Breastfeeding Education: disagreement of meanings

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Objective. This work sought to analyze how educational processes have been developed for breastfeeding in a health institution, starting from the meanings mothers, families, and health staff construct thereon. **Methods**. This was qualitative research of ethnographic approach, which included observations during the group educational activities of the programs, focal groups, and interviews of mothers, their families, and the health staff of a hospital unit in the city of Medellín, Colombia. The analysis was guided by the constant comparison method. **Results**. The categories emerging from the data were: 1) breast milk is an ideal food. 2) The mothers' experiences influence upon the breastfeeding practice. 3) Family beliefs sometimes operate as cultural barriers. 4) Disagreements are revealed in the educational process. **Conclusion**. The way educational processes have taken place for breastfeeding reveals a break expressed by the scarce interaction between the meanings professionals have constructed on the topic and those the mothers and their families give to the experience of breastfeeding.

Key words: health education; qualitative research; breast feeding.

La educación para la lactancia materna: desencuentro de significados

Objetivo. Analizar la forma cómo se han desarrollado los procesos educativos para la lactancia materna (LM) en una institución de salud, partiendo de los significados que las madres, sus familias y personal de salud construyen al respecto. **Métodos**. Investigación cualitativa de enfoque etnográfico, que incluyó observaciones durante las actividades educativas grupales de los programas, grupos focales y entrevistas a madres, sus familias y al personal de salud de una Unidad Hospitalaria de la ciudad de Medellín,

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Colombia. El análisis fue guiado por el método de las comparaciones constantes. **Resultados**. Las categorías emergentes a partir de los datos fueron: 1) La leche materna es un alimento ideal. 2) Las experiencias de las madres inciden en la práctica de la LM. 3) Las creencias familiares operan en ocasiones como barreras culturales. 4) Se revelan desencuentros en el proceso educativo. **Conclusión**. La forma cómo se han cumplido los procesos educativos para la LM revela un quiebre que se expresa en la escasa interacción entre los significados que los profesionales han construido sobre el tema y los que las madres y sus familias dan a esta experiencia.

Palabras clave: educación en salud, investigación cualitativa, lactancia materna.

A educação para a lactância materna: desencontro de significados

Objetivo. Analisar a forma como se desenvolveu os processos educativos para a lactância materna (LM) numa instituição de saúde, partindo dos significados que mães, famílias e pessoal de saúde constroem ao respeito. **Métodos.** Investigação qualitativa de enfoque etnográfico, que incluiu observações durante as atividades educativas grupais dos programas, grupos focais e entrevistas a mães, suas famílias e ao pessoal de saúde de uma Unidade Hospitalar da cidade de Medellín, Colômbia. A análise foi guiado pelo método das comparações constantes. **Resultados.** As categorias emergentes a partir dos dados foram: 1) O leite materno é um alimento ideal. 2) As experiências das mães incidem na prática da LM. 3) As crenças familiares operam em ocasiões como barreiras culturais. 4) Se revelam desencontros no processo educativo. **Conclusão**. A forma como se cumpriu os processos educativos para a LM revela um quebre que se expressa na escassa interação entre os significados que os profissionais construíram sobre o assunto e os que as mães e suas famílias dão à experiência na LM.

Palavras chave: educação em saúde; pesquisa qualitativa; aleitamento materno.

Introduction

Promotion of adequate feeding during infancy and early childhood has been considered a fundamental strategy to stimulate growth and development and reduce child morbidity and mortality.[1] Breast milk is estimated the most complete food for the child, given that it has the appropriate amounts of nutrients and it is a living and changing fluid that adapts to the needs of the child and of the family. Also, this breastfeeding practice is influenced by biological, social, economic, and cultural determinants.[2] In spite of breastfeeding being recognized as a healthy practice, the most recent statistics reveal a considerable decrease of exclusive breastfeeding in the national and local settings. The 2005 National Survey on Demography and Health (ENDS, for the term in Spanish) showed that the average for exclusive breastfeeding was 2.2 months in Colombia, and in the 2010 ENDS this value dropped to 1.8 in Colombia and to 0.7 in Medellín, figures that indicate a departure from the WHO recommendations of providing breast milk exclusively until the sixth month of life.[3]

These data brought us to wonder why said situation occurs. Thus, this research sought to inquire on some aspects of the context of the breastfeeding practice, among them its meaning from the perspective of health staff, pregnant and nursing mothers and their families cared for in a hospital unit in Medellín. Greater emphasis was assigned to understanding educational processes in the Institution for breastfeeding, an issue of principal importance for nursing professionals because they have been considered educators for health par excellence. This research began in September 2008 and was completed in October 2012. Between 2008 and 2010 the bibliographic review of some key themes of the study was conducted, along with the approach to the participating population and initial collection-encoding-description of information.

During the 2011-2012 cycle, new work of collecting, organizing, re-encoding, and analyzing of information was carried out, which permitted enhancing the findings and returning them to the participants. This article sought to analyze how educational processes have been developed for breastfeeding in a health institution, starting from the meanings mothers, their families, and the health staff construct on this practice.

Methods

This was qualitative-type research from an ethnographic perspective, using la focused or particularistic ethnography,[4] given that it was conducted in a hospital unit in the city of Medellín, with pregnant and lactating women from the health programs, their families, and the health staff. The methodological design constituted a dynamic, flexible, open, and emerging process configured according to the conditions, purposes, and findings. Intentional sampling was carried out supported by simple selection based on criteria[5] because the study participants were pregnant women, women who were lactating or who had had said experience, the families, and the health staff interacting with this population. No prior contacts had taken place with these participants. Informed consent was used to introduce the researchers and explain the reasons to conduct the research; voluntary participation was respected and communication was established with the particpants as valid interlocutors, avoiding bias and recognizing their knowledge and experience regarding the phenomenon being studied. Only one mother refused to participate in the study due to lack of time. The research team participating in all the phases of the study was conformed by two nurses – one with PhD formation – a male nurse, a nutritionist and a physician; all had Masters formation, with prior experience in qualitative research and as university professors during the development of the research. The researchers have no conflict of interest to declare.

To generate the information, primary and secondary sources were reviewed. A total of 16 semi-structured interviews were conducted: eight to mothers and eight to health staff; three focal groups with mothers and their families, each with 8 to 10 participants, two panel discussions (one with 13 physicians and another with 15 nurses), and five non-participant observations of the educational activities carried out in the Institution's programs; each observation had 12 to 15 individuals among boys, girls, mothers, fathers, grandmothers, and professionals. All the information was gathered in the health institution. Each of the techniques had a script to guide the data collection, yielding interviews that lasted 40 min and observations, panel discussions, and focal groups approximately one hour each, audio and video recorded with their corresponding field notes. Data analysis was performed via Microsoft Excel and it was guided by the constant comparison method[6] through inductive encoding. Triangulation[5] for this study contributed to obtaining the saturation point, when data began to be repetitive and no new contributions were obtained.[7] During open encoding, approximately 3000 codes or units of analysis emerged, which were grouped into 16 categories that in axial encoding were regrouped into four metacategories. During selective encoding, the categories and metacategories were integrated and refined.

Results

The way educational processes have been conducted on breastfeeding at the mentioned institution, starting from the meanings mothers, families, and health staff construct on it, is expressed here in four categories: 1) breast milk is an ideal food. 2) The mothers' experiences influence upon the breastfeeding practice. 3) Family beliefs sometimes operate as cultural barriers. 4) Disagreements are revealed in the educational process.

Breastfeeding is an ideal food

For all the study participants, breastfeeding is the ideal form of feeding for the child. Nevertheless, the meaning of *ideal food* is different in some aspects for the mothers, families, and for the health staff.

As noted in the following fragments, for mothers breastfeeding is mainly an *act of love* because it generates and consolidates bonding; it is a *divine command* because it is the complete and natural support provided by God, and an opportunity to *being a woman* that places the lactating mother in a privileged position: *breast milk is the best food; it is the ideal food... it is love it is everything one could offer the child... the bonds ...all that is true.* (Focal Group with Mothers) *(...) it has all the important components for the child, and if God created that [breastfeeding] as natural, it must be done.* (Focal Group with Mothers and Families). *In addition to it [breastfeeding] being something beautiful, I think it is very important; it is one of the steps that teaches you to be a woman... it is something quite beautiful, ... because not all mothers have that possibility* (Interview with a Mother).

For the health staff, it is the ideal food, nutritionally irreplaceable because *no other milk replaces breast milk* (Health staff panel discussion); and although for them this means an act of love and surrender by the mother, they emphasize on the child's wellbeing in terms of greater attachment, recovery from disease, and benefits during rearing. *The child who is breastfed will be attached to the mother, will recover faster from ailments, and will be stronger against disease* (Interview with Health staff). *I think breastfeeding, practiced from the desire to feed, love, teach, give love and affection, of the communication between them, from the first contact at the moment of birth, it is fundamental for upbringing.* (Interview with Health staff). For mothers, the most important advantage has to do with bonding: *I think breastfeeding is a beautiful connection because you get more attached to the child... I like it a lot; I am happy* (Focal Group with Mothers and Family).

For the health staff, the principal importance of breastfeeding lies in the biological order: *breast milk has the components no other milk has no matter how expensive. (...) it is free, it is at the reach of the child's mouth, it remains at room temperature, does not go stale, it develops in the child's organism defenses that will protect the child against diseases* (Interview with Health staff); *the mother will have a better relationship with her child for the rest of her life, which will not only be more healthy but will allow a better relationship* (Interview with Health staff).

The previous meanings on breastfeeding as an ideal form of feeding for the child are also reflected on the educational activities; from the point of view of the health staff, different contents and biomedical and morbicentric recommendations are highlighted to care for the child and prevent diseases: *we guide the mothers on the importance of providing children with healthy and balanced food, accompanied by good hygiene, which prevents many diseases*. (Interview with Health staff). In turn, the mothers tend to remember the teachings that go beyond the biological and which imply situations of human development and of the strengthening of the bond with the child: *we spoke of the child's rights in the previous session, we taught to make gifts and today was expecting the baby (*Interview with a Mother*).*

The mothers' experiences influence upon the breastfeeding practice

All the participants coincide in recognizing that work, study, and some obligations and experiences of the mothers influence upon the breastfeeding practice and analyze it from different perspectives, which generates tensions in the educational process. According to the mothers and families, work is one of the strongest reasons to interrupt breastfeeding. One of them states: *I stopped breastfeeding after three months because of work* (Focal Group with Mothers and Families). The health staff refers to the reasons, but not to the experiences, the mothers give for not breastfeeding: *I know many reasons the mothers offer: I have to go study... I have to go to work* (...) (Interview with Health staff).

It is not always recognized that breastfeeding and other issues related to maternity sometimes become obstacles for the mothers to develop professionally. In this respect, one father states:

my wife works and so do I. She is alone at home with the child, so she had to [stop studying] (Focal Group with Mothers and Families). Another mother comments that she wants to nurse her male child *until he is one year old*, and when asked if after the first year would she want to continue, she answers: *no, because I have not been able to work on anything else, I am waiting for him to turn one to get her off the breast a bit* (Interview with a Mother). It should also be considered that during breastfeeding, mothers undergo inconveniences due to pain, discomfort, weariness, or the bad odor resulting from nursing the child and which take away from enjoying this experience: *[...] you start smelling like a goat, you smell like milk* (Focal Group with Mothers and Families); *horrible, because at the beginning your nipples get sore, I suffered a lot with this... they would crack... they would be red sore* (Focal Group with Mothers and Families).

In spite of the aforementioned, mothers persist in breastfeeding: *I was among the mothers who fed my child exclusively with my milk [...] yes, I would be very tired because it hurt me, I was tired, sleepy, staying up late. My nipples were completely sore! [...] (*Interview with a Mother). *I suffered a lot, but I nursed her even if it hurt... She was a little vampire; it was all day and all night...* (Focal Group with Mothers and Family). Besides, the mother feels alone because she receives little support, along with demands to care for the home and notes lack of commitment from her partner in the father role: *they ignore it all ... [...] you have to make the decision* (Focal Group with Mothers and Family). *I had to do it all alone. Even when I had not gotten any sleep, I would ask him to help me burp the baby, but he wouldn't pay attention. He does love them, but was not very considerate with me [...] the hardest thing was that sometimes I would be breastfeeding and instead of helping me, he would say: "look at how messy the house is!" And I would answer: what do you see me doing*? (Focal Group with Mothers and Family).

The health staff also mentions aspects that influence upon breastfeeding, although they do so from a perspective in which underlie value judgments on vanity, which they consider the strongest threat against breastfeeding: *(...) the aesthetic aspect that is so much in vogue... But one would think that in these socioeconomic levels they do not care. And you are surprised when they are not breastfeeding and say: No, I had a mammoplasty so they would get ruined!* (Interview with health staff); *because many women think that if they breast-feed their breasts would be damaged, they don't want to nurse the child* (Panel discussion with Health staff).

Attitudes from all sides produce tensions reflected on the educational process. The health staff is quite reiterative in stating that mothers do not want to nurse their children due to ignorance and, thus, insist on the advantages, importance, and benefits of breastfeeding: *Mothers are still not clear on that breastfeeding is very important to stimulate the child's defenses* (Health staff panel discussion). *Mothers do not nurse their children, but it would be economically wise for them. When they go out with their child, they do not have to carry baby formula. That is explained to the mothers: it is warm, fresh, good, and inexpensive* (Health staff panel discussion). Mothers are repeatedly told to breastfeed their children, in spite of the pain and independent of their experiences and of the difficulties they face at that precise moment: *And what did you do during the control sessions, what did they tell you? I was told the baby affects the nipple from so much breastfeeding. Even if it hurt me, I nursed my child...*. (Focal Group with Mothers and Families).

Regarding the fathers, it was found that the health staff sometimes excludes them from the educational activities, which contributes to the mother's sense of loneliness. *When developing the activity, some fathers are present along with the group of mothers. While the nurse's aide evaluates a child and talks to the mothers, you hear the head nurse asking: Ladies: what do you use to your children's mouths?* (Observation of Health Programs).

Family beliefs as cultural barriers in the breastfeeding practice

Four recurring situations impact upon breastfeeding: 1) believing that the child does not like breast milk, as stated by one of the participants: *[...] for example, a friend of mine told me she complements with baby formula because her child doesn't like breast milk anymore* (Interview with a Mother). 2) There are those who believe that if the child does not get some baby formula after breastfeeding, the child could still be hungry: *There are others who have to spend a lot of time nursing their children. Instead, when they feed them baby formula it seems more filling; they can go longer without being hungry* (Focal Group with Mothers and Family). 3) The belief that exclusive breastfeeding hinders weaning: *The children get too accustomed to the breast. When you nurse them too much, they won't want to stop breastfeeding; it is a problem.* (Focal Group with Mothers and Families). *He is already used to the breast, so if I offer him baby formula he doesn't want it.* (Focal Group with Mothers and Families). 4) The family's custom of early introduction of complementary feeding also interferes; this is almost always at the grandmother's recommendation or that of the neighbors: *when they visit, they say: what a beautiful baby, what are you feeding him? —I am only breastfeeding— Oh no, dear, he won't eat later. So all the myths emerge: that the stomach need to start getting some salt, to have him start eating foods*.... (Interview with a Mother).

The health staff also recognizes these cultural aspects that impact upon the breastfeeding practices. *[Mothers] have many [beliefs] that lead them to not breastfeeding [...] Much has been heard during consultation* (Panel discussion with Health staff). These beliefs place mothers at a dilemma between the scientific positions of the professionals and the opinions of their relatives and friends: *neighbors and friends start visiting and you start to have conflicts between the indications you received during prenatal controls and the myths people have* (Interview with a Mother). In this case, there are three paths to deal with these situations: one thing is to ignore the recommendations from family and neighbors, another is to accept the indications from the health staff and, lastly, make your own decisions: *Many family myths emerge regarding breastfeeding; that the child stays hungry, that you have to give them water, and that the child gets very thirsty. What is important is knowing how to handle them because there is a moment when you have to stop listening to everything people tell you and continue breastfeeding...* (Focal Group with Mothers and Families). *Had I not been told that, one would listen to the mother. I would accept what the grandparents said, [...] my daughter and I [did not know] if a complement could be given to child, but we already saw that this could not be so, until the sixth month (Focal Group with Mothers and Families). Some talks really get to you. So, you end up saying: Oh, okay, but continue doing things on your own!* (Interview with a Mother).

Disagreements are revealed in the educational process

Tension was found in the very educational practice; among these, the difference between what is practiced and what is to be impacted by the health staff, which is concerned for the mothers to be attracted by the educational activities but they do not attend or heed recommendations: *these talks are not availed of because everyone says that the mothers continue with a bad technique, that they still refuse to breastfeed* (Panel discussion with Health staff); *we really have not found the acceptance we expected. It is very scarce* (Interview with Health staff). *Then, we would have to check on what is being done [...]. Are we doing it right? We assume these are people who know. Then, why do the mothers go back to bad practices? Why do they say: I don't nurse my child; my breasts will get ugly; what is the use of that? ...* (Panel discussion with Health staff).

That concern by health personnel contradicts the traditional education practices for health in the development of programs in which the personnel question the truth of the mothers' opinions and

correct their technical concepts on health: *the nurse asks the mothers –pointing to the upper part of the head: — what is this? The mothers together answer: —the soft spot… the nurse immediately states: — no!!! It is called the fontanelle* (Observation of Health Programs); *the nurse continues giving indications on aspects of the child's grooming and hygiene. She asks them what it is they do when the baby bottle falls to the floor and one of them answers that she places it in boiled water. The nurse asks: — are you telling me the truth? Some mothers laugh and another one responds: — yes, I am […]. In the end she says: — is it clear? —yes, ma'am — did you learn? —yes, ma'am. – Did you like the talk? —yes, ma'am. — Will you put it to practice? —yes, ma'am. – Very well!* (Observation of Health Programs). Likewise, for the mothers these attitudes that mark vertical and homogenizing relations do not go unnoticed: *(…) and noticing everything happen so fast, like guided from above! The nurses arrive and tell us to do something, and the mothers did that any way possible. There was no teaching as such. (…)* (Interview with a Mother) *[The nurse] did not know if it was the first time we attended, others had already gone (to the program)…* (Interview with a Mother).

Discussion

Analysis of the information indicates how the educational processes for breastfeeding have been carried out, there is a rupture revealed in the little interaction between the meanings professionals have constructed about breastfeeding and those the mothers and families assign to the experience, that is, these participants are placed at different perspectives. All coincide in stating that breastfeeding is the ideal form of feeding, but the health staff emphasizes on the nutritional contribution and its preventative effects, placing at the core the care for child and not the mother, and their educational task is centered on the biological and morbicentric. Mothers and their relatives, in turn, give greater importance to affectionate aspects that strengthen them from the human part, given that for them breastfeeding is *an act of love* and *a beautiful bond* in which they experience joy and fulfillment as mothers. Thus, for them wellbeing is materialized through the bond they establish with their child. This aspect was also reported in another study where the mothers stated that the act of nursing their children transcends instincts, given that it involves feelings that promote the link between the mother and the child.[8]

Traditionally, women have been taught that the essential role in their lives is that of being mothers, start families, and dedicate themselves with eternal love to their children and spouse. Their socialization and fulfillment has been focused on maternity as that which reaffirms their femininity, and they are prepared for a stereotypical role of spouse, mother, and housewife. By following this idea, this study found that for the health staff breastfeeding seems to be an obligatory, easy and natural practice. By considering it an obligatory practice, from the mothers' perspective inasmuch as it is a natural process or divine mandate and from the personnel's perspective inasmuch as it is an easy process, it seems peremptory for every woman to be suitable to successfully conduct breastfeeding. Consequently, not acknowledging their experiences, sometimes unpleasant and difficult in their attempts to breastfeed. Being a mother in modern times is not easy, the official discourse of programs, public policies, and society in general have delegated to women throughout history the duty to breastfeed given their mammary physical attributes, without permitting women to question and consider the possibilities of other choices.[9]

The three participants, mothers, fathers, and health staff, recognize the existence of some obstacles, like work outside the home and study that impede adequate breastfeeding, an issue that has been well documented in the bibliography.[10,11] In many cases, the mother must sacrifice and give up or postpone her work or study, in spite of current movements in favor of the rights of women and gender equality.[8] Add to this the sense of loneliness due to the scarce accompaniment from

the male in caring for the children, a problem to which often the healthcare professional contributes by excluding him from the activities carried out in the Health Programs. To this effect, it has been documented that involving the male is necessary to make decisions on rearing the children.[12] In the same line of thought, while some mothers engage in breastfeeding despite of the pain and discomfort, all are branded as conceited and the transformation of the body is conceived as a threat to breastfeeding. That is, the decision and responsibilities of breastfeeding fall exclusively upon the woman, ignoring their efforts and difficulties many have to endure in this process. These efforts were reported in another study, where the women assumed the lesions to the nipples as a challenge to continue breastfeeding.[8]

In conclusion, the way educational processes for health have been carried out is directly related to the difference in meanings constructed by the health staff, the mothers, and their families. Thus, the educational processes are ladened with disagreements in which the health staff considers that mothers are apathetic regarding their teachings, while many of the mothers are critical in relation to the indications by the health staff, reflect and make diverse decisions. Barni Nor *et al.,* found that mothers state that nurses have "their own rules", which are in conflict with their own perspectives by not agreeing with their particular contexts.[13] This calls for nursing professionals to always bear in mind the meanings of others during their professional practice. Often, those disagreements arise during the educational activities, when the health staff questions the truth of what the mothers say and judges their beliefs as imagination or unfounded excuses. The experience recognized as valid is not that of the mothers and their families, but that of the health staff. Not always is the contribution made by the mothers considered nor are their experiences or the meanings they construct taken into consideration. To this respect, literature shows that the members of the healthcare staff tend to homogenize their discourse to enhance their legitimacy and, hence, promote changes of behavior in participants in educational activities, which – in turn – refer to a normalizing proposal of education.[14]

Those disagreements are, finally, reflected in the contents, which in general are standardized and previously selected by the health staff in charge of the educational activity, instead of starting from the mothers' meanings and experiences and jointly generating new constructions with them. In this sense, Dos Santos Monteiro *et al.,*, show how throughout history educational processes for breastfeeding in the hands of health professionals have been limited, given that most of the time prioritize the technical and normative aspects, which leads to women not finding the support they need, causing anxiety, guilt, and worry that further hinder the process.[9]

Finally, with respect to the limitations of the study, with this being qualitative research, its results cannot be extrapolated to other places that do not share similar characteristics to those addressed in the study. Nevertheless, the results presented and their analysis permits reflecting on how the educational processes for breastfeeding are being carried out, which can be similar to those of other themes or practices of interest in public health and in Nursing; besides, these results expect to provide new educational research, given that in many studies reported in literature the methodological details of how the education takes place are not proposed and these are necessary to generate new, more pertinent, effective, participative, and humanizing education proposals.

We recommend establishing *an inclusive relationship with the other,* which rescues the individual, in this case the mother, to be a legal subject within treatment with equity and respect. The pedagogical approach applied to the educational process for breastfeeding can transform this practice that, undoubtedly, has multiple benefits; hence, the role of the health staff is fundamental therein. Change is warranted in the teaching-learning model and, for this, a permanent reflection-action process is required, as well as a deconstruction of the current pedagogical model to contribute to an inclusive and empowered society,

where citizens analyze and make conscious decisions. Likewise, it is worth reflecting on the myths and beliefs of relatives and mothers, thinking them from educational processes that share with them the reflections of research, but also where these relatives and mothers are heard to interpret their experiences and emotions. This is how a negotiation of cultural meanings would begin, that would put into practice a respectful and constructive dialogue regarding these meanings. It is, furthermore, important that at work and in the educational settings for mothers to be assigned spaces for breastfeeding and caring for their children, so that the co-responsibility of private enterprise and the State becomes effective in protecting and guaranteeing the rights of the maternal-infant population.

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