

Breastfeeding maintenance of very low weight premature babies: experience of mothers**A manutenção do aleitamento materno de prematuros de muito baixo peso: experiência das mães**

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ABSTRACT

The objectives of this study were to comprehend the breastfeeding process from reports of mothers of premature babies and identify factors facilitating or complicating this process. A descriptive qualitative study regarding the family centered care. We conducted 12 interviews with mothers of six months premature babies of chronological age and we submitted data to content analysis. Four categories emerged: The previous breastfeeding experience in the process of breastfeeding the premature baby; Emotional context versus the breastfeeding process; The ability to manage breastfeeding the premature baby and, Successes and failures. We concluded that family and professional support, adequate management and the welcoming of individualized services in the prematurity context were majorly responsible for the breastfeeding success, being even able to surpass the previous maternal desire. Breastfeeding accompaniment after discharge is indispensable for its success with premature babies.

Descriptors: Breast Feeding; Weaning; Infant, Premature; Neonatal Nursing.

RESUMO

Os objetivos deste estudo foram compreender o processo de amamentação a partir do relato das mães de prematuros e identificar fatores que facilitaram ou dificultaram esse processo. Estudo descritivo, de abordagem qualitativa à luz do cuidado centrado na família. Foram realizadas 12 entrevistas com mães de prematuros com seis meses de idade cronológica e os dados foram submetidos à análise de conteúdo. Emergiram quatro categorias: A experiência prévia em aleitamento materno no processo de amamentar um prematuro; Contexto emocional *versus* processo de amamentação; O domínio do manejo da amamentação do prematuro e Sucessos e fracassos. Conclui-se que no contexto da prematuridade, o apoio familiar e profissional, o manejo adequado e o acolhimento do serviço de maneira individualizada foram reconhecidos como grandes responsáveis pelo sucesso da amamentação, podendo até mesmo sobrepor o desejo materno prévio. O acompanhamento da amamentação após a alta é imprescindível para o seu sucesso nos prematuros.

Descritores: Aleitamento Materno; Desmame; Prematuro; Enfermagem Neonatal.

INTRODUCTION

The World Health Organization (WHO) preconizes that all newborn (NB) should be exclusively breastfed until their six month of life and complement it only after this period. Premature babies need exclusive breastfeeding (EB) even more, an important ally in the reduction of neonatal morbidity and mortality⁽¹⁾.

However, a integrative review about the prevalence/duration of breastfeeding among very low weight (VLW) premature babies, found unsatisfactory results in different studies and places, that came from peculiar difficulties in breastfeeding this population at risk⁽²⁾. The prevalence vary from 19,5% to 76% EB at discharge, considering different levels of prematurity. High rates of weaning were found on the first days after discharge, with decreases of more than 50% of weaning at the first ambulatory return. Increase of breastfeeding rates is related to specific intervention efficacy as the kangaroo method, oral stimulation, advice, support strategies, accompaniment and follow-up⁽²⁾.

Low rates of breastfeeding in premature babies can be explained by the major challenge of breastfeeding them due to their physiological and neurological immaturity, difficulty of suction-swallowing-breathing coordination and prolonged hospitalization, besides all feelings of maternal failure and emotional stress that could decrease lactation⁽³⁾.

In addition, during the baby hospitalization, mothers face difficulties with the early extraction and lactation maintenance due to cesarean fatigue; anxiety and stress due to premature delivery; worries with the child's health, finances; separation from the child; distance from their homes to the neonatal unit; lack of privacy; return to work; changes in social life⁽⁴⁾.

Considering diverse difficulties to establish breastfeeding of premature babies, the project "A support network to the premature family"⁽⁵⁾ was proposed, based on family centered care, to include the family in the care and on decisions, encourage and facilitate the family support and the support network,

recognize the family's strengths and individualities, within others⁽⁶⁻⁷⁾.

The project activities are developed since the premature birth, during the hospitalization process and follow-up until one year of life, breastfeeding support and stimuli are one of the main goals. Resident nurses in neonatology and teachers attend families with the support of a multi-disciplinary team⁽⁵⁾.

A study was conducted with 54 binomial mother/baby who were attended by the project, through the family records⁽⁵⁾ and interviews with the mothers. The dependent variable was the type of feeding at discharge. At the third and sixth month after birth, the EB prevalence was 50% between VLW premature babies at discharge and only 11% did not receive maternal milk (MM). At the third and sixth month of life the EB prevalence decreased to 34% of children, considering that at the third month 35,8% did not receive MM and at six months, this weaning prevalence increased to 51%⁽⁸⁾.

The growing weaning rates of premature babies despite the professional practice centered in the family and the major challenges for mothers to breastfeed their premature child, motivated the development of this research. Our aim was to comprehend the breastfeeding process from reports of mothers with premature babies; and to identify factors facilitating or complicating this process. The comprehension of the breastfeeding process in this integral support context to families, from the maternal perspective, can contribute to this practice enhancement.

METHODS

A descriptive qualitative study focused on the comprehension of breastfeeding experience of VLW premature babies.

We conducted the study in Londrina- PR, in an ambulatory from a hospital that has the title of Baby-Friendly for more than 10 years and it is a reference for pregnancy at risk.

The inclusion criteria for mothers were to participate in the project “A support network to the premature family”⁽⁵⁾, to be mothers of VLW premature babies at birth who were less than six months old in chronological age, and under ambulatory accompaniment at the moment of the study. Data collection lasted three months and the sample was finished with 12 mothers, when we observed theoretical saturation of findings⁽⁹⁾.

We conducted interviews using a script developed by the researchers, with the following guiding question: “Tell me how was for you to breastfeed this child?”

We used content analysis as method for data analysis, more specifically, thematic modality, proposed by Bardin⁽¹⁰⁾, which comprehends the process limited by: exploring the text through reading and meaning, fluctuant reading, designing the themes, thematic analysis and identification of meaning units focusing the representations, expectations and arguments used⁽¹⁰⁾.

From this process, we organized the data around three categories: The previous breastfeeding experience in the process of breastfeeding the premature baby; Emotional context versus the breastfeeding process; The ability to manage breastfeeding of the premature baby and Successes and failures. The last analysis consisted of an interpretative phase, aiming to create critical relationships between explicit and implicit ideas in the text and the scientific context⁽¹⁰⁾.

This research was approved by the Ethics in Research Involving Human Beings from the Universidade Estadual de Londrina (CAAE n°0152.0.268.000-08) and the mothers were interviewed after accepting and signing the Free and Informed Consent.

RESULTS AND DISCUSSION

This study brought the perspective of mothers of VLW premature babies about breastfeeding process and maintenance, which were attended by a program with a theoretical mark of family centered care. Main emerging themes were previous experiences, the emotional context influences, the necessary ability to manage this

situation resulted on the successes and failures stories composing the group representation in this assistance context.

Mothers were between 15 and 39 years old; education varied from incomplete middle school to incomplete high school; eight were primiparas and had between three and 12 pre-natal consultations, mostly at the public healthcare service. The babies were born with gestational age between 26 and 33 weeks and weight from 860g to 1.485g.

From reported experiences, two mothers could offer MM exclusively until the sixth month of life and two did not even breastfed. All other eight mothers offered MM, with duration varying from one and five months of life, associated to another type of complementary milk, that many times were already present during hospitalization and/or at discharge.

We presented the findings organized in the categories.

The previous breastfeeding experience in the process of breastfeeding the premature baby

The previous breastfeeding experience addresses reports from personal as well as family experiences from those women, experienced before the actual moment, being positive and negative factors. The breastfeeding choice is developed within a sociocultural context, influenced by cultures, beliefs, taboos, and the social network of that context⁽¹¹⁾ determined by different meanings of the breastfeeding process. The breastfeeding concept presented by the mother is also directly linked to breastfeeding during hospitalization and after discharge⁽¹²⁾.

Women presenting a negative family history were stimulated to early weaning, as these mother’s lines who breastfed until one month:

My mom breastfed me until one month and after took me away from her breast to get used to the bottle and to not be so hard to take me away from the breast (Mother 11).

The EB representation as the most adequate nourishing way for the child determine the decision of women to breastfeed, being established even before the birth, by constructed knowledge⁽¹³⁾.

A favorable representation about breastfeeding is due to the mothers being breastfed and they observed their family members offering MM:

I was breastfed until five years old, my mother always incentivized me to breastfeed. This incentive comes from the family [...] (Mother 06).

On the other hand, even the women with positive previous experience found difficulties in this new lactation due to prematurity and its specific issues⁽¹⁴⁾. The lines from this mother whom breastfed the first child but could not breastfeed the premature child, reinforce this:

[...] my first daughter left the hospital, went home and was sucking [...] it is impossible to compare with my other daughter who is extremely premature [...] (Mother 02).

A negative personal experience seemed to not lead to early weaning, although the unsafety feeling:

[...] I took that medication to dry the milk, because I had a spontaneous abortion. Because of it I thought I couldn't breastfeed now (Mother 08).

The mother who suffered previous abortion and was afraid not to be able to breastfeed offered MM exclusively until the sixth month.

In contrast with the study supporting the hypothesis that mothers who earlier weaned tend to repeat this conduct⁽¹⁵⁾, our study brings that specificities inherent to the prematurity can reposition the strength of the previous breastfeeding story, being positive or negative, as a social and cultural determination for adherence.

Emotional context versus the breastfeeding process

Reports point to contradictory feelings that swings very easily due to difficulties found: stress, discouragement, hope, frustration, and pleasure, which compete with all the difficulty of the process to establish breastfeeding.

The need for support to surpass this critical moment was identified in participant's lines, specifically characterized in three ways, considered essential to face diverse difficulties in the breastfeeding process of a premature child: spiritual, family and health professional support.

The spiritual support was identified many times in comfort words said by religious leaders and family members:

[...] I supported this because God was present in my life, [...] I had a lot of strength from pastors from my church who never left me alone (Mother 05).

This support collaborates when facing fears and limitations from mothers, positively contributing to the strengthening of EB⁽¹³⁾.

The familiar support was referred as positive factor by mothers, relating it to the incentive for milk maintenance and storage, domestic tasks, caring for the house and other children⁽⁴⁾:

[...] (the mother and mother-in-law) stayed at home to be helping me (Mother 02).

From the health professional support, mothers referred the nursing team as the closest to them, helping with breastfeeding management for milk production.

They (nursing residents) were always explaining, at the beginning, I was always alone, always crying because it is my first (daughter). My pregnancy was at risk, it was really complicated and they were always there close to me,

explaining and talking [...] They called, went to my house and were always together (Mother 01).

At the hospital and after discharge, the professional' role is to teach mothers about the problems and strategies about breastfeeding management with premature babies so that families can anticipate and identify problems when they happen⁽¹⁶⁾. It is of extreme importance an adequate institutional politics and the action of a multi-disciplinary team at the difficult period to transition the enteral feeding to the maternal breast⁽¹⁷⁾.

Another mother mentioned:

I had a lot of support inside the hospital. They (health professionals) incentivized me a lot. When I arrived with the milk that I took, and it was very little, they explained to me that that's how it is. This incentivized me to take out more each time (Mother 09).

For the lactation process to not overload these mothers and result in early weaning, it is important for professionals to offer knowledge about the theme, emotional support and help in the management⁽¹⁴⁾.

The low milk production or "little milk" was very referred and its relationship with the maternal emotional aspect:

*My milk dried because she was intubated (Mother 01).
[...] I've never received good News about her, so I think that it locked, locked (Mother 02).*

The impression that her milk was not sufficient was seen in the line:

[...] (At home) I managed to give the breast for only two weeks, without giving the artificial milk. Then he started to cry and cry and my milk almost did not come down (Mother 11).

At the puerperium, prematurity exacerbates the psychological anguish, hurting breastfeeding⁽¹⁸⁾.

About the moment after discharge, a mother reported:

I would get very nervous, because I was afraid that something would happen [...] So I thought that I wouldn't be able to make it (Mother 05).

Insecurity can be generated by the stress of caring for a premature baby, the cry, the fear of weight loss and re-hospitalization. Considering that, the mother starts to complement with another milk, as a personal decision. Mothers who consider themselves to have a low milk production introduced bottles earlier⁽¹⁷⁾.

Thus, an early ambulatory return is important to be closer to the moment in which the mother needs more support avoiding weaning the baby and the follow-up after discharge giving continuity in attendance for the family demands.

The ability to manage breastfeeding of the premature baby

To manage breastfeeding of premature babies, specific characteristics of this babies should be considered and to encourage mothers to initiate early milk extraction and maintenance of their milk production until the baby can suck the breast⁽⁴⁾. This commitment was observed in this mother lines:

[...] I tried to take a lot of milk to give him and then I could pass through all that suffering [...]

The mothers' lines reveal their knowledge regarding the importance to take out milk:

I milked, froze it and brought it to the hospital. I did that every day, so then my milk wouldn't dry (Mother 11).

One of the factors associated to the presence of breastfeeding at six months of age was the first expression of MM⁽¹²⁾.

Knowledge about technical aspects of milking and support from family members in this practice was identified:

I had to milk every three hours, (the husband and the mother-in-law) at freezing, sometimes boiled the glass containers (Mother 04).

At the same way in which some moments the milking practice stimulated the mother to breastfeed, in others, it generated anguish, with decrease in production:

I used to be every three hours massaging, it was a torture, because I used to massage it for the milk to come out (Mother 05).

The permission for parents to stay all day and permission for Kangaroo position are breastfeeding promotion practices:

I used to go to the hospital since early until the afternoon and stayed there to breastfeed her, I used to give my breast all times (Mother 08);
[...] I used to take her and keep her as kangaroo (Mother 12).

An observational descriptive study concluded that mothers who stayed hospitalized with their babies, through kangaroo method, interrupted breastfeeding later⁽¹⁷⁾.

Successes and failures

This category addresses elements contributing to breastfeeding successes and failures according to the experiences and representations of being a mother caring for a premature baby.

Difficulty to catch the breast and failure in sucking were factors related to failure perceived by mothers who could not breastfeed their children:

We put him to suck, but at home I couldn't make him do it right... he was too small and didn't have strength to suck (Mother 09).

The catheter, cup or direct parenteral feeding transition to the breast were identified as hard by mothers, who reported fear of apnea episodes at the breast, incorrect suction or insufficient milk to satisfy the baby's needs⁽¹⁹⁾.

Difficulties to catch the breast and suck influenced the mother's decision to start using bottles. The incapacity to keep a suction pressure appropriated to transfer more milk could lead to other methods⁽²⁰⁾. When introduced early, the bottle and the pacifier can generate "beak confusion" and consequently lead to breastfeeding reduction or interruption and early introduction of food and liquids⁽²¹⁾:

I also gave the bottle. I don't know why. Although having enough milk, it still wouldn't fill. I used to get tired and her too (Mother 01).

I could even count: it was four minutes in each breast, then it was over and I could complete with the bottle (Mother 07).

Factors justifying the beginning of the bottle were the low milk production, the need to go back to work and the insecurity to perform the cup technique:

[...] she was used to the breast and had milk in the cup at the hospital and when she went home she used to miss the milk in the cup. With the days passing she started to increase the cup amount [...] and then I decided to give her the bottle. By myself! (Mother 10).

[...] because I went back to work and my mother couldn't give her the cup because she was afraid. Then my mother

started to give her the bottle. Fear of her drowning (Mother 06).

Although they give the cup technique during hospitalization, many mothers refers to insecurity when they get home and end up using the bottle.

Affection between mother and child is one of the most favorable behaviors to establish breastfeeding and the long hospitalization period and intensive care could contribute for its failure⁽²²⁾:

Although I was every day at the hospital [...] it was not the same thing. (The baby) was in nurses and doctors hands, I almost couldn't pick her up. So I have been her mother for a month, being with her, picking her up (Mother 03).

Regarding the not frequent extraction, mothers reported lack of time and skill causes:

Because I did not have this skill that they had (to take out milk). It was me, who couldn't milk it (Mother 09).

Many mothers stopped to extract milk at the beginning of the post-natal period because they were frustrated with their milk production, apparently low⁽¹⁸⁾.

The "weak milk" concept is one of the main weaning factors, related to mother impressions⁽¹⁷⁾:

They tried with medicine, but it was coming very little and very weak milk (Mother 09).

The fear of having "weak milk" is justified by the baby fragility and every loss of weight can reflect a health problem, delay on discharge or need to be re-hospitalized.

Mothers also pointed the need to return to work. Although the right to breastfeed during work, this practice is not respected many times, and it was worse when women have an informal job, many times, going back before four months of the baby's life:

Then I've cut at the fifth month due to work. It was an intense work, I used to bother me a lot the breast full of paped milk, then I've decided to take out (Mother 04).

Previous knowledge about breastfeeding importance and management, and worries about health and recovery of their premature babies, helped in the justification to why breastfeed and resulted in tendencies for those mothers to keep breastfeeding for longer time⁽¹⁷⁾:

I don't know in words how to define, I understood well what is maternal milk for the child and this is why I breastfeed my mother until today (Mother 05).

[...] she really developed with maternal milk (Mother 08).

My daughter did not get sick [...] I am sure it's because of the maternal milk (Mother 10).

Maternal attitude occupies one of the main positions between the factors affecting successful breastfeeding⁽¹⁵⁾.

Facing all specific difficulties from the breastfeeding process, any breastfeeding duration should be valued and complimented when considering the prematurity, because it is a consequence of efforts and dedication.

Working with women, families and their representations and not only with mothers, puts the professional in contact with a vast conjunct of meanings and, due to comprehension issues, constitutes a real challenge⁽²³⁾.

FINAL CONSIDERATIONS

The knowledge and understanding of the context in which mothers experienced the breastfeeding process of very low weight premature babies, as well as the support and hearing from this premature family, were the major determinants in the breastfeeding process. The importance of specific technical guidance for the efficacy of breastfeeding management and practice was evident, since it was conditioned to support mothers and their families, attributing roles and welcoming them in the

service in a conception and organization of family centered care.

When giving voice to mothers of premature babies, a space for exchange and mutual learning is built between the team and the premature family. Thus, this study allowed the comprehension of the breastfeeding process in this integral support context to families, contributing to the enhancement of this practice.

It is important to constitute a continuity process and follow up the breastfeeding after the discharge confirmation, indicating the need to secure access to families in accordance with their demands related to

breastfeeding maintenance acquired during hospitalization.

This study was conducted in a regional hospital where a project for families with premature babies is developed based in a family centered care. Thus, it was in this context that those meanings emerged. Although this unveiling guides local assistance practice enhancement, it also contributes for the creation of multidimensional models to understand the breastfeeding process for premature babies in addition to all other studies conducted around this theme in different settings and cultures.

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