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WILDE, Matt

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Culture
A determinant of breastfeeding in SCPHN practice

The health benefits of breastfeeding are well researched and are recognised by professional bodies both nationally and globally, yet breastfeeding rates for many countries globally fall short of their respective national targets. Efforts have been made within both maternity services and Specialist Community Public Health Nursing (SCPHN) practice to provide training for professionals to improve breastfeeding rates, yet in many areas there remains a focus on the biological factors more than cultural beliefs, despite culture being widely accepted as an integral aspect of needs assessment in the field of SCPHN practice. This article explores the literature to identify cultural beliefs surrounding breastfeeding from both positive and negative perspectives, which further highlighted how SCPHNs can improve their practice in sensitively approaching this subject with new and expecting mothers. The purpose of this review was to identify the significance of culture as a determinant of breastfeeding and highlight potential methods for improving SCPHN practice in this area.

Matt Wilde, senior lecturer, Sheffield Hallam University, Sheffield

Regardless of the application, for many years the significance of culture has been widely accepted as an integral aspect of needs assessment in the field of SCPHN practice. However, it is suggested that the influence of cultural beliefs have been somewhat under-acknowledged in the context of infant feeding (Larsen and Kronborg, 2013). This is not to say it is not recognised, although increased emphasis could enhance SCPHN skills and practice, subsequently improving the support provided. Typical breastfeeding discussions have predominantly focussed on case studies and shared examples of white British families, yet the diverse nature of England suggests this may be insufficient, with 18% of the population identified as Black, Asian, mixed or other ethnic group (Office for National Statistics, 2021), which highlights the need to explore this in more depth.

Background

The health benefits of breastfeeding are well researched and are recognised by professional bodies both nationally and globally (UNICEF, 2021; World Health Organisation [WHO], 2021). Benefits which are commonly shared to support the education of parents and expecting parents include (Hatton-Bowers et al, 2017; UNICEF, 2021; WHO, 2021):

- Improved infant immune system
- Reduced risk of respiratory and gastrointestinal infections
- Reduced risk of obesity
- Reduced risk of SIDS.

The significance of exclusive breastfeeding is argued to have the potential to save the lives of over 800 000 children and 200 000

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> 'The significance of exclusive breastfeeding is argued to have the potential to save the lives of over 800 000 children and 200 000 women annually.'

women annually (Wanjohi et al, 2017; WHO, 2021).

Despite the overwhelming evidence in favour of breastfeeding, Wanjohi et al (2017) claim that almost two-thirds of infants in developing countries do not breastfeed exclusively for 6 months as per WHO recommendations. Dornan et al (2020) reported that England's breastfeeding rate was under 50%, which, according to Public Health England (2019) was the lowest in Europe at the time, with disadvantaged communities having the lowest rates, subsequently increasing the risk of health inequalities. The Office for Health Improvements and Disparities (2023) identified that 20/21 exclusive breastfeeding rates at 6-8 weeks in the UK were 36.5%, which falls significantly below the WHO's aim of increasing exclusive breastfeeding rates globally for the first 6 months to at least 50% by 2025. Brown (2018) identified that English women in the UK have the lowest rates of breastfeeding initiation (79%) when compared to other ethnicities residing in the UK including Black, Asian, Chinese, and European mothers (all>95%). This may be the reason more emphasis remains on English women breastfeeding within training. However, there is substantial evidence around the influence of community culture, where local beliefs and practices are often adopted by those living there. Renfrew et al (2012) claim a strong bottle-feeding culture within the UK explains why rates for bottle feeding remain high.

The review of the literature around cultural beliefs is pivotal due to the abundance of evidence which stipulates that breastfeeding success is not commonly a biological factor, but is influenced by cultural habits, beliefs, standards and behaviours which exist within the community (Daglas and Antoniou, 2012; Wanjohi et al, 2017; Osman et al, 2009; Hatton-Bowers et al, 2017; Dornan et al, 2020; Brown, 2018). The movement towards accepting this paradigm has been more evident in recent years, although Brown (2018) states that much of the initial research surrounding breastfeeding was conducted in and around clinical settings and followed the medical model, resulting in breastfeeding being viewed as a biological concept. It is vital that we continue to acknowledge and understand what these cultural beliefs are and more importantly how we may respect these to successfully support breastfeeding practice. Culture was also recognised as one of the most pertinent determinants for choosing to bottle feed (Goncalves, 2017). It is essential that we do not purely focus on the negative influences, as there was often a balance between beliefs and misconceptions, which either support breastfeeding or discourage it (Osman et al 2009; Brown, 2018). McCormack and McCance (2016) argued that the positives may be used as valuable resources in nursing and midwifery practice, particularly in accordance with a person-centred approach.

Cultural beliefs

Centre for Disease Control and Prevention (2021) claim culture is defined as 'practices, values, and norms which can be shared or learned, and may correlate with race, nationality, or ethnicity'. Numerous key cultural beliefs emerged within the literature, not always specific to ethnicity nor religion, but were strongly associated with the geographical area or the local community. Brown (2018) reviewed breastfeeding research from across the globe including Australia, USA, Sweden, Canada and the UK and claimed these themes could be separated in to two categories: 'direct negative attitudes about breastfeeding and impact; more subtle factors that despite intention and desire to breastfeed, erode maternal ability to do so'.

Perceptions

Symbolism of the breast was identified as a negative determinant. Individuals were concerned with sexualisation of the breast and their role being solely for pleasure, not feeding in public to keep the breasts private due to sexual connotations, anxiety around breasts changing appearance and affecting their sexual appeal (Purdy, 2010; Daglas and Antoniou, 2012; Hatton-Bowers et al, 2017). However, Daglas and Antoniou (2012) identified that in some Western African cultures the breast has no sexualised connections, and the breast has retained its primary biological function as an organ for feeding babies, resulting in an atmosphere that supports the initiation and continuation of breast feeding. Conversely, Daglas and Antoniou (2012) discovered that women from some Western African countries perceived artificial feeding by fathers in public places as demonstrating an acceptance by the father and increased bonding.

Nutrition

Colostrum was widely debated in the literature where it was either seen as healthy and beneficial for the baby in accordance with UK National guidance (Wanjohi et al, 2017), or it was highly discouraged where messages described it as 'dirty', could cause the baby to become sick, had no nutritional value or caused stomach-ache (Wanjohi et al, 2017; Brown, 2018).

Again, a popular yet negative belief identified in the literature was the notion of the 'Evil Eye'. Mothers from Kenya feared breastfeeding in public due to a risk that someone with an 'Evil Eye' or 'malevolent gaze' could look upon them while feeding causing their milk to dry up and them to develop breast sores (Osman et al, 2009; Wanjohi et al, 2017; Brown, 2018).

Another negative belief reported in several cultures was the notion that breastfeeding does not satisfy the needs of the baby. Mothers from African, Indian, South-East Asian, African American, and Hispanic regions made comments that the milk runs straight through the baby, formula feeding is associated with heavier babies, and strong thoughts around prelactal feeding, which all discourage mothers from breastfeeding (Purdy, 2010; Hatton-Bowers et al, 2017; Brown, 2018). Some of these beliefs support ideas such as offering formula milk for the first week until the milk is established as beneficial (Purdy, 2010), babies require prelactal feeds as they are born hungry (Brown, 2018), beginning on the third day postpartum is best and that offering seaweed soup promotes milk production (Hatton-Bowers et al, 2017), all of which do not align with professional guidance.

Family influence

Family influence has been well recognised as a determinant regardless of culture in the UK. Although a somewhat interesting development within the literature was the suggestion that mothers or expecting mothers were informed that they had inherited a poor ability to breastfeed stemming from the maternal line, which was reinforced through 'fussy' or 'poor sleeping' babies. On the contrary, biological issues which have scientific evidence were used to discourage breastfeeding in some

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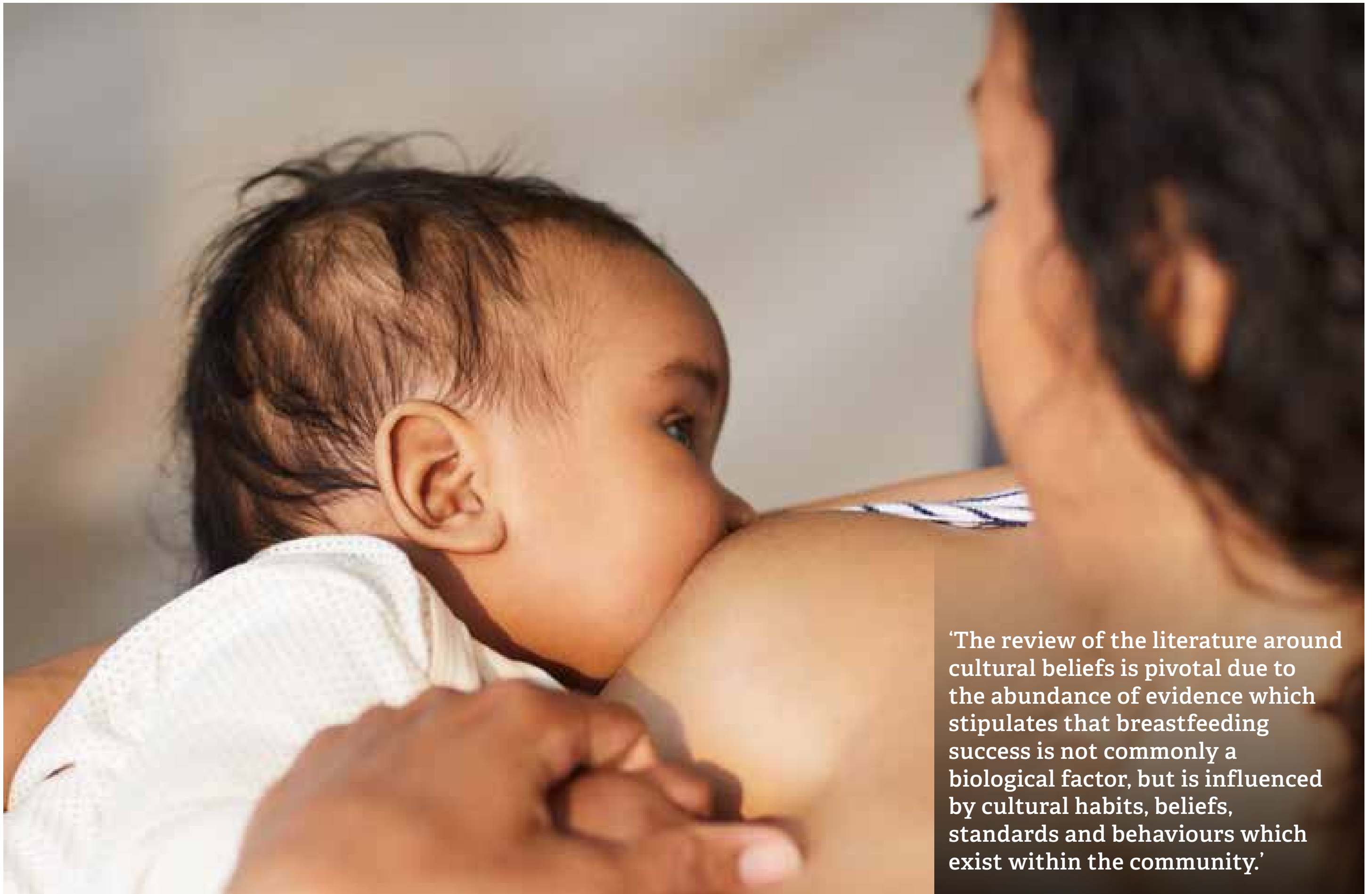

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cultures. Osman et al (2009) found that some women were led to believe that abdominal cramps felt in the normal retraction of the uterus following birth, influenced by breastfeeding, can be passed on to the baby through breastmilk. Others were informed that bad diet or medication had turned their milk 'bad' and would hurt their baby despite a lack of scientific evidence in those cases (Osman et al, 2009).

Timeline

Brown (2018) stated that mothers from Ghana believed breastfeeding should be delayed until day 3 (4 if a baby girl) so that they may undergo a cleansing process, which was also found to be the belief in Hindu medical literature (Laroia and Sharma, 2006). However, supportive beliefs for breastfeeding were also present in the literature, where a 40-day recuperation period following birth was encouraged, within Muslim and Mexican mothers, yet designated periods of rest were also present within Asian, Amish, East Indian Hindu's and South African Women (Dennis et al. 2007). Several studies identified that mothers from Asian Indian cultures and within Hinduism are excluded from housework following birth and do not leave the house so that they can focus on resting and feeding their baby (Hatton-Bowers et al, 2017; Brown, 2018). Within Islam, the Qur'an states that mothers should breastfeed for 2 years (Bayyenat et al, 2014), where Muslim mothers are said to believe they will be punished by God if this is not upheld (Brown, 2018). To support them further it is said that Muslim mothers who are breastfeeding are exempt from fasting during Ramadan, although it is reported that almost 50% of those exempt, continue to fast (Ertem et al, 2001; Brown, 2018).

Acculturation

Despite the multifaceted belief systems which occur in various cultures, whether positive or discouraging of breastfeeding, one core theme which emerged from the literature is that of 'acculturation'. Acculturation is defined as the attitudes, norms and practices which are adopted by the minority living within a community (Brown, 2018). The significance of this is widely reported where Gibson-Davis and Brooks-Gunn (2006) claimed there was a 4% decrease in the likelihood of a mother breastfeeding for every year she lived outside her native country, suggesting they abandon their goals to 'fit in' (Purdy, 2010). This determinant also has the potential to support breastfeeding, where Brown (2018) stated breastfeeding rates improved when White women breastfed in culturally diverse communities.

It is clear to see from these conflicting beliefs that this is a complex and challenging phenomenon. Although, it is not necessarily about changing these beliefs. The role of SCPHN practice is to acknowledge these, use a 'toolbox' of developed skills tailored to support and empower individuals. As noted, some of these beliefs are contradictory to WHO and UNICEF recommendations, which

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will inevitably be the most challenging to overcome. Yet, there are anecdotal reports of SCPHN's infant feeding training and skills updates concentrating on the biological issues associated with breastfeeding. These are important, yet the literature review has identified the significant influences cultural beliefs can have, particularly if they align with the biological presentations of the baby. Osman et al (2009) argue that a deeper understanding of culture aids in the ability to provide more culturally sensitive counselling, which can be crucial in establishing a therapeutic relationship.

What can be done?

There are many suggestions in the literature of how cultural beliefs can be 'addressed' or 'managed' more efficiently, where it is suggested that education is key. Popular concepts discussed in breastfeeding training in many areas may go some way to educating mothers against the aforementioned beliefs, including: education around changes in breast shape, the mechanics of baby's digestive system and size of stomach, the benefits of colostrum, the risks of prelactal feeding and legislation around feeding in public (Brown, 2018; Dornan et al, 2020). However, Livingstone (2018) opens with the notion, as echoed through this article, that recognition of the cultural differences and choices will help professionals better understand the barriers to successful or sustained breastfeeding. Purdy (2010) argues, when this is achieved professionals will be able to develop 'ethnically sensitive' interventions, overcome implicit bias and reduce maternal stress. Conversely, Baby-Friendly Initiative (BFI) training delivered across the UK was reported to potentially promote unrealistic expectations and not meet individual need, which may nurture adverse emotional experiences (Fallon et al, 2018). In support of this notion, the literature is suggestive of the need for peer counselling, lactation consultants, more culturally diverse images in educational material and cultural brokers (Hatton-Bowers et al, 2017; Brown, 2018; Wanjohi et al, 2018). The idea of commissioning, community development and service improvement are within the scope of SCPHN practice, therefore SCPHN's are ideally placed to make a difference.

Purdy (2010) examined an educational programme for professionals and discovered an increase in breastfeeding success rates, while knowledge and skills for professionals were enhanced. While education is important, it is essential that the approach to these conversations and therefore how health education occurs is prioritised. It may be considered an impossible task to teach all cultural beliefs, however, if used alongside other SCPHN skills such as motivational interviewing (MI) it allows the professional to tailor their approach, selecting tools from a 'toolbox' if you will. The goal being to understand how influential the beliefs are and how powerful acculturation is. Dornan et al (2018) claim there is a lack of skilled professionals who are culturally competent and therefore rely on leading with their own agenda (WHO and UNICEF, 2014). Hence, a somewhat interesting discovery in the literature was the use of a framework which would encourage culturally sensitive conversations and elicit cultural views, while having the potential to increase confidence around these conversations. Hatton-Bowers et al (2017) suggested the use of the LEARN framework (*Table 1*) developed by Berlin and Fowkes (1983) which helps professionals to prioritise mother's practices, values, and beliefs around breastfeeding by guiding communication and overcoming barriers in a co-productive style. While formal evaluative research of the LEARN mode has not been identified, the tool is heavily cited with in literature surrounding methods of improving culturally competent care (Millard et al, 2009; Jongen et al, 2018; Encisco, 2020; Ohlan et al, 2022) and has some similar characteristics of motivational interviewing, which has a strong evidence-base.

Conclusions

To conclude, although the wider social and environmental determinants are commonly considered when assessing individual and community health needs, cultural determinants need to be emphasised, not only in the support of breastfeeding but in other key aspects of public health. A popular approach to public health historically has seen a utilitarianism approach to essentially 'do the greatest good for the greatest number'. Therefore, focussing on White breastfeeding women as they have the lowest rates and are a majority population (Brown, 2018). However, the evidence behind acculturation as identified by Gibson-Davis and Brooks-Gunn (2006) suggests if more emphasis is not focussed on the impact of acculturation in the minority, there is a potential for an increase in inequality, particularly with the supporting evidence behind the benefits of sustained breastfeeding. This article has highlighted a myriad of cultural beliefs which do not align with professional recommendations, where numerous suggestions were made to reduce their influence. However, the use of a framework such as LEARN has the potential to identify the beliefs and values early, increase the confidence and skills of practitioners and reduce the impact of acculturation. Further primary research into the use of cultural brokers and the application of tools such as the LEARN model from the perspective of both professionals and services users would prove beneficial, where analysis against breastfeeding initiation and sustainability rates could occur. **CHHE**

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Table 1. LEARN framework

Stage	Description
L	Listen actively, with empathy and respect
E	Elicit the health beliefs of the mother by asking open-ended questions
A	Assess the mother's priorities, values, and supports
R	Recommend a plan of action
N	Negotiate a care plan

Source: As developed by Berlin and Fowkes (1983).

KEY POINTS

- Despite overwhelming evidence highlighting the benefits of breastfeeding, almost two-thirds of infants in developing countries do not breastfeed exclusively for 6 months as per WHO recommendations.
- Understanding cultural beliefs is pivotal to breastfeeding success, as it is commonly considered a biological factor, yet is influenced by cultural habits, beliefs, standards and behaviours.
- This article identified that the use of a framework could encourage culturally sensitive conversations and help professionals to prioritise mothers' practices, values, and beliefs around breastfeeding by guiding communication and overcoming barriers in a co-productive style.

REFLECTIVE QUESTIONS

- How can SCPHNs improve their approach to breastfeeding support from a culturally sensitive perspective?
- How significant is culture in influencing decisions around breastfeeding practice for new and expecting mothers?
- What communication model can SCPHNs adopt to support them to elicit mother's practices, values, and beliefs around breastfeeding?

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