

Wellness In the Community



Volume 13

Arkansas Breastfeeding and WIC Program Update

Spring, 2002

Barriers to Learning

By Dr. Buddy Lyle, Department of Vocational and Adult Education,
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The facilitators of Adult Learning must accept two major responsibilities regarding the learner. First, they must create an environment where learning may be maximized and secondly, they must assist in removing barriers to learning.

One study of barriers to learning has found that 62% of all adults 17 years and older believed that barriers kept them from taking adult education courses. There are myriad reasons identified in various studies of why potential learners may not fully participate; not enough time, childcare, transportation, employment obligations, lack of self-confidence, physical limitations, etc. There are many external barriers to learning that the facilitator may not be able to control. However, there may be some barriers over which the facilitator will have direct control.

If the learner is threatened by the learning situation, this becomes a barrier to learning. The facilitator

should make the learner feel welcome and let them know early in the session what will be covered and how. Get feedback from the learner on their expectations and give feedback to the learner in the form of encouragement and positive evaluation. If the learner does not trust her ability to learn, the facilitator may want to provide opportunity early in the session for successful completion of learning activities.

In creating an environment where learning may be maximized, the facilitator of learning must be mindful of the physical environment, such as seating, lighting, accessibility, the social environment (rapport between the learner and facilitator; and learner to learner), and the psychological environment (self-concept, emotional state, societal stereotyping). By creating an environment where learning may occur, the facilitator is increasing the learners' chances of learning.

Facilitator Characteristics

The facilitator of learning needs to possess characteristics that accommodate and complement the needs of individual learners. The facilitator should:

- *Be a facilitator and leader.* Help and guide, rather than dominate or control.
- *Be positive rather than negative.* Use praise rather than ridicule. Be optimistic and instill a "can do" attitude in learners.
- *Be patient.* Allow learners as much time as is needed or is possible to solve a problem.
- *Provide the learner with a reason to return to the next class.* Be sure that each learner takes something positive away from each session.
- *Be enthusiastic and creative.* Make learning enjoyable and interesting, for both the facilitator and the learner.



Nutri News

Learning Together – Feeding Our Children – Part 2

By Susan Handford, MS, RD, LD

Did You Know?

The NCEP (National Cholesterol Education Program) has published new adult cholesterol guidelines:

- Optimal LDL (bad) cholesterol = under 100 mg/dl.
- Desirable range for HDL (good) cholesterol = 40-60 mg/dl.
- Threshold for triglyceride treatment = 200 mg/dl.
- Advises less saturated fat and cholesterol in the diet.
- Encourages dietary intake of plant sterols/stanols and soluble fiber.

According to NCEP, HDL (good) cholesterol should be higher among:

- Women than men
- Thin individuals than obese
- Exercisers than couch potatoes
- Nonsmokers than smokers

NCEP lists Metabolic Syndrome as a strong a risk factor for coronary heart disease as cigarette smoking and is defined as three or more of the following factors:

- Abdominal obesity (Men = 40 + inch waist; Women = 35 + inch waist)
- Moderately elevated triglycerides; above 150 mg/dl
- Hypertension
- Low HDL cholesterol; below 40 mg/dl
- Moderately elevated FBS (Fasting Blood Sugar); above 110 mg/dl
- Insulin resistance (with or without glucose intolerance)

www.nhlbi.nih.gov

Toddlers are a challenge for adult caregivers who feel they have feeding all figured out; the infant who has transitioned over to solid foods, eating any food offered and drinking

from a cup is now a toddler who just won't eat anymore. The thirteen-month-old may have a drop in appetite that is alarming to adults.

Actually, the toddler may be right on schedule.

A toddler gains only 3-5 pounds over his second year, though he probably gained that much in 4 months during the first year. A slow steady growth rate, until puberty, is normal.

Caregivers need to realize responsibility for feeding splits two ways. The adult is in charge of deciding what to offer, the child in deciding whether to eat it or not. Keep priorities in perspective. Eating is food, not law enforcement. Providing healthy eating patterns-scheduling meals and snacks, preparing healthy foods in appropriate

forms and textures, and keeping the toddler company while eating, is the adult's role. At every age, it is up to the child to choose what and how

much or little to eat from the

food offered. When it

comes to persuading

a child to eat,

pediatricians

advise parents

to step back.

Healthy

children

don't starve

as long as

food is available.

When a

child is allowed to

make choices from

limited possibilities,

independence is fostered.

Encourage parents to let the toddler

help in meal preparation and table

service. Give the toddler a job he

can manage to help focus on a sense

of accomplishment and less on the

food. A toddler will eat what he needs.

A toddler portion should be about

a quarter of the serving for an adult –

1-2 tablespoons of vegetables and 1/2

ounce of meat.

American Academy of Pediatrics, *Guide to Your Child's Nutrition*, Editors William H. Dietz, M.D., Ph.D., F.A.A.P. and Lorain Stern, M.D., F.A.A.P., 1999.



Abreast of the News

By Carla Christensen, Pharm. D, UAMS Maternal Infant Clinical Pharmacy Specialist and Assistant Professor, UAMS college of Pharmacy

Metoclopramide (Reglan®) is a medication used to treat gastroesophageal reflux in adults and infants. This drug causes galactorrhea. It induces the release of prolactin from the anterior pituitary by blocking dopamine's action as an inhibitor of prolactin secretion.

Galactorrhea is the desired effect for a mother with minimal milk supply. Metoclopramide is the drug most often chosen for this purpose in the United States.

The literature reports over 75 women who have been treated. Studies report as much as a 50% increase in milk volume in 66-100% of the patients receiving metoclopramide. However, the drug may be less effective in prolonged and complete lactation failure. The doses ranged from 10-15 mg given orally 3-4 times a day, with effects in 2-4 days. It is recommended that the dose be weaned gradually over a 10-14 day period, as an abrupt discontinuation of the medication can cause a sudden drop in milk production.

While metoclopramide is considered safe for most patients, there are potential side effects to consider. The American Academy of Pediatrics lists it as a "medication whose effect on the infant is unknown, but may be of concern" in lactation. Small amounts of mother's dose will get into the milk, but side effects in the nursing infant have not been reported. The infant should be watched for sleepiness and poor feeding.

A small number of mothers have reported side effects including restlessness, drowsiness, fatigue, and diarrhea. Rare effects seen with preexisting conditions require discontinuation of the drug: sleeplessness, headache, confusion, dizziness, mental depression, and feelings of anxiety/agitation. In < 1/500 people, one will have difficulty controlling muscle movements ("acute dystonic reaction"). This effect is reversible with diphenhydramine (Benedryl®). With prolonged use many > 2 weeks, especially in-patients with underlying risk for dystonia, the movements may be irreversible.

It is important that patients with the following conditions should not receive this therapy: those with epilepsy/on anti-seizure medications, Parkinsonism, a history of mental depression/on antidepressant drugs, a history of hyperkinetic disorder, uncontrolled high blood pressure, intestinal bleeding/obstruction, or known allergy/reaction to metoclopramide. This therapy should never be used as the sole method of treatment for a diminished milk supply. The clinician prescribing this medication to assist in breastfeeding should carefully weigh the risks and benefits.

Hale TW. *Medications and Mothers' Milk*. 9th Ed. Amarillo, TX: Pharmasoft Publ; 2000: 442-444.

Smith GH: Metoclopramide – lactation promotion in partially or non lactating patients (Drug Consult). In Hutchinson TA & Shahan DR (Eds): DRUGDEX® System. MICROMEDEX, Inc., Greenwood Village, Colorado (Edition expires 3/2002).

Ask the Experts

Q. Recently there have been changes in the WIC Approved Food List and in the quantity of powdered formula issued to participants. What influences decisions about such changes?

A. Federal Regulations state the types of foods that must be provided in the various food packages, nutritional requirements of the foods offered, and the maximum quantity of each food type that can be given.

For example, juices must be 100% fruits juice (no juice drinks, aides or beverages) and contain a minimum of 30 milligrams of Vitamin C per 100 milliliters of juice. Cereals must contain no more than 6 grams of sugar and a minimum of 28 milligrams of iron per ounces of cereal.

In additions to these requirements, the Program tries to take into consideration brands that are available to the majority of participants and flavors/types that are the most popular while meeting the other federal requirements.

In the case of infant formula, WIC is mandated to provide standard formula based on a contract negotiated with a major formula company. Currently the contract is with Mead Johnson.

There is a maximum amount of formula that can be issued. The amount issued for concentrate is 403 fluid ounces, ready-to-feed, 806 fluid ounces, and powder at the rate of 8 lb. per 403 ounces of concentrate. Recent changes in the size of cans of powder made it necessary to change from issuing 9 cans of Prosobee and Lactofree to 8 cans.

Program Focus

By *Sandra Jones, RD, MEd, IBCLC*

What do WIC clients want most from the program? ... More food, formula or better lessons on nutrition? Clients from the Virginia Women, Infant and Children's (WIC) program were interviewed in focus groups conducted by a consumer research professional. The objective was to find out what these mothers wanted from the WIC program and to compare that to what WIC colleagues believe WIC clients need.

Kristen McNutt, PhD, reported the results in an article "What trends today tell us about tomorrow", Nov/Dec 2001 of Nutrition Today. She stated that the results of the research were heartbreaking. The WIC clients said they wanted: 1) to be smiled at; 2) to be told they are good mothers for trying so hard at a difficult role; 3) not to feel as if they are bothering the WIC staff when they come in for an appointment.

Kristen concluded the article with some wrap-up messages for staff:

- Smile more often at your clients and co-workers; it might make your efforts more effective and make you as well as others, feel less stressed.
- Listen more carefully to the people you serve; find out what they want from you rather than telling them what you know they need.
- Ask whether your messages and advice are adding to stress, and if so, decide whether you want to continue doing this.
- Pat yourself on the back; think more frequently about the good you are doing and the help you are providing to others.

Resources

Eat Right Montana (ERM), is a statewide coalition promoting healthful eating and active lifestyles. During 2002 the promotion focus is to help individuals take a sensible, successful approach to weight management. Each month the focus will be on unique issues related to healthy weight for different groups, i.e. men, pregnant women, children, babies and toddlers, seniors and people with diabetes etc. On-line packets in PDF files contain a press release, facts sheet, statistics or resources, and handouts that are designed with a simple, sensitive and creative approach. Access these free materials to use in counseling at the Montana Dietetic Association website (www.montanadieteticassociation.org/promo.html).

The Pump List is a website and e-mail list service packed with information for women who pump breastmilk. Members can contribute their own

experiences and non-member can get the answers they need about a number of pumping related issues. The site's primary feature is the "Frequently Asked Questions (FAQs)" which provides answers related to the following issues:

- Supply Boosters
- Relaxation and Letdown Techniques
- Pumping Frequency and Duration
- Tips To Lessen the Time it Takes to Pump
- Pump Brands and Suction
- Milk Storage
- Thrush Remedies

Other features allow mothers to rate and comment on the various types of pumps on the market. This is a great resource to share with expectant parents in prenatal and breastfeeding classes. Access the site at <http://www.pumpingmoms.org>.

Spotlight

By Sandra Jones, RD, MEd, IBCLC

During the spring of 2000, Arkansas WIC launched a breast pump program that greatly expanded benefits for breastfeeding mothers and infants. Breastfeeding mothers who deliver premature and chronically ill infants are provided with a "Personal Double Pump" to initiate and sustain milk production. This pump has more than met the expectations anticipated by the program. The following are examples of how the personal double pump has helped mothers meet and exceed their breastfeeding goals.

- ❖ A mother from Craighead County delivered a baby boy at 31 weeks gestational age weighing 2# 14 oz. Mom used the personal double pump to initiate her milk production and was able to provide exclusive breastmilk during the baby's hospitalization and at home. At one year postpartum, mom was able to return to school and continue to provide the baby with breastmilk. Mom was still exclusively pumping at 18 months postpartum. Chronic bronchitis is the baby's only known medical problem and he is otherwise healthy and developing normally.
- ❖ In Howard County a mother delivered a baby girl at 31 weeks gestational age weighing 3# 9 oz. The baby was discharged home with an apnea monitor. Mom consistently pumped every 2 1/2-3 hours collecting about 3 ounces each session using the personal double pump. She frequently struggled with a low milk supply as a result of multiple factors. At four months postpartum mom had surgery and her milk production dropped to only 5 1/2 ccs per pumping. In a final attempt to boost her milk supply, mom took a prescribed course of

Reglan to augment her pumping efforts. Her milk production increased to a total of 10 ounces from both breasts each pumping session! Mom was still exclusively pumping at 15 months postpartum and maintaining a sustained increase in milk production. The baby remains on the apnea monitor at night, but is otherwise healthy and developing well.

- ❖ A Lawrence County mother delivered a baby boy at 33 weeks gestational age. The baby weighed 4# 7 oz, and had multiple health problems: Down's Syndrome, Tetralogy of Fallot, and Hirschsprung's disease which required a colostomy. The baby was flown to Ohio immediately after birth for heart surgery. Mom used the personal double pump from WIC to provide breastmilk and was soon able to begin some feedings at the breast.

Breast pumps make a difference for premature babies.

After six months, the baby's colostomy was removed and within a month the baby was exclusively breastfeeding. A few months later, the baby underwent open heart surgery and mom resumed using her pump during an 8 day hospital stay and later transitioned the baby back to the breast. The baby is still breastfeeding at 16 months of age. Mom plans to continue breastfeeding through the spring and wean the baby after the cold and flu season has passed. He is doing well, and should require no further surgeries for several years.

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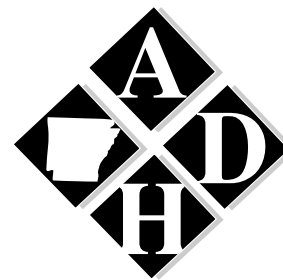
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