Application of the Baby Friendly Hospital Initiative to Neonatal Care: Suggestions by Swedish Mothers of Very Preterm Infants
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J Hum Lact 2008 24: 252
DOI: 10.1177/0890334408319156

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Background

Although the World Health Organization (WHO)/United Nations Children’s Fund (UNICEF) Baby Friendly Hospital Initiative (BFHI), with the 10 steps to successful breastfeeding, was targeted at healthy term infants, it has also had indirect effects in neonatal intensive care units (NICUs). As a result of the BFHI program in a US hospital, the NICU breastfeeding initiation rate increased from 35% to 74%, the rate of 2-week-old infants receiving any breast milk rose from 28% to 66%, and the proportion of infants receiving only breast milk increased from 9% to 39%. These effects were attributed to the influence of changes in the units caring for term infant-mother dyads, as well as attitudes and practices in the NICU. After application of the BFHI in an Australian hospital, the breastfeeding rates among preterm infants at discharge from the NICU increased from 44% to 71%, and in a Brazilian NICU, the rate of exclusive breastfeeding at discharge rose from 36% to 55%; this was explained by a more breastfeeding-oriented attitude also in neonatal care and replacement of bottle-feeding by cup-feeding.

Spatz proposed modifications of the 10 steps, including informed feeding decision, skin-to-skin care, nonnutritive sucking at the breast, transition to breast, measuring milk transfer, preparation for discharge, and appropriate follow-up. Information about the benefits of breast milk for preterm infants can cause mothers to change their initial feeding decision to breastfeeding without feeling pressured. After introduction of an international board-certified lactation consultant service in an NICU, the proportion of infants who were ever given their own mother’s milk increased from 31% to 47%.

Application of the Baby Friendly Hospital Initiative to Neonatal Care: Suggestions by Swedish Mothers of Very Preterm Infants

Kerstin Hedberg Nyqvist, PhD, RN, and Elisabeth Kylberg, PhD

Abstract

The aim of this study was to obtain suggestions from mothers of very preterm infants regarding modification of the Baby Friendly Hospital Initiative (BFHI) 10 Steps to Successful Breastfeeding. Thirteen mothers were interviewed 2 to 6 months after their infants’ discharge from the hospital. The interviews generated 13 steps, which partly agree with the BFHI steps. The new steps address respect for mothers’ individual decisions about breastfeeding, education of staff in specific knowledge and skills, antenatal information about lactation in the event of preterm birth, skin-to-skin (kangaroo mother) care, breast milk expression, early introduction of breastfeeding, facilitation of mothers’ 24-hour presence in the hospital, preference for mother’s own milk, semi-demand feeding before transition to demand breastfeeding, special benefits of pacifier sucking, alternative strategies for reduction of supplementation, use of bottle-feeding when indicated, a family-centered and supportive physical environment, support of the father’s presence, and early transfer of infants’ care to parents. J Hum Lact. 24(3):252-262.

Keywords: Baby Friendly Hospital Initiative, neonatal, preterm infant, Sweden, breastfeeding
demand feeding. Assessment of infants' milk intake preterm infants benefit from the application of semi-
the transition from scheduled to cue-based feedings,
and evaluation of infant growth. Encouragement of breast milk expression is crucial, as the onset of milk production can be delayed after a premature delivery. Early attainment of adequate milk production during the first 2 weeks after birth has significance for later production of breast milk. Simultaneous expression of milk from both breasts can result in higher milk volumes. Early initiation of breastfeeding, irrespective of postmenstrual age (PMA, corresponding to gestational age after birth), postnatal age, or weight, was supported in a study by the first author, in which early oral motor competence was observed in very preterm infants. Supplementation by tube or cup instead of a bottle during the transition to full oral feeding increases the likelihood of breastfeeding. During the transition from scheduled to cue-based feedings, preterm infants benefit from the application of semi-demand feeding. Assessment of infants’ milk intake at the breast by test weighing has been experienced as helpful and not stressful by mothers during the process of attaining full breastfeeding at home.

There is ample evidence from low-income countries that the kangaroo mother care (KMC) method, based on early, continuous, and prolonged mother-infant skin-to-skin contact, exclusive breastfeeding, early discharge, and adequate follow-up, is a powerful intervention for increasing breastfeeding rates. In industrialized countries, this method, practiced as limited periods of mother-infant skin-to-skin care, has shown correlation to successful lactation. “Steps to Successful Breastfeeding of the Premature Infant,” a tool proposed for helping nurses to provide evidence-based breastfeeding counseling, included skin-to-skin holding and gavage feeding during skin-to-skin holding. Other steps in this tool dealt with privacy for milk expression, positioning at the breast, rooming-in, and postdischarge considerations, as well as interpretation of infant cues of readiness to breastfeed and signs of stress during feeding.

Undoubtedly, mothers of very preterm infants (born at a gestational age [GA] of less than 32 weeks) face special challenges in the establishment of breastfeeding. Not surprisingly, the medical condition of preterm infants and their length of hospital stay have shown associations with lower rates of breastfeeding. This unfavorable situation calls for the formulation of guidelines tailored to these mothers’ particular needs. A Swedish survey found a similar breastfeeding initiation rate in preterm and full-term infants, but the preterm infants were weaned earlier. According to national breastfeeding statistics, comprising 97.2% of all Swedish infants, the initiation rate for infants born in Sweden in 2004 was 98%. After the initial promulgation of the BFHI, all Swedish hospitals with labor and delivery units were accredited as Baby Friendly. When this article was written, 64% of all hospitals had renewed their accreditation.

For breastfeeding guidelines to meet the mothers’ expectations and acceptance, they must be formulated in cooperation with the mothers themselves. This was the impetus for the present study, which was conducted with the aim of obtaining suggestions from mothers of very preterm infants regarding modifications and expansion of the BFHI 10 Steps.

Methods

Sample

Permission to carry out the study was obtained from the Research Ethics Committee of the medical faculty of Uppsala University. The study was conducted in the NICU at the University Hospital in Uppsala, which has 14 beds for intensive care and 12 for intermediate care. Maternal inclusion criteria comprised intention to breastfeed, sufficient ability to speak and read Swedish, and birth of an inborn singleton at a gestation of less than 32 weeks. Infant inclusion criteria were absence of any congenital anomaly, chromosomal abnormality, or severe illness that would preclude development of a normal oral motor capacity. The aim of the recruitment was the participation of mothers and their prematurely born infants in a prospective study of the development of infant oral motor behavior during breastfeeding and establishment of breastfeeding in the hospital (to be reported elsewhere), in which the mothers completed a breastfeeding diary, and participation after the infant’s discharge from the hospital in an interview concerning application of BFHI in neonatal care.

Infant criteria for early discharge, with infant care by the parents at home, were absence of apnea, ability to maintain a normal temperature without technical assistance, partial oral feeding, adequate weight gain, and absence of illness; parental criteria were confidence in caring for their infants, ability to perform tube and/or cup feeding, and ability to recognize signs of infant illness. A further criterion for participation of breastfeeding mothers in the early discharge
Data Collection Process

A qualitative descriptive design was chosen, with interviews as the data collection method. The primary investigator (KHN) approached mothers about participation in a prospective study of the development of preterm infants’ breastfeeding capacity, including an interview after the infant’s discharge from the hospital about the mother’s experience of breastfeeding support in the hospital. The mothers gave their informed consent after they had received oral information and read an information letter about the study. As the prospective study required that the primary investigator should be available to meet all mothers as soon as breastfeeding could be initiated and once a week thereafter throughout the infants’ hospital stay, the sample recruited was a convenience sample of infants born during a period of 2 years. Fifteen of 17 mothers who met the inclusion criteria gave their informed consent to participate. The reasons for nonparticipation of the other 2 mothers were postnatal depression and severe eclampsia. Their infants, both female, were born at a GA of 30 and 31 weeks. Two of these 15 mothers did not want to be interviewed, which gave a sample of 13 mothers for the present study.

The second author, who was not known by the mothers, conducted all interviews. The mothers were contacted a few weeks after the infants’ discharge and asked to decide the date and place of the agreed interview. An interval of at least 2 months after discharge was suggested to allow the mother time to reflect about her experiences in the NICU. The mothers could choose to be interviewed in their own homes or in a room at the hospital with adequate privacy. During the interview, the mothers were made aware of the 10 steps and asked to comment on them from their unique perspective. They were also asked to suggest topics to add to the steps that would increase their relevance to breastfeeding a preterm infant. The mothers were also asked to talk freely about their experience of establishing lactation and breastfeeding in the hospital.

Data Analysis

The interviews were tape-recorded and transcribed verbatim by the second author, and this yielded 65 single-spaced pages. The tapes were erased after transcription.

Results

Sample Characteristics

For the majority of the 13 mothers who constituted the sample of this study, the infant was their first child (Table 2), and most of them had a vaginal delivery. Only 2 were smokers. All except 1 mother had stayed in a parent room for a variable number of days before the infant went home. The infants’ ages when the mother first spent a night in the unit ranged from about 1 week to nearly 3 months, immediately after she had been discharged from the maternity unit or after she had lived at home for a period of time. The infants, the majority of whom were male, were born at a GA of 29 to 31 weeks. All except 1 had an Apgar score of above 7 at 5 minutes. Most of the infants had initial respiratory problems, 7 of them respiratory distress syndrome and 1 pneumothorax; most of them received treatment with continuous positive airway pressure (CPAP) and additional oxygen, and some infants also required initial ventilator treatment. One girl born at a GA of 26 weeks was discharged from hospital with oxygen via nasal prongs. Eight infants had anemia, 5 had apnea that required treatment, and 4 had an infection (2 of them septicemia). All infants needed phototherapy for hyperbilirubinemia.

The mothers started breastfeeding when the infants were at a median (range) PMA of 31.3 (29.7-33.6) weeks, at an age of 11 (2-51) days. All infants were initially fed through an orogastric tube. Ten infants were supplemented by cup, and 3 infants were bottle fed expressed mother’s milk (EBM) before being formally discharged from hospital. Ten mother-infant pairs attained full breastfeeding in hospital. All parents provided the concluding part of their infants’ neonatal
The following is a summary of the mothers’ statements made during the interviews. Direct quotations have been inserted to support the key issues raised by participants. These summaries describe women’s perception of their NICU breastfeeding experiences in relation to the BFHI 10 Steps to Successful Breastfeeding and do not necessarily reflect current standards of care. Ten of these 13 steps are modifications and expansions of the original 10 steps, and 3 are additions: steps 2, 11, and 12. The original 10 steps and the new 13 steps are shown in Table 2.

The mothers mainly used the word *nurse* for all nursing staff they had encountered: registered nurses, nurse midwives, and practical nurses. Participant number is indicated after each quotation.
Step 1: Have a written breastfeeding policy, adapted to infants who require neonatal care, that is routinely communicated to all concerned staff and to parents. Parents should also be informed routinely about the policy, orally and in writing. Several mothers complained that they had not received adequate information about it and considered that there were shortcomings in its practical application, especially regarding problems in lactation and breastfeeding. Awareness of the policy must be reflected in clinical practice. A mother who takes it for granted that she will breastfeed may encounter unexpected obstacles—for example, prolonged need of hospital care for her infant, stress caused by the NICU environment, inability to increase her milk production despite frequent pumping and advice about facilitation of pumping, and lack of interest on the part of nurses.

When it did not work I did not receive the necessary help and support. (P9)

Mothers should be supported to an extent depending on their ability. Mentioning the possibility of other modes of delivering breast milk to infants (tube, cup, or bottle if the mother prefers this to using a cup) may help mothers in trying to breastfeed. Occurrence of obstacles may lead to discontinuation of pumping and breastfeeding as the best choice. Some mothers who had decided to bottle-feed EBM partially or fully in the hospital complained about lack of support for their decision and lack of adequate help. Strategies recommended for reaching agreement between staff and parents on the breastfeeding policy were to ask for mothers’ opinions and suggestions and to involve them in task forces.

You need this little extra, empathy, somebody who says “You are doing great.” (P10)

Step 2: Treat every mother with sensitivity, empathy, and respect for her maternal role. Support her in making informed decisions about milk production and breastfeeding according to her own wishes. Basic information could be given shortly postpartum. However, the shock of premature birth affects the memory, and comprehensive information should therefore be postponed until the mothers have “landed.”

I have a vague memory that they informed me about breastfeeding soon after the delivery but everything was like a haze. (P5)

A “breastfeeding expert” must be able to relate to people. Sensitivity is expressed by paying consideration to the mother’s unique situation and feelings of vulnerability after the shock of premature birth and grief after the loss of a normal pregnancy, showing empathy, giving the mother time, and providing encouragement in a way that does not make her feel stressed, pushed, or coerced.

Anxiety about the infant’s condition and insensitive treatment of infants by individual nurses had a negative influence on the letdown reflex and caused a negative spiral in the lactation process. It sometimes happened that mothers did not dare to criticize nurses, as they depended on them for their infants’ care, and a protective instinct superseded the normal maternal instinct. The mothers described a “caring nurse” as a nurse who involves the mother (parents) in the plan for infant care and feeding, promotes advances in this plan, supports transfer of the infant’s care to the parents, asks the parents for their suggestions, and takes their presence for granted. Efficient communication and organization are also important. When one nurse after the other asked a mother if she had pumped or breastfed, she felt as if the nurses did not trust her.

Every shift had to double-check. I don’t need anyone to boss me around. I didn’t come of age until I got home, and then he was my baby 100%. (P6)

Mothers should be expected to make their own decisions, with nurses presenting alternatives. If the nurses base lactation counseling on the idea of only 1 approved goal—for example, “breastfeeding at all costs” or “all mothers can breastfeed”—the mothers may feel pressured, blamed, guilty, and worthless. The nurses must make it clear that breastfeeding is not a goal in itself, even in a Baby Friendly hospital. Mothers who spend a lot of time in the hospital with their infants may lose the energy needed for pumping and breastfeeding. The mothers should therefore be told that motherhood is not primarily a matter of nutrition and breastfeeding but is equally expressed by holding, cuddling, and having visual contact.

I felt summoned just like some kind of feeding machine; that was my task, not cuddling. (P6)
Acknowledging the mother’s problems and accepting whatever decision she may take about breastfeeding makes her existence more tolerable and will not necessarily decrease her will to breastfeed. Being together with the infant, holding, and bonding are much more important. It felt good when a nurse confirmed that inability to provide enough milk was not the mother’s fault, that this could be explained by psychological mechanisms, and that she did not have to continue pumping or breastfeeding unless she really wanted to.

A child may be unhappy even if he receives breast milk, if the mother is unable to bond because of problems with lactation. Motherhood is more than providing nourishment. (P6)

Step 3. Educate and train all staff in the specific knowledge and skills necessary to implement this policy. The mothers understood that some nurses were “experts” who made breastfeeding observations and gave mothers practical tips for succeeding in lactation and breastfeeding. When there was no “expert” on duty, the mothers had to wait. Some nurses displayed lack of interest, telling the mother to ask another nurse or “try what you yourself think is best.” Nurses without children of their own seemed more ignorant. All staff should have basic knowledge, but mothers should also have access to an expert breastfeeding counselor when required. Competent support is particularly important when the mothers are initiating milk expression and breastfeeding and when they have problems with insufficient milk production. All professionals concerned should have adequate knowledge about preterm infants, including breastfeeding, feeding, and nutritional questions. This applies not only to nurses in NICUs and maternity units but also to those in maternal health centers and child health centers (CHCs).

The staff need training that enables them to give practical breastfeeding support. (P6)

Step 4. Inform all pregnant women about initiation of lactation and breastfeeding in the event that the infant is born preterm or ill. Few mothers had attended antenatal classes as these were offered later during the pregnancy. One mother who had attended such classes had not felt motivated to learn about breastfeeding at that time but found it helpful in retrospect. The importance of early basic information about lactation and breastfeeding was emphasized: antenatal classes should cover breast milk benefits, breastfeeding techniques and possible problems, establishment of lactation by using a breast pump, and the fact that it may take some time before breastfeeding is possible, in addition to different aspects of preterm birth and basic facts about preterm babies. Talking about preterm birth and infant illness was described as a difficult question of balance—honest information had to be imparted without frightening the expectant mother, but lack of information would make the shock worse if these events actually happened. Mothers who were hospitalized before giving birth had also missed information, although there had been plenty of time for it. The staff must take the initiative:

When you lack knowledge you don’t even know what you need to know. (P3)

Step 5. Encourage early, continuous, and prolonged mother-infant skin-to-skin care (kangaroo mother care) without unwarranted restrictions, and offer opportunities for mothers to remain together with their infants 24 hours a day. All mothers had suffered from being separated from their infants and regarded this step as the most important item in a breastfeeding policy. Some parents hesitated to leave the hospital even for legitimate reasons.

Having to go home and leave a small vulnerable preemie was not humane. (P10)

Ideally, the mother holds the baby skin-to-skin within a few hours after birth. Several mothers held their infants on their chests before each planned meal or for the major part of the day, but the common pattern had been to hold the infant in connection with 2 meals, about 6 hours/day. The infants were calmer when held skin-to-skin and picked up “good family bacteria.” When the father provided skin-to-skin care, the infant knew him well before discharge. Problems encountered had been conflicting staff opinions about the timing and duration of skin-to-skin contact and differences in helpfulness.

Most of the mothers had slept together with the infant at least 1 night before going home. One mother who was unable to do so had been terrified the first night at home, as she feared that he would stop breathing. The plan for the reconstructed unit was considered ideal: parents would take over the infant’s care early, with nurses as supporters. Mentioned benefits
of co-care (mother and/or father staying together with the infant in a single room and providing the infant’s care) were that the mother does not have to feel stressed and awkward in the presence of others, which facilitates frequent pumping and earlier establishment of breastfeeding. But when an infant needs a long hospital stay, the mother is unlikely to cope with several months of uninterrupted presence in the hospital environment.

Step 6. Inform, encourage, and support mothers in early initiation and establishment of breast milk expression and maintenance of milk production. Instruction in how to assemble and use a breast pump should be given as soon as possible. Just describing the equipment is not enough; a nurse should stay with the mother the first time she pumps to give practical advice and support. Several mothers had to wait for some time after the delivery before they were given any information. A few mothers were instructed in manual expression and used this technique the first day. Mothers should be told that it is common not to obtain any milk the first few times they pump and that the first important drops should be aspirated in a syringe and given to the infant. Having 1 designated nurse as a lactation counselor is optimal. One mother, whose milk supply increased when she began to express her milk during the night as well as the day, suggested that mothers should be told the following:

If your baby had been strong enough to suckle you would do this every 2-3 hours, so try to imitate that pattern right away by pumping your milk every 2-3 hours, also during the night. (P10)

Most mothers found pumping a necessary evil, but some of them had experienced feelings of joy and fulfillment. Complaints concerned conflicting information about the frequency and duration of pumping and the inability of some nurses to help when pumping did not work—just saying that it might improve over time. Some mothers with small milk volumes despite an increased pumping frequency noted an increase as soon as they started breastfeeding.

Step 7. Encourage and support mothers in early initiation of breastfeeding, with infant stability as the only criterion. Give mothers individual support. Several mothers had believed that it was no use trying to breastfeed, as the infant mostly looked tired, but as soon they were allowed to place him or her at the breast, they noticed signs of interest. Breastfeeding should therefore be commenced as soon as possible. Several mothers were convinced that the start of their breastfeeding was delayed for no reason. A strong feeling of pleasure was common the first time a mother placed the infant at the breast, not expecting him or her to “feed.”

It was fascinating to see that—oh my God—this little 1-kg baby is able to suck, he sort of fixed it, even if I don’t believe that he took much milk. (P5)

This first start helped the infant to associate the breast with nourishment. The mother appreciated suggestions about positioning and holding the infant, as this differs from holding a healthy term infant. Observing a nurse demonstrate positions with a doll and using a breastfeeding pillow helped the mother to get started. Hearing too many opinions was a major problem, especially regarding the duration of the breastfeeding sessions. The infant should be allowed to suckle before receiving supplementation and be given the time he or she needs before starting to suck and be allowed to suckle until content.

My mistake was that I listened to everybody . . . and then you want to please them all and just feel confused, that was my biggest mistake. (P12)

Several mothers were convinced that a nipple shield would have contributed to more rapid progress in the breastfeeding, if offered earlier. Most of those who tried it noticed a difference when they received it and supported its use whenever there were signs that the infant needed it.

Step 8. Give the infant the mother’s own milk as first choice and pasteurized donor breast milk as second choice, fortified when indicated. All mothers were informed about donor breast milk and regarded it as more natural than formula. Some wondered why their permission to use donor milk had not been obtained. Although it was calming to know that donor milk is pasteurized and its availability gave some relief from performance anxiety, some mothers felt uncomfortable with it. Lack of information about whether the infant was getting fresh or thawed milk in chronological order and before protein fortification powder was added to their own milk was also upsetting; in the latter case, the mothers believed that something was
wrong with their milk. The mothers considered use of formula to be natural when a mother cannot attain adequate milk production or is exhausted by frequent breastfeeding, as well as when a breastfed infant does not gain weight.

**Step 9.** Encourage breastfeeding on demand as early as possible, with semi-demand breastfeeding as a transitional strategy for preterm infants. (The mother nurses when an infant shows signs of interest and also offers her infant the breast to reach a breastfeeding frequency per 24 hours that is sufficient for adequate infant milk intake.) All mothers had tube fed, and the majority learned to insert a feeding tube. Although they disliked the tube, they enjoyed being in charge of the feeding. Tube feeding should not be performed routinely for supplementation after breastfeeding; instead, occasional large milk volumes could be given. A tube should not be inserted soon after the infant has suckled. Infants capable of oral feeding should not be tube fed because of the discomfort; when infants mature, they respond by vomiting. Most mothers found cup-feeding easy. A few mothers of infants who were difficult to cup-feed had used a syringe instead.

Transition from scheduled feeding to feeding on demand via semi-demand feeding should occur as soon as possible. Some mothers had felt uncertain about what could be expected from the infant. Guidance in identifying shifts in the infant’s behavioral state and of interest in sucking helped mothers to gain confidence. Several infants did not show clear signs of hunger and satiety until after discharge. Avoiding routine supplementation after breastfeeding was helpful, but hastening the infant’s progress by “starving” him or her did not work; the infant did not gain weight in this way. Staff expectations regarding the infant’s growth had been stressful. Most mothers test weighed; they felt confident in how to reduce supplementation and happy when the scales proved milk intake, but comparisons with the milk intake of other infants could also cause stress and despair. Mothers should therefore be offered to choose alternative strategies for reducing supplementation; each mother-infant dyad must be allowed the time they need to complete this phase.

**Step 10.** Offer the infant a pacifier for relief of pain, stress, and anxiety and for stimulating the uptake of nutrients during tube feeding. Introduce bottle-feeding when there is a reason. A few mothers had been informed why their infant would be offered a pacifier. Several mothers believed that pacifier sucking spoils the development of normal sucking and that the infant will prefer the pacifier to the breast, but the majority had understood the benefits during tube feeding, for pain relief and for helping the infant to settle. The mothers had not understood why bottle-feeding was avoided. The reasons given by nurses for using a cup instead had been that the use of feeding bottles violates the BFHI guidelines and may be detrimental to breastfeeding. Several mothers held the opinion that breastfeeding is the best choice, but bottle-feeding can also be the best choice when a mother is unable to produce enough milk despite having done her best to increase her milk production, when she is so emotionally drained after spending a lot of time with the infant in the hospital for several months that she cannot cope with the “job” of breastfeeding, and when coming home with a baby with medical problems. It was also considered natural to bottle-feed in cases of prolonged difficulties in attaining functioning breastfeeding after discharge from the hospital. Once a mother has made up her mind about what is best for her, the staff must respect and support her decision and not respond in a way that makes her feel guilty. Of course the nurses should not encourage the use of bottles, but when breastfeeding does not work, it is the mother’s decision. (P10)

**Step 11.** Provide a family-centered and supportive physical environment. The mothers complained about the large number of infants, staff, and parents in the nurseries. They had felt awkward when exposed to the view of strangers, especially other fathers. Lack of privacy also acted as an obstacle to healing from the crisis of giving birth prematurely, as they had to withhold their feelings of sadness. A noisy and stressful environment meant a resistance to be overcome every time they pumped and breastfed.

You need peace and quiet, a “den,” or you get stressed and breastfeeding goes into a deadlock. (P5)

All mothers emphasized the need of privacy in a pumping room or hidden behind a curtain. The room where mothers express their milk should be quiet, with pleasant illumination—no fluorescent lights. Written information on posters ought to be clear and
orderly, with nice, easily comprehended pictures, and should be prepared in collaboration with mothers. The mothers’ opinions about pumping together with other mothers varied and depended on the mother’s current mood; company could both be therapeutic and disturbing.

**Step 12. Support the father’s presence without restrictions as the mother’s main supporter and the infant’s caregiver.** An infant’s birth is also the birth of a new family who needs to be together. Mothers found it distressing to be alone in the hospital, especially in the beginning, when the infant was in intensive care. The mother needs the father’s support just as much when the infant is in the hospital as after the infant’s discharge. The father’s presence ought to be taken for granted as a resource person for both mother and infant, as he participates in the infant’s care and develops a close relationship with the infant.

He was there from the very beginning in hospital, tube fed, kangarooed and all. (P5)

**Step 13. Plan the infant’s discharge by early transfer of the infant’s care in the neonatal unit to the parents. Inform the mother about where she can obtain breastfeeding support after discharge by staff with adequate knowledge.** The parents should take over the infant’s care as soon as possible. The decision to send an infant home must be made jointly by staff and parents so that they are not taken by surprise. Only a few mothers remembered having been informed about where lactation counseling was available after discharge: the Breastfeeding Mothers’ Support Group, the hospital breastfeeding policlinic, and the CHC. This information should be given face-to-face some time before the infant is sent home. Several mothers preferred to call the NICU for advice over the telephone after discharge, as they had the impression that CHC nurses and midwives at the breastfeeding policlinic lacked knowledge about premature babies and mainly focused on how small the infant was. In contrast, the staff at the hospital neonatal follow-up policlinic paid attention to each infant’s individual situation.

When we weighed her the first time at the CHC she had gained 100 g and they said that she should gain 150-200 g/week. Then I called the hospital and they said it was normal. (P8)

Most of the mothers appreciated the initial home visit by the CHC nurse and the opportunity to monitor their baby’s growth at the CHC. Some mothers enjoyed participating in parent groups at the CHC, whereas others would have preferred special preterm parent groups.

**Discussion**

These mothers’ accounts and suggestions demonstrated that the 10 steps to successful breastfeeding are relevant also for mothers of very preterm infants but need clarifications and additions to provide adequate guidance for these special mothers, and the guidelines for breastfeeding support must be based on the mothers’ perspectives. Several mothers talked at length about the negative impact on their pride when nurses gave indirect messages that there was only one “right way” to be a good mother—that is, to succeed in breastfeeding. The goal of a supportive policy for these mothers must not be expressed as an expectation that all mothers should meet “the norm.” Nearly all Swedish mothers intend to breastfeed, but this does not mean that breastfeeding is something all mothers can do, especially not after a premature birth. Differences were also found between Australian nurses’ and mothers’ constructs of motherhood; mothers valued skin-to-skin contact with the infant and breastfeeding mostly in relation to their role, whereas nurses gave more priority to the mothers’ performance of care. In the present study, the mothers’ reflections about breastfeeding in relation to motherhood are consistent with those in a study in which mothers of infants in a Swedish NICU were interviewed about their view of the maternal role. When the mother felt that she was participating, she also felt cared for as a unique person. When a feeling of exclusion predominated, she felt a lack of interaction and had a sense of nonbelonging, which had a negative effect on her maternal role. Aguayo suggested that the goal of lactation counseling should be the well-being of the child and his or her family. In that study, it was considered that lactation support of mothers of preterm infants must promote mother and child bonding, early skin-to-skin contact, and individualized care and that research is needed to evaluate the effects of training health care professionals, not only regarding knowledge but also with respect to emotional and communicational skills.

It is commonly assumed that failure in lactation and breastfeeding in mothers of preterm infants can be attributable to stress. However, this assumption has not
been consistently supported by the existing evidence. For example, no differences in milk production were found between mothers of term and preterm infants during the first 6 weeks, despite higher levels of anxiety, depression, and hostility in the latter. Likewise, neither salivary cortisol nor amylase levels were found to be associated with oxytocin and prolactin levels and milk production in mothers of preterm infants.  

The study mothers’ accounts of frustration in response to the way in which the guidelines for feeding were implemented in clinical practice warranted the addition to the breastfeeding policy of a special step to emphasize the importance of sensitivity, empathy, and respect for the maternal role and to underline the mothers’ right to make their own informed decisions. This right was highlighted in the mothers’ view on bottle-feeding, which they considered a natural choice in certain situations. Furthermore, from these mothers’ statements, it seemed that mixed feeding (breast and bottle) was never discussed with them as a possible option. From the mothers’ perspectives, practices regarded as beneficial by professionals may, on the contrary, be perceived as alarming (eg, protein enrichment of a mother’s own milk for enhancing her infant’s growth and the use of a pacifier for facilitating the infant’s self-regulation when separated from the parents).  

Other steps that were added to the original 10, relating to the vulnerability of mothers and infants, were minimization of mother-infant separation, skin-to-skin care (kangaroo mother care), and the provision of a family-centered supportive physical environment with sufficient privacy to allow natural parent-infant interaction and bonding. The father’s role in supporting the mother and sharing in the infant’s care was emphasized as invaluable. This is in agreement with the fathers’ own descriptions of their role in assisting with the pumping process and as providers of moral support.  

A practice that is a matter of controversy is test weighing before and after breastfeeding. Although benefits for breastfeeding mothers have been identified during the process of reducing supplementation, doubts are also expressed. These are based on the fear that assessment of infants’ milk intake will lead to a view of breastfeeding as merely provision of nutrition, which may be detrimental to the mother’s pride and joy in her role. An alternative approach is to offer the mother a choice between different strategies for reducing supplementation on the path toward full breastfeeding.  

Although the study design made it impossible to obtain a consecutive sample, there was no systematic bias, such as selection of mothers who expressed certain opinions about the feeding policy and practices. Thirteen mothers were interviewed, which can be regarded as a moderate sample size. However, the extensive data obtained in the interviews rendered it possible to reach saturation. The diversity in these mothers’ accounts and comments supports the reliability of their statements. At the same time, these must be regarded as culture dependent—in a setting with optimal health and medical care resources characterized by a pro-breastfeeding culture and a national health insurance that enabled mothers to spend as much time as they wished in the hospital with their infant. These 13 steps are therefore presented as a suggestion for how guidelines for the promotion of breastfeeding in an NICU can be formulated from the joint perspective of professionals and mothers.

References


Resumen

El objetivo fue obtener sugerencias de madres de bebés muy prematuros en relación a las modificaciones de los 10 pasos para una lactancia exitosa de la Iniciativa Hospital Amigo del Niño (IHAN). Se entrevistaron 13 madres entre 2-6 meses después de que sus bebés salieran del hospital. Como resultado de las entrevistas se generaron 13 pasos, que estaban en acuerdo parcial con los pasos de la IHAN. Los pasos nuevos incluyeron: respeto a las decisiones individuales de las madres sobre la lactancia materna, educar al personal en habilidades y conocimientos específicos, información durante el prenatal sobre lactancia materna, educar al personal en habilidades y conocimientos específicos, información durante el prenatal sobre lactancia materna, facilitar la estadía de las madres en el hospital durante 24 horas, preferir la leche de la propia madre, lactancia materna a semi-demanda durante la transición a lactancia a demanda, beneficios especiales de la succión del chupete, estrategias para reducir la suplementación, uso del biberón cuando sea indicado, facilitar un ambiente físico para la familia, apoyar la presencia del padre y referir tempranamente el cuidado del bebe a los padres.