Latina migrants´ breastfeeding experiences living in a Spanish-speaking country : a qualitative descriptive study

Blanca Iglesias-Rosado
University of Seville Faculty of Psychology: Universidad de Sevilla Facultad de Psicologia
Fatima Leon-Larios (fatimaleon@us.es)
University of Seville Faculty of Nursing Physiotherapy and Podology: Universidad de Sevilla Facultad de Enfermeria Fisioterapia y Podologia https://orcid.org/0000-0001-9475-0440

Research

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Abstract

Background

The migratory flows in Spain have changed due to the arrival of migrant population. Among them, the Latino collective predominated, of which more than one half are women of childbearing age. However, there is no previous study exploring their breastfeeding experiences in a country where their mother tongue is spoken. This study aimed to explore Latina migrants' breastfeeding experiences in a Spanish-speaking country.

Methods

A descriptive qualitative study was carried out. The study used intentional sampling. Study participants were contacted by video calls, and data were collected through a semi-structured in-depth interview (*n* = 19). The interviews were transcribed and analyzed by thematic analysis.

Results

The two main categories that emerged were breastfeeding facilitators and barriers, divided into ten interrelated subcategories: work conditions; precarious socioeconomic conditions; lack of support (health professionals, family and society); physiological changes, pain and fatigue; ignorance and wrong beliefs; support networks (partner health professionals and family); host country versus home country; religious practices/worship; appropriate attitude, knowledge and experience; breastfeeding support groups. Most of the study participants stated that their breastfeeding experiences were influenced by barriers such as work and by facilitators such as peer support.

Conclusions

More support from caregivers and more sensitivity to cultural diversity are demanded by women, and well-trained professionals are needed to extend breastfeeding for a longer time. This paper provides caregivers, such as nurses, more knowledge about the care demanded by migrant women to contribute to a longer breastfeeding experience.

1 Background

Although the World Health Organization's (WHO) recommendations are to breastfeed up to six months, breastfeeding (BF) rates in Spain are not as desired [1]. According to the latest WHO report by country, there is 68.4% exclusive BF in Spain at six weeks postpartum, and it is gradually decreasing, reaching 24.7% at

six months [2]. These data reflect the need for measures to promote BF in an increasingly diverse country, such as Spain.

In recent years, there has been a change in the migratory flows to our country, largely due to the arrival of migrant population. Considering the country of birth of the foreign population registered in Spain, 24.43% of them come from Latin America, of whom 57.47% are women [3]. This feminization of the data is observed at national, regional (Andalusia), and provincial (Seville) levels. The predominant nationalities are Colombian, Venezuelan, Bolivian, Paraguayan, or Peruvian [3]. This Latina population is of childbearing age when they migrate to Spain (between 20 and 39 years old), as reflected in the most recent data from the National Institute of Statistics [4].

Latina immigrants in Spain are more likely to breastfeed than Spanish women [5–8]. Nevertheless, previous studies have shown barriers and facilitators only for Latina women living in a non-Spanish-speaking country [9]. But there is no previous study exploring their experiences in a Spanish-speaking country [10].

Despite this, migrant mothers continue to face difficulties for successful BF [11–21]. This is why some researchers suggest that culturally adapted health services are necessary to maintain BF rates in migrant mothers [10,22].

This study aims to explore Latina migrants' breastfeeding experiences in a Spanish-speaking country.

2 Methods

2.1 Study design

This qualitative study was carried out following the Consolidated Criteria for Reporting Qualitative Research (COREQ)[23] (See supplementary File 1). It took place in three local districts of Seville, the main province in southern Andalusia (Spain), between November 2019 and June 2020.

2.2 Participants

Participants were selected following the non-probability "snowball" sampling procedure. The inclusion criteria were: Latina women who had children in Spain; a BF experience in the host country of at least two months (during the last five years); involvement in BF support groups (BFSG); and consent to participate in this study.

2.3 Measures

In-depth semi-structured interviews were carried out until reaching data saturation. They lasted approximately between 20 and 70 minutes. For this purpose, an interview script was created (Table 1), which included three dimensions: sociodemographic factors, obstetric data and knowledge, as well as support and feelings.

2.4 Data Collection

Due to the current public health situation caused by COVID-19 and the established lockdown restrictions, the interviews were performed online. In this way, different video- calling applications such as Skype® or WhatsApp® were used, with prior informed consent. In this context, we took the participants' resources into account. For all participants, we attempted to maintain a comfortable environment to favor the interviewees' privacy. The interviews were carried out by the main researcher of the study. They were recorded (audio and image), using three different devices and, finally, they were transcribed by the same researcher. All information was triangulated between researchers.

2.5 Data Analysis

The interviews were analyzed with inductive content analysis. The transcribed interviews were examined using thematic analysis to identify their meanings. For this purpose, a reflective, iterative and systematic process was performed, attending to the phases proposed by Braun and Clarke [24]: 1) Familiarization with the data through readings and annotations; 2) Coding; 3) Preparation of a thematic map; 4) Defining and naming themes; 5) Preparation of the final report with an analysis of the selected fragments. The structural analysis of the different parts, the reflexivity, and the semantic and pragmatic triangulation by the researchers allowed us to offer quality and rigor to this study. Information was extracted and categorized into themes and subthemes. Rigour was ensured through transferability, confirmability, dependability, and creditability [25].

2.6 Ethical Consideration

We received ethical approval from Andalusian Biomedical Research Ethics Portal (Ethics review committee (REC)) (Ref: TFM-IGAL-2020). Verbal informed consent was obtained from all participants prior to the interviews. Through an information sheet, participants were informed about the study procedure, purpose, and risks and benefits to the participants. The anonymity and confidentiality of the data were guaranteed, following the Protection of Personal Data and Guarantee of Digital Rights Law and the ethical principles contained in the Declaration of Helsinki and its subsequent modifications [26,27].

3 Results

Initially, out of a list of 36 Latinas, 31 met the inclusion criteria. But finally, 19 were selected because six of them refused to participate at the last minute and another six women did not have the available time to participate, the necessary connectivity for the video call, or enough emotional stability. The total number of participants was based on data saturation. These 19 participants were between 22 and 43 years old and came from six different countries in Latin America, mainly Peru. Nevertheless, there was heterogeneity of home countries (Table 2). Those who had a longer BF duration were associated with an advanced educational level, multiparity, a regular administrative situation at the time the baby was born, and participating in BFSG.

During the data analysis, two main categories and ten interrelated subcategories emerged (Table 3).

3.1 Breastfeeding Barriers

3.1.1 Work conditions. This was the main obstacle because there were no places prepared for breastmilk (BM) expression and storage nor was there enough time for pumping at work. Furthermore, precarious working conditions forced the women to spend most of the day working, preventing BF.

"... if they express their milk, where do they store it? ... the majority ... resort to formula." (MML-5).

"... you have that pressure ... either you stop working to breastfeed or you continue to work so that you can get food for everyone." (MML-9)

3.1.2 Precarious socioeconomic conditions. In addition, the interviewed mothers said that, if their administrative situation is irregular, they could only access precarious jobs without maternity leave because degrees' homologation is difficult.

"... if we don't have documentation... who is going to give you your salary while you are on leave?... how are we going to cover what we have to pay?" (MML-2)

"Another limiting factor is the shortage of clothing specifically designed for working nursing mothers or the high prices of the existing clothing." (MML-12)

3.1.3 Lack of support: health professionals, family, and society. On the one hand, the women identified unpleasant experiences with some healthcare professionals. In addition, the professionals played a paternalistic role that the participants found difficult to trust because they encouraged the women to interrupt BF and they were not very updated.

"Health professionals are not trained... it is horrible how little they know about BF... he called me negligent…" (MML-1)

On the other hand, study participants also stated that the extended family can negatively interfere with the BF process. They offer inadequate or erroneous information and encourage mothers to substitute formula milk (FM) for BM.

"... I was not breastfeeding all the time required and it was because of the inadequate information that I had around me... they [family] are trapping you until you switch to FM." (MML-12)

Besides, the participants frequently stated that they feel questioned and judged by society whether they give prolonged BF, or whether they decide or are forced to interrupt it early.

"But in society, there are many people who see me on the street, with the child… [and they say to her]: 'Are you still breastfeeding the baby? When are you going to stop?'… Sometimes, I break down, I feel

frustrated… nervous because everyone comes and tells you that this is not right [extending BF for a long time]."(MML-5)

Finally, a third of the interviewees stated that the aesthetic component is another barrier imposed by society in their culture. However, our participants recognize that biological function prevails over aesthetics.

"I felt sad and accused ... because people didn't want me to breastfeed my children so that my breasts wouldn't droop." (MML-9)

3.1.4 Physiological changes, pain, and fatigue. Women emphasized that the most common problems were ankyloglossia (frenulum) or nipple abnormalities (umbilical nipples or cracks). These impeded a proper grip, requiring training for effective BF. In addition, most said they wanted to quit BF because of pain and fatigue. Although pain is intense, it diminishes over time. Meanwhile, tiredness increases due to continued demands.

"I encountered the cracks, the pain, the frenulum issue… that was what prevented my baby from eating well. " (MML-12)

3.1.5 Ignorance and erroneous beliefs. Everyone recognized that a component that greatly hinders BF was insufficient BF knowledge, such as breast stimulation techniques, BF postures, interferences, or a lack of scientific information.

"... A difficulty that mothers have is the misinformation on ... unknown subjects: braces, interferences, pacifiers." (MML-1)

One-third of the interviewees also highlighted erroneous BF beliefs, among which predominated insufficient BM perception.

"Women are afraid of not having enough milk to give to their babies and that is when they stop breastfeeding and start using formula." (MML-19)

3.2 Breastfeeding Facilitators

3.2.1 Support networks: partner, health professionals, and family. Participants acknowledged their partners as the main source of support. Partners were essential to opt for BF instead of FM, as well as in collaborative functions with the baby and household chores. Likewise, the participants highlighted support networks made up of mothers, sisters, or close friends.

"If he hadn't made this big effort with me, I probably wouldn't have been nursing for 25 months." (MML-3)

These women also viewed the health professionals who positively influenced them as indispensable to their successful BF. They identified the midwife as the closest professional who provided them with knowledge, support, and accompaniment throughout the process.

"I really received a good explanation from my midwife, she was very participatory." (MML-5)

3.2.2 Host country versus Home country. Most of the participants identified the host country (Spain) as a BF facilitator. Here, they have found more institutional resources to support BF, as well as more updated and official information. Conversely, half of the interviewees thought that their home country also favored their BF process because they could have family councils and a greater support network there.

"... there are more institutionalized resources here, as BF groups ... and more informal and traditional information over there." (MML-10)

Some participants highlighted that differences in BF duration were not due to cultural issues. They suggested they were caused by individual factors (lack of means to access resources such as BFSG) or the vital moment they were going through.

"I believe that access to BFSG... more than a cultural barrier, it's a technological [media] barrier." (MML-3)

3.2.3 Religious practices/worship. One-third of the sample recognized the importance of the religious component or worship as a resource of support and accompaniment in the most difficult moments of BF. This was highlighted by mothers belonging to minority religious groups such as Evangelists or Jehovah's Witnesses.

"*Emotionally, you feel good, that you can do it… people of your same church also give you support and you feel more secure* [Evangelist]." (MML-2)

3.2.4 Appropriate attitude, knowledge, and experience. All the participants showed a good attitude towards BF and recognized that it was the best way to feed their babies. Moreover, most of them attended antenatal classes during pregnancy and showed adequate knowledge about BF advantages, as well as a satisfactory BF experience. *"It's tailor-made, like the perfect and exclusive food for your baby ... there are only advantages." (MML-10)*

3.2.5 Breastfeeding support groups. Longer BF periods were observed in mothers who participated in BFSG compared to those who did not, as represented in Table 4. In the first group, the mean duration was 18 months, compared to 13 months for mothers who did not participate in BFSG. Furthermore, tandem BF was more frequently observed in mothers who participated in BFSG. The participants in BFSG had a high educational level, such as university or postgraduate levels, whereas the women who did not get involved in BFSG habitually had vocational training or A level education.

The participants considered it important to increase the number BFSGs to help new mothers or experienced mothers by providing knowledge or recycling previous ideas. The interviewees highlighted various functions of BFSG such as: offering up-to-date knowledge; psychological support; women's empowerment; and recreation and social interaction.

"... it has been a revelation because of the high-quality information ... I have learned much more with them than from any professional." (MML-1)

“Those little tribes are like my… oasis, my relief.” (MML-3)

“… they give you the chance to meet other people, interact… that is the best thing because you come from another country, you don't know anyone and that helps you a lot. " (MML-15)

4 Discussion

To our knowledge, this study is the first in Spain aiming to understand Latina BF experiences from a qualitative perspective. In general, our results were quite consistent with the existing literature [28–30].

In our study, the main element that hindered BF is work. In line with several authors [14,31–33], our participants stated that this is due to the absence of adequate facilities and an early back-to-work during the postpartum period. Women maintained this is determined by the economic pressure and the precarious socioeconomic conditions in which they live, as shown in the literature [34]. The interviewees commented that, despite having a regulated administrative situation, degrees’ homologation is difficult. Thus, they feel relegated to unstable jobs with inflexible conditions, without maternity leave (in Spain, maternity leave lasts 16 weeks to allow a good BF and motherhood experience), and working almost all day. This limits BF maintenance, in agreement with many researchers [16,34–36].

Support of healthcare professionals and the family was controversial, as they were described both as facilitators and barriers. The participants commented that health professionals acted as a barrier when they had little BF knowledge. This led the participants to experience unpleasant situations, according to various authors [30,37,38]. Conversely, if the professionals were trained, the women considered their support as essential for their BF maintenance [29,31]. In this context, participants identified the midwives as the professionals giving them the treatment best adapted to their needs, coinciding with the proposals of various researchers [12,14].

Concerning the family, these mothers said they sometimes felt forced to opt for FM to avoid offensive comments from family members or society, coinciding with Hohl et al.[31]. However, when their partners or family members were proactive, they acted as positive reinforcers to continue BF, agreeing with the evidence [29,31]. Thus, one could conclude that the negative influence of health professionals and family could be due to a lack of updating or inadequate training in BF. In this case, they would not know how to respond to mothers’ needs and concerns, acting as BF barriers.

Moreover, interviewees granted special importance to painful breasts and nipples or to fatigue in the process as an obstacle to BF, coinciding with some studies [19,38]. Finally, another limiting factor was insufficient BF knowledge or erroneous beliefs such as the subjective perception of not producing enough milk, in line with existing literature [31,37]. Another facilitator identified was the religious component, as

stated by recent studies [39,40]. However, in our study, this predominated in Evangelists or Jehovah's Witnesses. Moreover, a proactive attitude towards BF, a positive BF experience, and adequate knowledge were associated with higher BF rates because the mothers identified benefits for their babies and themselves, coinciding with other authors [16,37,41].

The host country's influence was also controversial. Most of the participants identified the host country as positive for their BF process because they received more up-to-date information and institutional resources, agreeing with Schmied et al.[18]. Nevertheless, cultural influence could have had a negative influence because the shortest BF periods were found in women who had been longer in the host country, in accordance with Bigman et al.[42]. But as De Bocanegra suggests [14], the most culturally influenced women may have had more social support, reducing the negative effects of a lower Spanish BF culture and increasing their BF duration. This may explain the longer BF periods among residents who have been living longer in Spain. Furthermore, in our study, participation in BFSG was associated with a longer BF duration, coinciding with various studies [43,44]. Mothers reported that they were provided with updated and scientific knowledge as well as psychological support that encouraged and empowered them in their process. Likewise, BFSG offered them a recreational space that facilitated mothers' sociocultural integration, as proposed by researchers [38,45].

Finally, participants expressed the need for instruction and accompaniment by healthcare professionals before and during birth, as well as in the early postpartum, as suggested by other authors [14,30,46]. BFSGs were associated with an improvement in BF duration in Latina mothers [18]. Hence, participants demanded greater BFSG visibility to facilitate access to them and improve BF rates in our country.

The established lockdown that began in March 2020 could be the main limitation of the study, as some mothers might finally have decided not to collaborate in the research. They reported difficulties due to connectivity or emotional management. To minimize this, the main researcher conducted the interviews online through different platforms and at flexible times, so that the participants could reconcile them with their personal situations.

5 Conclusions And Relevance To Clinical Practice

This research has highlighted the needs of migrant groups, such as Latina migrants, to promote a more inclusive and culturally sensitive society. In this context, contributing to migrant literature, openness to diversity is also encouraged. We believe that by identifying the facilitators and barriers of BF, we can use the former to mitigate the negative effect of the latter. For this purpose, we should always take into account the cultural idiosyncrasies of the groups.

Our participants were normally convinced that BF is the best option. But they need more information and strategies to engage in BF, and peer support has been shown to be useful. Thereby, health care professionals should adapt BF-friendly practices to the reality of migrant women, taking into account

their barriers such as work and cultural practices. More support from caregivers and more sensitivity to cultural diversity are demanded by women, and well-trained professionals are needed.

Abbreviations

BF
breastfeeding
BFSG
breastfeeding support groups
BM
breastmilk
COREQ
Consolidated Criteria for Reporting Qualitative Research
FM
formula milk
REC
Ethics Review Committee
WHO
World Health Organisation

Declarations

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Author information

Affiliations

Nursing Department. Faculty of Nursing, Physiotherapy and Podiatry. University of Seville, Spain.

Fatima Leon-Larios.

Faculty of Psychology. University of Seville, Spain.

Blanca Iglesias-Rosado.

Contributions

FLL designed the study, BIR collected, analyzed data and wrote the first version of this manuscript. Both authors approved the final version of this article.

Corresponding author

Correspondence to Fatima Leon-Larios (fatimaleon@us.es)

Ethics declarations

Ethics approval and consent to participate

This study was approved by the Research Ethics Committees of the Virgen Macarena and Virgen del Rocío University Hospitals (Seville). Code TFM-IGAL-2020. The participants were asked to provide their written informed consent.

Consent for publication

Not applicable.

Competing interests

The authors declare no conflict of interest.

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Tables

Table 1	
	Interview script
Themes	Sample questions
Sociodemographic factors	What is your name?
	How old are you?
	What is your educational level?
	What is your country of birth?
	When did you arrive to Spain?
	Why did you migrate?
	What was the administrative situation when the baby was born?
	Did you have maternity leave?
	Do you feel comfortable in Spain?
Obstetric data and knowledge	How many children do you have?
	How long did BF last in each one?
	How was your labour experience/s?
	Did you go to antenatal classes?
	In your opinion, what are BF advantages?
	Did you feel that you received the information you needed?
	Did you have difficulties for healthcare professionals to resolve your doubts?
	In your opinion, what are the barriers that have not helped you/other women to maintain BF for longer?
Supports and feelings	What family do you have here?
	Who has been your main support?
	Do you think that BF in your home country would have been different?
	What predominates in your home country: breast milk or formula?
	What role have healthcare professionals played in your BF experience?
	What do BF support groups bring you?
	Do you practice religion here?
	How did you feel/are you feeling about your BF experience?
	Is there anything else you would like to say?

Note. *Source: self made.*

Table 2

Sociodemographic characteristics

Participants	Age	Education level	Children	Home country	Administrative situation	Host country (time)
MML-1	33	University	2	Costa Rica	Regularized	9 years
MML -2	27	A level	3	Honduras	Regularized	5 years
MML -3	41	University	1	Costa Rica	Regularized	20 years
MML -4	37	Vocational training	1	Peru	Irregularized	2 months
MML -5	40	Posgraduate	2	Peru	Regularized	4 years
MML -6	43	A level	4	Peru	Regularized	14 years
MML -7	32	Secondary	3	Peru	Irregularized	8 months
MML -8	37	University	1	Peru	Regularized	4 years
MML -9	34	Vocational training	2	Honduras	Regularized	2 years
MML -10	36	Posgraduate	1	Costa Rica	Regularized	2 years
MML -11	31	Vocational training	2	Venezuela	Irregularized	1 year
MML -12	38	University	2	Panama	Regularized	11 years
MML -13	40	Primary	3	Honduras	Regularized	4 years
MML -14	37	Vocational training	3	Colombia	Regularized	2 years
MML -15	42	Vocational training	4	Venezuela	Regularized	3 years
MML -16	30	A level	2	Colombia	Regularized	12 years
MML -17	40	Vocational training	1	Peru	Regularized	20 years
MML -18	33	University	2	Peru	Regularized	4 years
MML -19	22	Secondary	1	Colombia	Regularized	12 years

Note. *Source: self made.*

Table 3	
Categories and subcategories	
Categories	Subcategories
Breastfeeding Barriers	Work conditions
	Precarious socioeconomic conditions
	Lack of support: health professionals, family and society
	Physiological changes, pain and fatigue
	Ignorance and wrong beliefs
Breastfeeding Facilitators	Support networks: partner, health professionals and family
	Host country VS Home country
	Religious practices/worship
	Appropiate attitude, knowledge and experience
	Breastfeeding support groups

Table 4 not available with this version

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- ISSMCOREQChecklist.pdf