

BREASTFEEDING ENCOURAGEMENT AND SUPPORT PRACTICES FOR PREMATURE NEWBORNS FROM THE MOTHER'S PERSPECTIVE

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ABSTRACT

Objective: To analyze breastfeeding encouragement and support practices for premature newborns in the hospital environment and soon after hospital discharge, from the mother's perspective.

Methods: Descriptive study conducted at the follow-up outpatient clinic of a Baby-Friendly Hospital in the city of Rio de Janeiro, from June to October 2015. Data collection was through interviews, using a structured form with 17 mothers of 21 premature newborns in the first two weeks after hospital discharge. Data were organized using Excel® software, exported to the R® statistical program and analyzed using descriptive statistics.

Results: At the hospital level, 17.6% of mothers had skin-to-skin contact in the delivery room, 94.1% did breast milking, 94.1% breastfed directly, and 58.8% of mothers participated in the support groups during prenatal care and/or during hospitalization. After hospital discharge, 93.7% of mothers had help from their healthcare professional to breastfeed.

Conclusão: It is necessary to reinforce tools for breastfeeding support strategies for initiation and maintenance of breastfeeding during and after hospitalization.

Descriptors: Breast feeding; Mothers; Infant, premature; Neonatal nursing; Health promotion.

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INTRODUCTION

Breastfeeding is one of the main strategies for reducing morbidity and mortality in premature newborns (PTNBs). This is an important initiative for the survival of PTNBs, whose impact is positive both on length of stay, prognosis, growth and neurological development, as well as on the economic impact[1].

However, despite the above benefits, the prevalence of breastfeeding in PTNBs is lower compared to term infants[2], and it is necessary to discuss the supportive strategies used to initiate and maintain breastfeeding of PTNBs in order to increase this prevalence.

Among the strategies adopted to increase the prevalence of breastfeeding in PTNBs are actions to support breastfeeding. The encouragement of skin-to-skin contact, which begins with the welcoming of the family in the neonatal unit, prenatal and postnatal breastfeeding counseling, educational programs for health professionals and family members are examples of these support strategies.

To promote and support the practice of PTNBs breastfeeding, in 2012 a group of researchers from the Nordic countries and Canada designed the expansion of the Baby-Friendly Hospital Initiative (BFHI-Neo), considering the needs inherent in preterm infants, since they need differentiated care in relation to breastfeeding in the context of the neonatal unit[3].

BFHI-Neo presents three principles: the attitude of the team, which should focus and respond to the mother's individual needs in their context; encouraging actions that favors the family-centered care approach; and finally, the continuity of care between the pre, peri and postnatal periods, as well as after hospital discharge[3].

BFHI-Neo also proposes Ten Steps to Successful Exclusive Breastfeeding in Neonatal Units: 1. To have a written policy that is routinely communicated to all health professionals; 2. To educate and train all health professionals in the specific knowledge and skills required to implement this policy; 3. To inform all hospitalized pregnant women at risk of premature birth or sick child about the management of lactation and breastfeeding, and the benefits of breastfeeding; 4. To encourage early and continued mother-to-child

skin-to-skin contact (Kangaroo Care); 5. To demonstrate to mothers how to initiate and keep lactation and establish baby stability as a single criterion for early initiation of breastfeeding; 6. Do not offer food or drink other than human milk to newborns unless medically indicated; 7. To allow mothers and babies to stay together 24 hours a day; 8. To encourage free demand or, when necessary, partial breastfeeding as a transitional strategy for premature or sick infants; 9. Use of alternative methods to the bottle at least until the complete establishment of breastfeeding and only use of nipples or pacifiers for justified reasons; 10. To prepare parents for continued breastfeeding and ensure access to support groups/services after discharge[3].

The process of breastfeeding the premature is not easy, as mothers of PTNBs face an extremely stressful situation at birth, where mother-baby are apart. In addition, there is still no consensus on the exact time for the PTNBs to start breastfeeding (suction in the breast). A study suggests clinical stability as the only criterion to start breastfeeding without the need for oral stimulation programs[3]. Other authors suggest to health professionals the stimulation of the oral-sensorimotor system to promote the deve-

lopment of oral functions of neonates before starting breastfeeding(4).

Due to the mentioned challenges, many mothers report difficulties related to the initiation and maintenance of breastfeeding, such as the slow progression of breastfeeding and maternal exhaustion due to the high number of breast milking required to keep lactation/breastfeeding(5). In addition, in the context of prematurity, breastfeeding becomes a secondary issue in the among fears of loss, distress of separation time, due to long hospital stay and child's clinical instability[6].

Given the above, the objective of this study was to analyze the practices of encouragement and support to breastfeeding premature newborns in the hospital and soon after hospital discharge, from the perspective of the mother.

METHOD

This study is part of the multicenter research entitled "Breastfeeding in Premature: Impact of BFHI for Neonatal Units". This is a descriptive study conducted in a follow-up outpatient clinic of a public maternity hospital, recognized as Baby-Friendly Hospital, located in the city of Rio de Janeiro (hospital-control of Southeast Brazil).

The sample calculation for data collection in this study was based on the calculation performed for the multicenter study, using the computer program named G Power analysis 3.1., obtaining a minimum sample size of 21 premature mothers for each hospital. Thus, this study was conducted with 17 mothers of 21 preterm newborns (four twins) who were attended in the first two weeks after hospital discharge, from June to October 2015.

The study included mothers of premature newborns who were admitted to the neonatal intensive care unit of the researched institution during the first 48 hours of birth, who attended the outpatient clinic during the data collection period. Mothers who had a history of psychiatric disorders and/or neurological problems and those who had

a temporary or definitive contraindication to breastfeeding were excluded (e.g.; having human immunodeficiency virus and/or human T-lymphotropic virus 1 or in use of drugs that prevented breastfeeding).

Data were collected from a single interview guided by a structured tool in which notes on the answers of the study participants were taken. The average duration of each interview was 15 minutes. Prior to data collection, a pilot test was performed with five mothers, two with twin children, making a total of seven preterm infants who were not included in the final sample. From the results found in the pilot test, the data collection instrument was adjusted for its content.

The data collection tool had five blocks: sociodemographic data of mothers, gestational and delivery data, birth data, PTNB birth conditions during hospitalization, and data on breastfeeding support strategies (NICU parents welcoming, skin-to-skin contact and/or kangaroo position, breast milking, breastfeeding counseling, participation in breastfeeding support groups and receiving breastfeeding educational materials).

For data collection, the researcher or research assistant attended the outpatient clinic on the scheduled days and, in a private

room, read the Informed Consent Form and collected the signatures of the participants; then they started the interview.

The data obtained were double entered and organized in spreadsheets, with the aid of Excel® software version 2010, and compared to correct inconsistencies. They were later exported to the R® statistical program version 3.1.1.

After this step, the data were analyzed descriptively from simple percentage, mean (\bar{x}) and presented in tables.

In accordance with the ethical precepts in research involving human beings, of Resolution n. 466 of December 12th, 2012, the research obtained a favorable opinion by the Research Ethics Committee with protocol CAAE: 44033215.3.0000.5238 and Opinion number: 1.349.465.

RESULTADO

This study had a greater participation of women aged 30-41 years (52.9%) and high school level (41.1%). Regarding information related to pregnancy and childbirth, 58.8% [10] of the women reported having had previous births, and of these, 20% [2] said they had premature birth and 90% [9] of the mothers had breastfed (maternal breast) their newborns at least once. Regarding the current pregnancy, 88.2% [15] of the mothers received guidance on breastfeeding during prenatal care, 88.2% [15] had caesarean section and only 17.3% [3] claimed to had skin to skin contact with PTNBs at birth.

None of these PTNBs were breastfed in the first hour of life and 66.6% [14] had respiratory distress at birth, just as 47.6% [10] of the PTNBs required neonatal resuscitation; 61.9% [13] were late preterm infants (32 to 36 weeks), 76.1% [16] were underweight and 9.52% [2] had 5-minute Apgar score less than 7. Frequency distribution on the support strategies inserted in steps 3, 4, 5, 7 of BFHI-Neo is described in Table 1 below.

Table 1 – Distribution of support strategies for the initiation and maintenance of breastfeeding from the perspective of preterm mothers (n=17) at the *follow-up* outpatient clinic. Rio de Janeiro/RJ, Brazil, 2015.

VARIABLES	N	%
NICU PARENT WELCOMING ON FIRST DAY OF BIRTH		
Mother	3	17,6
Father	15	82,3
APHYSICAL APPROACH OF MOTHER TO PREMATURE BY SKIN-TO-SKIN CONTACT IN THE MOTHER'S CHEST"		
Right after birth	3	17,6
>24th hour	11	64,7
None	3	17,6
PHYSICAL APPROACH OF MOTHER TO PREMATURE BY SKIN-TO-SKIN CONTACT BY TOUCH		
Right after birth	4	23,53%
Between the 2nd and the 24th hour	8	47,1%
>24th hour	5	29,41%
KANGAROO POSITION DURING HOSPITALIZATION		
Mother	14	82,3
Father*	9	52,9
KANGAROO POSITION AT HOME		
Mother	12	70,6
Father*	7	41,2

VARIABLES	N	%
GUIDANCE ON MILKING ON MOTHER'S FIRST VISIT TO THE NICU		
Yes	8	47,1
No	8	47,1
Ignored	1	5,9
PERFORMING MILKING DURING HOSPITALIZATION		
Yes	16	94,1
No	1	5,9
BREASTFEEDING GUIDANCE DURING HOSPITALIZATION		
Yes	16	94,1
No	1	5,9
FREQUENCY OF BREASTFEEDING GUIDANCE DURING HOSPITALIZATION		
Daily	7	43,8
Most of the time	5	31,2
Only in the first days	4	25,0
PARTICIPATION IN BREASTFEEDING SUPPORT GROUPS		
Yes	10	58,8
No	7	41,1
RECEIVING EDUCATIONAL MATERIAL ON THE BENEFITS OF BREASTFEEDING		
Yes	14	82,3
No	3	17,6

*Data provided by the mother.

It is noteworthy that three (14.3%) PTNBs had skin-to-skin contact in the maternal chest immediately after birth. Such PTNBs were born at gestational age, at the last menstrual period (LMP), at 33 weeks and 2 days (two PTNBs) and 32 weeks and 5 days (one PTNBs).

Regarding skin-to-skin contact in the kangaroo position (BFHI-Neo step 4), 80.9% [17] of the PTNBs had this contact at some point during hospitalization. Of these, 64.7% [11] experienced the kangaroo position with more than 24 hours of life and for 28.5% [6] the mothers of PTNBs did not remember the correct moment when they did it. The average number of days for the first kangaroo position of mothers who remembered the information was 10.4 (\pm 6.9) days. Regarding this practice at home, only 70.6% of premature infants continued to receive skin-to-skin contact through the kangaroo position.

Regarding step 5 of the BFHI-Neo, the practice of breast milking, 12.5% [2] of mothers did it in the first 24 hours of life of PTNBs; 23.5% [4], between 48 and 72 hours of life; 52.9% [9], after 72 hours of life; and 5.8% [1] did not remember the information. As for the first place doing it, for 50% was in the human milk bank; 43.75% in the neonatal

intensive care unit (NICU); and 6.25% did not remember the site. In addition, 87.50% of the 16 mothers who did milking had help from the nursing staff in this technique.

About the time when breastfeeding support groups were offered to mothers, 60% [6] reported joining during prenatal care (BFHI-Neo step 3); 20.0% [2] during prenatal care and hospitalization (steps 3 and 5 of BFHI-Neo); 10% [1] after discharge and during the baby's hospitalization (steps 5 and 10 of BFHI-Neo); and 10% [1], only during their stay in the maternity ward (BFHI-Neo step 5).

During the hospitalization of PTNBs, 82.3% [14] of the mothers had help from health professionals to breastfeed and 100% [17] felt supported by the Human Milk Bank to breastfeed.

Regarding the help and support offered to mothers by health professionals after the hospitalization of the PTNB (step 10), 94.1% [16] received breastfeeding help and 52.9% [9] felt supported to breastfeed.

DISCUSSION

Mothers of PTNBs need to receive breastfeeding support strategies in order to favor its initiation and maintenance. Such strategies should be based on scientific evidence and should be systematically offered during prenatal care, during the hospitalization of the baby in the neonatal intensive care unit and even after discharge at home[2].

The early entry of parents into the neonatal intensive care unit (NICU) and the encouragement of their participation in baby care is a recommendation of the Ministry of Health and one of the principles of BFHI-Neo, with the purpose of promoting family-child bonding, since the NICU environment is often associated with the possibility of death and the experience of this hospitalization causes a milestone in family life[6].

Within what is recommended by BFHI-Neo as the Ten Steps to Success in Exclusive Breastfeeding in Neonatal Units, steps 3 and 5 involve the management and maintenance of lactation and, in this context, breast milking is extremely relevant.

For the process of initiation and maintenance of lactation and breastfeeding, as re-

commended in the first principle of the BFHI-Neo, health professionals should consider the particularities that mothers of newborns admitted to neonatal units face, such as experiencing hospital routine, dealing with feelings of loss, stress, anxiety, adaptation and resilience[7].

This way, as a support strategy for the initiation and maintenance of breastfeeding, breast milking is necessary, which is pointed out in the scientific literature as one of the practices that favors breastfeeding. Early expression of breast milk results in successful and longer lactation in mothers of very low birth weight infants[8].

The timing of the first expression of breast milk is closely linked to successful lactation. The scientific literature recommends that health professionals encourage the mother to stimulate the breast and remove milk early, preferably within the first six hours after delivery[8]. Despite this recommendation, the present study shows that this practice was still postponed in the unit where the research took place.

A cross-sectional study of 100 mothers of PTNBs in Milan, Italy showed that 58% of the interviewed mothers started to breastfeed within the first 24 hours of delivery and

12% of them started breast milk within the first 6-8 hours[9]. These data, compared with the present study, show that the time to start milking practice is still a challenge for the researched institution, since most mothers (52.9%) performed the milking practice 72 hours after birth. The institution's routine at the time of data collection did not stipulate a time to start milking and the goal was always to start milking as early as possible, and all health professionals in the institution could guide and support breast milking.

The fourth step of BFHI-Neo refers to early, continuous and prolonged skin-to-skin contact. The Kangaroo Method is part of a public health policy adopted by the Brazilian Ministry of Health to strengthen the role of the family in the care of PTNB, as well as to stimulate skin-to-skin contact early. It is noteworthy that this skin-to-skin contact at birth can be initiated by touch, until it evolves to the kangaroo position when the PTNB reaches clinical stability. Thus, skin-to-skin contact in the mother chest/abdomen can occur at birth or during hospitalization in the neonatal unit through the kangaroo position[10].

The kangaroo position is effective because of its benefits in increasing exclusive

or near exclusive breastfeeding rates[11]. In the sample under study, 17.6% of mothers and 58.8% of fathers did not perform the kangaroo position during hospitalization. And most mothers and fathers who had the opportunity to do it, did not do it so early, as the average time for first skin-to-skin contact by the kangaroo position of the mothers who remembered the information was 10.4 (\pm 6.9) days. According to the institution's routine, the kangaroo position can be performed as soon as the PTNB reaches clinical stability, either at birth or during NICU admission.

Regarding the practice of kangaroo position at home, a cross-sectional study conducted with 43 mothers of PTNBs attended at the Kangaroo Neonatal Intermediate Care Unit of a reference university hospital in the Northeast of Brazil showed that after 15 days of hospital discharge, the majority (90.7%) of the mothers still used the kangaroo position and its duration in 48.7% of the mothers was about 2 to 5 hours a day. However, only 39.5% of the mothers received the follow-up home visit, which shows weaknesses in performing the third stage of the Kangaroo Method by primary care and the tenth step of the BFHI-Neo for most mothers attended[12].

In the health institution under study, after discharge from hospital, premature newborns were referred for follow-up directly to the basic health units or to the follow-up outpatient clinic of the institution that performs kangaroo care shared with primary care.

Regarding breastfeeding support after hospital discharge, the strategy that is highlighted in step 10 of BFHI-Neo is maternity to ensure the maintenance of breastfeeding through access to support groups. Researchers have shown that mothers of late preterm infants who received breastfeeding support during hospitalization and who had access to information about breastfeeding support groups were more likely to breastfeed during the first 10 days after birth[13].

Participation in breastfeeding support groups, upon educational resource, should take place from prenatal care, through the hospitalization of preterm infants until hospital discharge. Unfortunately, the results of this study showed that such breastfeeding support strategies were not offered equally to the entire sample under study.

It should be emphasized that all health professionals who provide care to

mothers of PTNBs must acquire enough knowledge and skills for the management of breastfeeding and the particularities of breastfeeding a preterm infant. However, authors of an integrative review study concluded that health professionals, regardless of their area of expertise, need to be better trained to work with breastfeeding, as most studies used in the review showed that health professionals had theoretical domain in relation to breastfeeding, but did not have practical know-how[14].

Limitations of the study are the small number of participants, limiting the results found only for this sample, and the loss of two participants who did not attend the appointment scheduled at the follow-up outpatient clinic. It is noteworthy that data on the time of onset and duration of skin-to-skin contact both in the delivery room and during hospitalization were obtained through interviews with the mothers, since no such records were found in the medical records of the unit under study.

CONCLUSION

The results show that support strategies for breastfeeding initiation and maintenance, such as welcoming parents in the NICU, breast milking, skin-to-skin contact, receiving guidance and educational materials on breastfeeding, participation in support groups, are present in the hospital and at home, but need to be consolidated and offered to all mothers of preterm infants admitted to the neonatal intensive care unit.

During hospitalization, the support strategies offered by the researched institution, from the mothers' perspective, are part of what is recommended by the BFHI-Neo. However, some strategies should be strengthened, such as the time to start breast milking, which is still late, as well as the time to start skin-to-skin contact at the time of birth and the kangaroo position during hospitalization and at home. The implementation of colostrotherapy is advised as a routine in the researched unit, so that health professionals can encourage the mother to perform breast milking earlier. It is noteworthy that this practice also helps to promote skin-to-

-skin contact, due to the greater proximity of the mother with the PTNB.

And, regarding the maintenance of breastfeeding at home, it is noteworthy that after hospital discharge, there was a decrease in mothers who felt supported in relation to breastfeeding. This result shows weaknesses in complying with step 10 of the BFHI-Neo and the challenges to keep breastfeeding after hospital discharge until 6 months, as recommended. Therefore, it is necessary to strengthen the articulation of hospital care with primary care through shared kangaroo, thus favoring the creation of multiprofessional support groups.

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