

The Need for Culture Sensitive Participatory Health Promotion Activities To Promote Breastfeeding

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ABSTRACT

Breastfeeding practices are no longer a norm nowadays. Exclusive breastfeeding is an even bigger challenge, and although it is recommended by the World Health Organisation (WHO) that mothers should exclusively breastfeed for the first six months of a baby's life, not many mothers actually practice it. Health promotion activities to promote exclusive breastfeeding are necessary to improve the practices within communities. There is a need to be culturally sensitive when addressing communities as there are already values and beliefs in place that can either promote or hinder the process of health promotion. Community participation is also an important aspect to incorporate during implementation of breastfeeding-promotion activities, because it encourages active participation and is more likely to be accepted than an approach where the community is given information in a directive manner.

Keywords: Culture sensitive, health promotion, exclusive breastfeeding, participatory approach.

INTRODUCTION

In 1978, at the International Conference on primary health care, the urgency for the need to promote and protect the health of all people was articulated. The Alma-Ata Declaration strongly reaffirmed health as a human right, and the implementation of primary health care was required to provide the necessary first level contact health care to the community.¹ The declaration set a standard to achieve health for all by the year 2000, but as the year 2000 approached, it was clear that the goal could not be attained. In 2000, the 191 United Nations (UN) member states met at the Millennium Summit and developed the Millennium Development Goals (MDGs).²

The MDGs were meant to address the social determinants of health i.e. eradication of poverty, promotion of education, gender equality and women empowerment, and ensuring a sustainable environment, as

well as health-related issues i.e. child and maternal health, the Human Immuno deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), malaria and other diseases as well as global partnerships for development.^{3,4,5} Some of the MDG targets have already been met or are within close reach whilst others require accelerated focus and bolder action so as to make improvements.⁶ Amongst the MDGs that require improvements is the health-related MDG 4, which aims to reduce child mortality.^{6,7}

MDG 4: REDUCE CHILD MORTALITY

MDG 4, target 4a aims to reduce the under-five child mortality by two-thirds between 1990 and 2015.^{8,9} The indicators set to monitor progress at the World Millennium Summit for target 4a include the under-five mortality rate (UFMR) as well as the infant mortality rate (IMR).¹⁰ UFM is the death of a child before age of five, and UFMR is the

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probability of a child dying per 1,000 live births before reaching the age of five. IM is the death of a child under one year of age and the IMR is the probability of a child dying per 1,000 live births before reaching the age of one.^{9,10,11}

The IMR has been reported by the World Health Organisation (WHO) to have decreased globally, from 63 deaths per 1,000 live births in 1990 to 35 deaths in 2012, whilst the overall UFM has decreased from 90 deaths per 1,000 live births to 48 deaths per 1,000 live births.^{12,13} Despite this improvement, the world is unlikely to reach its target of decreasing child mortality by two-thirds by the year 2015 if the current trend in the decrease of mortality continues.^{7,14–16}

Sub-Saharan Africa has made slight improvements in the goal to achieve MDG 4, from 177 deaths per 1,000 live births in 1990, to 98 deaths in 2012. In South Africa, the UFMR decreased from 62 deaths per 1,000 live births in 1990, to 47 in 2011 whereas the 2015 target is 20.^{17,18} According to the South African MDG report of 2013, the UFMR target is likely to be achieved by 2015. The IMR in South Africa has had improvements with a decrease from 54 deaths per 1,000 live births in 1998, to 35 in 2011.^{10,28} According to the South African MDG country report of 2013, the IMR target of 18 is likely to be achieved by the year 2015. Both the IMR and UFMR targets are likely to be achieved following the introduction of the Prevention of Mother to Child Transmission programme (PMTCT) in 2001 and the pneumococcal and rota virus vaccines in April 2009.^{19–21}

Causes of infant mortality

The United Nations Children's Fund (UNICEF) reports that globally, pneumonia, meningitis, tetanus, malaria, pre-term birth complication, intra-partum-related complications and diarrhoea are the leading causes of death among children under the age of five years.^{19,22} In South Africa, the Department of Health, Committee on Morbidity and Mortality in Children under Five Years (CoMMIC) reported that the top five causes of deaths in children were neonatal disorders, diarrhoeal disease, lower respiratory tract infections, HIV/AIDS and severe malnutrition.²⁴ Lack of trained health care personnel to provide sufficient information on infant health to the caregivers also affects the rate of infant mortality.²⁵

Malnutrition is a major cause of mortality (directly or indirectly) and thus, it is important that nutrition becomes an important aspect that should be emphasized in programmes that involve child and new-born survival.^{24,27,28} Globally, one third of all child deaths are due to malnutrition.²⁸ In South Africa, malnutrition resulted in over 6% of direct causes of under-five infant

deaths, and was also a contributing factor in over 50% of under-five infant deaths in 2005. Optimum nutrition in children under the age of two is critical in child development and growth thus education about nutrition for child guardians and mothers is important.^{27,28} Exclusive breastfeeding is an important aspect of nutrition and has been shown to have a protective effect on infant mortality and morbidity especially in low income settings.^{29,30}

Importance of exclusive breastfeeding

WHO recommends that a baby should be breastfed exclusively for 6 months after birth, which means that an infant only receives breast milk and no additional foods or liquids, not even water, for 6 months.³¹ Early initiation of breastfeeding (within the first hour of birth) reduces the chances of new-born mortality.^{31,32} Exclusive breastfeeding is associated with several benefits for both the mother and the child. Breastfeeding is effective in the prevention of child deaths because breast milk contains the correct amounts of water and essential nutrients that are critical for infant growth and development.^{32–34} Breast milk protects against illnesses as it contains antibodies which also promotes recovery of a sick child.^{32,34,35}

Infants under the age of two years who are not breastfed especially within low income communities, are more likely to die from diarrhoea, gastrointestinal infections or respiratory infections than those who are breastfed.^{24,32,34} The breastfeeding process improves the mother and child bonding but poor breastfeeding techniques, especially latching and positioning, are known to predispose women to breast health problems including mastitis, engorgement and cracked nipples.^{35–37} In studies conducted in South Africa and Zambia, women who exclusively breastfed were less likely to experience breast problems than women who did not exclusively breastfeed.^{33,36–38}

Exclusive breastfeeding practices in South Africa

Unfortunately in South Africa, exclusive breastfeeding is no longer regarded as a 'cultural norm' thus most mothers practice mixed feeding i.e. both breast milk and formula feeding. Low exclusive breastfeeding rates, i.e. 12% in 0–3 months old infants and 1.5% in 4–6 months old infants, were reported by the South African Demographic and Health Survey (SADHS) in 2003. Within the survey, 85% of the 10,214 households that were targeted for inclusion took part in the survey.^{27,39} Low income communities within South Africa usually lack running tap water. Formula feeding then poses a greater risk to the child due to use of contaminated water in the preparation of the formula milk, thus exposing

the child to conditions such as diarrhoea which can cause death. Avoiding breastfeeding in such a situation can also lead to malnutrition of the infants as formula feeding is very expensive especially when compared to breastfeeding.^{28,33,34,40,41}

In South Africa, some mothers receive counselling on breastfeeding practices from health care professionals within the public sector but the counselling has been shown to be insufficient.^{42,43} Interventions have been employed to provide mothers with additional support at community level, such as peer counselling and support through community health workers, and these have been used successfully to promote exclusive breastfeeding. During these interventions, issues were brought up by the mothers about the challenges and barriers that they experience when breastfeeding, and these will be discussed in the next section.^{54,55,57}

Common factors affecting breastfeeding practices in South Africa

Most mothers when interviewed in the studies done in South Africa acknowledged that they do not breastfeed for several reasons, and the most common ones will be discussed in this section. Women raised their concerns about sore nipples associated with breastfeeding. Some of these women were first-time mothers who had been told by friends or family members that breastfeeding causes sore nipples, whilst others had experienced it before. Weight loss was also an issue that was concerning to the mothers, as most of them said they had read that breastfeeding results in weight loss. Some of the mothers expected to lose weight, but when they did not they stop breastfeeding. Some women were worried that their babies would not be properly nourished by breast milk only and therefore they either decided on their own, or they were encouraged by their mothers, sisters or husbands to add complementary foods to the baby's diet.⁴³⁻⁴⁵ The influence of the fathers was found to be very substantial, and being the primary support to the breastfeeding mother, has been shown to contribute largely to the decision to either breastfeed or not, thus resulted in most of the mothers agreeing to the decision to add complementary foods.^{46,47}

In South Africa, HIV-positive mothers are encouraged by health care professionals to strictly exclusively breastfeed for 6 months. Promotion of exclusive breastfeeding has proven to be difficult for both HIV-positive and HIV-negative mothers because they fear the stigma that is associated with being HIV-positive and exclusively breastfeeding. From the factors listed above, it is clear that most of mothers make a decision to either breastfeed or not without sufficient knowledge on breastfeeding. Studies conducted in South Africa have

recommended that promotion of optimal breastfeeding practices is paramount and before breastfeeding promotion programmes are developed, there is need to have a clear understanding of what the women who breastfeed believe and know, as well as what they are actually putting into practice.^{36,37,41,42,43}

HEALTH PROMOTION

The promotion of health was affirmed in the Alma-Ata declaration of 1978 when the 'health for all concept' was articulated. The declaration also emphasized that it was the people's duty to participate, whether as an individual or collectively in groups in the planning and implementing of health care plans that suit them.¹ Health promotion supports personal and community development through the dissemination of information which ultimately increases community capacity and empowerment.⁴⁷ In order to successfully implement health promotion activities, social, spiritual and cultural resources should be harnessed to promote community action and development.^{48,49} Health promotion interventions are appropriate strategies for increasing exclusive breastfeeding practices, and this has been done successfully in different countries.^{45,48,49,50}

The health promotion status in most African countries is low. Few of the countries have actually developed health promotion policies and even fewer have implemented one.^{51,52} In South Africa, there exists a Directorate of Health Promotion located within the Social Sector Cluster (SSC) within Primary Health Care (PHC), District and Development operations which falls under the Deputy Director General for Health Service Delivery in the National Department of Health (DoH) in South Africa.^{51,53} This directorate mainly offers support to provincial and local governments which implement health promotion activities but because there are non-governmental organisations (NGOs) who also conduct health promotion activities around the country, there is no single body coordinating activities. It is therefore necessary to establish a well-coordinated monitoring and evaluation infrastructure to support health promotion activities that encompasses both governmental and NGO bodies so that the programmes can take effect.^{51,52,53}

Some of the funding for health promotion activities is available from the National Treasury, via the Department of Health (DoH). This is not the only funding available, as agencies such as the United Nations Agencies, bilateral Aid agencies and various foundations support health promotion interventions both technically and financially.⁵¹ The shortage of human resources is being addressed by some universities within South Africa that offer courses in health promotion, which

range from short courses, diplomas, bachelor's degrees to master's degrees in health promotion. These courses are meant to develop the knowledge and skills required in health promotion implementation within the country.^{51,52}

The WHO Health Promoting Schools Initiative (HPSI) documents were useful in the development of HPS in South Africa.⁵³ This initiative is responsible for the implementation of primary school nutrition programmes, school food gardens and the sanitation facilities installed in some schools around the country.^{51,52} In 2012, the Integrated School Health Programme was launched by the President in an attempt to maximise the learning capabilities of learners within primary and secondary schools in South Africa through improving their physical, mental and social wellbeing.⁵⁴

Health promotion for exclusive breastfeeding

WHO and UNICEF (1989) report that health care practices that relate to mothers and their new-born infants stand out as one of the means that increase the duration and prevalence of breastfeeding.⁵⁵ The support to breastfeed provided by health workers can become part of a society's commitment to accept and implement appropriate breastfeeding practices. This is especially crucial in communities in which bottle feeding is prevalent and the elders within the community know little or nothing about breastfeeding. Mothers should be well equipped with information regarding breastfeeding because ultimately, they are the ones who practice it.⁵⁶

Culture in health promotion

Culture is a system of values and beliefs within a society that have influence on behaviours. Cultural values are some of the causes of health disparities and are associated with health and health-related behaviours.^{57,58} In order to try and eliminate health disparities, the influence of culture on knowledge, attitudes, beliefs and practices should be acknowledged by public health policymakers as well as health care professionals who are responsible for the provision of health care services to the people. Cultural values are therefore essential in the development of health promotion programmes.^{57,59} The development of such programmes also require the participation of the individuals affected as well the communities that they come from in order to be able to formulate interventions that consider culture.⁵⁷ The concept of using community health workers (CHWs) to reach out to communities in an attempt to bridge the gap between culture and health promotion, has been successfully implemented in some communities.^{57,58,59} CHWs have the advantage that an element of trust has already been established with the community.⁵⁹

Role of culture in breastfeeding

Breastfeeding practices are a balance of both culture and biology. Problems with breastfeeding can arise when cultural beliefs and practices do not support the biologically based needs of both the mother and the child. Information that is new to the mother can challenge a mother's beliefs such that she can disregard it as it goes against her beliefs. Women in communities therefore rely on society for support and approval to breastfeed. Many at times, mothers and aunts of the women in the child bearing age are considered the models and advisors in relation to breastfeeding information, but some of these models may actually have little information about breastfeeding.⁶⁰ In some communities within central Sahara, Mexico, Iran, Greece, Myanmar and Malaysia, colostrum is/has been considered a harmful substance by the elders and people within those communities such that the mothers will also disregard colostrum within the first days post-partum.^{56,61} In some cultures, breastfeeding mothers cannot be involved in sexual activities as these are believed to affect the milk, and if a baby cries, then the mothers' milk is stale and unsuitable for the child to feed on.^{56,62,63}

In low income areas where mothers cannot afford formula milk, it is not a realistic option not to breastfeed especially when main sources of water are ponds or rivers, such that there is inadequate access to clean water. From a study conducted in South Africa, mixed feeding was culturally acceptable in both rural and township settings, although within rural settings where the homes are isolated, exclusive breastfeeding was more likely to be of longer duration. Non-prescribed medicines were found to be administered for cultural and spiritual reasons and this was mostly common if the leaders of the community initiated it.⁵⁶ Some of these medicines were believed to protect the infant and the mother from evil influences e.g. Doepa, Vimbela and Amafuta Enjayolwandla. In a study conducted in the Eastern Cape province of South Africa, between 66% and 85% of medicines purchased from 'African chemists' or 'Amayeza stores' were mainly for the protection of infants from evil spirits.⁶⁴ Such locally sensitive issues need to be discussed in breastfeeding programmes as well as when counselling mothers. Breastfeeding programmes also need to include issues such as milk let-down and breast health problems as these are usually considered as culturally based problems thus the need to educate and inform the mothers with the details on how to tackle such issues is pertinent.⁵⁶

Participation in health promotion

Community participation involves the community in the planning and implementing of health development

programmes such that the individuals are viewed as participants within, rather than passive recipients of a programme.⁶⁵ The concept of participation was a key principle in the Alma-Ata declaration.¹ Most of the health programmes that encourage health promotion in South Africa are developed by the NGOs, and the participation of the community within those programmes has been shown to be significant, for instance, the health promotion policy.⁵¹ This policy was built on four approaches, community participation and reorientation of health services, the setting approach, education and information as well as policy, advocacy and health environments.⁵⁴ The participatory approach has principles that include enabling empowerment of the participants themselves, in realising that they need to take charge of their own health, be self-aware and that their ideas and desires are also important in the development of health promotion programmes.⁶⁶

Recently, the individuals who are involved in health and development programmes started using a new approach to health promotion. They began to act as facilitators who support the local communities to become active participants in the development and decision making processes that evolve around health promotion.⁶⁷ Successful national health programmes in which the com-

munity participation approach was used, were reported in China, Cuba, Tanzania and Sri Lanka. In Western Kenya and the state of Maharashtra in India, smaller scale sub-national pilot programmes that implemented such health projects showed evidence of drastic effects within the community. However, these same projects could not be easily replicated on a larger scale because once it became a national programme, bureaucratic rules and top-down directives changed the nature of community participation, which then hurried the process necessary for engagement with the communities.^{66,67} It is therefore necessary for the implementation of health promotion that encourages participation, makes use of the bottoms up approach (active participants), rather than the top-down approach (passive recipients).⁶⁵

Theoretical model: PEN-3 model

The PEN-3 model was developed in 1989 by Professor Collins O. Airhihenbuwa from Pennsylvania State University, as a strategy to address the impact of culture on health-related behaviour and decision making.^{68,69} The PEN-3 model comprises three interlinked dimensions which are dependent on each other: cultural identity, relationships and expectations, and cultural empowerment (see Figure 1 below).⁶⁸⁻⁷⁰

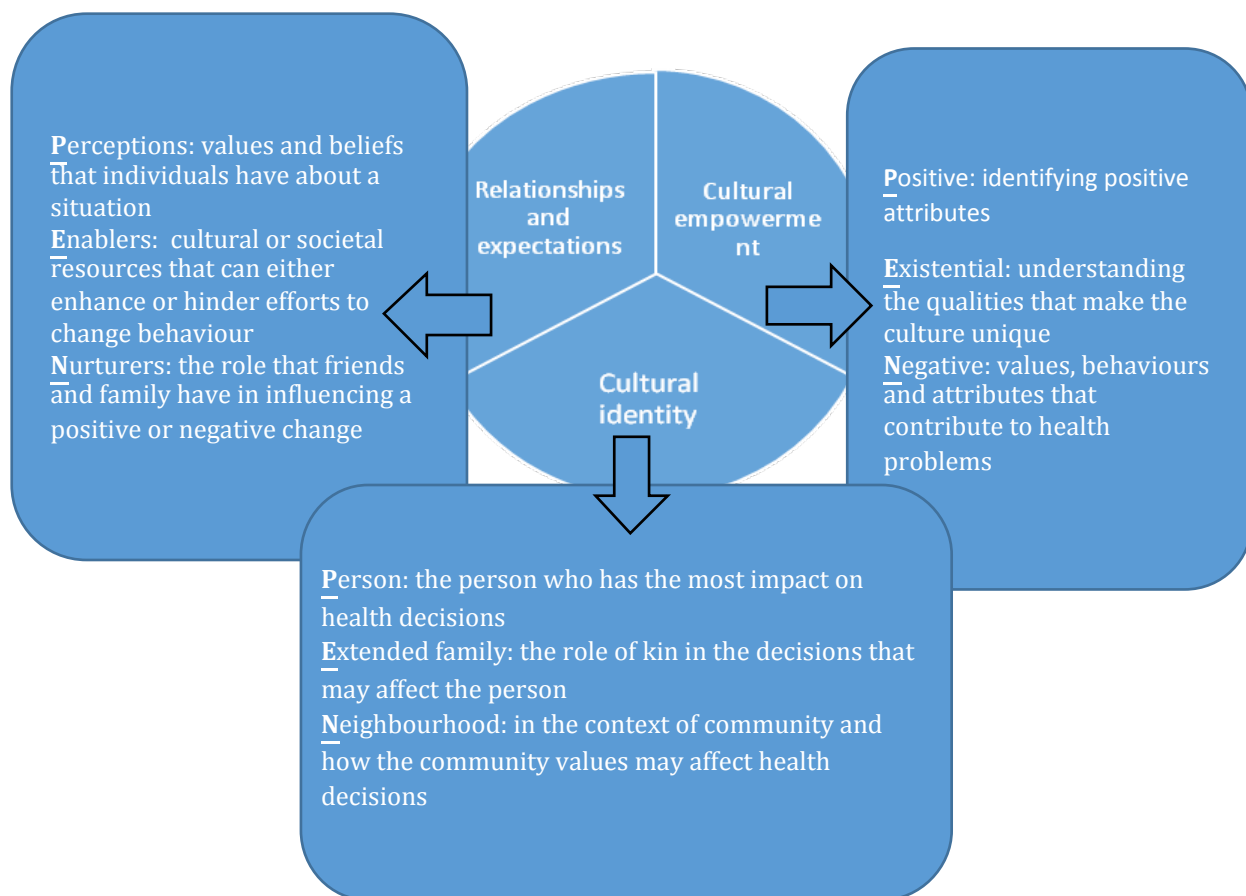


Figure 1: The PEN-3 model

Cultural identity: identifies and defines the target audience, i.e. either the person, the extended family or the neighbourhood in which they live. The target audience have to change their health-related behaviour and this serves as the point through which the intervention will be initiated. Relationships and expectations: this dimension is made up of three domains, which have a huge impact in the influence of the target audience.

Cultural empowerment: this dimension is important in the development of interventions that are culturally sensitive by noting the different positive, existential and negative values and behaviours within a community, which actually influence health-related decision making processes.^{69–71}

The concept focuses on magnification of cultural issues and their importance for the people who want to address health issues as well as health promotion.⁶⁸ Since this framework provides a cultural framework to researchers that enables them to partner up with the communities when addressing health problems, researchers and the communities involved are able to seek solutions together.^{68,69,70} This model has been used widely and successfully to address issues relating to hypertension, cancer, diabetes, smoking and food choices as well as obesity, and can be useful in addressing health promotion issues.^{68,69,71}

CONCLUSION

The MDGs provide a set of goals for advances to be made globally with respect to different aspects, which are indirectly or directly linked to health. Child and maternal health are indicators of global progress on health. Most child deaths in the world are from preventable causes, especially diarrhoea, pneumonia and malnutrition. Reports suggest that if the few interventions that are available were fully implemented, most of the preventable child deaths could be prevented. Breastfeeding has been found to positively influence child health. WHO recommends that a child be breastfed exclusively for the first six months of their life, but this is no longer a norm in South Africa. This is mainly because most mothers decide to either breastfeed or not, without sufficient knowledge on breastfeeding. The promotion of breastfeeding and exclusive breastfeeding practices in low-income communities has been shown to be of utmost importance with drastic positive effects on child health. Health promotion activities are difficult to implement successfully if there is no behavioural change and culture sensitivity. These two aspects influence the acceptance of health promotion activities. It is therefore crucial that health workers and communities are involved in the health promotion activities that are

culturally sensitive and which also take into consideration the views and opinions of the communities into which the activities will be implemented. Community based participatory action is a requirement to enhance the sustainability and to also ensure accountability of activities.

CONFLICTS OF INTEREST

None.

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