Maternal allegations for weaning: qualitative study

Carmen V. Ramos,1 João Aprígio Guerra de Almeida2

Abstract

Objective: To study the reasons for weaning given by women receiving care at a Baby-Friendly Maternity in Teresina, state of Piauí, Brazil.

Methods: The methodological principles of qualitative research were applied, supported by the social representation theory. Data were collected from 24 women who were in the process of weaning their babies before the 4th month of life.

Results: The decision-making process that leads women to wean their babies is complex and guilt-ridden. The following reasons for weaning were mentioned: having weak or little milk; puerperal problems affecting the breasts; lack of experience; disparity between the needs of the mother and the needs of the baby; external factors; work; ambiguity between wish/capacity to breastfeed and between burden/desire.

Conclusions: A sense of solitude/isolation on the part of the mother and the need for support, not only from health services, but also from other segments of society, were conveyed in all interviews. The model of health care providing should be amended so as to treat breastfeeding as an act to be learned by women and protected by society.


Introduction

In the light of current scientific knowledge there is consensus that human milk is the only food that is capable of adequately meeting all of the physiological peculiarities of an infant’s metabolism.1 Furthermore, the benefits that the practice of breastfeeding allows the woman-mother should be highlighted, such as savings for the family and a significant reduction in costs to the State, which is often obliged to import breast milk substitutes and powdered milk to supply the needs resulting from premature weaning.

With these perspectives as a starting point, those formulating official policy at the international level have developed proposals to be implemented across the world’s continents in support of the adoption of strategies which will encourage the practice of exclusive breastfeeding until the six month of children’s lives.2

At the culmination of the “Breastfeeding in the 1990s: A Global Initiative” conference, held at Spedale degli Innocenti in the city of Florence, the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) outlined the global target for the nineties, declaring that: “... all women should be enabled to practise exclusive breastfeeding and all infants should be fed exclusively on breastmilk from birth to 4-6 months of age. Thereafter, children should continue to be breastfed, while receiving appropriate and adequate complementary foods, for up to two years of age or beyond.”3

1. MSc., Instituto Fernandes Figueira, Fundação Oswaldo Cruz.
2. Ph.D., Public Health, Instituto Fernandes Figueira - IFF / Fundação Oswaldo Cruz; Professor, Graduate Course on Women and Children’s Health, Instituto Fernandes - IFF / Fundação Oswaldo Cruz; Chief, Milk Bank team, IFF.
Manuscript received Mar 24 2003, accepted for publication Jun 11 2003.
These proposals are founded on another issue which is beyond the question of the advantages which breastfeeding offers to infants, which is that from a biological perspective all women are assumed to be capable of producing milk of a quality and quantity sufficient to sustain the adequate development of their children. In order that this takes place it is necessary that hormone levels are sufficient and that milk is drawn off efficiently.

With the intention of further reinforcing the importance of developing activities to encourage breastfeeding, the proposals also bring to the fore factors of interest to women, such as: a reduction in post-natal hemorrhages due to contraction of the uterus, the increased intervals between pregnancies, assuming that exclusive/predominant breastfeeding is performed on demand, the reduced number of mothers suffering anemia, due to delayed menstruation and the reduced risks of breast and ovarian cancer.3

Nevertheless, despite all the effort expended, it is observed that the practical roll-out of the official discourse does not assume the universal character implicit in its theoretical premises, i.e. there is a significant number of women who follow to the letter the ritual recommended by the State policy, aimed at successful breastfeeding, but who are unable to reach the target established - exclusive breastfeeding until the sixth month.

According to the most recent survey carried out by the Health Ministry, in 1999, including all of the Brazilian state capitals with the exception of Rio de Janeiro, the prevalence of maternal breastfeeding among children aged 6 months was 80.5 %. In 1996, the National Demographic and Health Census (Pesquisa Nacional sobre Demografia e Saúde - PNDS)4 returned a value of 59.8% for the same index, which, when compared with a survey carried out in 1989, the National Nutrition and Health Census (Pesquisa Nacional sobre Saúde e Nutrição - PNSN),5 reveals a significant increase. In 1989 the rate was 49.9%. According to the Health Ministry, this growth during the nineties is due to the intensification of activities to incentivize breastfeeding and to the increased investment in this area.6

Far from these figures describing advances, revealing epidemiological scenarios denoting increased breastfeeding prevalence, they highlight the need to increase understanding of the factors which lead women and children to exclude themselves from all these benefits.

There is a searching question which must be answered with a comprehensive insight: what leads women who submit themselves to the routines of healthcare recommended by the State policy as the foundation for successful breastfeeding to prematurely wean their children?

With the objective of widening comprehension of the factors which result in premature weaning7 among patients cared for at the Dona Evangelina Rosa maternity unit (DER), it was decided to study the explanations given by women who, contrary to the institution’s avowed policy and guidance, prematurely weaned their children, before the fourth month of life.

Methods

The nature of this objective imposes the adoption of the methodological precepts of qualitative health research as the theoretical approach concept, to the extent that it is that “which corresponds to a deeper area of relationships, processes and phenomena which cannot be reduced to the operation of variables”8 This being so social representations were chosen as the theoretical and methodological principal, taking them to be “the categories of thought, action and emotion which express reality, explaining, justifying or questioning it.”9 i.e. social representations are the form in which the individuals of a given society, pertaining to a given social group, express their reality and interpret it, according to their level of understanding and guided by their experience of daily life. It is through this prism that it is intended to project the light of the representations of breastfeeding given by the mothers who made up our study.

The Dona Evangelina Rosa maternity unit, chosen for the development of the study, is a state owned institution for the care of women, children and adolescents in the city of Teresina - Piauí. As this is a Child Friendly Hospital, all of its procedures and standards are aimed at completing the ten steps which comprise the model.3 From prenatal care to postnatal childcare, activities have put in place to promote, protect and support breastfeeding.10 In observance of this institutional directive, women who begin weaning before the fourth month of their children’s lives are referred for a Nutritional Monitoring consultation at the pediatrics department. At the consultation the mothers are assisted to achieve the objective of returning to exclusive breastfeeding or, when this is not possible, they receive nutritional instruction appropriate to the age of their children. Starting from the assumption that premature weaning is founded in difficulties that the care model has in dealing with the sociocultural issues which permeate breastfeeding, it was decided to interview women cared for at the DER who: attended a minimum of six prenatal care, had full term pregnancies, continued their children’s postnatal care at the unit and who began the weaning process before the fourth month of their babies’ lives.

The main concern in respect of sampling, given the nature of the study, was centered on achieving an understanding of the object that was as deep and all-encompassing as possible, taking the correct number of interviewees to be that capable of reflecting the whole in all its dimensions.9 Thus, observing the criterion of saturation, twenty-four women were interviewed, a number which corresponded to the point at which categories were exhausted in the interviewees’ replies.
The women participated voluntarily after giving their consent and approval. The study protocol was approved by the ethics committee at the Instituto Fernandes Figueira - FIOCRUZ.11 The interviews were conducted with the aid of a thematic guide, without limiting the range of the interviewees’ responses. On the specific subject of breastfeeding, the guide aimed at: what; why; previous experience; experience with current child; difficulties experienced; how their pregnancy and labor had been; myths and taboos; family, neighbors and relatives; time required; relationship between want/can, burden/desire, option/imposition.; use of other foodstuffs, including water, teas and juices; maternal employment; daily routine. All of the interviews were recorded and transcribed.

For the analysis of the mothers’ discourse the technique of content analysis was used. From the operational point of view this technique “starts from a first-level reading to reach a deeper level: that which transcends the manifest meanings”.9 It is worth pointing out that this is a technique which is particularly suited to verifying hypotheses or answering questions and also to confirm or deny statements made based on field-work.12

Results and Discussion

Comprehensive analysis allows the terms “weak milk”, “not enough milk” and “milk dried up” to be located, associated with the baby being hungry or crying, as the true conditions affecting the course of breastfeeding:

“...she suckled for almost 6 months and then they dried up, so I didn’t give them any more, I was giving her porridge because the milk wasn’t enough... she sucked and sucked and cried, there were times when she sucked, had a fit and went on screaming and crying...”

“I only have little milk if I don’t let him suck a lot, there won’t be any at all...sometimes while he is suckling, because there’s so little that’s when it really dries up.”

“...I used to cry a lot because I didn’t have much milk to give him... not even that water would come out... he would wake up mad with hunger. He wouldn’t let me sleep, no way, because I didn’t have any milk...”

“...I don’t have any more milk, I don’t have any more milk at all...he sucks even though and I think nothing comes out...my tits are dry.”

“...he used to suckle well, but then in a little while he would already be crying, then I’d feed him again, he would cry...me thinking it was hunger...then I was like, in doubt, my God what could this be, could it really be true that there is no such thing as weak milk? And I remained like, in this doubt, up to now I still wonder...sometimes I think my milk is weak, I believe so, because he used to cry a lot, and from the moment I started giving him milk he cried less and started to sleep better...”

Almeida,1 working with questions relating to weaning, points out that weak milk is one of the social constructions most often employed as an explanatory model for the abandonment of breastfeeding. Innumerable other studies, performed at different points in history, have pointed in the same direction.13-17 From this perspective, two factors deserve highlighting. The first is the fact that women from many different countries worldwide verbalize “weak milk” as the reason for weaning18 and the second is that from a biological perspective weak milk does not exist and that intercurrent conditions which make breastfeeding impossible are rare.19 The use of weak milk as a reason for weaning has a secular basis in the hygienist movement of the XIX century which promoted breastfeeding by means of activities which try to make the woman responsible for the health of her child and blame her for weaning.1 This type of allegation verbalized by women is pregnant with a latent cry for help in the face of difficulties experienced with breastfeeding, with which they cannot or do not know how to cope.20,21

Postnatal intercurrent conditions affecting the breasts came up as the second factor interfering in the course of lactation, in order of importance, taking frequency and emphasis as classification criteria: “...the truth is that he sucked so much, you know that it hurt and today it’s gonna be, let me think, yes it’s gonna be two months on the 24th and they still hurt, my breasts are sore”; “...it seems that my breasts were really full, you know, heavy, then I couldn’t bear it, my tits used to get this big (laughter).”; “...on the day she was born, by night my tits were already hurting...after the suffering of giving birth, to the suffering of breastfeeding, you know. After 7, 8 days I couldn’t bare breastfeeding anymore...”; “...then I had a problem with this breast here, it’s because it’s different from the other, it’s hard, the nipple goes inwards and it’s hard, so it would hurt his mouth and hurt my tit...my tit couldn’t take it. It used to hurt so much it would bleed.”. All of these problems are perfectly avoidably by the adoption of prophylactic measures in the course of the pregnancy-childrearing cycle.19 The lack of instruction and support result in women suffering physically when this could be avoided with preventative or curative measures.22 Thus, it must be considered, and given the appropriate importance, that the care activities envisaged by the standards and routines currently in force are not capable of responding in a universal manner to the needs of the patients to the extent they are supposed to be; and should be, therefore, revised, giving emphasis to the differentiated needs which have their foundation in the subjective dimension of women.

Another factor which deserves to be highlighted from within the women’s replies is the way their suffering was treated as banal by the health team: “...the nurses used to say - it doesn’t really hurt, in the beginning it’s going to hurt... but if you keep doing it the pain will diminish...I tried to do like, the maximum you know, to bear those pains, but only I knew...” . The insensitivity of the health professionals to the pain of their patients springs from the vision which enshrines maternity as an act of donation by the woman in exchange for love from her child and social recognition.23
This impermeable and verticalized posture, typically hygienist, does not make the necessary support for women possible and finds its place as one of the factors in weaning detected. Araújo found evidence of the same thing in a study which showed the manner in which the lack of consideration for women’s feelings on the part of the health professionals who care for them contributes to the abandonment of breastfeeding.

Experience of having been a mother was given great value in the interviewees’ replies: “I wasn’t very experienced, I didn’t know, it was my first child...” “...I had difficulties because I didn’t have experience...” “In the beginning it was very difficult for him to grab it, I didn’t know either, I wasn’t experienced with how to give him my tit”. These reports coincide with what is to be found in scientific literature where lack of experience is considered a risk factor for premature weaning. Attentive to this question, the Health Ministry, alert to the risk of premature weaning among primiparous mothers and emphasizes in the CFHI (Child Friendly Hospital Initiative) training manuals the attention that it is necessary to pay to women in this category.

The care model currently employed shows itself effective in detecting the risk was has a low level of resolution in tackling it. As the replies reveal, the lack of previous experience can be compensated for by infrastructure which supports women, giving them a voice and understanding their individual demands in the face of breastfeeding. The error is to consider that, being primiparous, all of them require the same type of help and that this can be resolved by means of the transfer of information – “...although I had received a lot of information here in the DER, even though, the first daughter, I had lots of problems”. Katz describes breastfeeding as a process which needs to be learnt and relevant by women.

The exercise of maternity, in particular in terms of breastfeeding, is shown to be a burden in consequence of the multiple roles performed by the woman-mother: “...the thing is I have to cook, I have to wash, because she pees on us all the time you have to change clothes...”; “we just can’t all the time just be with her, we have other things to do...”; “...I’ll be doing something and have to put work aside to breastfeed...”. The mother’s fatigue, the lack of external help and the loss of liberty, in addition to the overload which breastfeeding represents, are common causes offered to justify weaning. Similarly, Silva emphasizes the importance of the influence exercised by family members, friends and professionals who interact in some form or another with the nursing mother. Indeed they are not always prepared to make breastfeeding less of a conflict. From this springs the necessity of making these support mechanisms more efficient.

The inability to meet the needs of both mother and child often leads to the mother underestimating her own needs in a disproportionate manner, a fact also demonstrated by Nakano: “...sometimes I can only have a shower at night...wash my hair, don’t even think about it, it’s very difficult...The girls go on like: you have changed so much, you used to be all dolled up, you don’t do your nails anymore. My friend, I don’t have time for that I don’t, instead, I’m taking care of the boy...I have to help my mum, I have to put the nappies to soak...he wakes me up at like four and something and then I just don’t feel sleepy anymore...” The stress and load imposed by employment as revealed in the women’s replies, added to anxiety and depression, are related to low milk production levels as they result in the synthesis of suppressive peptides in the alveoli of the mammary glands which impede the process of synthesis. The emotional state of the woman also interferes in the prolactin and oxytocin reaction, contributing to “hide the milk”, which will once more “appear” once the cause of the stress is removed.

The women disclosed that they had received two types of external interference. One spoke of the support necessary to breastfeeding: “Only with my mum’s help, really. It was very important, she spent a month with me, there, looking after me” “The mother has to be willing to, she has to be guided, she has to have support at home...”; “if it hadn’t been like that, her telling me, don’t take away the breast, don’t do it, don’t give him the bottle”. Another, in contrast, contributed to premature weaning: “I tried and do what my mother had told me to do straight away and porridge was the best solution...”; “...my granny and my auntie told me to give the milk because she wasn’t full...my milk didn’t keep her fed...” [...] “they said I should buy the milk and complement the breastmilk, you know...”. Thus, the woman feels compelled to accept the intervention of family members and friends, and takes decisions based upon the constant interactions which make up her rational environment. On this subject, Araújo reports that the external opinions and interferences contribute to the “success” or not of breastfeeding. The author observed that in her study women who breastfed for greater periods of time or who had positive experiences considered that the participation of their mothers and husbands was important to the process.

Maternal insecurity in the face of the child’s crying presented as an event which triggered weaning: “... the baby’s belly fills up, it gets full, you can tell, but he cries...”; “... he cried the whole night long [...] crying is from hunger...”. Crying was invariably associated with the baby being hungry and in consequence with problems related to insufficient milk production or the fact that it is weak. This concept, despite being strongly supported by cultures, has no foundation in the biological dimension.

Another element which deserves attention is the confrontation between the references offered by the DER and those which make up the matrices of their daily lives: “my sister said – no, best thing is give this boy milk, he cries because he’s hungry, I said – I don’t think so, the doctor said there’s no such thing as weak milk...”, “People talk a lot, some say one thing, others say another, you don’t know what to do, who to listen to, the doctor or other people...”
Thus, rather being indecisive, the mothers are revealed as suffering in the light of these contradictions, especially when it falls to them to make the decision of whether to continue breastfeeding or not.

Employment was revealed as an element which impeded or made more difficult breastfeeding. The women demonstrated a huge difficulty in conciliating the multiple roles, which becomes transformed into a motive for anxiety and worry, emotions which negatively impact on the physiology of lactation: “...if I didn’t work I’d give him my breast until he didn’t want it no more...”; “...I’m working and studying so I don’t have time for her, so I worry...”. The inadequacy of social systems to support working mothers induce the premature interruption of breastfeeding.

Breastfeeding was not always described in a positive manner and often sparked off ambiguous or contradictory sentiments: “I used to feel very sad because my desire was to be able to breastfeed, but...”; “I think it’s important, if I could I would breastfeed...”; “we think it’s bad because it disturbs our sleep, but on the other hand, we feel good...”. From the same perspective, Silva says in his that breastfeeding is experienced as an obligatory burden and a pleasurable desire, with it being possible for both of these sentiments to appear simultaneously or alternately.

The changes which occur during the life of a woman also deserve attention as one of the principal impediments to the continuation of breastfeeding: “...I have to dedicate all my time to him and there’s no time left for anything else...”. Feelings about the child’s dependence end up generating significant limitations and interfere greatly with the woman’s life, which often results in sentiments of demotivation and contradiction, transmuted into impatience, nervousness, irritability and anger, invariably manifest at the moments when the child is most demanding.

Embarrassment at suckling in public, ambivalent emotions relating to the dual function of the breast, maternity during adolescence, mammaplasty and taboos, all figure as factors impeding breastfeeding with reduced frequency and importance in the speech of the women.

In terms of duration, the majority of mothers referred to the six-month period as ideal, without recognizing the official recommendation - exclusive breastfeeding for six months and mixed for 2 years or longer. A part of this conceptual confusion is related to the diffusion of information by means of campaigns and health services, which end by giving evidence on the six-month period without the necessary emphasis on the exclusive nature of the breastfeeding.

The concept of breastfeeding revealed by the mothers oscillates between an exclusive concern with the child’s well-being: “It’s good to breastfeed because the child grows up healthy...”; and the greatest proof of love that a mother can give to a child: “...to breastfeed is the greatest proof of love that a mother can give to a child, the greatest proof of love that a mother can give to a child is to feel the pains of giving birth no, that you are supposed to feel anyway, there’s no other way, it’s not the love for the child to give birth no, now, the biggest proof of love that a mother can give to a child is to breastfeed.”

Final considerations

The difficulties experienced by the women in the course of breastfeeding, lead them to make constant evaluations of the act, both in relation to the child and to themselves. Based on the references that they have available, they judge values and decide upon the course to be followed. However, it was possible to prove that this decision making is something complex and invariably charged with guilt, a sentiment which in turn has its origin in the model of breastfeeding care currently in vigor. The care practices attempt to model women’s behavior in favor of breastfeeding, making them responsible for the health of their children. This tendency, which has hygienist roots, does more than just make them responsible, it also blames women for failure, i.e. for premature weaning, at the same time that it is incapable of comprehending the needs or promoting support.

Despite the allegations made by the women - weak milk, postnatal breast conditions; lack of maternal experience; the burden caused by breastfeeding added to the daily activities performed by the women; incompatibility between the needs of the mother and of the child; external interference from family members friends and the remainder of interactions the women perform; maternal employment; ambiguities between the want and can of breastfeeding, among others-two issues were constantly present at all moments of the interviews: the loneliness/isolation of the woman-mother and the necessity of obtaining support for breastfeeding to succeed. This support, referred to by the women at every point, was not made explicit as something exclusively of the health sector, but as activities to be developed for the good of breastfeeding, which should be present in the remaining sectors; from the family nucleus to the social apparatus for supporting maternity and as a consequence, the act of breastfeeding.

Public health activities aimed at the promotion, protection and support of breastfeeding, developed, primarily, during the last decade, notably the Child Friendly Hospital Initiative (CFHI), have contributed to improved maternal breastfeeding rates during this period. The same cannot be said in relation to exclusive breastfeeding rates, which still remain low, with a median of 33.7 days, when what is envisaged is 180 days. From this perspective, adjustments must be proposed to the model currently in vigor, giving priority to activities which contemplate the introjection of new cultural values in favor of breastfeeding, values which consider it an act which needs to be learnt by the mother and protected by society.
References


Corresponding author:
Carmen V. Ramos
Condomínio Verde te Quero Verde - Bl. 19 - Ap. 302
Bairro Santa Luzia
CEP 64022-000 – Teresina, PI, Brazil
Tel.: + 55 (86) 217.0614
E-mail: carmenutri@bol.com.br