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The Psycho-Sociocultural Considerations of Breastfeeding in a Group of Cameroonian Women with Inadequate Practices

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Abstract

With regards to nutritional and immunologic needs, the breastmilk's content makes it a necessity for the normal development of growing infants. However, the "act of breastfeeding" seems important as well, given the affective and emotional interactions involved between the mother and her baby. This has a key role in neuropsychological development of newborns and helps relieve stress in breastfeeding mothers. However, lactation and breastfeeding may have environmental or sociocultural determinism, impacting mothers' readiness to breastfeeding. This study aimed to investigate beyond risk factors, psycho-sociocultural-related issues and background as a predictor of inadequate breastfeeding practices among a group of newly delivered Cameroonian women. We conducted an analytic cross-sectional study over a period of six months from December 2018 to May 2019. We included all mothers with livebirth neonate infants weighing > 2000g and with no contraindication to breastfeeding. A total of 250 mothers were enrolled, the mean age was 27.9 ± 6.2 years. Ninety women (36%) had the Centre region as sociocultural background. Poor breastfeeding practices were found in 153 mothers (61.2%). Among which 60 women (39.2%) originated from the Centre region, with 37 (61.6%) having traditional beliefs and practices antagonizing breastfeeding, though 48 women (80%) had school education ≥ secondary level. Caesarean section delivery was overall practiced in 78 women (31.2%), with 72 (92.3%) evoking it as motif for breastfeeding refusal. After multivariate analyses, psycho-sociocultural background related to geographical origin and probably ethnicity occurred as a predictive factor for inadequate breastfeeding practices. From this, we concluded more emphasis should be led on perinatal counselling and geo-sociocultural-focused interventions to promote good breastfeeding practices.

1. Introduction

Adequate breastfeeding may be defined as the timely initiation of the act, its effectiveness in terms of the technique, exclusiveness, and duration. In newly delivered women, it is mostly determined by the early initiation of breastfeeding (EIBF). According to the World Health Organization (WHO), timely breastfeeding may be considered as the proportion of newly born infants who are breastfed within the first thirty minutes to an hour following delivery [1, 2]. A number of research studies generally report the rate of EIBF in low and middle-income countries as being comparatively higher than in developed countries [3]. The act of breastfeeding is also known to be bound with sociocultural considerations [2-6]. More so, it is thought to be reinforced in developing countries, due to its cost-effectiveness and natural availability, making it accessible for the neonate at any time from its mother. Because breastmilk feeding is necessary for the adequate physical, neurological and psycho-affective development of the child, the WHO together with UNICEF recommend exclusive breastfeeding during the first six months of life as well [2, 4-6]. In effect, recent studies in Ethiopia, Ghana, Bolivia and Madagascar among others revealed that breastfeeding could prevent as much as 20-22% of neonatal and under 5 infant deaths [5-7]. Though the pattern of breastfeeding seems to vary from one study to another, across cultures and civilizations, it is estimated that less than two-third infants are adequately breastfed worldwide. This may partly be determined by geographical and anthropological factors including cultural beliefs, socioeconomic status, education, modernization of behaviors, local feeding practices, urbanization and development, which impact the psychological perception of the act of breastfeeding and the process as a whole [8-12]. Nevertheless, a most convincing understanding of the process may be based on a multifactorial determinism [8-12]. The aim of our research study was to investigate beyond risk factors, psycho-sociocultural background as a predictor of inadequate breastfeeding in our context.

2. Methodology

We conducted an analytic cross-sectional study with prospective data collection, over a six-month period from December 2018 to May 2019, at the Yaoundé Gynaeco-Obstetric and Paediatric Hospital which is a University Teaching Hospital in Cameroon. We included all newly delivered women with livebirth newborn infants weighing more than 2000g, with no contraindication to breastfeeding and who consented to participate in our study during the said period. The enrolled mothers were observed during the first week of postpartum to detect those that would practice adequate breastfeeding in terms of the time of initiation, the effectiveness, exclusiveness and duration in conformity with the WHO's recommendations. However, the duration of exclusive breastfeeding could only be evaluated after 6 months, and so we rather assessed the mother's intention to do so. We conducted simple, adapted, and oriented interviews using a pretested questionnaire, so as to improve investigations. Bivariate analysis made possible the identification of risk factors, and was followed by multivariate analysis to isolate predictive factors. The data were analyzed using CS Pro version 6.2 and SPSS version 20.0. Chi-square testing was used to identify statistical associations between variables. The P value < 0.05 was used to characterize statistical significance. The Odds ratio with 95% confidence interval was used to reveal risk factors.

Ethical clearances from the Institutional Ethics and Research Committee of the Faculty of Medicine and Biomedical sciences of the University of Yaoundé 1 and the Yaoundé Gynaeco-Obstetric and Paediatric Hospital were obtained before the beginning of the survey. The data collected was kept confidential and used for the purpose of the study only.

3. Results

A total of 250 mothers were enrolled, the mean age was 27.9 ± 6.2 years. Ninety women (36%) had the Centre region as sociocultural background. Poor breastfeeding practices was found in 153 mothers (61.2%). Among which 60 women (39.2%) originated from the Centre region, with 37 (61.6%) having traditional beliefs and practices antagonizing breastfeeding, though 48 women (80%) had school education ≥ secondary level. Caesarean section delivery was practiced in 78 women (31.2%), with 72 (92.3%) evoking it as motif for breastfeeding refusal.

3.1 Characteristics of inadequate breastfeeding

The various characteristics of inadequate breastfeeding considered are summarized in (Table 1) below.

Variables	N (153)	Percentage (%)
Delayed initiation of breastfeeding > 60 minutes	153	100
Formula use or other breastmilk substitutes	102	66.8
Ineffective breastfeeding technique	77	50.3
No intention for 6 months exclusive breastfeeding	51	33.3

Table 1: Characteristics of inadequate breastfeeding**.**

Reasons	N (153)	Percentages (%)
"Spoiled Milk" or "bad milk" concept	107	69.9
Colostrum apprehensions	101	66
“Dried breast” or agalactorrhea	86	56.2
Instruction from mother or family relatives	81	52.9
Delivery by caesarean section	72	47
Falling or sagging breasts	58	37.5
Need for traditional treatment and cleansing	54	35.2
Mystical beliefs and practices	46	30
The transmission of illnesses and undesired traits	40	26.1
Previous death of a baby due to breastfeeding	45	29.4

Table 2: Psycho-sociocultural aspects evoked by women with inadequate breastfeeding.

3.2 Factors associated with inadequate breastfeeding practices

Primary education level, Centre region, Caesarean delivery, HIV infection, gestational age below 37 weeks of pregnancy, low birthweight and neonatal infection at birth were associated with inadequate breastfeeding after bivariate analysis. Logistic regression permitted to isolate the Centre region as a psycho-sociocultural background, and Caesarean delivery as independent predictors of inadequate breastfeeding (Table 3).

Variables	Adjusted OR (CI à 95%)	Adjusted p-value
Primary school education level	2.3 (0.8 – 6.5)	0.110
Centre region	2.54 (1.8 – 4.5)	0.033
HIV Infection	4.5 (0.9 – 22.3)	0.062
Caesarean section	11.3 (4.6 – 27.7)	< 0.001
Gestational age < 37months	2.3 (0.5 – 10.4)	0.267
Low birthweight < 2500g	1.2 (0.2 – 5.8)	0.847
Neonatal infection	6.6 (0.8 – 56.9)	0.088

Table 3: Predictors of inadequate breastfeeding after multivariate analysis.

4. Discussion

The rate of inadequate breastfeeding in this survey was quite high with more than one newly delivered woman out of two having poor breastfeeding practices. This was mainly as a result of delayed breastfeeding initiation, as the rate of EIBF was as low as 39% in this survey, which is lower than values reported from a number surveys in some East African countries [10, 13]. Due to the said delay of timely breastfeeding, up to 66.8% neonates received other fluids than breastmilk and 33% of such women were not interested by exclusive breastfeeding over the first six months. This is slightly higher than values obtained from earlier surveys conducted in Cameroon, according to which 20-28% of women do not abide to the first six months exclusive breastfeeding recommendation [14-16]. This may be due to progressive “urbanization and development effect”, which is responsible for the modernization of behaviors, with changing local feeding practices, and the psychological perception of breastfeeding in modern African communities [8-12].

The Centre region as origin appeared as a predictor for inadequate breastfeeding in this survey, with more than 66% of women belonging to this geo-sociocultural background or ethnicity having poor breastfeeding practices. This result is similar to studies showing that breastfeeding practice may be affected by geographical factors, socioeconomic and even cultural-related influences [16, 17] In this survey, the Centre region was the most represented background among women with poor breastfeeding (39.2%), though a selection bias may have occurred, due to the fact that the study was carried out in Yaoundé, which is the capital city of the Centre region. Yaoundé is

as well the capital of Cameroon, with a standard of life which may be considered as higher compared to other regions. This is supposedly correlated with improved and modernized mentalities, emancipation, job occupation and probably insufficient maternity leaves for women, which makes them less prone to breastfeeding [17, 18]. Whereas, in regions with lower life standards, breastfeeding is readily practiced, given its cost-free accessibility and natural availability [17]. This has led to suggestions for geographically-focused promotion campaigns for breastfeeding, culturally competent education and interventions in indigenous communities in order to encourage and improve breastfeeding [16].

Just as in a number of African countries, different regions in Cameroon may have specific cultures, traditions and different levels of socioeconomic development. Though the level of school education was acceptable in average, there existed limited knowledge about breastfeeding in women enrolled in our survey. This further paved the way for the reinforcement of sociocultural considerations with negative beliefs concerning colostrum and wrong thoughts about "spoiled breastmilk" or "bad milk transformation" [16, 17]. Such beliefs are frequently encountered in Cameroon, especially in the Centre region, where some women believe their breastmilk may be spoiled by some processes, including the initial yellowish colostrum, at times referred to as "bad milk", not good enough for neonate infants [16, 17]. Some women described sexual intercourse as not recommended for lactating women, given that it is thought to render breastmilk unsafe for infants as well. In close to 70% of cases, these recommendations were opportunistic, when women, mainly primiarous in 55% of cases had difficulties to breastfeed. The recommendations were mediated by mothers or elder sisters and rooted in family inheritance as origin, or past experience [18-20]. In the same vein, a number of women attributed the previous death of an infant to breastfeeding, evoking some mystical and cynic traditional practices related to witchcraft [18-20]. Such mothers were the most difficult to counsel, as they were characterized by strong, inflexible convictions that only a traditional indigenous cleansing would be the definite solution for them. Moreover, the fear of "breast sagging" led to the refusal of exclusive breastfeeding in many women, as shown by their recorded intentions. These women thought continuous breastfeeding is responsible for breast falling-off with undesirable effects on their beauty and attractiveness. On the other hand, women with initial agalactorrhea and relatively smaller breasts, were referred to as "dried breasts" and were either considered as a family-inherited anomaly or a curse from the "Gods" or the "evil eye" [18-20]. These women were not receptive to the demand for continuous stimulation through repeated baby suckling of mother's nipples. The rejection of this advice was mainly due to misunderstandings [11, 21-25]. Whereas these women were more susceptible to drink specific traditional galactogues including some herbal infusions and local beers. A considerable number of women avoided breastfeeding because of the fear to transmit malaises such as abdominal cramps whereas related to oxytocin-mediated uterine involution. The fear of baby contamination with mother infection and the communication of undesired traits through breastmilk was equally evoked by some women. Nevertheless, they were encouraged to breastfeed by family, medical staff, education, counselling, and model influencing based on idealistic representations of breastfeeding.

On the other hand, caesarean section which appeared as the main cause of maternal indisposition, may be responsible for psychological modifications causing inability and unwillingness to breastfeed. Close to 36% of post-operative women evoked caesarean section as a motif for not breastfeeding. Indeed, caesarean section is a well-known and documented determinant of delayed breastfeeding initiation, already described by a number of researchers in various contexts [17, 21, 25]. The increasing rate of caesarean section noted in some urban communities may suggest progressive acceptation and vulgarization of its culture in our context. However, in some few deeply traditionally encultured, and illiterate African women, mainly primiparous and women who had not delivered by caesarean section before, the intervention may be wrongly apprehended from a psychological standpoint, with considerable emotional involvement [26]. Undesirable feelings may thus occur as a result of anxiety and victimization, associated with a first time experience of a foreign practice which is unnatural in essence. Especially in the African context, where “the strong woman” is considered as one whom has gone through labor pains of vaginal delivery. This psychosociological conflict may lead to the "carry-over phenomenon" which is marked by the occurrence of psychological impairments during the postpartum, as a result of prenatal exposition or predispositions, with parturition being a decompensation [26]. Some of these disorders include the post-traumatic stress, baby blues, postpartum depression and psychosis, which are all susceptible to alter lactation and breastfeeding [22, 27]. However, these do not appear as absolute contraindications to breastfeeding.

Some pertinent hypotheses on various psychophysiological hormone variations after caesarean section, including the drop of blood endorphin level in the immediate post-operative period have been evoked to explain the effects of caesarean delivery on delayed breastfeeding initiation [25]. In fact, endorphin as a neuro-peptide whose secretion is stimulated by intense physical activity and pain such as during labor, excitation and orgasm, is responsible for positive emotional and affective interactions in mothers, including “desire and satisfaction” in breastfeeding [17-25]. After caesarean delivery these sensations are diminished or late coming, thereby impacting negatively the breastfeeding process.

Despite WHO’s 2007 recommendations for maternal antiretroviral therapy (ART) and infant prophylaxis to reduce HIV transmission among exposed neonates, exclusive breastfeeding during the first six months in such infants is not always guaranteed in our context. There still persist a reluctance to breastfeed in such women which may be due to difficulties in overcoming psychological barriers of fear and anxiety related to frustrations and stigmatization [17, 21]. This may as well be associated with a mental self-protective behavior bound to the fear of infecting one’s own infant. In effect, a number of studies report mother infection especially with HIV as a factor of poor breastfeeding practices [17, 21]. This may however be overcome by the reinforcement of antenatal counselling with an accent on the advantages of breastfeeding in such infants compared to deleterious consequences of not breastfeeding. As such mothers would be confronted with a stronger motivation to keep their infants safer through protected breastfeeding which strengthens neonates’ immunity, reduces morbidity, mortality and assures normal growth [22, 23].

5. Conclusion

Regardless of the countless benefits of breastmilk feeding and WHO recommendations, there persists a considerable number of women who practice inadequate breastfeeding, mainly characterized by delayed initiation, ineffectiveness, unexclusiveness, and briefness. Psycho-sociocultural considerations, probably bound to geographical background and ethnicity influences appeared to be a predictor of inadequate breastfeeding practices. Therefore, more emphasis should be laid on geographically-focused breastfeeding interventions, culturally competent education and interventions in indigenous communities to promote and improve breastfeeding practices.

Author Contributions

Authors participated in all steps of the study.

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Conflict of Interest

The authors declare that they have no competing interest.

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