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ORIGINAL RESEARCH

Counseling for the nursing mother or about the breastfeeding technique?

¿Consejería para la madre lactante o para la técnica de lactancia materna?

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Abstract

Introduction: In Colombia, despite the implementation of initiatives such as breastfeeding counseling (BFC), exclusive breastfeeding (EBF) rates are low.
Objective: To understand the experience of a group of nursing mothers regarding exclusive breastfeeding counseling provided at Women and Children Friendly Institutions (WCFI) in Bogotá D.C., Colombia.
Materials and methods: Qualitative research with a phenomenological approach. In-depth interviews were administered to 19 breastfeeding mothers who were provided with exclusive breastfeeding counseling (EBFC) at 3 WCFI between August 2016 and January 2017. Units of meaning (UM) were identified through a comprehensive analysis performed in NVivo 10 and based on the reading of the textual transcripts of the interviews and the identification of essential structures in the mothers' narratives associated with the experience they had while being counseled at three moments (gestation, delivery/immediate postpartum, and puerperium).
Results: The average age was 23 years. Only 37% of the mothers exclusively breastfed their children until they were 4 months old. Nine UMs were identified. During gestation and the immediate postpartum period, participants received instructions on how to breastfeed but were not provided with EBFC by healthcare staff. During the puerperium, the mothers' families and support networks provided them with help and guidance regarding breastfeeding.
Conclusion: It is possible that the legal provisions on breastfeeding counseling and initiatives such as the WCFI are not being complied with in the country, as there are obstacles that hinder their proper execution. Thus, it is necessary to propose and develop effective strategies for the training of breastfeeding counselors among health personnel.

Resumen

Introducción. En Colombia, pese a la implementación de iniciativas como la consejería en lactancia materna (CLM), las tasas de lactancia materna exclusiva (LME) son bajas.
Objetivo. Comprender la experiencia de un grupo de madres lactantes respecto a la consejería en lactancia materna exclusiva (CLME) recibida en Instituciones Amigas de la Mujer y la Infancia (IAMI) en Bogotá D.C., Colombia.
Materiales y métodos. Investigación cualitativa con enfoque fenomenológico. Se aplicaron entrevistas a profundidad a 19 madres lactantes que recibieron CLME en 3 IAMI entre agosto de 2016 y enero de 2017. Las unidades de significado (US) se identificaron mediante un análisis comprensivo realizado en el programa N-Vivo versión 10 y basado en la lectura de las transcripciones textuales de las entrevistas y la identificación de estructuras esenciales en los relatos relacionadas con la experiencia que tuvieron durante la CLME en tres momentos (gestación, parto/posparto inmediato y puerperio).
Resultados. La edad promedio fue de 23 años. Solo el 37% lactó exclusivamente hasta los 4 meses. Se identificaron 9 US. Durante la gestación y el posparto inmediato las madres recibieron indicaciones sobre cómo lactar, pero no recibieron CLME por parte del personal de salud. En el puerperio, la familia y la red de apoyo de las madres les brindaron ayuda y acompañamiento respecto a la lactancia materna.
Conclusión. Es posible que en el país no se estén cumpliendo las disposiciones legales sobre la CLM ni iniciativas como las IAMI, ya que se evidencian dificultades para su correcta realización, por lo que es necesario plantear y desarrollar estrategias efectivas para la formación de consejeros en lactancia materna entre el personal de salud.

Introduction

In Colombia, policies such as the 2010-2020 Ten-Year Breastfeeding Plan have been implemented[1] and guidelines have been formulated to create strategies such as the Human Milk Banks[2] and the Breastfeeding Family Friendly Rooms[3] to promote and support exclusive breastfeeding. Thus, in the early 1990s, the Women and Children Friendly Institutions (WCFI) were created through the World Health Organization's (WHO) Baby-Friendly Hospital Initiative, where breastfeeding counseling (BFC) is considered as an educational strategy to train the mothers and their family on how to feed their children according to WHO guidelines.[4] Thus, since the accreditation in Colombia in 1992 of the first 7 Baby-Friendly Hospitals, many professionals have been trained in BFC in accordance with the WHO guideline[4] in order to promote breastfeeding (BF).

According to the WHO, BFC is not just about telling the mother what to do, but also about helping her decide what is best for her and her baby. This requires assisting her to become more self-confident and keep control of situations that may arise while she is breastfeeding.[5] However, international studies that confirm the effectiveness of BFC employ a variety of definitions and terms such as counseling, guidance and support.[6,7] The present study follows the premise of Pinzon-Villate *et al.*, who state that "All concepts of counseling have in common that it is a process that involves an interrelationship between two or more people, that it is a communicative activity, and that it requires the acquisition of knowledge and the development of attitudes and skills on the part of the person carrying out this process."[8, p 287]

In Colombia, the relevance of BFC was ratified when the Ministry of Health issued Resolution 3280[9] in 2018, which establishes the mandatory implementation of such counseling, from antenatal checkups to hospital discharge. This regulation is essential because it helps to improve BF rates, which, according to the Encuesta Nacional de Situación Nutricional (National Nutritional Situation Survey),[10] are low and tend to decrease (the prevalence of EBF went from 46.5% in 2010 to 36.1% in 2015). This is also significant because, if complied with, the WHO target of having at least 50% of children under 6 months of age fed with EBF could be reached by 2025.[11]

Despite the recognition of the importance of BFC, in Latin America, and especially in Colombia, information on this topic is limited since published studies are more oriented to describe and educate on BF than to present results of intervention studies or BFC guidelines.[12-21] This is an issue that can be explored through dialog with women with experience in gestation, especially if they received BFC. In this regard, the objective of the present research was to understand the experience of a group of nursing mothers with regard to exclusive breastfeeding counselling (EBFC) received at Women and Children Friendly Institutions (WCFI) in Bogotá, Colombia.

Materials and methods

Qualitative research approaching Martin Heidegger's phenomenological method, which seeks to understand the participants' individual subjective experiences by means of in-depth interviews to identify in the subjects' discourse the meanings given by them to their experience in a specific situation,[22,23] which, as stated by Marí-Mollà *et al.*,[24] are fundamental to phenomenological research.

This article is derived from the principal author's doctoral thesis,[25] which was conducted between November 2015 and January 2017. The findings of the second stage of this research (August 2016 to January 2017) are presented here.

The number of participants was not predetermined, as the field stage was developed concurrently with the comprehensive analysis (described below). Thus, 19 nursing mothers who were provided with BFC between August 2016 and January 2017 in 3 WCFI, of which 2 were public (part of a secondary and tertiary care hospital) and 1 was private (part of a quaternary care hospital), were included. With this number of participants, it was considered that there were enough interviews to respond to the research objective and, therefore, enough meanings attributed to the EBFC experience and expressed in the mothers' narratives.[26]

The inclusion criteria were being a first-time mother, being in the lactation period, being over 18 years of age, belonging to any socioeconomic stratum (for more details on the socioeconomic classification in Colombia, see Table 1), having given birth to children with birth weight >2500g and without chronic diseases, and being provided with BFC in one of the 12 WCFI in Bogotá D.C., where the first stage of the investigation was carried out. The exclusion criteria were being a mother with listening and comprehension difficulties, having given birth by cesarean section, and having any disease requiring specialized care; the latter criterion was established because it was considered that this circumstance would prevent the mother from receiving the BFC that she should receive without restrictions.

Table 1. Socio-economic strata in Colombia according to the National Administrative Department of Statistics.

Stratum	Description
1	Low-low. Beneficiaries of home utility subsidies.
2	Low. Beneficiaries of home utility subsidies.
3	Medium-low. Beneficiaries of home utility subsidies.
4	Middle. They are not beneficiaries of subsidies, nor do they pay surcharges; they pay exactly the amount that the company defines as the cost for providing home utilities.
5	Middle-High. They pay surcharges (contribution) on the value of home utilities.
6	High. They pay surcharges (contribution) on the value of home utilities.

Source: Elaboration based on the data by National Administrative Department of Statistics.[27]

After obtaining permission from the WCFI to conduct the study with the nursing mothers who were there and collecting their data, the mothers were contacted by telephone to explain the purpose of the research, invite them to participate, and arrange for a personal meeting at their place of residence or work. The interviews were conducted in a comfortable place away from interruptions to favor intimacy and generate mutual trust. Before beginning the interview, the mothers were asked to sign the informed consent form and to authorize the recording of the interview.

The in-depth interviews (one for each mother) were administered by the main author, who initiated them with the following guiding question: What was your experience with EBFC? To maintain the anonymity of the mother, her data were coded with her initials and the WCFI in which she was treated, followed by consecutive numbers.

For the identification of units of meaning (UM), we first differentiated what was considered to be "essential" to respond to the objective of the research by carrying out an initial coding of the expressions related to the EBFC experience. This is a statement comprised of small phrases or expressions that contain the meaning of counseling for participants.

Then, using NVivo 10, a comprehensive analysis was performed based on the reading of the textual transcriptions of the interviews and the essential structures identified in the narratives related to the experience they had during the EBFC at three specific moments: gestation, immediate delivery/postpartum, and puerperium. This analysis allowed for a vague and broad understanding of the phenomenon, which corresponds to Heidegger's

first methodological moment,[28] as well as the identification of UMs that denote the meanings attributed to the experiences of nursing mothers during EBFC at the three moments.

The study took into account the ethical principles for medical research involving human subjects established by the Declaration of Helsinki[29] and the provisions on health research of Resolution 8430 of 1993 of the Ministry of Health of Colombia.[30] It was approved by the ethics committees of the Faculty of Medicine of the Universidad Nacional de Colombia, in accordance with Minutes No. 152-15 of September 23, 2015, and the Faculty of Sciences of the Pontificia Universidad Javeriana, in accordance with Minutes No. FM-CIE-8732-15 of December 15, 2015.

Results

Characterization of mothers

The mean age of the participants was 23 years, and the majority (63.15%) were in a domestic partnership. The distribution with respect to the level of schooling was diverse: 10.53% had only completed primary school, 42.11% were high school graduates, and 47.36% had university education. All of the interviewees resided in Bogotá, in neighborhoods of socioeconomic strata 2 (47.37%) and 3 (53.63%), and only 37% breastfed exclusively up to 4 months.

Units of meaning and vague and broad understanding

Nine UMs were identified, which are presented below along with some of the narratives that originated them.

UM1. EBFC during pregnancy has two meanings: i) lack of counseling for failing to attend check-ups or not receiving it during the check-ups, and ii) contact with healthcare staff (nurses and assistant nurses) through talks or explanations about the BF technique.

> "[…] the truth is that I did not receive much information about breastfeeding in the hospital." (AOHK10)
> "[…] they explained to me the position, the baby's posture, how she has to be positioned to eat." (LPHK8)

UM2. The explanations provided by health personnel during EBFC were not useful for the breastfeeding mothers because they did not receive them or because they found the advice given by their relatives, especially by their mothers (grandmothers), more useful or made a search on the Internet.

> "[…] during pregnancy, I did not receive any counseling, but I already knew what it was like […] because my mom has young children […] and I saw her feeding them, so I kind of knew." (AOHK10)
> "[…] I worked throughout my pregnancy until the last day, so I didn't have any time for that […] Also on the Internet, yes, out of curiosity, because the truth is that I didn't receive much information about breastfeeding at the hospital." (AOHK10)

UM3. In the immediate postpartum period, EBFC consisted of the instructions given by health professionals to nursing mothers regarding the technique and importance of BF and colostrum.

> "Well, yes, a nurse came up to me and said: Look, you have to hold the baby like this, expose your breast like that, and feed her, right?" (XCHK4)

During this period, half of the mothers experienced difficulties with breastfeeding, and the response of the health staff was to reinforce the technique for breastfeeding through a negative and authoritative attitude.

> "[…] because he didn't latch well, so it was difficult and they didn't say something like "let me help you" or "do this" […], they would only threaten me by saying that that the child would stay at the hospital if I didn't feed him." (APHE2)

Likewise, it was established that health personnel in the immediate postpartum period recommended providing starter formula while the mother learns to breastfeed.

> "[…] We were told before leaving: "If you wish, you can buy formula and give it to your baby while you get used to it." (AEHSI11)

The mothers' narratives also exposed that the most inconsistent message was about how frequently the baby should be breastfed, with some professionals recommending it on demand and others every 2 to 3 hours.

UM4. EBFC in the immediate postpartum period was useful, as the indications given to mothers by health professionals regarding posture and lactation helped them to produce milk.

> "[…] and she said to me: make her suck and that will make you produce milk […] That was a good thing because I would have given her the bottle otherwise. But thanks to her instructions […]". (YAHE18)

UM5. The experience of EBFC in the puerperium meant support, accompaniment and especially the presence of the family of the nursing mothers (grandmothers), but little accompaniment by the institution's health personnel.

> "[…] The one who has been with me is my mother. She is the one who tells me: calm down, feed him calmly, be patient." (ASHK6)

UM6. For the interviewees, breastfeeding was an experience of pain, fear, stress, anguish and despair due to their inexperience and the difficulties they encountered. Some of these difficulties included engorged and sore breasts; cracked nipples; mastitis; difficulty to accommodate and hold the baby and to let the milk come out; and reduction in the quantity of milk.

> "One day my breasts got so engorged at night that I didn't know what to do the next morning. I thought "God, I am not feeling well, this hurts." (AEHSI11).

UM7. Family support during the puerperium was deemed as useful for new mothers in learning how to breastfeed the baby, be calm, feed well, and produce milk.

> "To learn, to know how I should breastfeed my daughter, to feed her well." (KMHK3)

UM8. Family support was mediated by a variety of popular beliefs and practices, particularly in getting mothers to produce more milk and solving problems such as engorgement or nipple fissures.

> "[...] My mother suggested massages and herbal baths. So, yes, I used them, and they helped a little with the pain." (LAHSI12)

UM9. For mothers, counseling entails making known, teaching, or explaining the proper technique for breastfeeding and the benefits it provides in terms of disease prevention.

> "The teachings they give us to be able to breastfeed our babies properly. Yes, teaching" (RRHSI13)

Discussion

Gestation is a decisive moment in the preparation for initiating BF. Therefore, during this period, it is necessary for the pregnant woman to have the accompaniment and support of her partner, her mother, a close relative and/or a health professional trained in BFC,[12,31-33] as it will allow her to cope with and overcome emotions such as uncertainty and insecurity, which often arise after childbirth.

The present study found that some mothers did not have any experience with EBFC during pregnancy, either because they did not attend antenatal checkups or because, when they did, health personnel were limited to giving them basic instructions on the breastfeeding technique. Thus, it is evident that, according to the current literature,[1,34,35] the instructions that the mothers received are far from being considered BFC.

Due to the lack of EBFC during pregnancy, health institutions should provide additional support to mothers at the time of delivery, in order to address their concerns and guide them so that they can breastfeed correctly.

The nursing mothers interviewed in this study had to fill the gap in EBFC with family indications or recommendations found on the Internet. This confirms what has been established in the literature, namely that family support, particularly from other women, is critical for mothers to be able to breastfeed properly.[12,36,37] In this regard, it has also been found that the role of the baby's grandmother is a determining factor in the mother's decision-making regarding BF.[38]

As for the information available on the Internet, the present study established that it can be very useful. However, studies such as that of Robinson *et al.*[39] show that while BF advise available in social networking groups like Facebook can compensate for insufficient support received within mothers' networks, further research is needed to understand the mechanism by which these tools can help prolong the duration of BF. This is especially relevant for low-income women, who, according to Balogun *et al.*,[40] usually do not follow WHO recommendations to initiate BF within the first hour after delivery.

The present study also found that although the participants had contact with health personnel during the immediate postpartum period, their narratives did not show that they felt supported by these people because they did not consider their needs, fears, and insecurities regarding milk production. In this sense, compliance with WHO guidelines and regulations[35] is required to ensure that BFC is continuously provided through medical care by appropriately trained professionals and counselors.

Although some mothers acknowledged the usefulness of the EBFC received from the health personnel during antenatal check-ups, their narratives demonstrated that it was

not enough to give them confidence during BF in the immediate postpartum period. Furthermore, when some mothers encountered difficulties, they received indications accompanied by a negative and imposing attitudes on the part of the health personnel. This is consistent with the findings of Silva-Castro *et al.*,[41] who concluded that nurses should reflect on their BF practices and training in order to motivate mothers to breastfeed, not only from a technical and normative perspective, but also from a psychosocial standpoint, so that they can breastfeed based on their needs.

Similarly, it was noticed that health personnel advised mothers to use artificial feeding as a temporary, albeit somewhat facilitating, measure while they produced milk. This may be associated with a lack of knowledge on the part of health professionals to manage the situation and could be influenced by their perception of BF,[42] affecting EBF promotion and going against international guidelines and provisions.[11]

The mothers also reported receiving contradictory messages from the health personnel, mainly in relation to the frequency of feedings, which is consistent with what was reported by Silva-Castro *et al.*[41] and Lucchini-Raies *et al.*[43] This situation creates feelings of uncertainty, unease, confusion, and frustration in mothers, which add to those they already had as a first-time mothers, especially when breastfeeding is difficult.

The mothers' experience with EBFC during the puerperium implied the permanent presence of the family. However, it should be noted that the father's involvement was less visible and was limited to being present when it was necessary to purchase infant formula or the breast pump and to remind the mother of the importance of eating properly. Analyzing this latter aspect is critical because, due to the valuable supporting role the father can play during BF, it seems necessary for health personnel to instruct him in the implementation of basic newborn care procedures and in supporting the mother during breastfeeding.[31,44]

In summary, the lack of support and follow-up to the mother during the puerperium by the health personnel evidenced in the interviewees' narratives corroborated the lack of EBFC, considering that the counselors who accompanied them did not completely fulfill their role of monitoring if they were nursing adequately and instructing them on the correct way to do so.[4]

For the interviewees, BF was an experience of pain, fear, distress and frustration, which coincides with what was reported by the mothers who participated in the research by Lucchini-Raies *et al.*[43] In the case of the present study, it is believed that this situation was caused by the mothers' inexperience as first-time mothers, the difficulties they encountered with BF, the lack of BFC, and the poor care they received from some health professionals who scolded and threatened them, as previously reported by Silva-Castro *et al.*[41]

Given the experiences lived by the interviewees in the three moments analyzed, it can be established that mothers have a different perception of the true meaning of EBFC because, for the majority of them, it means giving indications or explanations for breastfeeding; in other words, counseling is based on giving recommendations on the breastfeeding technique rather than on offering mother-centered counseling considering her needs, experiences, concerns, and insecurities.

In this sense, it is important to make visible the need the mothers interviewed in this research have for health personnel who are properly trained in EBFC, understand them, are humane, and treat them well. This will allow for better support for mothers, which will be evident in the increase in EBF and total BF rates, as reported in the literature.[45-48]

It is important to stress that the present study had no limitations.

Conclusions

The findings of this study lead to the conclusion that it is possible that in Colombia the legal provisions on BFC or initiatives such as the WCFI, whose purpose is precisely to promote, protect and support BF through counseling, are not being complied with since difficulties in their correct implementation are evident. Thus, effective strategies for the proper training of health personnel in BFC must be proposed and developed.

Conflicts of interest

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