Nutrition from Michigan State University (MSU) and completed the dietetic internship program at the University of Nevada, Reno. She worked as a clinical dietitian, inpatient and outpatient diabetes educator, and extension nutrition specialist at the University of Nevada, Reno in Las Vegas, NV. She is currently a fifth-year doctoral student in the Department of Food Science and Human Nutrition at MSU. Her research interest is investigating how culture influences dietary behaviors in Mexican-Americans with type 2 diabetes. Julie is also conducting research on cultural competency training for undergraduate dietetics majors. This past year, she was a recipient of the Foundation's Commission on Dietetic Registration Doctoral Scholarship. Julie started as a LAHIDAN student member in 2007 and subsequently held the positions of Newsletter Editor, Treasurer, and Chair. She was named the 2011 Nevada's Young Registered Dietitian of the Year for her volunteer work in the dietetics profession, specifically for her involvement with LAHIDAN. She looks forward to increasing participation in LAHIDAN's mentoring program to help students and mentors mutually enhance each other's skills.

Breastfeeding History and Trends in the United States

Zariel Grullón, Nutrition Student


Zariel Grullón

Breastfeeding, an intimate chance to form an everlasting bond with an infant, has had a long journey into acceptance in today's society. Before the 20th century, nearly every baby was breastfed. Mothers had to feed their children themselves, seek wet nurses (women who were paid to breastfeed), or use animal milk. The use of wet nurses was popular among wealthy European women because the breast was deemed unfashionable (1). The use of wet nurses became essentially extinct by the 1900s due to the advancements in feeding bottles and animal milk (1).

These sources of feeding became the unintentional inspiration for artificial feedings such as infant formula. In the 1930s, pediatricians began recommending an unsweetened condensed milk formulated by the scientist John B. Myerling. His invention was a form of evaporated milk that was advertised to pediatricians as a viable source of nutrition for infants. These artificial milks were high in fat and low in nutrients that were necessary for a growing infant. The missing nutrients were eventually added to the formulas (2).

At this time, women, who were recently given the right to vote, wanted to detach themselves from the ties of breastfeeding. They began to view breastfeeding as old-fashioned as their roles in the home began changing. During World War II, woman had many more opportunities to leave their homes to work. The most viable solution for the working mother was bottle-feeding of formula. Once the war was over, bottle-feeding had become an accepted method of infant feeding.

By the late 1950s, the rate of breastfeeding had fallen to a record low of almost 20%, spurred by another feminist movement. Women were torn between the freedom from breastfeeding and the dictates of formula manufacturers. Ultimately, women began to focus on developing their own knowledge and understanding of their bodies, their children, and breastfeeding. It was during this time that women founded La Leche League International, a nonprofit organization whose aim is to help all mothers obtain adequate information on breastfeeding, guidance, and support (3). Such organizations created a forum for mothers to counsel and collaborate with each other.

In the 1970s, scientific studies began focusing on the benefits of human milk, ultimately concluding that breast milk was the best milk. More organizations formed in the early 1980s, such as the International Board of Lactation Consultation Examiners (4) and the International Code of Marketing of Breast-milk Substitutes (5). The later one was developed by the World Health Organization to address concerns about marketing practices of the infant formula manufacturers. Although the United States did not vote to pass the code of marketing, breastfeeding rates increased, reaching 61% by 1984. In 1991, the World Alliance for Breastfeeding Action (WABA) was created to unify breastfeeding around the globe (6).

The 21st century became a turning point for women in the United States as breastfeeding became normalized and laws were created to accept and allow breastfeeding in public venues. By 2006, it became legal in almost all states to allow mothers to breastfeed in any public place or place of public accommodation (7). At the end of the 2000s, states started passing laws that allowed women a break to express breast milk at work.

To celebrate the importance of breastfeeding, a single dedicated day to breastfeeding established by the WABA has evolved into a World Breastfeeding Week that now involves more than 170 countries and includes pictures of women breastfeeding on social media. Women can take part in World Breastfeeding Week by visiting the WABA website (6).

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Literature Review: Benefits and Barriers to Breastfeeding in the Latino Community

Alexandria Wolz, Drexel University ISPP Dietetic Intern


Alexandria Wolz

The Academy of Nutrition and Dietetics and the *Nutrition Care Manual* emphasize breastfeeding as an important component of maximizing infancy health and growth. Breastfeeding is especially beneficial for an infant's immunity because breast milk contains immunoglobulins and other important nutrients (1). Ample scientific evidence supports the importance of breastfeeding, but there are very legitimate barriers preventing some mothers from nursing their babies.

Children who were breastfed as infants are at a substantially reduced risk of becoming overweight (1), which is of particular interest to the Latino community. Obesity and diabetes are prevalent at disproportionate rates among Latinos in the United States (2). Due to the lack of general diversity and specifically Hispanic representation in many investigations, more research is needed to establish the protective effect of breastfeeding against obesity in the Latino community. Most of the research exploring this topic involves white, non-Hispanic participants. The Centers for Disease Control and Prevention National Immunization Survey found that 80.6% of Latinas have breastfed their infants, but breastfeeding rates decrease rapidly after infants reach age 6 months. The protective effect of breastfeeding has been shown to be greatest when breastfeeding is extended for 12 months or more (3).

Numerous factors inhibit women from breastfeeding. Some that affect all women are low socioeconomic status, young maternal age, lower maternal education, and single marital status. Other factors involve a mother's need to return to work and or school, being unable to afford extended maternity leave, poor access to flexible work schedules, and unsupportive family or partners. The privacy and sexualization of breastfeeding can also deter a mother from choosing to breastfeed. Some mothers may also experience excessive nipple pain or bleeding, difficulty getting the infant to latch, and insufficient production of breast milk (2,4).

Barriers that are unique to immigrant populations, particularly Latino communities, may be related to the process of acculturation. Formula feeding may appear to be the "American way" and discourage breastfeeding. Some Latin communities view breastfeeding as a lower socioeconomic practice used only by people who can't afford formula, a sentiment shared by some in the United States Hispanic population. A chubby or "gordito" infant is revered as a healthy baby in many Latin cultures. This perception may interfere with breastfeeding while encouraging mothers to supplement with formula feedings as well as initiate solid foods too soon (5). Breastfeeding laws and policies can also have an impact on a mother's ability to breastfeed. *Womens Health Issues* published a study noting that Mexican-American infants were 30% more likely to be breastfed in areas that have laws requiring businesses to provide mothers break time at work to pump (6).

The absence of health information services about breastfeeding is a further barrier to breastfeeding. A thorough review of the most current public health measures established to improve breastfeeding outcomes among minority mothers highlights that interventions provided by nurses alone were less effective when compared to an interdisciplinary team-based intervention (7). This finding indicates the need for RDNs, nurses, doctors, social workers, and other health professionals to work together to improve the knowledge and practice gaps about breastfeeding. Positive breastfeeding outcomes were observed and best achieved through a combination of interventions such as group prenatal classes, breastfeeding-specific clinical appointments, support groups, and hospital policies that prevent distribution of free formulas. More research is needed to evaluate the efficacy and determine the best types of intervention to improve breastfeeding outcomes specific to minority group populations (7). Studies show that women who take prenatal classes on breastfeeding are more likely to breastfeed and are more knowledgeable on the subject. Support from hospitals and health care clinics is essential, especially employment of trained and knowledgeable bilingual team staff members. All health care professionals should be trained to promote breastfeeding in a culturally sensitive manner because mothers who are encouraged by health care professionals to breastfeed are four times more likely to do so (7).

The importance of understanding both the benefits of and barriers to breastfeeding among Latinas and Hispanics is vital for RDNs and other health professionals serving the community. A health professional's ability to explain the benefits of breastfeeding and offer sound advice for overcoming obstacles can help improve breastfeeding practices, beliefs, and health outcomes within the Latino and Hispanic community of the United States.

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Lessons From the Field: Promoting Breastfeeding in Your Community

Sandra Arévalo, MPH, RDN, CDE

Sandra Arévalo, MPH, RDN, CDE

Breastfeeding rates in the United States (US) are low compared to many other countries. According to the World Health Organization, about 74% of US infants are ever breastfed and only 14% of babies are being breastfeed exclusively for the first 6 months.

Many efforts can be undertaken at the community level to encourage women to initiate and maintain breastfeeding. In my experience, most women who learn about breastfeeding are willing to try it. They might not commit to breastfeed, but moving them from denial to a contemplation stage is a big win that increases the chances for them to move to action and initiate breastfeeding. Once they make that commitment, they need continued support to maintain breastfeeding for a few months after birth.

Identifying and Overcoming Barriers

While working more than 10 years with women and children from Latin American and African countries, I have observed the most common barriers to breastfeeding expressed by women. They differ slightly from those found in the literature and include need to return to work and school, nipple soreness, embarrassment, lack of support, and perceived insufficient milk. In my experience, most women state that breastfeeding is difficult, they don't know how to breastfeed, they can't get their babies to latch to the breast, their baby starts crying and gets frustrated when trying to breastfeed or doesn't like breast milk, their milk looks and smells weird, and it's inconvenient because they can't breastfeed in public. All of these barriers share a common factor: lack of education.

We have anticipated these barriers and promoted breastfeeding by educating pregnant women during prenatal care about breastfeeding. With this approach, they are fully aware of what to expect and how to breastfeed. We encourage them to request a lactation consultant as soon as their baby is born, room in with their newborns in the hospital, talk to their obstetricians about their desire to breastfeed, talk to nurses and other hospital staff about their refusal to use bottles and pacifiers, and request to have their babies on their breasts as soon as the babies are born to experience the miracle of the "breastfeeding crawl." We show them videos of the crawl and breastfeeding positioning, discuss troubleshooting, and answer any questions to help fully prepare them to experience the best gift of Mother Nature and maternity.

Tips for Counseling

Mothers often can begin to breastfeed during their hospital stay with the help of a lactation consultant or other clinicians. When they leave the hospital, though, they might face difficulties and their need for support increases substantially. As a breastfeeding supporter, RDNs should be ready to help these women. If you cannot be there in person, providing a list of resources for them can help, such as a list of WIC offices or numbers to La Leche League International peer educators and consultants. If they come to you for help, consider the following factors:

1. Communication skills

Mothers appreciate attentive listening to their complaints and full stories. Such listening allows them to vent and feel appreciated and aids in establishing rapport and trust. Don't forget to ask them how they feel when they are breastfeeding and make sure they are comfortable. Also ask

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them how they feel in their new role as moms or moms of a new baby. This information can help you identify which skills they need to learn to address perceived barriers, build confidence, and feel supported. The final step is to schedule a follow-up suitable to the mother's situation. Moms should be encouraged to seek help when they need assistance with breastfeeding every time the baby is having difficulty attaching to the breast.

2. Breast and nipple concerns

Most RDNs don't feel comfortable examining breasts for engorgement, blocked ducts, mastitis, or sore or inverted nipples. If you fit into this category, ask a nurse or other clinician to examine the woman's breasts and give you a diagnosis so you can educate the mother on the issue. Understanding what is happening and how to manage it increases the likelihood of maintained breastfeeding. Women who are experiencing any of these problems usually are not positioning the baby correctly to the breast. Asking them to breastfeed while you observe the process is key to identifying and correcting issues as well as assuring them that the situation will improve and breastfeeding can be maintained. Mothers need to learn how to assess their breastfeeding and recognize correct positioning and attachment.

3. Encouragement

Many women come to the RDN already defeated, stating that they weren't able to breastfeed. Do not take "no" for an answer. Make every effort to help them find possible solutions and look for a support system. Supporters could be partners, mothers, mothers-in-law, sisters, friends, or clinicians who are willing to help the women in this process. It is important to identify a person to whom the mother can talk when she feels frustrated with breastfeeding or is tired. Her support person should understand that sometimes moms want to give up, and the supporter's role is to encourage them to maintain breastfeeding and help them with other tasks that allow the moms time and rest for themselves. Reminding moms and supporters of the advantages of breastfeeding for both mother and baby, bringing the father into the picture, and showing your support and willingness to help is usually enough to help moms maintain breastfeeding.

Other commonly expressed barriers are that breastfeeding is painful, takes a long time, is perceived as "gross" (most often by younger new moms and fathers), and that smaller breasts don't produce enough milk or larger breasts can suffocate the babies. Women also raise concerns that they can't return to work or school if they are breastfeeding. Discussing these issues during the pregnancy, taking the time to deconstruct these myths, can increase breastfeeding initiation and maintenance rates.

Moms need to learn that milk production is mostly related to demand; the higher the demand, the higher the production. If the mother is already breastfeeding on demand, nearly every 2 hours, RDNs should evaluate other factors. Increased stress, discomfort, and maternal diet and liquid intake also can affect milk production. Talk to the women about their sleep, making sure they are sleeping enough hours and resting when baby is sleeping. If they are having difficulty finding time for themselves, encourage them to use their support system. Mothers who believe that being on medications or having had a cesarean section means they can't breastfeed need to learn that there are very specific contraindications to breastfeeding: positive test for human immunodeficiency virus; taking antiretroviral medications; untreated, active tuberculosis; infection with human T-cell lymphotropic virus type I or II; use or dependence on an illicit drug or alcohol; taking prescribed cancer chemotherapy agents; or undergoing radiation therapies. Breastfeeding is also contraindicated for children with galactosemia.

Work with other people in your community to gain breastfeeding supporters. If you are working in a hospital or community health center, think about developing staff trainings and breastfeeding campaigns. Ask your staff to support and show appreciation to every mom whom they see breastfeeding to make them feel special, with something as simple as a courteous smile or "thumbs up." Talk to your administration about designating a safe space for breastfeeding or providing a room in which mothers can comfortably nurse their babies. Discourage use of bottles and pacifiers and minimize exposure to materials advertising formula. Talk to staff about the services covered by insurance companies, WIC packages, tax deductions, and other benefits offered for breastfeeding mothers and babies and ask them to disseminate this information. Design programs, events, and quality improvement projects around breastfeeding practices and promotion. Join breastfeeding support groups, leagues, and organizations to keep up to date and locate resources. No effort is too small to help initiate and maintain breastfeeding at an individual, group, or community level.

Chronicles of a Breastfeeding Latina

Christina McGeough, MPH, RD, CDN, CDE

Christina McGeough, MPH, RD, CDN, CDE

I grew up in a very strong quasi-feminist Nuyorican household, with little exposure to breastfeeding. My mom was young and single and always worked two jobs, so my aunts and grandmother helped raise me. The most vivid memory I have of someone breastfeeding is from my aunt breastfeeding my cousin and yelping in pain from what I now presume was a poor latch. However, when I learned I was pregnant, I was sure I wanted to breastfeed or at least give it a shot. A few years earlier, I had taken a Certified Lactation Counselor (CLC) course and learned about the benefits of breastfeeding and how to troubleshoot common problems.

As a CLC, I regularly work with moms and their newborns who are struggling with breastfeeding. What I have learned most as a CLC and a new breastfeeding mom is that support is essential. Anything we can do as health professionals, women, moms, partners, family, and friends to support a new mother's journey through the trials and triumphs of breastfeeding can be empowering and uplifting. Providing unbiased advice and technical assistance is so much better than using language that suggests the new mom is doing something wrong, such as not producing enough milk or not eating the right things. New parents have enough on their plates without being made to feel worse about their parenting and feeding choices.

When my son was born, I was elated to begin breastfeeding while in the hospital, but he was sleepy and just not interested in nursing the first few days. Nonetheless, I continued to offer my breast anytime he showed signs of hunger. What I was not prepared for was the nipple discomfort and pain I began to feel at each feeding. I immediately felt like a failure, especially because I was a trained CLC and was doing everything I had learned to prevent poor latch and nipple pain.

After about 2 weeks, I began to get the hang of what on-demand breastfeeding really meant, and the constant feeding really challenged me emotionally. I had this notion that breastfeeding would be easy and I'd go back to work and my physically active life rather easily. However, by week three, my son had become a ravenous eater and was feeding every 90 minutes, which left little time in my day the first three months of his life for anything other than eating and showering. My family and my friends would ask, "Are you really feeding again?" and "How long do you plan to breastfeed?" They may not have been telling me to quit, but I often felt they were saying that my life could be so much easier if I just fed him formula. My response was always that I planned to breastfeed as long as I could. When I went back to work, I spoke with new moms about their experiences and advocated with colleagues to have the administration designate a pumping room at work.

The other factor I had not considered much before breastfeeding was how comfortable I would be exposing my breasts in public. I initially thought I would be comfortable but quickly realized that a large part of my pre-pregnant body and sense of beauty was tied to my breasts. My son is now 10 months old, and breastfeeding has become a transformative process for me in terms of my sense of beauty, self-esteem, and self. I thought getting back in shape with a diet and exercise regimen would be easy, but it has proven harder than I imagined because up until recently I was always hungry and devoid of enough time or energy to devote to my former healthy lifestyle. I've had to retrain myself on what my new mom self needs nutritionally, spiritually, and physically to be healthy.

The Use of Donor Human Milk

Diana Romano, MS, RD, LD
Adapted from the National WIC Association

Human milk is the normal food for infants and young children including premature and sick newborns, except in rare circumstances (1, 2). Human milk provides optimal nutrition, promotes normal growth and development, and reduces the risk of many childhood illnesses and diseases. The unique composition of human milk includes nutrients, enzymes, growth factors, hormones, and immunological and anti-inflammatory properties that are not found in infant formulas (3, 4). Human milk fights infection while providing ideal nutrition for the infant. Exclusive breastfeeding for six months is recommended with introduction of complementary nutritionally adequate foods at about this time.

In situations where mother's own milk is not available, provision of pasteurized, screened donor milk* is the next best option particularly for ill, or high-risk infants (5,6). In 2012, the American Academy of Pediatrics (AAP) released a policy statement recommending that all preterm infants receive mother's milk, or pasteurized donor milk if mother's milk is unavailable or contraindicated. It also recommends the use of donor milk as an alternative to breastfeeding or expressed mother's milk for healthy term infants (7).

In a recent survey of donor milk use, 42% of medical directors in 302 level 3 neonatal intensive care units (NICUs) across the country are using donor milk (8). Some states offer reimbursement through Medicaid for infants with a medical need after hospital discharge. These level 3 NICUs and Medicaid programs have recognized the safety and benefit of utilizing donor human milk to improve health outcomes of their patients. Donor milk can be life-saving when threatening out-patient conditions are present.

Who Receives Donor Milk?

Donor human milk should only be used when the biological mother's own milk is not available, such as due to a maternal illness and treatment or the mother's physical inability to produce breast milk. While most women can adequately produce milk for their infants, mothers with children in the NICU face incredible challenges to establish milk supply during the most critical period following birth. Common reasons for prescribing banked donor milk may include: preterm birth, failure to thrive, malabsorption syndromes, allergies, feeding/formula intolerance, immunologic deficiencies and post-operative nutrition.

Banked donor milk has been reported to be effective for infants of preterm birth, post-operative treatment, and provision of immunological benefits. Patients with varied conditions including bowel surgery, failure to thrive, formula intolerance, malabsorption syndromes, suppressed IgA levels, allergies, chronic renal failure, leukemia, intractable pneumonia, and HIV have responded positively to the use of donor milk (7,9,10). Banked donor milk should only be provided by a physician's prescription for the critical needs of fragile infants, with a specific diagnosis warranting donor human milk after hospital discharge. All situations should be evaluated based on priority, and donor milk availability.

Is Donor Human Milk Safe?

Non-profit donor human milk banking has a long safety record in North America where processed human milk from screened donors has been provided to patients in selected neonatal intensive care units since 1943. Human Milk Banking Association of North America (HMBANA) is an association of non-profit milk bank members and a multidisciplinary group of healthcare providers that promotes, protects, and supports donor milk banking. HMBANA promotes the collection and distribution of donor human milk in a safe, ethical and cost effective manner. It sets the standards and guidelines for donor milk banking. Milk bank members of HMBANA comply with mandatory guidelines for operation as published in the Guidelines for the Establishment and Operation of Donor Human Milk Banks, 2013 (11). These evidence-based guidelines are informed by advisory groups including AABB, US Food and Drug Administration (FDA), and the Centers for Disease Control and Prevention (CDC). Member milk banks are evaluated for compliance to the guidelines annually by a peer milk bank director.

Potential milk donors provide complete medical and lifestyle histories, and undergo blood tests, similar to the screening process used at blood banks. The donor's healthcare provider submits medical information on both the donor and her child as well. Donated milk is then tested for bacteria and levels of nutrients, and pasteurized. Before the pasteurized milk is dispensed, bacteriological testing is conducted to ensure its safety; dispensing milk depends on seeing zero growth on a 48 hour agar plate culture. Any bacterial growth post pasteurization leads the milk to be discarded.

There have been no documented cases of disease transmission from donor milk provided by a HMBANA-member milk bank. Banked human milk should not be confused with informal milk sharing. WIC can educate mothers on the risks of informal milk sharing in order to properly protect their babies (12). When WIC supports

breastfeeding and banked human milk, mothers become more aware of the value of their own milk. Many WIC moms who have donated their breast milk reported the rewarding experience they felt to have helped other mothers and babies (13). The presence of donor human milk in the NICU has been found to be associated with increased breastfeeding rates (14).

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Around Latin America: Dominican Republic and Bolivia

Toby Levin, Nutrition Student

Dominican Republic

Capital: Santo Domingo
Currency: Dominican Peso

Average Climate/Topography: The Dominican Republic occupies the eastern half of Hispaniola, the second largest island in the Caribbean. Four mountain ranges divide the country. The highest is the Cordillera Central, where the Caribbean's tallest mountains rise to more than 10,000 feet. To the north of the Cordillera Central is the fertile Cibao valley, home to most of the country's farming (primarily sugar, coffee, rice, and cacao). Despite the country's relatively small size, the climate varies substantially, with temperatures ranging from lows around freezing in the mountains to highs of more than 100°F in sheltered valleys. Rain is equally variable, with rainfall in the wettest mountains averaging more than 100 inches and in the driest valleys less than 14 inches.

Places of Interest: Tourism is the fastest growing part of the economy of the Dominican Republic. Beaches draw sunbathers to Punta Cana year round. Santo Domingo is rich with history; its Colonial City is the oldest permanent European settlement in the western hemisphere, founded in 1493. It is home to the first cathedral, monastery, and castle built in all of the Americas.

Cuisine: Dominican cuisine is heavily influenced by Spanish and African cuisines as well as the indigenous Taíno cuisine. Lunch is the largest meal of the day and typically consists of rice, red beans, and stewed or roasted meat, often pork, sometimes with a salad, a combination called La Bandera. The "official" national breakfast is mangú, made of boiled and mashed plantains. It is typically served with queso frito, fried salami, and eggs topped with avocado or sautéed onions. Fish is eaten extensively in coastal areas. Other popular dishes include pastelón de platano maduro (yellow plantain casserole) and mofongo, made of fried green plantains seasoned with garlic, olive oil, and chicharonnes (fried pork skins) that is mashed with chicken broth. Tostones, or fried plantains, are also essential to Dominican cuisine.

Bolivia

Capital: Sucre (Constitutional),
La Paz (Administrative)
Currency: Boliviano

Average Climate/Topography: Bolivia is one of only two landlocked countries in Latin America. Its climate and topography are among the most varied in the world, with altitudes ranging from 230 feet along the Paraguay River to nearly 21,500 feet atop the Nevado Sajama, the highest peak in the nation. The Llanos region, which covers almost 60% of the country, is flat and covered with rainforests. Weather is hot and rainy, with an average temperature around 85°F. The second largest region, the Altiplano, is the most elevated area of Bolivia, located between two Andean mountain chains, the Cordillera Occidental and the Cordillera Central. Although high temperatures can reach 70°F during the day, nights are cold and ground frost occurs every month of the year. Between the Altiplano and the Llanos, the sub-Andean region is a narrow intermediate zone with milder temperatures and heavy rains as the humid air of the Amazon basin begins to climb over the Andes.

Places of Interest: The largest draws to Bolivia are undoubtedly its geography and biodiversity. Bolivia contains the world's largest salt flat, the Salar de Uyuni (more than 4,000 square miles) and the largest lake in South America, Lake Titicaca. More than 17,000 species of plants are native to Bolivia, and many agricultural crops are believed to have originated there, including peppers, peanuts, yucca, and potatoes. About 14% of the world's bird species also call Bolivia home. Bolivia contains many pre-Columbian archeological sites. The most popular of these is El Fuerte de Samaipata, a religious site built by the Chané people (a pre-Incan culture) and later destroyed by Guarani raiders from the south.

Cuisine: Bolivian cuisine is built around three traditional Andean ingredients: corn, beans, and potatoes (over 4,000 varieties are native to the country). These are combined with staples imported by the Spanish, such as rice and beef, pork, and chicken. Lunch is the most important meal of day, with several courses, including a soup, an entrée with meat and potatoes, and a dessert with coffee. Typical lunch entrees include pork chorizo served with a simple salad and bread; silpancho, a dish of layered rice, potatoes, fried meat, and chopped tomatoes; and salteñas, a savory empanada stuffed with beef, pork, or chicken mixed with a sauce and vegetables, potatoes, or eggs. Salteñas vary widely from town to town and local flavor is a source of great pride. Locro, a thick stew made with corn, beef, and vegetables, is also popular, particularly in winter. Late in the afternoon, Bolivians typically take a tea break with pastries and either black tea or coca. Pastries are often sweet packaged cookies, but traditional humintas are also served. Humintas are made from fresh corn and lard mixed with queso fresco or raisins and sugar, then wrapped in corn husks and baked, boiled, or steamed. Dinner is typically much lighter than lunch and is usually eaten late, after 8 pm.

Recipe Corner

Christy Wilson, BS, RDN
www.christywilsonnutrition.com

Carrot and Jicama Slaw

Servings: ½ cup serving size, serves 4

Cooking Time: 15 minutes

Ingredients

1 tablespoon extra virgin olive oil

1 medium shallot, diced

1/4 teaspoon fennel seed

3/4 teaspoon ground cumin

3 cups carrots (3-4 large), grated

1 cup jicama, grated

2-3 tablespoons fresh lime juice

2 tablespoons cilantro leaves, chopped/torn

Salt and pepper, if desired

Directions

1. In a small, nonstick skillet, heat olive oil over medium heat.
2. Add shallot and cook until softened.
3. Add fennel seed and cumin to the skillet and cook until fragrant, about 1 minute.
4. In a medium bowl, combine shredded carrots, jicama, lime juice, and shallot mixture. Toss until colors and flavors meld.
5. Add salt and pepper, if desired (I didn't add any and it is tasted fantastic!). Garnish with cilantro or mint leaves for added color and flavor.

Nutrition Information per serving:
Calories: 50; Total fat: 2.5 g, Saturated fat: 0 g, Sodium: 30 mg; Total carbohydrates: 7 g, Dietary fiber: 2 g, Sugar: 3 g, Protein: 1 g; Vitamin A: 60% DV, Vitamin C: 20% DV

Ensalada de Zanahoria y Jicama

Porciones: 4 porciones de ½ taza cada una

Tiempo de Preparaccion: 15 minutos

Ingredientes

1 cucharada de aceite de oliva extra virgen

1 cebolla shallot mediana picada

1/4 cucharadita de semilla de hinojo

3/4 cucharadita de comino en polvo

3 tazas de zanahoria rallada (3-4 grandes)

1 taza de jicama rallada

2-3 cucharadas de jugo de limon fresco

2 cucharadas de cilantro picado

Sal y pimienta al gusto

Directiones

1. En un sarten pequeno anti adherente, caliente el aceite de oliva a fuego medio.
2. Agregue la cebolla shallot hasta que se ablande.
3. Agregue el hinojo y el comino y cocine hasta que sienta el aroma, mas o menos 1 minuto.
4. En un tazon mediana mezcle la zanahoria, la jicama, el jugo de limon, y la cebolla shallot cocinada. Revuelva hasta que todos los sabores y colores se mezclen bien.
5. Agregar sal y pimienta al gusto. (Yo no agregue y supo delicioso) Adorne con hojas de cilantro o de menta para agregar color y sabor.

Informacion Nutricional por Porcion:
Calorias: 50; Grasa Total : 2.5 g, Grasa Saturated: 0 g, Sodio: 30 mg; Carbohidratos Totales: 7 g, Fibra Dietaria: 2 g, Azucar: 3 g, Proteina: 1 g; Vitamina A: 60% DV, Vitamina C: 20% DV

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We hope you can join us for the following events at this year's FNCE®. Please take this opportunity to learn more about LAHIDAN and meet current members and the Executive Committee.

FNCE® DPG/MIG Showcase
Monday, October 5
9:00 AM–12:00 PM
OMNI Hotel
Area TBD

Joint MIG Reception
Monday, October 5
5:00–6:30 PM
OMNI Hotel
Legends Ballroom ABC

About LAHIDAN

Latinos and Hispanics in Dietetics and Nutrition (LAHIDAN) has served members since 1995 as a networking group. On May 16, 2007, LAHIDAN became the first Member Interest Group (MIG) of the Academy of Nutrition and Dietetics.

Mission
Empowering members to be the nation's food and nutrition leaders for Latinos and Hispanics.

Vision
Optimizing the health of Latinos and Hispanics through food and nutrition.

Purpose
The purpose of this MIG shall be to support member needs while fostering the development and improvement of food, nutrition, and health care for Latinos and Hispanics and their families in the United States and related territories, with outreach to Hispanic and Latino international members.

Functions
a. Lead in the planning, implementation, and evaluation of food, nutrition, and health service delivery to Latino communities.

b. Promote professional practice, research, and educational advancement.

c. Promote cultural competency of LAHIDAN.

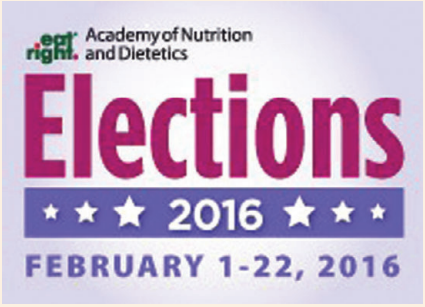
d. Strengthen the influence of the MIG on professional organizations, policy makers, government, and other identified entities through coordinated action.

e. Highlight the contributions of member dietetic practitioners with significant contributions to the Academy and profession.

f. Support leadership development and promote member service utilization.

g. Identify, mentor, and support promising future Latino/Hispanic dietetic practitioners.

h. Maintain a resource directory of LAHIDAN dietetic practitioners and those interested in supporting the MIG.



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Benefits of Membership

Benefits of being a LAHIDAN member include opportunities for professional development and for increasing cultural competency.

- Leadership Opportunities
- Electronic Mailing List
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- Networking
- Student Scholarship
- Website
- Connections With Friends and Colleagues
- Newsletter
- Language and Cultural Exchange
- Webinars

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