

Cultural practices about breastfeeding among families enrolled in a Family Health Program

PRÁTICAS CULTURAIS SOBRE ALEITAMENTO MATERNO ENTRE FAMÍLIAS CADASTRADAS EM UM PROGRAMA DE SAÚDE DA FAMÍLIA

PRÁCTICAS CULTURALES SOBRE AMAMANTAMIENTO MATERNO ENTRE FAMILIAS REGISTRADAS EN UN PROGRAMA DE SALUD DE LA FAMILIA

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RESUMO

Objetivou-se identificar as práticas culturais em relação ao aleitamento materno entre famílias cadastradas em um PSF. Estudo descritivo, exploratório, realizado em Pentecoste, Ceará, com 15 mães que demonstraram algum fator restritivo ao aleitamento. A coleta de dados ocorreu por meio de observação direta e entrevista semiestruturada e, após análise, emergiram as categorias empíricas: prazer em amamentar e prevenção de doenças; influência da família/comunidade; e dificuldade em manter a amamentação. As mães verbalizaram dificuldades na prática da amamentação, ausência de um suporte adequado do serviço de saúde que envolva fatores não somente biológicos, mas no âmbito social e cultural. Conclui-se que há distanciamento entre o discurso científico e as práticas culturais do dia-a-dia dessas famílias.

DESCRIPTORIOS

Aleitamento materno.
Cultura.
Programa Saúde da Família.

ABSTRACT

The objective of this study was to identify the cultural practices about breastfeeding among families enrolled in a Family Health Program (FHP). This exploratory study was performed in the city of Pentecoste (Ceará, Brazil), with 15 mothers who showed some restrictive factor for breastfeeding. Data collection was through direct observation and semi-structured interviews. The analysis revealed empirical categories of pleasure in breastfeeding and the prevention of diseases; influence from family/community; and the difficulty to sustain breastfeeding. The mothers reported difficulties related to the practice of breastfeeding, a lack of adequate health service support involving not only biological but also social and cultural factors. There is a disconnection between the scientific discourse and families' everyday cultural practices.

KEY WORDS

Breast feeding.
Culture.
Family Health Program.

RESUMEN

Se objetivó identificar las prácticas culturales en relación al amamantamiento materno entre familias registradas en un PSF. Estudio descriptivo, exploratorio, realizado en Pentecoste, Ceará, con 15 madres que demostraron algún factor restrictivo al amamantamiento. La recolección de datos ocurrió por medio de observación directa y entrevista semiestructurada y, después del análisis, emergieron las categorías empíricas: placer en amamentar y prevención de enfermedades; influencia de la familia/comunidad; y dificultad en mantener el amamantamiento. Las madres verbalizaron dificultades en la práctica del amamantamiento, ausencia de un soporte adecuado del servicio de salud que contenga factores no solamente biológicos, y si también del ámbito social y cultural. Se concluye que hay un distanciamento entre el discurso científico y las prácticas culturales de lo cotidiano de esas familias.

DESCRIPTORIOS

Lactancia materna.
Cultura.
Programa de Salud Familiar.

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INTRODUCTION

The attempts to reorganize Brazil's Primary Healthcare in the last decade resulted in the creation of the Family Health Program (FHP). The Program has been coordinated and financed by the Ministry of Health since 1994 as one of the major structuring strategies to the Unique Health System (UHS). In that same year, the State of Ceará triggered the implementation of FHPs in 20 cities, counting on 81 healthcare teams; nowadays, the program is found in 184 towns and counts on 1,525 teams, representing 100% of the State's municipalities and covering 56% of the population⁽¹⁾.

The Family Health Program model, according to the Ministry of Health⁽²⁾, intends to highlight actions that promote, protect and rescue people's health based on their family environment, at their homes, thus creating a more permanent bond between the healthcare team and the population it is responsible for, contributing to the democratization of knowledge and aiming to consolidate the healthcare concept as an exercise of citizenship.

Some aspects of this healthcare attention model, however, are questioned, especially regarding the demonstrative studies on how this strategy is influenced by traditional practices divorced from family contexts. The users' cultural values, beliefs, myths and cosmovisions need to be shared with the healthcare team engaged in the process of re-orienting its action focus, in order to consolidate the healthcare surveillance mode.

This vision elicits cultural understanding of and respect to the user, as well as anthropological and congruent approaches to family life and sanitary realities. It must be highlighted that despite the positive meaning of the FHP in many municipalities, there is no connection between the program and the families' daily life, and that stems from the tenuous bond between the healthcare professional and the families.

Child mortality is said to have a narrow relationship with cultural practices; although it tends to decline, this health indicator in Brazil still shows meaningful rates when compared with developed countries.

In 2001, the Brazilian Mortality Rate reached 28.7 per 1,000 live newborns; in the same year, Chile presented 10/1,000; Argentina indicated 18/1,000; and Paraguay showed 24/1,000. In Brazil, the Northeastern region keeps the highest rate (39/1,000) according to the Basic Attention Information System (BAIS), pointing out significant variations among municipalities⁽¹⁾.

In accordance with the BAIS statistics, child mortality in some regions of Northeastern Brazil, mainly in Ceará, was considerably reduced. Such a perspective renders it vital to take into effect educational actions grounded on the socio-

cultural comprehension of the assisted population and the understanding of the region's epidemiological profile.

Scientific studies show that the vast majority of breast-fed children, especially in their first months of life, grow strong and healthy, meaningfully reducing the child morbidity, once breastfeeding has long been recognized, even by ancient civilizations, as a relevant action towards disease prevention processes that also favors the mother-child bond. The World Health Organization (WHO) highlights the importance of the breastfeeding up to the second year of life and the relevance of establishing it as an exclusive practice in the first six months. The WHO also states the need of maintaining maternal breastfeeding, added by complimentary food, up to two years of life or over. However, in spite of the attested benefits of breastfeeding, governmental programs in Brazil have not been able to fulfill those recommendations⁽³⁻⁴⁾.

The precocious interruption of breastfeeding still prevails and occurs in quite a meaningful way, justifying the inappropriate life conditions of most Brazilian children, especially referring to child morbimortality; it must be highlighted that part of the weaning process takes place on the first weeks of the baby's life⁽⁵⁻⁶⁾.

Actions that address child mortality issues must naturally involve the whole family in the promotion and follow-up of the child development process, prioritizing those practices related to the improvement of child attention and care and encompassing knowledge, procedures, attitudes and behaviors that can contribute towards survival in accordance with beliefs, values and habits⁽⁷⁾.

Current child-oriented healthcare programs formulated and implemented in all governmental levels provide neither visibility nor effectiveness to family care related actions; there is a perception of little stimulus towards strengthening such a practice. We can infer that society at large does not assign child-based healthcare models a real value that makes the difference in maintaining child health statuses in day-to-day activities. It is widely known, however, that this family daily practice includes this type of care, expressing a culturally built reality. Literature indicates that the care reveals a sense of practice that, on its turn, is permeated by customs, conceptions and cultural transformations⁽⁸⁾.

The cultural interface of breastfeeding related practices resounds in the healthcare conditions of the child, the mother and the family, and the approach of the cultural context of the families experiencing breastfeeding processes by the healthcare professional favors a culturally competent practice. In this sense, research identifies cultural practices regarding maternal breastfeeding among families enrolled in the Ceará Family Healthcare Program.

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METHOD

The current descriptive, exploratory study was carried out in the municipality of Pentecoste, State of Ceará. The city has six Family Healthcare Basic Units (FHBUs), being one of them located in the district of Pedreiras, the *locus* of the study, with 1,131 enrolled families. Located 85 km west from the capital Fortaleza, Pentecoste has a population of 32,742 inhabitants, being 725 of them younger than one year. This municipality was chosen for presenting a Child Mortality Rate (CMR) of 21/1,000 live newborns in 2002; the causes of the deaths were predominantly infectious and parasitary diseases⁽¹⁾.

The subjects of the study were 15 mothers of children younger than one year enrolled at the FHBUs in the Pedreiras district who were available to spontaneously participate in the research. Resolution 196/96⁽¹⁰⁾ on the goals of the study, the risk-free status of the research, the benefits of discussing the relevance of maternal breastfeeding to the child's healthcare, as well as the guarantee of full anonymity of information, were all complied with. The project was approved by the Committee of Ethics and Research of the University of Fortaleza under legal opinion 278/2004.

Data collection was made through observation, field diary notes and application of semi-structured recorded and ultimately transcribed interviews, thus providing a better categorization of results. The interviews were made at the mothers' homes and were carried out in order to identify the practices related to maternal breastfeeding and its peculiarities.

Data were analyzed at the light of the Minayo thought that points out three objectives: data comprehension - confirmation or non-confirmation of the presuppositions of the research; responses to the formulated questions; and expansion of the knowledge on the issue, articulating it to the cultural context into which it is inserted⁽⁹⁾. From these analyses the following empirical categories were produced: pleasure in breastfeeding and prevention of diseases; family/community opinion and influence; and difficulty in maintaining breastfeeding.

RESULTS AND DISCUSSION

All three empirical categories present the major significant elements in the breastfeeding process and the cultural factors that can influence this practice based on the reality of the informants, identified as follows: Mother 1, Mother 2, Mother 3... Mother 15.

1st empirical category. Pleasure in breastfeeding and prevention of diseases

It was possible to pinpoint the fact that breastfeeding is translated into an act of maternal love, but above all a feeling of obligation, a social assignment imposed to mothers. It can be realized that the myths and beliefs on the

nutritional value of the milk are strongly rooted in the practice and discourses of those mothers.

I had never breastfed before, she is my first, because my first boy was not breastfed... I have plenty of milk, she breastfeeds abundantly, I think that my milk is not good, it's weak... she wants to breastfeed all the time (Mother 1).

I know that the maternal milk is good, it is a complete food that does not demand water, it's just a question of stimulus. But it did not work out fine with me, my milk just did not flow, I placed him on my breasts to suck and after finishing it he kept crying of hunger (Mothers 10 and 15).

Literature indicates countless obstacles, as well as myths, beliefs and taboos internalized by these mothers during their cultural formation regarding maternal breastfeeding, such as insufficient milk production, weak milk, weeping of the child, damage to the body aesthetic, pain on the nipples, breast engorgement, and so on and so forth^(5-6,11).

Besides being related to personal decision, the mother's breastfeeding choice is also related to the value assigned by society to this act. However, this personal option and its maintenance are influenced by psychological, social, economic and cultural aspects as well. We can realize that the breastfeeding practice is more related to the compliance with a social obligation than the result of a rational choice motivated by a personal comprehension of the advantages and benefits of the breastfeeding process to the mother, the child, the family, and the State.

On the first days my nipples ached terribly! Sometimes I thought I would give up! Now, when it's breastfeeding time my breasts are filled up, the sensation is very good, it's wonderful! (Mother 2).

Breastfeeding...is the most important food a child has because...it prevents the child of getting sick and avoids many other things, you know. I think mothers should definitely breastfeed their babies (Mother 3).

Maternal milk is very good to children and meanwhile my baby is just being breastfed, but he is not enjoying the breastfeeding alone anymore, he feels like it's not enough. Then, I'm complementing with another milk, the NAN... (Mother 4).

In a certain way, the breastfeeding practice is a *representation* of how society conceives cultural roles, its perspectives on motherhood, the way it cares for its children and approach diseases, as well as a comprehension of the family dynamics. Although breastfeeding is a biologically determined process it is strongly conditioned by socio-cultural factors. In this study, mothers indicated to be aware of the importance of the maternal breastfeeding to the child, showing in their discourses the recognition of the value of the milk as being a type of food that prevents diseases both in the childhood and in the adult phase.

...to take care of the child so that he does not get sick, and...so that nothing bad happens to him. A child that is

breastfed is joyful and... there are children that are not breastfed, and gets sick with diarrhea, and go to the hospital (Mother 5).

He does not have any defense in his organism, maternal breastfeeding will be efficient both now and in the future. It prevents him from getting sick... it's better for him (Mother 2).

Even though the relationship between the breastfeeding practice and the decrease of the incidence of infectious diseases and reduction of child mortality have been evidenced, we can observe that the prevalence of maternal breastfeeding has diminished in several parts of the world due to social, political, economic and cultural reasons⁽⁴⁾.

The vast majority of reports regarding the knowledge of the breastfeeding have elected the child as the single beneficiary of the breastfeeding practice, often associating the procedure with the properties of the maternal milk in preventing diseases. Nonetheless, the psychosocial advantages of this practice have not been indicated for the construction and strengthening of the bonds between mother and child, and above all, the socio-cultural factors that somehow interfere in the success of breastfeeding have not been mentioned. This reductionist understanding demonstrates the significant influence of the hygienist model on the maternal breastfeeding practice as a natural phenomenon that emphasizes physical health over the affective bond that is established between mother and baby, which is so relevant to the child's emotional health status.

Given the above mentioned reality, a bibliographic research of scientific evidences concerning the demand of breastfeeding assistance and the mothers' experience in this process highlighted the breastfeeding difficulty mothers undergo. The study described that society charges mothers towards the breastfeeding act; therefore, such a practice is understood as a maternal obligation rather than a procedure that yields mutual benefits for both mother and baby. The healthcare professional has the mission of disseminating such knowledge based not only on a biological perspective, but also inserting nursing mothers into all the dimensions of being a woman⁽¹²⁾.

Although the value of the maternal milk to the child's health is beyond any question, the breastfeeding practice reflects the attitude of the woman at life and receives strong influences stemming from several different factors, such as social, economic, cultural and emotional. In this context, the breastfeeding practice does not occur satisfactorily, thus contributing to its precocious interruption.

2nd empirical category. Family/community influence.

In this category it was possible to realize the duality of the influence from other agents in the breastfeeding scenario, both positive and negative. A study carried out in Fortaleza, capital of Ceará, involving seven adolescents verified that in the majority of times elderly family members, such as mother and grandmother, exert influence at breast-

feeding time, taking into account the fact that the child care is an instruction passed from generation to generation, preserving customs and inserting new beliefs and values featured as *family cultural care*⁽¹³⁾.

She struggled to introduce the pap to the baby, but she just refused it because she was used to breastfeed from the beginning. Some people say it is not good. My husband said that the baby should have it as long as she wants it, as long as it's satisfying her (Mother 6 and 15).

Everyone supports me, cares for me, no one is against it. Nobody wanted me to give other milk, just the breast, but I just could not stand it. That's why I gave her the pap. I was sort of weak, dizzy... Many people said it happened because I was breastfeeding (Mother 7).

The women's experience reveals that breastfeeding is a complex process that demands teaching and support from family members, professionals, healthcare institutions and the State. Breastfeeding must be remodeled in the family in such a way that it widens built-in knowledge by identifying the practice as an aggregation of various knowledges resulting from biological, social, economic and political aspects⁽¹⁴⁾. In such a way, it will be possible to constitute a more consistent and effective process towards the breastfeeding practice.

My mother-in-law says that I should give pap to this girl, but I am beating around the bush; in order not to give her the pap I give her cow milk. As long as I give her the cow milk and the breast, I won't give her the pap. The father says, *what about these big breasts there?* On the other hand, my neighbors tell me to give her milk, that breastfeeding is not enough. I think that the breast and the cow milk are working out, right? She is quite a silent girl, spends the whole day quiet, she just cries when she's hungry, I think it's enough (Mothers 3, 9 and 11).

The discourses of the mothers reveal that the act of breastfeeding results from individual experiences and is marked by the environment that surrounds each woman. The knowledge and experience of the mother, mother-in-law, sister, grandmother and neighbors are passed on as examples, advices and teachings, and the discourses are sometimes favorable, sometimes contrary to breastfeeding. This knowledge originated in the common sense is permeated by taboos, myths and beliefs, thus determining either the continuity or interruption of such a practice.

The investigation on the influence of grandparents in supporting the breastfeeding practice was found in a study carried out in the city of Florianópolis with 11 grandmothers. The study identified the direct influence of grandmothers in the breastfeeding process experience by the nursing woman, and collaborated to provide security and confidence to daughters and daughters-in-law, once they know they will receive care, support and stimulus from their parents. In this way, they are positively influenced and will certainly replicate those experiences in the future⁽¹⁵⁾.

So, one of the major objectives of the healthcare unit is to re-orient assistance-based attention models and restructure public services focusing on healthcare promotion. Promotion processes are effective when families directly share the execution of improvements in healthcare indicators. Among these actions we highlight the strategies applied towards developing a critical awareness aimed to change behaviors, thus minimizing the existence of negative factors in the breastfeeding practice.

My mother wants me to give her the pap, my mother-in-law does, too, but the father wants me to only breastfeed her... But I think it's not been enough, she cries, I place her at my breasts but she is not satisfied. Then, on the first day, I breastfed her, and I gave the pap as soon as she arrived from the hospital, you know. I've been giving her the pap and breastfeeding her since then (Mother 1).

It is known that it is possible to reduce the precocious weaning index from the moment that new policies that favor the life dynamics of nursing mothers are created. In this way, the morbimortality rate can also decrease, as the maternal milk is a strong ally, together with other political, economic, social and cultural measures.

In 2001, the article titled *Maternal Breastfeeding and food beliefs*⁽¹⁶⁾ addressed the influence of foods culturally known as milk producers – lactogogues – in the breastfeeding practice by means of a study carried out with three mothers who lived in the city of Ribeirão Preto. The research detected that human beings in general are made of cultural traditions, beliefs and values established in accordance with the context in which they are inserted into, or in other words, they have their own subjectivity. Sometimes we forget the relevance of culture and try to comply with imposed models, in conformity with dictated norms.

3rd empirical category. Difficulty in maintaining breastfeeding

The reports of the mothers ratified that despite the orientation/information on breastfeeding received at the healthcare unit or disseminated by the media, breastfeeding moments revealed conflicts between the received guidelines and the practical experience. Myths, fears, insecurity and difficulties strongly bound to common sense showed up.

I started giving the pap, my milk was weak and did not sustain her. She started crying, my milk was not filling her tummy... and I give it to him three times a day, morning, afternoon and evening, he eats very well and sleeps well, too, you know (Mothers 1 and 13).

When I breastfeed the baby in a frequent basis I feel dizzy, weak [...] he sucks for a long time, and causes me to be weak, but I have to keep it on, if we don't breastfeed the baby, he gets weak and sick (Mother 5).

On the first months it was difficult, my breasts got huge, full of milk, they hurt, I had to drain it, I was just not willing to breastfeed the baby, it hurt a lot! But now I got used to it,

thank God, it does not hurt anymore, but it does takes much of our time (Mother 3).

In the search for new strategies aimed to improve breastfeeding indexes, we came across a study⁽¹⁷⁾ that assessed the degree of implementation of a strategy called *Incentive to Maternal Breastfeeding* (IMB) in the city of Olinda (PE). The study defends a thesis that provides evidences to the importance of inserting programs such as the IMB into Family Healthcare Programs depicting several contexts, such as precocious incentives to exclusive maternal breastfeeding, prenatal orientation by means of educational procedures, food orientation towards the weaning process, among other educational practices, besides the orientation provided in the puerperal period.

The mothers' discourses highlighted their need of support and indicated breastfeeding related issues that must take into account the socio-cultural and psychological aspects that surround this phenomenon. The anguish of these mothers when experiencing the behavior of the child during breastfeeding was notorious, as well as when they listened to conversations based on the customs that transcend generations, such as *the milk is weak* and *the amount is little*.

The vulnerability of mothers to such a context is potentialized by the stress, adynamia, sleepless nights and, several times, by the fact of taking care of their first child. The summation of these factors favors weaning processes before the fourth month and the incentive, more and more precocious, to the employment of pacifiers and formulas.

For this purpose, the precocious weaning process is influenced by several factors, such as the anxiety regarding the amount of milk produced and the satisfaction of the child as the main focus. This level of distress can be minimized by inserting the mothers into a maternal context that involves socio-cultural peculiarities⁽¹⁸⁾.

The research showed the importance of transforming myths and scientific knowledge into allies regarding the genesis and the maintenance of the breastfeeding with an adequate volume to the children's demands. The study also recorded the need of getting acquainted with healthcare beliefs, which are portions of the histories of people, and ultimately embody them in the scientific knowledge of healthcare professionals.

The child care practices vary from one culture to the other, and even between groups within one given culture. Those distinctions are recognized, supported and adapted to each environment; however, the basic needs of the child concerning food, healthcare, protection, shelter and love are similar in the vast majority of cultures, although the way of satisfying them can be diverse in each culture.

The first difficulty is the work involved in the process. I felt I had to complement his nourishment with the NAN 1 milk; when I started giving it to him he had a fever and I quit for some days. I tried again but he feels like he's being rejected. He puts quite a sad look at me, and as a mother I

feel that I'm not being fair to him...preventing him from breastfeeding (Mothers 8 and 12).

Mothers play a critical role in the family, from raising, educating and caring for the children to coping with illnesses. However, the lack of knowledge, the poverty condition they are submitted to, and the current conception of public policies directed to the child and the family make it very difficult for them to perform such tasks.

The mothers' discourses point out that the attention to the child is associated with health, hygiene, food and illness, aimed to accelerating the welfare of their children. These mothers have scarce opportunities of exchanging mutual experiences and knowledge that can promote their *empowerment* or make access to other information they may eventually need.

In such a way, it is hard for families to perceive themselves as political and social beings in which roles are complemented, or in other words, the acquisition of rights and the responsibility for duties towards an effective holistic care of their children. If this perspective were taken, family records on the importance of the psycho-affective aspects that are inherent to the act of protecting and educating would be certainly be highlighted.

The guidelines proposed by international macro-programs corroborate this affirmation, such as the Healthcare Promotion, recommending a new healthcare culture to the population. Bearing in mind the necessity the healthcare sector has of developing this *new culture*, in which professionals and technicians perceive themselves as educators - even though they are not aware of this role -, it is urgent that the background of those professionals include the contextualization of new healthcare practices and social insertion⁽¹⁹⁾.

A contradiction was observed between the discourse of the mothers and the maternal breastfeeding practice. In spite of verbalizing the relevance of the human milk in the prevention of illnesses, they also mention the introduction of teas, other milks, water or any other food, as well as the use of formulas and pacifiers on the first weeks or months of life. Some records also identified the establishment of timetables, thus not following the guideline of the free demand.

Therefore, literature is emphatic when referring that the promotion of the maternal breastfeeding practice aiming to improve the quality of life of the families should be a top priority, especially concerning the children's healthcare,

once breastfeeding is a clear, satisfactory and, above all, a cheap alternative.

FINAL CONSIDERATIONS

The cultural practices concerning maternal breastfeeding observed in a Family Healthcare Program in Ceará ratify those disseminated by literature. In this way, the breastfeeding act for mothers is still seen as a duty/responsibility imposed to women, going beyond their desire or refusal to comply or not with the practice. This act is more related to a social obligation than a result of a rational choice motivated by the construction of a structural knowledge of the advantages and benefits of the breastfeeding to the mother, the child, the family, and the State. Such a fact can be associated with the insufficiency of healthcare educational strategies that make possible the development of a critical awareness in the cultural scope.

Mothers, in their discourses, reported the difficulties in practicing breastfeeding, highlighting the absence of an adequate healthcare support. The current model tends to operationalize the practice mainly focused on the biological dimension, thus underestimating the approaches that consider the psychological, social and cultural components. The reports of the participants depicted the distance between the official healthcare discourse and the singular practice experienced by the woman in her everyday life, thus contributing to the precocious weaning process on the first weeks or months of the baby's life.

This phenomenon is stressed by the mothers' discourses on the introduction of water, teas, juices and other milks, and the use of pacifiers and formulas. Despite the advances achieved in the breastfeeding practice by the creation of norms, legislations and programs that promote, protect and support breastfeeding procedures, it has not yet been possible to overcome the challenge of the precocious weaning.

The researchers conclude that to inform mothers on the importance of the breastfeeding alone during the activities of maternal breastfeeding promotion is not enough. We need to take a leap forward and implement educational actions that include the perspective of healthcare promotion that opens way to the comprehension of life, involving the women's families, favoring the self-construction of the subject, and working towards improving quality of life. Therefore, given this reality, we must create effective measures that resignify educational actions that have long been recommended by healthcare public policies.

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