Enfermería Global
ISSN 1695-6141 Revista electrónica cuatrimestral de Enfermería
Nº 76 Mayo-Agosto 2025
www.um.es/eglobal/

REVIEW

Cultural beliefs and practices about women's breastfeeding behaviors: a Scoping Review

Creencias y prácticas culturales sobre comportamientos de lactancia materna en mujeres: una Revisión Sistemática Exploratoria

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https://doi.org/10.6018/eglobal.648551

elocation-id: e648551

Received: 06/02/2025
Accepted: 02/07/2025

ABSTRACT:

Introduction. Cultural issues are strongly related to women's life habits. The World Alliance for Breastfeeding Action, led by the United Nations Children's Fund and the World Health Organization, recommends exclusive breastfeeding in the first six months of life and supplementary breastfeeding up to 2 years. There are different cultural beliefs and practices about breastfeeding that can negatively influence it. According to the World Health Organization, only 4 out of 10 infants under 6 months of age have received exclusive breastfeeding in the world.

Objective. To explore the role of cultural beliefs and practices on women's breastfeeding behaviors.

Method. A scoping review following the PRISMA-ScR checklist was conducted using six electronic databases: PubMed, Scopus, CINAHL, PsycINFO, Web of Science and Cochrane Database of Systematic Reviews. Adherence to reporting guidelines in observational studies were assessed.

Results. 3078 studies were located, of which 37 were finally selected. Two thematic categories were proposed: 1. Perceptions and beliefs concerning women's breastfeeding. 2. The influence of social norms on women's breastfeeding.

Discussion: The results highlight the beliefs that colostrum is considered "dirty milk" and that mother's milk has a low nutritional value, which is associated with some religious practices, family impositions, social barriers, sensational and false news stories, and the early return to work, resulting in low breastfeeding rates worldwide.

Conclusion. This review has advanced the understanding that cultural issues are strongly associated with breastfeeding among women. Educational programs, counseling and health professionals' training should be offered to increase breastfeeding.

Keywords: Breastfeeding Women; Cross-Cultural Comparison; Infant Care; Systematic Review.

RESUMEN:

Introducción. Las cuestiones culturales están fuertemente relacionadas con los hábitos de vida de las mujeres. Se recomienda la lactancia materna exclusiva en los primeros seis meses de vida y la lactancia materna complementaria hasta los 2 años. Según la Organización Mundial de la Salud solo 4 de cada 10 lactantes menores de 6 meses de edad han recibido lactancia materna exclusiva en el mundo.
Objetivo. Explorar el papel de las creencias y prácticas culturales en las conductas de lactancia materna de las mujeres.
Método. Se realizó una revisión sistemática exploratoria en seis bases de datos: PubMed, Scopus, CINAHL, PsycINFO, Web of Science y Cochrane Database of Systematic Reviews.
Resultados. Se localizaron 3.078 estudios, de los cuales 37 fueron finalmente seleccionados. Se propusieron dos categorías temáticas: 1. Percepciones y creencias sobre la lactancia materna en las mujeres. 2. Influencia de las normas sociales en la lactancia materna en las mujeres.
Discusión: Los resultados destacan las creencias de que el calostro se considera "leche sucia" y que la leche materna tiene un bajo valor nutricional, lo que se asocia a algunas prácticas religiosas, imposiciones familiares, barreras sociales, noticias sensacionalistas y falsas y el retorno temprano al trabajo, lo que resulta en bajas tasas de lactancia materna en todo el mundo.
Conclusión. Esta revisión ha avanzado en la comprensión de que las cuestiones culturales están fuertemente asociadas con la lactancia materna entre las mujeres. Se deben ofrecer programas educativos, asesoramiento y capacitación de profesionales de la salud para aumentar la lactancia materna.

Palabras clave: Madres Lactantes; Comparación Transcultural; Cuidado del Lactante; Revisión Sistemática.

INTRODUCTION

The World Alliance for Breastfeeding Action, led by the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), called on governments to "Support breastfeeding for a healthier planet" in 2020 [1,2]. However, only 4 out of 10 infants below 6 months of age have received exclusive breastfeeding in the world [3].

Several studies are supporting the benefits of breastfeeding for both mothers and children, prompting WHO to set a global goal to increase breastfeeding rates by at least 50% in the first 6 months of life in 2025 [4]. Current evidence has shown that mother's milk offers several benefits to newborns [5]. In the short term, it reduces infant morbidity and mortality due to acute otitis media, gastrointestinal, and respiratory infections. In the long term, it protects against chronic diseases such as diabetes mellitus, obesity, high blood pressure, celiac disease, and inflammatory bowel disease [6-10].

Other benefits were also observed for the mother and for public health, such as reducing the probability of suffering postpartum hemorrhage, anemia and the existence of breast and gynecological cancers [11,12], strengthening the mother-child emotional bond and the promotion of maternal well-being, producing personal satisfaction and decreasing rates of postpartum depression [11,13], lowering the rates of child neglect [14,15] and reducing family [16]. Costs for the health system are also reduced due to the benefits of breastfeeding, as the number of primary care consultations, emergencies and hospital readmissions are reduced [17,18].

Although breastfeeding is an instinctive act for the newborn, it has a cultural component and requires learning from mothers. In this context, it is expected that women's own experiences and cultural issues may have an important influence on breastfeeding practices and behaviors [19,20]. On the one hand, in high income countries, the social "normalization" of the use of milk formulas, bottles and artificial teats are reasons that keep many women away from breastfeeding [21,22]. In these countries, there is a difficulty to reconcile family and professional life after the incorporation of women into the labor market, resulting in low rates of breastfeeding [23,24]. On the other hand, in low-income countries [25,26], cultural beliefs may have an influence on the early weaning of the baby, such as the belief that the milk is "weak", that the production is low or concerns about the aesthetics of breasts. In some countries in Africa, for instance, there is a belief that intaking cold foods (i.e., cucumber, watermelons, beans, and guava) may cause difficulties in women's recovery in the puerperium [20]. Other beliefs are disseminated in different countries [27].

Some authors recognize the existence of a gap between different cultures and demographic zones worldwide, as well as a midwifery training and care not unified, resulting in a significant disparity in breastfeeding practices and support, favoring those communities in developed countries [28]. That is why the Food and Agriculture Organization of the United Nations (FAO) and WHO are working to prioritize public policies that allow health professionals to implement projects and interventions focused on the promotion, protection and support of breastfeeding [29], favoring the verbal expression of expectations and difficulties of the breastfeeding mother and individualizing the needs of each woman [30].

Since 2016, the International Code of Marketing of Breastmilk Substitutes commits member states to regulate the marketing of human milk substitutes and to increase exclusive breastfeeding rates worldwide by 50% [31-34]. The consideration of this Code is an impetus for the promotion of breastfeeding, and claims its great repercussion on health, economic and social level. Within this context, a scoping review could provide useful information for professionals involved in maternal and pediatric care, considering women's origin and cultural context and promoting the development and improvement of their practice as well as the well-being of mothers.

Therefore, the purpose of this scoping review is to explore the role of cultural beliefs and practices on women's breastfeeding behaviors, through the following guiding research question: What is the current evidence for the role of cultural beliefs, practices, taboos, or myths on the initiation, maintenance, or cessation of breastfeeding in women of different cultures?

METHOD

Design and search strategy

A scoping review following the PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews checklist was done [35]. It was conducted using PubMed, Scopus, CINAHL, PsycINFO, Web of Science and Cochrane Database of Systematic Reviews. The searches were performed by two researchers independently, using the following boolean expression,

slightly adapted for each database: (cultur* OR customs OR taboo OR myths) AND (breastfed OR breastfeeding OR “breast fed” OR “milk sharing” OR “breast feeding”). No manual searches were performed.

Inclusion and exclusion criteria

Studies included: 1. Studies investigated how cultural beliefs may influence breastfeeding patterns. 2. Peer-reviewed articles with original data published between 2017 and 2023. 3. Quantitative, qualitative, or mixed-design studies. No language restrictions were applied.

Studies excluded: 1. Editorials, opinion essays, literature reviews and books or if they did not address cultural issues or breastfeeding patterns. 2. Studies that focused on infant feeding or nutritional approach in pathologies during breastfeeding.

Study selection and data extraction

After the search, all references were included in the Mendeley software. The screening procedure was carried out by two researchers independently. First, duplicate publications were removed and then, the reviewers screened by title and abstract. Full text articles were screened by two researchers and another reviewer was consulted if any disagreement.

Finally, the data was extracted for each study. The summary table was thoroughly reviewed by three reviewers independently, with critical discussions of the extracted data (Table 1 and Table 2).

Assessment of methodological quality

The studies that met the inclusion criteria were assessed for methodological validity prior to inclusion in the review. Adherence to reporting guidelines (EQUATOR) in observational studies were assessed using STROBE checklist (Strengthening the reporting of observational studies in epidemiology) [36]. Concerning qualitative studies, Standards for Reporting Qualitative Research (SRQR) guidelines were used [37]. For the SRQR, even though this score does not rate items, the following categorization was used based on the percentage of items meeting the appraisal criteria (Excellent: 80-100% of the items, Good: 50-80%, Regular: 30-50% and Poor: <30%).

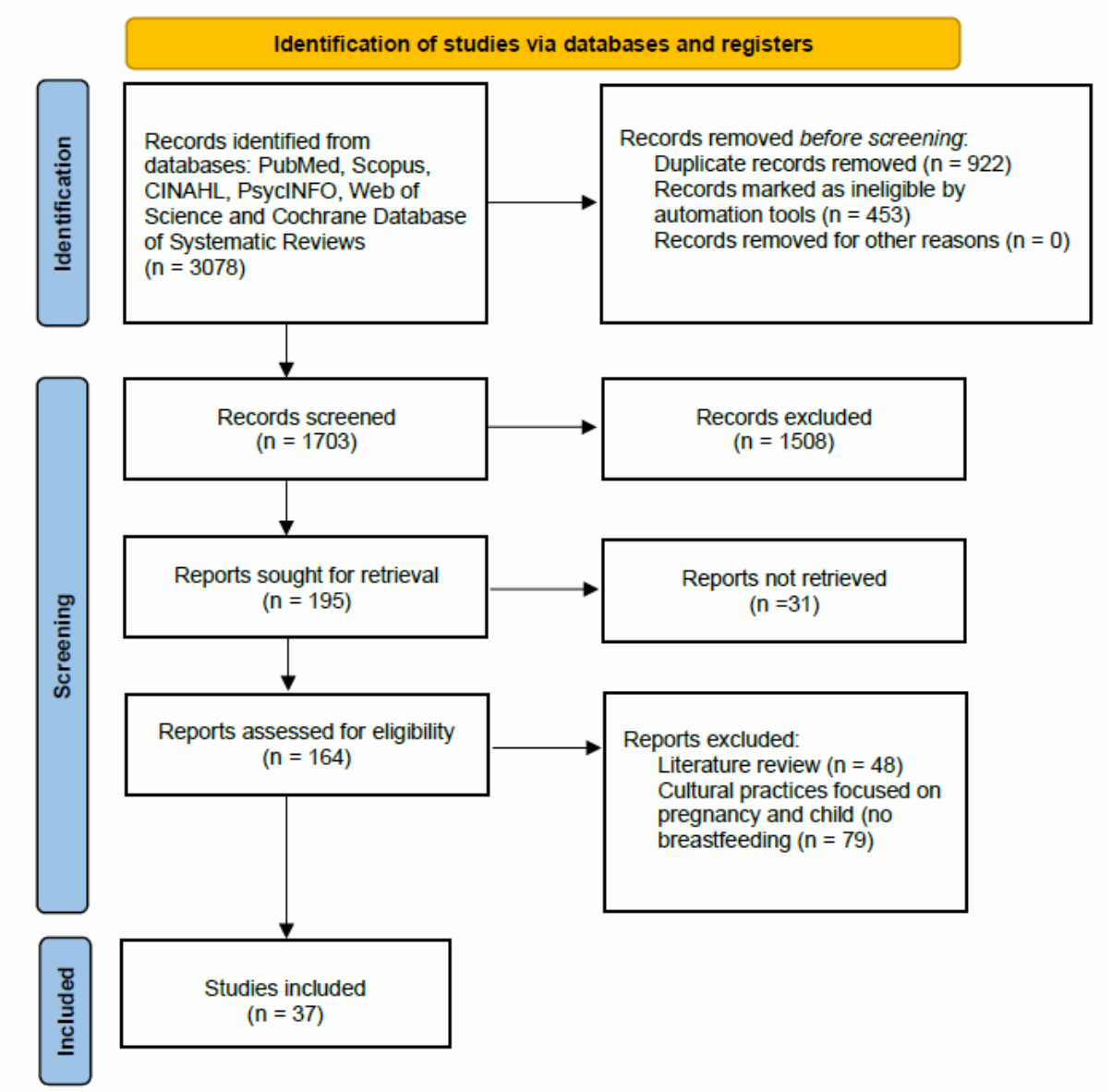
Development of categories

To develop the categories for this scoping review, a thematic analysis approach was used [38]. Two reviewers participated in the searches, screening, articles assessment and data extraction. They organized descriptive labels and focused on emerging or persistent concepts and similarities or differences in breastfeeding behaviors or practices, perceptions, beliefs and statements of women and family members. The coded data from each paper was examined and compared with the data from all the other studies.

RESULTS

There were 3078 publications matching the search criteria, and 164 articles underwent the full-text analysis. After reading the full-text articles, our final sample included 37 studies. The flowchart is included in Figure 1.

Figure 1: Study selection diagram, according to PRISMA flowchart.



Characteristics of the included studies

A total of thirty seven studies were included in the final sample. These studies were mainly conducted in Africa (n=10), Asia (n=13), and America (n=10). Most studies used a qualitative design (n=26) and were characterized by interviews (n=15), followed by group technique (n=8). Regarding studies with mixed-design, four studies were carried out through questionnaires and interviews, and five studies through both questionnaires and focus group technique.

In the adherence to reporting guidelines assessment, all papers included in this review were considered from a high or medium adherence, ranging between 14.1 to 20.6 /22

for observational studies (STROBE) [36]. Regarding SRQR guideline [37], no article was rejected, since they fulfilled most of the items. The most frequent weaknesses were related to the lack of description of the interview scripts and the lack of presenting the characteristics of the researchers.

Synthesis

In this scoping review, target populations were predominantly lactating women from different cultures. Table 1 shows references, objectives, design methods and selection samples of each of the selected studies.

Table 1: References, design methods and selection samples of each study for this scoping review.

Reference	Design method	Sample
Acheampong et al.[38] / Ghana, Africa	Qualitative (interviews)	13 HIV-positive mothers with children under 1 year of age. Ethnicity / Nationality: Ghanaian (West Africa) Mean age: 33.5.
Adda et al.[39] / Ghana, Africa	Qualitative (4 FGDs and 8 in-depth interviews)	29 first-time mothers who participed in FGDs; 4 traditional birth attendants (TBAs) and 4 health workers (heads of health facilities). Ethnicity / Nationality FGDs: Kassena (N=13); Nankana (N=14); Others (N=2) (West Africa) Mean age: between 20 years and below and 26 years old.
Amaral et al.[40] / Brazil, South America	Qualitative (semi-structured interviews)	14 nursing mothers Ethnicity / Nationality: Brazilian Age: 20-38.
Chakona[41] / South Africa, Africa	Mixed methods (9 FGDs and surveys)	84 household pairing mother/caregiver and 94 participants in FGDs. Ethnicity / Nationality: South African. Mean age: 34.7 years for mothers/caregivers and 16.3 months for children.
Dietrich Leurer et al.[42] / Tanzania, Africa	Qualitative (interviews)	30 Maasai mothers of infants zero to six months of age Ethnicity/Nationality: Maasai Tanzania (East Africa) Mean age: 26.
Hinson et al.[43] / USA, North America	Qualitative (6 FGDs)	34 African American mothers of infants aged 0 to 3 months. Ethnicity/Nationality: African American/ Northeastern US City (North American). Mean age: 25.6.

Reference	Design method	Sample
Horwood et al.[44] / South Africa, India (Africa and Asia)	Qualitative (14 FGDs in South Africa and 9 in India)	Total N = 87 South Africa participants (62 women with children under 5 years and 25 men working in the informal economy for more than 6 months). Ethnicity/Nationality: African Mean age: 26-45 years old. Total N= 92 India (54 women with children under 5 years and 38 men had been working in the informal economy for more than 6 months) Ethnicity: Hindu (N=80); Muslim (N=11) and other (1) Mean age: 20-25.
Kim et al.[45] / Champaign County (USA), North America	Mixed methods (semi structured interviews based on the Theory of Planned Behavior, Iowa Infant Feeding Attitude Scale, and Breastfeeding Self-Efficacy Scale–Short Form to measure attitudes and self-efficacy, respectively)	15 first-time BF mothers. Ethnicity/Nationality: African American (black). Age: 15 - ≥30.
Ruhmayanti & Yasin[46] / Indonesia, Asia	Quantitative analytical study with an observational cross-sectional study (Administered questionnaire)	112 breastfeeding mothers and mothers who had toddlers (0-3 y old) and had a history of breastfeeding. Ethnicity/Nationality: Indonesia (Asia)
Zhao et al.[47] / China, Asia	Qualitative (semi-structured interviews)	27 mothers who had one child aged under three years. Ethnicity/Nationality: -China (East Asia) Mean age: 27.
Atyeo et al.[48] / Guatemala, South America	Qualitative (semi-structured interviews)	178 mothers Ethnicity / Nationality: Maya Age: 29-30 years old.
Zakar et al.[49] / Pakistan, Asia	Qualitative study (12 FGDs)	38 mothers and 40 fathers Ethnicity/Nationality: Pakistan (South Asia) Age: 25 and above.
Yalçin et al.[50] / Turkey, Asia	Qualitative (46 FGDs)	335 people (Turkish HCWs working in maternity hospitals, Syrian HCWs working in Refugee Health Centers (RHCs), Syrian pregnant women, mothers, fathers, and grandmothers). Ethnicity / Nationality: Syrian (262) and Turkish (73) Mean age: Syrian refugee: 43 years old; Turkish personnel: older than 40 years old.

Reference	Design method	Sample
Christoffel et al.[51] / Brazil, South America	Qualitative (semi-structured interviews)	30 health professionals (six nurses, five nursing technicians, three physicians, fifteen community health agents, and one dental surgeon) Ethnicity / Nationality: - Age: 21-56.
Idris & Palutturi[52] / Indonesia, Asia	Cross-sectional study (questionnaires ad hoc)	104 mothers of children from 6 to 12 months. Ethnicity/Nationality: - Indonesia (South Asia) Mean age: 30-34.
Nuño Martínez et al.[53] / Peru, South America.	Qualitative (semi-structured interviews)	40 women Ethnicity/Nationality: - Mean age: 28.
Budiati[54] / Indonesia, Asia	Mixed methods Qualitative (interviews and FGD) Quantitative (survey).	Qualitative phase: 14 post-cesarean mothers breastfeeding, and 3 husbands/partners of breastfeeding mothers and FGD with 4 mothers-in-law/parents of postpartum caesarean mothers. Quantitative phase: 148 respondents (quantitative phase) who had babies between 6-24 months. Ethnicity/Nationality: Indonesia (Southeast Asia): Sundanese (44%), Betawi (21.6%), Jawa (15.5%), Batak (6.8%), Padang (12%), others (4%). Mean age: 29.67 ± 6.22 years old.
Mgongo et al.[55] / Tanzania, Africa	Qualitative (9 Focus Group Discussions - FGD)	78 mothers with babies from 0 to 12 months. Ethnicity/Nationality: Pare (Same) and Chagga (Rombo) Tanzania (East Africa) Mean age: 28.
Talbert et al.[56] /Kenya, Africa	Qualitative (Semi-structured interviews)	20 first-time mothers Ethnicity/Nationality: Kenya (East Africa) Mean age: 17.
Khan & Kabir[57] / Bangladesh, Asia	Mixed methods (2 FGDs, qualitative interviews and quantitative questionnaires)	220 infant-mother pairs (babies aged 4-12 months) Ethnicity/Nationality: Bangladesh (South Asia) Mean age: 21-29.
Debnath et al.[58]/ India, Asia	Mixed methods (semi-structured questionnaire with open ended questions)	306 mother-newborn dyads Ethnicity / Nationality: Indian (South Asia). Mean age: 22.6.
Anazonwu et al.[59] / Nigeria, Africa	Mixed methods (questionnaire and in-depth interviews).	592 childbearing pregnant women, 9 married men and 9 grandmothers. Ethnicity / Nationality: Nigerian. Mean age: 30-34 years old (highest percentage).

Reference	Design method	Sample
Hernández-Cordero et al.[60] / Mexico, South America	Mixed methods (surveys and semi-structured interviews)	Surveys (N = 543 mothers) and 60 semi-structured interviews (N=31 from urban areas; N=29 from rural areas) Ethnicity / Nationality: Mexican. Mean age: 24.16.
Amaral et al.[61] / Brazil, South America	Qualitative (semi-structured interviews and fiel diary)	24 Quilombola mothers with children aged 0 to 2 years. Ethnicity / Nationality: Brazilian (Quilombola). Mean age: -
Ahmed et al.[62] / Pakistan, Asia	Qualitative (semi-structured in-depth interviews)	20 mothers of malnourished children Ethnicity / Nationality: Pakistani Mean age: 30.
Pemo et al.[63] / Bhutan, Asia	Qualitative (semi-structured interviews)	24 pregnant Bhutanese women in the third trimester of pregnancy (22 of them were also interviewed at 6 weeks postpartum). Ethnicity/Nationality: Bhutanese (Asia) Age:20- 25.
García-Magdaleno & Laureano-Eugenio[64] / Mexico, North America	Qualitative (6 FGDs)	23 women belonging to the Prospera program who live in rural and urban communities in Jalisco. Ethnicity / Nationality: Mexican. Mean age: 29.4 years old (n = 14 women from rural areas) and 27.3 years old (n = 9 from urban areas).
Kamoun & Spatz[65] / USA, North America	Mixed methods (interviews and survey)	10 community leaders (5 women and 5 men) and 44 community members (37 women and 7 men). Ethnicity/Nationality: African American Muslims in West Philadelphia (USA, North America) Mean age: 37 - ≥45 years old (community leaders) and 28-36 years old (community members).
Tsegaye et al.[66] / Ethiopia, Africa	Mixed methods (Structured questionnaires and 2 FDGs)	631 mothers Ethnicity: Ethiopia (East Africa) Age: 15-25.
Murad et al.[67] / Saudi Arabia, Asia	Qualitative (semi-structured interviews)	16 mothers with babies 0-2 years old Ethnicity/Nationality: Arabia Saudi (Middle East) Age: 25-34.
Acheampong et al.[68] / Ghana, Africa	Qualitative: 6 focus group discussions (FGDs)	30 pregnant teenagers Ethnicity / Nationality: Ghanaian (West Africa) Mean age: 13-19.
Hauck et al.[69] / Australia, Ireland, and Sweden, Oceania and Europe	Qualitative (online surveys)	14.265 women breastfeeding / breastfed in the previous two years. Ethnicity / Nationality: (N=10.910 Australian; N=1.835 Irish; N=1.520 Swedish). Mean age: 33.3.

Reference	Design method	Sample
Maviso et al.[70] / Papua New Guinea, Oceania	Qualitative (semi-structured interviews and two FGDs)	20 first-time mothers. Ethnicity/Nationality: Papua New Guinea (Oceania) Age: 15-34.
Reno[71] / USA, North America	Qualitative (Group model building-GMB)	Total N = 21: pregnant (N=8) and postpartum (N=13) women. Ethnicity/Nationality: African American (USA, North America) Mean age: 24.81.
Ratnayake & Rowel[72] / Sri Lanka, Asia	Mixed methods (questionnaire) and 4 FDG	FDG: 21 mothers. Quantitative study: 333 mothers with infants aged 6 months. Ethnicity/Nationality: Sri Lanka (South Asia): Sinhalese (237); Muslim (72); Tamil (44); Malay (1) Mean age: 19-38.
Newman & Williamson[73] / United Kingdom, Europe	Qualitative (semi-structured interviews)	8 women with breastfeeding experience. Ethnicity/Nationality: British (Europe) Mean age: 32.
Guo et al.[74] / China, Asia	Qualitative study (Semi-structured interviews)	13 Chinese working mothers who continued to breastfeed for 1 month or more after returning to work. Ethnicity/Nationality: Chinese Mean age: 33.4.

Self-made table based on the narrative analysis of the results

Table 2 shows references, major findings, quality and breastfeeding process of each of the selected studies. Two thematic categories were proposed: 1. Perceptions and beliefs concerning women's breastfeeding. 2. The influence of social norms on women's breastfeeding. The results are presented below.

Table 2: References, major findings, quality and breastfeeding process of each study for this scoping review.

Reference	Major findings	Quality	Breastfeeding process
Acheampong et al.[38] / Ghana, Africa	Spouses and siblings of women were a source of support for initiating and maintaining breastfeeding. However, women avoided disclosing their HIV status to certain community members, as they were harshly judged on whether they could transmit the infection to their babies through their milk and they could be chastised. In the case of midwives, there was ambivalence between those who encouraged breastfeeding and those who judged and made women feel bad about their HIV status.	SRQR	Initiation and cessation
Adda et al.[39] / Ghana,	Knowledge of the physiological, emotional and economic benefits, as well as the possibility of	SRQR	Initiation and maintenance

Reference	Major findings	Quality	Breastfeeding process
Africa	breastfeeding as a contraceptive method were predictors of its success. However, some mothers believed a baby could die from thirst, if exclusively breastfed or the colostrum was contaminated, so these beliefs prevented breastfeeding. Rituals ("Kacheeri", "pog-saare") to purify the milk or the use of herbal concoctions, family influence (especially mothers-in-law) or the need to go to work were also predominant, forcing the introduction of complementary feeding.		
Amaral et al.[40] / Brazil, South America	The interruption of EBF is linked to routines of maternity wards, ignorance of the physiological aspects of lactation, and difficulty to child in accepting the breast. The participants claimed that their milk production was insufficient or “weak”, which contributes to the early use of water and teas. Mothers did not identify the benefits of breastfeeding, like the mother-child bond, reducing family expenses and reducing the risk of postpartum bleeding.	SRQR	Maintenance
Chakona[41] / South Africa, Africa	Most children under the age of 24 months were not breastfed. One of the factors that influenced the interruption of BF was the women's fear of losing their husbands (having sexual relations makes the milk comes out dirty and the child weak). In addition, the cost of food and the change from the traditional practices to supplementing or substitute breastfeeding (i.e., porridge) generated disputes between mothers and grandmothers.	16.4/22 STROBE	Maintenance
Dietrich Leurer et al.[42] / Tanzania, Africa	Regarding beliefs and knowledge about BF, the most important reason for women to breastfeed was because it was recommended by older women, and they considered it the best food for newborns. They also stated that they were not aware of the recommendations on BF and for many they were unrealistic in their situation. In addition, they gave cow's milk and other foods as they felt that human milk was not enough. Regarding the complementary feeding of babies, twenty of the women did not carry out an EBF, giving them juice, honey, butter, or water, starting solid food at 8-9 months.	SRQR	Initiation and maintenance
Hinson et al.[43] / USA, North America	Breastfeeding facilitators were the knowledge about the benefits of breastfeeding such as mother-child bonding, the belief that it is a perfect creation of God that should be carried out, which they relate to spirituality and the	SRQR	Maintenance

Reference	Major findings	Quality	Breastfeeding process
	support network (spouse, friends, family). However, the sexualization of the female breast, as well as public shame, life priorities versus breastfeeding, lack of prenatal knowledge, support and information about breastfeeding and independence of the newborn are the most prominent obstacles.		
Horwood et al.[44] / South Africa, India (Africa and Asia)	Knowledge about the benefits of BF and the disadvantages of artificial formula, comfort and economic reasons were the main motivators for initiating BF. However, the return to work due to economic needs or the impossibility of combining both activities, the time required or the belief in dependence on the baby influenced the introduction of complementary feeding, total abandonment of BF and/or EBF. In addition, it is showed the discomfort of breastfeeding in front of male colleagues or the unhealthy conditions of some workplaces.	SRQR	Cessation
Kim et al.[45] / Champaign County (USA), North America	Some sociocultural factors such as sexualization of the breasts so women did not breastfeed in public or the negative perception of society of breastfeeding children older than 1-year, and unhealthy diet of mothers (e.g., dairy, spicy, and greasy foods) by producing unhealthy human milk. Some factors that benefited BF were work flexibility and knowledge about the benefits of BF, such as babies are smarter, having better digestion and diaper smell, and having fewer illnesses, that it was a nice bonding experience, saved money on formula and it helped to relieve stress.	18.5/22 STROBE	Cessation
Ruhmayanti & Yasin[46] / Indonesia, Asia	In the sample of 112 women surveyed, 66 of them (58.9%) gave EML and 46 (41.1%) did not, with variations between the ages of both groups. The results of the sociocultural perceptions between both groups were significant (p50.00) and show that 81.8% of the mothers who exclusively breastfed had a good perception of breastfeeding which included the consideration of the importance of breastfeeding in the first 6 months to meet nutritional needs, feeding colostrum and awareness to add foods from 6 months and continue with BF until 2 years. 73.9% of those who did not give had a poor perception of breastfeeding and exclusive breastfeeding, with most feeding their babies with pre-electal foods such as honey, bananas, milk or other foods/drinks at birth, the thought	17.7/22 STROBE	Maintenance and cessation

Reference	Major findings	Quality	Breastfeeding process
	that formula milk is a substitute for breast milk or feeling it as an obligation.		
Zhao et al.[47] / China, Asia	There is an ambivalence between the desire and knowledge of the benefits of breastfeeding and the women's embarrassment about doing it in public because there are no spaces adapted to breastfeeding. This leads them to breastfeed only in private, and to use artificial milk or dummies to soothe the baby when they are in public, although they themselves consider it natural, they still feel fear and shyness.	SRQR	Cessation
Atyeo et al.[48] / Guatemala, South America	Beliefs transmitted by relatives, such as the colostrum was "dirty" milk and harmful to the gastrointestinal system of the newborn, were influential factors in delaying lactation. Some mothers used *atoles* (a mixture of water, sugar, and starch), store-bought formula, water, coffee, and tea as early mother's milk substitutes. Other ones asked other mothers to breastfeed their children while they waited for the colostrum to cease.	SRQR	Initiation
Zakar et al.[49] / Pakistan, Asia	It should be continued for as long as possible without specifying it, most mothers and fathers believed that colostrum is not good for the newborn, so they fed the babies with ghur-ati (first food in the form of sweets). Cultural influences encourage husbands' involvement in reproductive health issues as well as their opinion on normal feeding under normal breastfeeding conditions. The main obstacle they highlighted to breastfeeding was the pain caused by nipple tearing.	SRQR	Cessation
Yalçin et al.[50] / Turkey, Asia	There are several cultural factors such as the custom of giving the baby herbs from birth or the marital pressure that falls on the woman that prevents the EBF from being maintained over time, as well as the lack of knowledge that prevents it from being carried out correctly in Syrian shelters in Turkey.	SRQR	Initiation, maintenance, and cessation
Christoffel et al.[51] / Brazil, South America	The health professionals interviewed highlighted the importance of encouraging the mother to initiate and continue BF by education through theoretical and practical training, information, postpartum follow-up, as well as family support. The main obstacles encountered were the mothers' perception that their milk is too weak for the nourishment the baby needs, the belief in religions that ensure the lack of water in milk	SRQR	Initiation

Reference	Major findings	Quality	Breastfeeding process
	and encourage babies to start breastfeeding earlier, the influence of maternal stress on breastfeeding, and the return to work and the cultural influence of differing opinions of family members.		
Idris & Palutturi[52] / Indonesia, Asia	Most of the women surveyed gave mother's milk to their children (84.6%) and were aware of its benefits, but only 58.7% practiced EBF. Some mothers (25%) gave extra food to infants <6 months between in a form other than human milk: sun porridge, rice porridge, banana, or papaya. Most mothers (87.5%) agreed that infant formula was not better than breastfeeding.	13.6/22 STROBE	Maintenance
Nuño Martínez et al.[53] / Peru, South America.	The socio-cultural influence that milk is scarce for the baby and erroneous beliefs about its composition were obstacles to its continuation. Likewise, there was also the belief that it produced infant diarrhoea, which was a determining reason for its cessation or abandonment on many occasions.	SRQR	Not specified
Budiati[54] / Indonesia, Asia	The reasons for initiation were encouragement from their own mothers and spouses, social pressure, influence of mothers-in-law and support from nurses. The main reasons for abandonment focused on return to work, substitution of milk with other foods (honey, banana, and dates with water), perceived insufficiency of mother's milk, pain from caesarean wound, lack of spousal support, family influence and maternal health problems.	14.1/22 STROBE	Maintenance
Mgongo et al.[55] / Tanzania, Africa	Mothers breastfeed because it is an obligation to their children, it creates happiness and greater attention from their family environment. However among the main reasons for not doing so are the perceived inability of human milk to nourish, bad smell, circumstances that make the milk impure (breastfeeding if pregnant or extra-marital relations), the chango, Zongo (fear of the evil eye) and the burping of children at the mother's breast.	SRQR	Cessation
Talbert et al.[56] / Kenya, Africa	The main barriers described to exclusive breastfeeding (EBF) in the first 6 months were work-related difficulties, medical problems of the newborn, breast pain and incorrect positioning of the baby as well as infant attachment to breastfeeding. It also includes a cultural influence of the need to incorporate other foods such as coconut water and sugar solutions,	SRQR	Maintenance

Reference	Major findings	Quality	Breastfeeding process
	Ayurvedic herbs and tap water to treat thirst, abdominal colic, irritability, crying spells, possible headaches, or the belief that mother's milk is insufficient as exclusive food for the baby.		
Khan & Kabir[57] / Bangladesh, Asia	Significant drops in EBF were observed after the third and fifth months, mainly in working mothers, those with higher incomes and living in rural areas. Factors influencing the different experiences with EBF included shyness and embarrassment, the perceived knowledge of the real benefits of BF, the influence of different family members on the introduction of other foods before 6 months, and the perception of not producing enough milk, which led to the provision of other products.	17.1/22 STROBE	Cessation
Debnath et al.[58]/ India, Asia	The main reasons for discontinuing EBF were related to lack of self-conviction, mainly due to lack of knowledge; the strong influence of cultural beliefs (feeding with honey was a deeply rooted ritual), family persuasion to introduce foods, self-perceived lack of nutrients in human milk and home treatments for colds. In turn, the fact that the father was not the main source of income and the non-belief in the lasting effect of BF increased the risk of abandoning the practice. Thanks to the advice of professionals, many of them maintained BF.	16.7/22 STROBE	Maintenance
Anazonwu et al.[59] / Nigeria, Africa	Most of the women believed that coconut water reduced gastrointestinal discomfort, that children had to drink cereals such as soy, porridge, and other liquids, and that expressed mother's milk was harmful. In addition, they thought that non-exclusively breastfed babies were less sick than exclusively breastfed babies. In turn, the attitude taken by mothers to opt or not to opt for EBF depended to a large extent on lack of support, work pressure and refusal of the idea that the breast might fall out.	15.4/22 STROBE	Initiation
Hernández-Cordero et al.[60] / Mexico, South America	Women acknowledged that the facilitators of maintaining BF focused on the belief that infant formula is harmful for infants' teeth and causes colic, the information received during pregnancy, the benefits of BF (easier weight loss and quicker recovery), financial savings and family support. Mothers or mothers-in-law of participants were the primary sources of support	SRQR	Initiation and maintenance

Reference	Major findings	Quality	Breastfeeding process
	to continue breastfeeding (47.9%) and living in a rural area was a protecting factor against the use of infant formula 1 month postpartum.		
Amaral et al.[61] / Brazil, South America	In Quilombola communities, intergenerational traditions and customs are perpetuated (even if there are different thoughts among mothers), such as cross-breastfeeding and the introduction of different foods to human milk (i.e., thickeners and porridge). It occurs due to the belief that the milk itself is insufficient for the newborn and these practices "kill hunger", make children have a peaceful sleep and fatten them. breastfeeding longer.	SRQR	Initiation and maintenance
Ahmed et al.[62] / Pakistan, Asia	Due to transgenerational influence by mothers and grandmothers, is added the introduction of various foods and water because they believed they had a dry mouth. This influence also directly affects the rejection of colostrum due to its appetence and physical properties such as smell, viscosity, stickiness, and gumminess (cheerhon), as well as the difficulty of swallowing it (aara). Lack of support and inexperience in novice mothers, low income, workload, formula milk, psychological stress and marital relationship were other barriers to initiation and maintenance of breastfeeding.	SRQR	Initiation and maintenance
Pemo et al.[63] / Bhutan, Asia	All women demonstrated their intention to breastfeed because they were aware of its physical and emotional benefits. At the same time, as it was considered a natural process, intrinsic to the care of the child, the fact that it was painful was not considered by society, but something normal. Therefore, they had to keep it until they got used to it; however, it was a taboo subject for them because they were ashamed to ask. Many were influenced and forced by their relatives to introduce other liquids such as water to quench thirst and discomfort, a piece of butter after birth or cow's urine (Bhutanese ritual).	SRQR	Maintenance and cessation
García-Magdaleno & Laureano-Eugenio[64] / Mexico, North America	The main barriers to BF (myths and conditioning factors) were having small breasts for milk production, younger age which means less experience, flat or inverted nipples, pain, and community prejudices. The determinants that favored BF among rural women were self-production of milk, empowerment about the decision to breastfeed, and the transmission of information by nurses and social networks like	SRQR	Maintenance and cessation

Reference	Major findings	Quality	Breastfeeding process
	Facebook. In urban areas, the previous experience of women within the family and the properties of milk attributed by God stood out.		
Kamoun & Spatz[65] / USA, North America	Both groups of participants demonstrated positive attitudes toward breastfeeding, with higher rates of BF (at 6 months and 1 year) and EBF (for the first 3 months) in Muslim women than those of African Americans in Pennsylvania and nationally. Islamic texts encourage BF practices. From an Islamic perspective the breastfeeding builds human connection in their community, either through the mother–infant bond or through cross-feeding and wet nursing.	20/22 STROBE	Not specified
Tsegaye et al.[66] / Ethiopia, Africa	Through FGDs show that many of the mothers were unaware of the true meaning of EBF and saw it as unusual or surprising, confusing it with partial breastfeeding and including other foods (milk, biscuits, fruit) or water to quench thirst. The main barrier to EBF is education about it as well as cultural beliefs such as the custom of giving the baby fresh cow or goat butter right after birth, the belief that the milk produced by the mother is insufficient, the custom of work outside the village by the husbands, which makes the whole burden of domestic tasks fall on the woman, and the lack of family support. For health professionals these beliefs stem from the general population's lack of knowledge about BFE.	18.9/22 STROBE	Maintenance
Murad et al.[67] / Saudi Arabia, Asia	Breastfeeding information from healthcare professionals in KSA predominantly encouraged mothers to breastfeed. In addition, policies, staff, and systems were the main barriers to the initiation of and to exclusive breastfeeding. Mothers who were juggling multiple roles and who had other concerns about their infant's feeding were more likely to stop EBF 6 months before and to stop breastfeeding earlier than planned. In addition, the eye' or 'evil eye' disturbed mothers and interrupted breastfeeding.	SRQR	Cessation
Acheampong et al.[68] / Ghana, Africa	The motivation to exclusively breastfeed was derived from the participants' recognition of the nutritional value of human milk when experienced positive exclusive breastfeeding outcomes in the family (i.e., healthy growth of the baby, bonding with the mother), approval by mothers, grandmothers and sisters, financial support from the partner, and the knowledge	SRQR	Initiation

Reference	Major findings	Quality	Breastfeeding process
	attributed to older health professionals. However, if EBF do not meet the expectations, mothers would introduce complementary feeding in less than 6 months. Participants also recognized the need for community-based education in EBF.		
Hauck et al.[69] / Australia, Ireland, and Sweden, Oceania and Europe	The main challenges mothers face in breastfeeding are the lack of a supportive environment, inappropriate clothing, baby-related issues (distress, distraction), uncomfortable public and unwanted attention. The strategies used by mothers for the latter two are based on striving to be discreet, walking away or doing it in private and avoiding the situation and apologizing maintaining BF by not feeling uncomfortable, using expressed milk or formula. What helped them most was the support network, the right environment, normalization with other mothers, preparation and wearing appropriate clothing.	SRQR	Maintenance and cessation
Maviso et al.[70] / Papua New Guinea, Oceania	Three main factors are differentiated that benefit or harm the continuation of BF. In the first place, the mothers affirmed that the lack of information on this subject by health professionals prevented them from knowing with certainty how to do it. On the other hand, they showed that social networks were an important asset to know how to carry out this activity, as well as the influence of other young mothers in the community. Finally, the cultural load of the grandparents and the gender role they suffer as a woman, as well as the need to return to work, strongly influenced the inclusion of semi-solid foods before 6 months of life.	SRQR	Initiation and cessation
Reno[71] / USA, North America	The lack of support (individual, institutional and related to culture and ethnicity), emotional barriers, the difficulty of breastfeeding in public, sexualization of breasts, and the dependency of breastfeeding on the baby were the barriers most highlighted by mothers.	SRQR	Initiation, maintenance and cessation
Ratnayake & Rowel[72] / Sri Lanka, Asia	The main reasons associated with early abandonment of EBF were lack of knowledge about what exclusive breastfeeding means, negative attitude of mothers towards breastfeeding and the fact that the woman was employed. Difficulty in obtaining maternity leave, embarrassment about breastfeeding in public, unfavorable environment for BF in the workplace, professional influence with	20/22 STROBE	Cessation

Reference	Major findings	Quality	Breastfeeding process
	controversial messages and family influence, as well as rituals influencing infant feeding emerged as the main barriers in the focus groups		
Newman & Williamson[73] / United Kingdom, Europe	The unfavorable reasons faced by mothers who had breastfed focused on the discomfort caused by people's judgmental stares (sexualization of the breast on many occasions); the fact of feeling exposed, not only by showing the breast, but also the belly (sometimes deformed due to pregnancy). All agreed on the importance of support, especially from a spouse, for the maintenance of breastfeeding.	SRQR	Maintenance
Guo et al.[74] / China, Asia	Employed mothers were faced with stressors and supportive factors, and their interaction with these environmental factors stimulated their inherent qualities of resilience to continue lactation. Mothers who were informed about breastfeeding and the reinforced belief of the benefits for their children, strengthened their determination to continue breastfeeding despite being tired. Peer understanding, a reduced workload and other external support mitigated the negative effect of the conflict between work and breastfeeding.	SRQR	Maintenance

STROBE = Strengthening the reporting of observational studies in epidemiology (Appendix 1)
SRQR = Standards for Reporting Qualitative Research (Appendix 2)

Self-made table based on the narrative analysis of the results

Category 1. Perceptions and beliefs concerning women's breastfeeding

Although there are several factors that support the initiation and continuation of breastfeeding, such as its nutritional value, maternal-infant bonding, education level, contraceptive effects, and weight gain of the baby [38-47], there are also beliefs that may hinder breastfeeding practices.

In countries like Ghana and Guatemala, despite some awareness of breastfeeding's benefits, there is a belief that colostrum, or the first milk, is "dirty milk," leading women to opt for others to breastfeed their children [39-48]. A similar belief is found in Pakistan, where the first milk is replaced with rose water, honey, or goat's milk, often provided by an elder or a religious person [49]. In Tanzania, women may use a mixture of water, sugar, and starch (called atoles) and ask other mothers to breastfeed while waiting for the colostrum to cease [48]. In Turkey, the use of herbs for newborns also prevents exclusive breastfeeding [50].

Another concern is the belief that breast milk does not fulfill all the nutritional needs of a newborn, and that cow's milk protein is better than human milk [51,52]. Historically, the discontinuation of breastfeeding was driven by socio-cultural perceptions that milk was not beneficial for the baby. A common belief that breastfeeding could cause infant diarrhea also contributed to its cessation [53]. This negative attitude towards breastfeeding often led to early introduction of cow's milk, juices, honey, butter [40,42,54,55], or even traditional remedies on the advice of family members [56].

Additionally, there is a belief that herbal concoctions can prevent deformities in the baby or issues with walking [39], and that water, as a substitute or complement to breast milk, is essential to quench thirst or hunger [39,57]. Honey is also a culturally significant ritual for welcoming newborns [58]. Given the belief that colostrum is insufficient or unpleasant due to its smell, viscosity, and difficulty swallowing, formula milk is often seen as a better alternative, providing more nutrients and reducing the risk of illness [45,59,60].

Other cultural beliefs suggest that the environment can influence milk. For example, the idea that breastfeeding in low light weakens milk and prevents adequate nourishment [61]. Painful breastfeeding experiences also contribute to its abandonment in countries like Mexico [50], Kenya [56], and Pakistan [49,62]. However, in Bhutan, while breastfeeding was initially perceived as painful, women recognized its necessity and benefits [63].

Religious or spiritual beliefs can also influence the decision to breastfeed. Some mothers believe in the divine benefits of human milk or that breastfeeding transmits religious or behavioral traits to the baby [49,64]. For example, African American mothers may associate breastfeeding with God's perfect design of humanity[43]. In Islam, the Qur'an and Hadith emphasize the mother-infant bond, with Muslim women encouraged to breastfeed for up to two years[65]. In Ethiopia, a practice called Turufa involves giving newborns fresh cow or goat butter or milk. People believe the baby will inherit the traits of the person offering it (i.e., a respected community member or religious figure) [66]. However, spiritual beliefs, such as the “evil eye” (Zongo) in Saudi Arabia, can also disrupt breastfeeding practices [67].

Category 2. The influence of social norms on women’s breastfeeding

In these category two subcategories were found: Social support networks and Society.

Social support networks:

Support networks and social context significantly influence breastfeeding initiation and maintenance culturally and intergenerationally [40,59]. A lack of social and marital support, low income, and pressures from gender roles and sexualization of women often hinder breastfeeding initiation and continuation [62,66,68]. Conversely, emotional support from family and society, as well as seeing other mothers breastfeed publicly, positively impact breastfeeding rates [67,69].

Family plays a central role in breastfeeding decisions. Mothers, mothers-in-law, and older women are particularly influential in encouraging or discouraging breastfeeding within the family [39,42,54,60,63]. Positive family support enhances breastfeeding rates [43,58,61,69], however, its absence can discourage it. For example, in Ghana, paternal

families sometimes advocate for early introduction of semi-solid foods, undermining breastfeeding [39]. Similarly, in Bhutan, older generations accept breastfeeding, but they put at risk exclusive breastfeeding by promoting cultural practices such as offering butter or blessed water [57,63,70]. These rituals reflect beliefs that the child inherits qualities from the provider of these foods.

Marriage-related social factors also affect breastfeeding. In South Africa, some women stop breastfeeding prematurely for fear of losing their husbands. This is due to the belief that sexual intercourse during breastfeeding weakens the child [41]. Thus, social and cultural dynamics, whether supportive or challenging, significantly shape breastfeeding practices globally.

Society:

From a societal perspective, public breastfeeding remains controversial due to cultural constructs and concerns about the mother's image, including the "sexualization" of women [71]. Barriers such as fear of breast sagging or perceptions of breastfeeding as dirty and smelly were highlighted by Mgongo et al. [55]. Negative beliefs about small breasts implying lower milk production [64] and the sexualization of women contribute to feelings of shame when breastfeeding in public [72].

Additional barriers include the lack of suitable public spaces for breastfeeding [47,71], fear of judgment for breastfeeding older children, and disapproval through comments or disapproving looks [43,45,69]. Consequently, many women invest significant effort in choosing clothing and locations to avoid unwanted attention. Cultural differences also play a key role. Horwood et al. [44] found that Indian women feel ashamed to breastfeed publicly but still do so. However, South African women avoid public breastfeeding entirely due to cultural norms that deem exposing breasts unacceptable [73].

The role of work also presents challenges. Balancing breastfeeding with returning to work often leads to abandoning exclusive breastfeeding (EBF) due to stress, social pressure, and the absence of adequate facilities for milk extraction or breastfeeding. This is exacerbated by workplace criticism and comments from colleagues, particularly in certain job settings like street vending [44,54,67,72,74].

DISCUSSION

This scoping review has provided further evidence for the role of cultural issues on breastfeeding behaviors of women. There are several beliefs that may have an influence on the breastfeeding patterns among women, which could impact WHO recommendations for exclusive breastfeeding in the first six months of life and should be considered by health professionals.

An important factor affecting breastfeeding behaviors is the perception that human milk is "dirty," especially in low-income environments [75-77]. Similarly, the belief that mother's milk lacks sufficient nutrients is common worldwide, leading to formula use [78]. These beliefs contrast with growing evidence showing breastfeeding benefits, such as improved gastrointestinal outcomes, better weight gain, faster recovery, and enhanced immunity [79,80]. Healthcare systems should address these misconceptions

through advertising, maternal education, and counseling. Evidence suggests maternal education increases breastfeeding rates and overcomes barriers [81,82]. Access to breastfeeding support, such as specialists, breast pumps, and educational materials, also facilitates breastfeeding. However, in Colombia, barriers like mother-child separation, cultural beliefs, and care practices persist [83].

Spiritual beliefs also influence breastfeeding behaviors. In religious contexts, breastfeeding may be viewed as sacred [84] or hindered by beliefs in malevolent forces against it [77,85]. Involving spiritual communities in breastfeeding education, training religious leaders, and hosting lectures at religious services can promote breastfeeding [86].

Social support significantly impacts breastfeeding, acting as a facilitator or barrier. Family members may encourage breastfeeding [78], but some may promote early introduction of other foods [39]. In Ireland, while breastfeeding in public is socially accepted, a strong formula-feeding culture remains a barrier [87]. Health professionals should assess family dynamics to address cultural issues and educate families about breastfeeding benefits [88].

Societal factors also play a role in breastfeeding success. Public disapproval of breastfeeding due to "sexualization issues" [89], dissemination of fake news, and early workforce reintegration hinder breastfeeding. Strategies like creating public breastfeeding spaces and laws supporting women's careers can address these challenges [81]. Health professionals must identify and address cultural issues impacting breastfeeding. Studies reveal that many professionals lack awareness of their patients' cultural and religious beliefs [90,91]. Training healthcare workers to understand these factors can reduce biases and improve breastfeeding support in clinical practice.

There are some limitations that should be considered. First, although six databases were searched, it is possible that some articles were not indexed in these databases and therefore, not included. Second, the studies were selected between 2017-2023, but the date restriction was based on changes in the breastfeeding scenario worldwide, since in 2016, the International Code of Marketing of Breastmilk Substitutes commits member states to regulate the marketing of human milk substitutes and to increase exclusive breastfeeding rates worldwide by 50%. Therefore, this review aims to capture the publications occurring in this new context. Third, a range of different people and contexts were included in this review, although this could be a limitation due to the heterogeneity of populations, the objective was to understand the different perspectives and cultural practices of breastfeeding women independently of their profiles, in addition to including different professionals related to the topic.

CONCLUSIONS

Cultural issues are strongly associated with breastfeeding among women. Beliefs such as the colostrum being considered “dirty milk” and that mother’s milk has a low nutritional value are associated with some negative religious practices, family impositions, social barriers, fake news, and the early return to work, resulting in low breastfeeding rates worldwide. Educational programs, counseling and health professionals’ training should be offered to reduce such problems.

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