Thai cultural influences on breastfeeding behaviour

Lesley Dornan*, BS, RN, SCFHN, HV, Marlene Sinclair† PhD, MEI, PG Dip, BS, RN, RM, RN, W George Kernohan* PhD, BS, Lamine Sigl*, BS, RN, RN, Varnangkh Rhuwtryakorn* MD, Pitkal Suppasan* RN

1Health visitor and PhD student, Institute of Nursing and Health Research, University of Ulster, Newtownabbey BT37 0QB Northern Ireland. Email: leslie.dornan@ulster.ac.uk
2Professor of midwifery and senior lecturer, Division of Neonatal Care, Department of Pediatrics, Chiang Mai University, Chiang Mai 50200 Thailand. Email: wkernohan@cmu.ac.th
3Professor of health research, Institute of Nursing and Health Research, University of Ulster, Newtownabbey BT37 0QB Northern Ireland. Email: vg.kernohan@ulster.ac.uk
4Research Assistant, Institute of Nursing and Health Research, University of Ulster, Newtownabbey BT37 0QB Northern Ireland. Email: ramos.alex@ulster.ac.uk
5Neonatologist and instructor, Department of Neonatology, Faculty of Medicine, Chiang Mai University, Chiang Mai 50200 Thailand. Email: psuppas@gmail.com
6Lactation nurse, Faculty of Nursing, Chiang Mai University, Chiang Mai 50200 Thailand. Email: pp@pattaya.com
7Maternal educator, University of Ulster, Newtownabbey BT37 0QB Northern Ireland. Email: mf Sinclair@ulster.ac.uk

The authors would like to thank Dr Winatcharntamapay WW George Kernohan MD for overseeing the Thai research team, Dr Fragalde Tongstress RN and Khun Surinph Suranuw RN, head nurse of the postnatal unit for facilitating observations and information-gathering within the maternity unit of Chiang Mai University Hospital. This study was funded by the Vice Chancellor Scholarship, Ulster University. This research was presented at the Doctoral Midwifery Research Society meeting, Autumn 2014, in Ulster.

Abstract

Background. Breastfeeding is recognised as a complex behaviour that is influenced by many factors. This creates challenges for all breastfeeding mothers and health professionals seeking to support women in their breastfeeding journey. Personal, psychosocial, cultural and economic factors create a complicated interplay that need to be understood to ensure a successful breastfeeding experience. Maternal motivation is acknowledged as a determinant of breastfeeding behaviour; however, it is important to recognise that motivation is influenced by the cultural environment in which women live. Understanding how cultural influences impact breastfeeding practices is essential to ensure breastfeeding is a culturally appropriate, as well as a systematic and theoretical, framework. While traditionally understood within an organisational or conflict management situation, this framework was introduced to understand the data collection process, in particular in overcoming potential cross-cultural barriers.

Methods

Observational data were collected at national, corporate and individual levels using the Attention, Relevance, Confidence, Satisfaction (ARCS) educational model (Keller, 2010) and Gardenswartz et al’s (2003) cultural model to gain a deeper understanding of key factors influencing breastfeeding education and maternal motivation. A total of 75 hours of observation were conducted in eight maternity environments. The data collected included national data profiles, corporate policies, protocols and everyday practices. Ethical approval was obtained from universities in Northern Ireland and northern Thailand.

Findings

Published national breastfeeding rates were 49.6% for initiation and 35% for duration at six months. Breastfeeding policies in seven settings were identified and analysed. These were all based on the Baby Friendly Initiative (BFI) guidelines. Organisational culture was evident in the timing, venue and structure of the breastfeeding classes with individual and group breastfeeding classes prenatally and postnatally and specific self-efficacy and postnatal discharge classes. The maternity staff took a holistic approach to breastfeeding and this was reflected in the cultural and contextual aspects of the environment. The nurses were aware of the importance of breastfeeding, including the significance of breastfeeding, which was reflected in the cultural and contextual aspects of the environment.

Conclusion

This observation of Thai breastfeeding behaviour has demonstrated strong cultural influences as being inextricably linked to individual and national goals. The systematic process of gathering information about the educational and cultural components of breastfeeding behaviour and practices in a Thai setting using a combination of the ARCS model by Keller (2010) and Gardenswartz et al’s (2003) model to gain a deeper understanding of the interplay between the individual and societal factors evident in this unique culture.

Key words: Breastfeeding, instruction, motivation, context, culture, adaptation, evidence-based midwifery

Background

Breastfeeding is internationally recommended as being the most effective way to meet an infant’s nutritional needs within the first year of life. The WHO advises exclusive breastfeeding up to the age of six months with supplemented breastfeeding to the age of two years (WHO, 2014; 2002). The breastfeeding relationship between mothers and their infants is foundational in order to ensure the design and content of the delivery of the milk is both relevant and effective. The challenge within a design process is to incorporate cultural sensitivity, appropriateness and the cultural components that are relevant to reduce potential negative influences (Buhl, 2010).

A recurrent theme within literature investigating maternal breastfeeding behaviour is the presence of a support system, which may be either personal or professional (Johnston and Eppiseto, 2007; Persad and Mensinger, 2007). McInnes et al (2013) suggested that a paradigm shift is required away from the traditional approach of support and education of individual women, to a more holistic approach, which recognises what influences how the mother and infant learn.

Understanding the context in which women learn to be breastfeed is critical when developing a breastfeeding education programme in order to ensure the design and content of the delivery of the milk is both relevant and effective. The challenge within a design process is to incorporate cultural sensitivity, appropriateness and the cultural components that are relevant to reduce potential negative influences (Buhl, 2010).

A clear understanding of the cultural components that exist within a breastfeeding environment will enable a more integral approach to supporting women. This paper presents the methods and findings of information gathered to explore the education and cultural factors influencing breastfeeding in Thailand.

Aim

The aim of this paper is to identify contextual and cultural influences in breastfeeding education in a Thai setting. The objectives are to:

• Explore the policy context for practice
• Identify the key components of current breastfeeding education in a university hospital setting in Thailand
• Map the influence of Thai culture on breastfeeding culture.

Literature review

Culture is recognised as being a key component within breastfeeding education and is relatively unexplored with great diversity reflected between ethnic groups (Fischer and Olsen, 2014; Kelly et al, 2006; Thomas and Avery, 1997). However, the literature rarely provides direction on why cultural aspects of a breastfeeding programme are important and considered within the design and development of interventions (Im, 2015). Independent variables of social and cultural significance should be unpacked to identify distinctive cultural elements, such as values and behaviours (Whiting, 1976). Dodgson et al (2002) discovered four patterns of influence on breastfeeding behaviour within an indigenous population: local and mainstream culture, mixed messages received by the mother, life circumstances, and social support. Recognising these varied influences within breastfeeding culture as a culturally determined behaviour may go some way to explaining why successful Western-style breastfeeding programmes may not be effective in some ethnic groups or culturally diverse situations (Sutton et al, 2007).

Breastfeeding is not just influenced by the individual’s choices in what way of breastfeeding and this was reflected in the cultural and contextual aspects of the environment, such as family, workplace and geographical area (Unger and Schwartz, 2012; Trickett, 2009). A lack of support during life-changing circumstances, a lack of culturally relevant, timely and comprehensible information and the cultural norms of feeding in public can affect maternal expectations to succeed with breastfeeding (Glover et al, 2009). Family opposition or cultural beliefs and practices may also be influenced by traditional and non-traditional cultural beliefs (Elter et al, 2014; Ergenekon-Ozelci et al, 2006; Tarrant et al, 2004). In some contexts, religious beliefs appear to play a part in breastfeeding practices; for example, Buddhist teachings in Japan support extended breastfeeding to the age of six as part of their religious teachings (Segawa, 2008; Foo et al, 2005). Traditional postpartum practices in Asian countries are believed to be grounded in two main perspectives: humoral theory (the assumption that the human body is composed of four elements: earth, fire, air and water; and traditional Chinese medicine (Elter et al, 2014; Manderson, 1981). In addition to this, traditional Thai medicine incorporates folk medicine, Khmer medicine and Buddhist and animistic beliefs (Elter et al, 2014; del Casino, 2004; Department for the Development of Thai Traditional and Alternative Medicine, 2004; Salguero, 2003; 2007; Bambr, 1999). These cultural influences can all have an effect on maternal motivation.

Motivation

Motivation is defined as the energy and goal that directs behaviour towards achieving a goal (Sonsone and Harackiewicz, 2000). Keller (2010) suggested that if a person’s motivation is strong enough, there is little that will dissuade them from persisting until they achieve their goal. The application of the ARCS model to routine breastfeeding instruction was first applied to breastfeeding by Stockdale et al (2014; 2011). When applied to breastfeeding instruction, the ARCS components resulted in a significant increase in maternal motivation to breastfeed through the creation and implementation of a breastfeeding intervention (Stockdale et al, 2008). Therefore, the ARCS was deemed to be an appropriate theoretical framework of reference for undertaking this study and the authors used Keller’s information analysis to guide the data collection and analysis.

A cultural model (Gardenswartz et al, 2003) was adapted and integrated into the information analysis in order to maintain a culturally appropriate, as well as a systematic and theoretical, framework. While traditionally used within an organisational or conflict management situation, this framework was introduced to understand the data collection process, in particular in overcoming potential cross-cultural barriers.

Method

A three phase approach was used to gather this information:

• Phase 1: National information pertaining to breastfeeding strategies and behaviour.
• Phase 2: Corporate information regarding breastfeeding policies and practices.
• Phase 3: Analysis of the influences of personal cultures of the researcher and Thai health professionals.

Setting

Data collection took place in a university hospital in northern Thailand, which is a regional referral centre for women and has an approximate birth rate of 2000 per annum. Observations were completed in each context where routine breastfeeding instruction occurred. A convenience sampling approach was implemented and women and staff were offered an explanation of the study and consent forms given prior to each observation session. A total of 75 hours of observation were completed in eight environments of potential breastfeeding instruction.

Ethics

Ethical approval was obtained from Ulster University and Chiang Mai University.

Data collection and analysis

Data collected using a semi-structured observation schedule and a field diary to gather cultural and contextual, as well as motivational, content of routine breastfeeding instruction.

Phase 1: National culture

Data were collated and mapped at a national level. This included a synthesis of national policies and breastfeeding strategies, current national breastfeeding rates and their implications for practice. All health and welfare policies affecting breastfeeding behaviour were identified and mapped. Additional information was gathered regarding the organisation and implementation of national health services, medical and nursing training and


© 2015 The Royal College of Midwives. Evidence Based Midwifery 13(3): 84-91

© 2015 The Royal College of Midwives. Evidence Based Midwifery 13(3): 84-91

84-91
Thai cultural influences on breastfeeding behaviour. Evidence Based Midwifery 13(3): 84-91


Thai cultural influences on breastfeeding behaviours. Evidence Based Midwifery 13(3): 84-91


Thai cultural influences on breastfeeding behaviour. Evidence Based Midwifery 13(3): 84-91

National surveys conducted by the Department of Health and the Ministry of Public Health in 1996, 2000 and 2002 showed increasing rates of breastfeeding in comparison to 1993, but the rates of exclusive breastfeeding remained lower than the government target of 30% by 2006 (Department of Health and Ministry of Public Health, 2006; 2002; 2000; 1996; 1994). This target was set by the National Corporate Plan and has now been extended (Department of Health and Ministry of Public Health, 2006).

Breastfeeding rates were reported at 49.6% initiation rate, with a 5.4% exclusive breastfeeding rate at six months (World Breastfeeding Initiative, 2006). These rates of initiation fell in 2001 to the lowest exclusive breastfeeding rates in South-East Asia. This information was based on Multiple Indicator Cluster surveys conducted in 2006 (National Statistical Office, 2007), however, a more recent report suggested an exclusive breastfeeding rate of 15.10% (Trading Economics, 2014). Data in Thailand is collected through a range of systems, including government surveys such as hospital project surveys, Family Bonding Reports, Education for All assessments, Multiple Indicator Cluster surveys, Demographic and Health surveys, national household surveys and data from routine reporting systems. These systems are used by the WHO and UNICEF for their data collection as well as the United Nations Population Division. The international statistics are evaluated and adjusted by WHO, UNICEF and UNICEF-UNDP to account for under-reporting and data bias and other factors. Although these systems are centralised and documenting services, there are areas where it still appears fragmented, in part due to the range of care offered between the various health services including government, private, along with many other organisations, corporations, government and non-governmental systems. These systems are used by the WHO and UNICEF to assess breastfeeding rates in Thailand and map for influence on breastfeeding behaviour.

Meetings were held at various levels within the hospital, with key health professionals and staff to be advised by the BFI (WHO, 2006; Hangchaovanich and Voramongkul, 2006). The influence of personal culture had to be considered when developing the breastfeeding programme. It was acknowledged that cultural miscommunication and misclassification. Although Thailand does have some recommended policies advised by the BFI (WHO and UNICEF, 2009) and breastfeeding guidelines and policies were developed and implemented. Traditional Thai culture is very focused on teamwork and all of the changes undertaken were done in consultation with staff. The International code of marketing breastmilk substitutes was adhered to within the unit, unless it was deemed necessary by medical staff to give formula. Other policies included the Baby Friendly ‘10 steps to successful breastfeeding’ (WHO and UNICEF, 1989), which were implemented in the seven instructional environments. These environments were implemented in 2009, informing women regarding the benefits and management of breastfeeding, assisting women with initiation of lactation within within half an hour of birth and encouraging the practice of rooming in. The workshops were designed to promote breastfeeding for vulnerable infants (Spatz, 2004) were also implemented in the special baby care units and nurseries.

These policies were observed as everyday practices throughout the observation period in each unit. Breastfeeding and skin-to-skin, where possible, were encouraged within half an hour of birth. Women were taught within four to six hours of arrival on the postnatal wards how to prepare and massage their breasts and how to express and store breast milk. Assistance was given by nurses when positioning, expressing and promoting breastmilk supply. The self-efficacy classes were designed to build a mother’s confidence in her breastfeeding effort and increase her self-efficacy class, was also offered between day three and day four. This class was led by nurses from the lactation clinic and was introduced in the unit by the lead nurse in the lactation clinic following an internal research project that examined self-efficacy in breastfeeding mothers in the hospital (not published). This class consisted of a video of a mother explaining her breastfeeding experience and challenges and a second video of the lactation nurse explaining positioning and latch while watching two mothers feeding.

Observation of breastfeeding goals was a key aspect of this study and during the educational classes, these were categorised into:

- **Purpose goals** – these included messages to women about the reasons why they should consider breastfeeding.
- **Target goals** – these were specific ways mothers can learn to breastfeed, including positioning and attachment.
- **Performance feedback goals** – these included confidence in positioning the infant on the breast, evidence of milk flow and supply, wet and dry nappies.

The self-efficacy classes were designed to build a mother’s confidence in her breastfeeding effort and increase her persistence with the newly learned behaviour.

In this Thai context, the above goals were evident within the classes offered, including the peer support provided, and were visible in the written materials, where there was a strong emphasis on the cultural value of breastfeeding to Thai women and the Thai population. A high value on staff training in breastfeeding instruction and teamwork was also evident in the analysis and all members of the multiprofessional team were encouraged to attend training both outside and within the hospital and apply it to their practice.
Thai cultural influences on breastfeeding behaviour. Evidence Based Midwifery 13(3): 84-91

Thai cultural influences on breastfeeding behaviour.
Conclusion

The adaptation of the cultural model into a breastfeeding context gave an additional framework to collect, organise and analyse the barriers to breastfeeding at the national, corporate and personal levels. While the national culture may have some conflicting values, the high value of breastfeeding within the organisational culture was evident in everyday practice. This study implemented the BFI breastfeeding policies, ownership of the breastfeeding instruction by the staff and a sense of collective purpose and teamwork.

Cultural components played a key part in creating a supportive environment for mothers to begin their breastfeeding experience, meet their breastfeeding goals and overcome potential potential and analysing the barriers. The systematic process of gathering information about the educational and cultural components of breastfeeding behaviour and practices in a Thai setting, using a combination of the ARCS model by Keller (2005) and culled Awastri et al (2003), provided an enriched understanding of the interplay between the individual and societal factors evident in this unique culture.

References


