

## ORIGINAL RESEARCH

# The paradox of nursing practice on breastfeeding promotion: what they say and what they do

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## Abstract

**Background:** Nursing professionals qualified and aware of the importance of breastfeeding as a practice permeated by social, cultural, historical, economic and psychological factors contribute significantly to its establishment and maintenance. The objective was to describe the breastfeeding-related performance of nursing professionals in the Family Health Strategy from the perspective of health promotion.

**Methods:** An observational and cross-sectional study developed between April and July 2010, involving 45 Registered Nurses who work in the Family Health Strategy in Uberaba, Minas Gerais, Brazil. Data were collected through a self-administered questionnaire and through participant observation of the professionals at educational groups for pregnant and breastfeeding clients, home visits in the postpartum period, prenatal and children consultations. We used univariate data analysis and data obtained by observations were described.

**Results:** Most professionals said that they often guided about breastfeeding on the activities investigated. These assertions about the development of breastfeeding promotion activities were not very consistent with practice. Their practical performance was not consistent with the proposal of health promotion to go beyond the biological dimension of breastfeeding.

**Conclusions:** We found a discrepancy between what the professionals stated in the questionnaires and what they used to do in their practice in health services. These findings contradict the assumptions of the Family Health Strategy and provide opportunity for further studies to clarify this gap.

## Key words

Breast feeding, Nursing, Health promotion, Health knowledge, Attitudes, Practice, Primary health care

## 1 Introduction

In the last 30 years, Brazil has advanced in its strategies to promote, protect and support breastfeeding. However, despite the innumerable advantages of breastfeeding, supported by scientific evidence, and the improvement of breastfeeding rates in Brazil, its indicators have revealed a tendency towards stabilization, and remain far from the recommendation of

the World Health Organization, i.e., exclusive breastfeeding until the age of six months and complemented breastfeeding until the age of two years or more <sup>[1]</sup>.

As a social practice, breastfeeding is not limited to biological factors, but comprises social, cultural and psychological dimensions, since it combines biological determinants with breastfeeding women's subjective conditions <sup>[2-3]</sup>.

Health care in Brazil is considered a universal right. The government guarantees access to health care, including promotion, protection, cure and rehabilitation. The Unified Health System (SUS) aims to reduce disparities in health care by providing access to publicly funded health care <sup>[4]</sup>. In this context, the Brazilian health system is historically marked by a curative care model centered on medical consultations and, therefore, requires deep and radical changes in its organization <sup>[5]</sup>.

The Family Health Strategy is considered the major government effort to improve primary health care in Brazil. Its intent is to restructure care practice and refocus the care model that exists in the SUS <sup>[4-6]</sup>. In this logic, this strategy aims to transpose the fragmented view of the patient to an integral perception that encompasses the individual, familiar and social dimensions and retrieve general practice, in which the disease process is considered within a local reality <sup>[7]</sup>.

Maternal and child health care, which includes the promotion of breastfeeding, figures on the list of primary healthcare actions <sup>[8-10]</sup>. In routine health care, however, mothers' biological complaints are focused on, with little or no attention to the subjective aspects of the breastfeeding process. This entails a gap between the professional staff, whose education is based on a fragmented and individual care logic, focused on curing diseases, and these women, with their difficulties and limitations that come with the practice of breastfeeding and are intrinsic to their social context <sup>[11-13]</sup>. As a result, early weaning and infant mortality rates in Brazil are high <sup>[14]</sup>. Study have shown the protective effect of breastfeeding on child mortality. It is estimated that breastfeeding avoid 60 % of infant mortality due to respiratory infection and 80 % due to diarrhea <sup>[15]</sup>.

Primary healthcare professionals are responsible for the continuous follow-up of the breastfeeding process, from prenatal care to childcare <sup>[16]</sup>. Nursing professionals are considered able to promote, protect and support breastfeeding and to act in line with national and international pro-breastfeeding policies <sup>[3]</sup>. In this context, the description of professional nursing practices in the family health teams is justified by the fact that nurses comprise the largest group of healthcare professionals in the SUS services <sup>[17]</sup>. The strategy of describing the breastfeeding promotion practices aims to recognize the setting created to support breastfeeding, judge the effects of a program and, thus, reflect about their practice considering the principles of primary healthcare. This analysis allows for planning, designing and evaluating public policies regarding breastfeeding. Changing the service paradigm is a challenge that must be faced and overcome <sup>[18]</sup>.

Recent Brazilian <sup>[19-21]</sup> and international <sup>[22-23]</sup> studies identified and characterized practices and attitudes towards breastfeeding among health professionals at different care levels. These studies are focused primarily on how frequently professionals develop breastfeeding promotion activities and practices in their daily work and reveal that most professionals say that they provide guidance on breastfeeding since antenatal care. They present a restricted vision of professionals' actions and instructions, without looking deeper into how these activities take place and ignoring essential elements in the breastfeeding approach to promote this social practice.

Starting from the existing scientific knowledge and our professional practice in primary health care and breastfeeding, we question whether the daily work of Registered Nurses in the Family Health Strategy meets the demands of women breastfeeding or planning to breastfeed, in order to understand and value their beliefs, feelings and experiences and offer support during the breastfeeding process. In this way our objective was to describe the breastfeeding-related performance of nursing professionals in the Family Health Strategy from the perspective of health promotion.

## 2 Subjects and methods

An observational and cross-sectional study was developed between April and July 2010, involving Registered Nurses who work in the Family Health Strategy in Uberaba, Minas Gerais, Brazil. The city of Uberaba serves as a health referral hub for 21 cities. Approximately 300,000 inhabitants live in the city itself, 97 % of whom in urban areas.

The Family Health Strategy was implemented in Uberaba in 1996. In 2010, 50 family health teams were active, offering care to approximately 57.8 % of the population. All teams are composed of a doctor, a Registered Nurse, a Nursing Technician, a dentist, a dental assistant and, on average, six community health agents.

Working at a family health team in the urban area of the city was set as the inclusion criteria. Thus, the study population comprised all Registered Nurses who were working in the 46 Family Health Strategy teams active in the urban area of Uberaba, totalling 46 professionals.

One professional could not participate because she was in the process of hiring. Therefore, the final population included 45 Registered Nurses.

Data were collected in two phases: the first consisted of applying one questionnaire, and the second referred to observing the care provided by Registered Nurses to pregnant women and the mother-child binomials.

For the first phase, the professionals were contacted by phone, informed about the study and then invited to participate. A time and date were scheduled to apply the questionnaire, according to their availability. The data collection was performed using a self-administered and semi-structured questionnaire with a three-point Likert scale. The questionnaire was tested and validated before the study <sup>[19]</sup> and included questions about the professionals' sociodemographic characteristics and their own breastfeeding experience and also about the frequency with which they counseled about breastfeeding at educational groups for pregnant and breastfeeding women, home visits in the postpartum period, and prenatal and children consultations. The mean time for completing the questionnaire was 35 minutes.

The instrument used has a restricted vision of the actions and guidelines performed by professionals. Therefore, it does not allow a deepening on how the activities take place. Thus, intending to address the limitations of this tool and get a broader view that allows detecting essential elements in the approach of breastfeeding by nursing professionals, we started the second stage of data collection, which used the methodology of participant observation.

The observation allows the direct contact with the phenomenon observed and obtains information about the reality of the subjects in their own contexts, which cannot be obtained through questions <sup>[24]</sup>. It is through participant observation, while intellectual act, that we form a conception of the object of study as a direct source of data and information obtained at spontaneous occurrence of events <sup>[25]</sup>.

Before the second phase of data collection, the questionnaires responses were briefly analyzed in order to identify the Family Health Units where the activities supposed to be observed took place. Afterwards the principal researcher observed the professionals at all times that these activities occurred. The aim of the participant observation was to gain a broader view and detect the essential elements in nursing professionals' approach of breastfeeding.

The observations were performed with the purpose to follow Registered Nurses in their practice of caring for pregnant or breastfeeding clients who attended the unit. The following aspects were considered in the observations: the dynamics of the service; the client's flow in the health unit; the welcoming; the unit's physical structure; the ambience; the privacy; and the professionals' conduct during the activities. Regarding the home visits, the conditions of the residence, mainly on how the professionals approached the mother-child binomial. Observations were chosen in order to not interfere with the

development of activities, focusing on the need for a broad vision of the space and subjects involved. Field notes were recorded at the end of each observation.

For statistical analysis of the data from the self-administered questionnaires, we used the Statistical Package for Social Sciences (SPSS), version 16.0. Univariate analysis was used to identify absolute and relative frequencies distributions and, for quantitative variables, we calculated the means and standard deviations.

The observations were analyzed descriptively and served as a complement to the questionnaires. In this way, they were triangulated with the questionnaires findings to strengthen the researcher's interpretation of data obtained. The observations were described against a background of health-care promotion.

The research proposal of the present study was approved by the Research Ethics Committee of University of São Paulo at Ribeirão Preto College of Nursing (Process number 1035/2009), in compliance with Resolution 196/96 of the National Health Council. The study followed all ethical standards for nursing professionals and mothers participating in the attendance of researchers at home, respecting human dignity, and a Free and Informed Consent Form was used.

## 3 Results

### 3.1 Participants' characteristics

Practitioners' average age was 31.7 years (SD = 7.8; range 22-55). Participants were mostly female (93.3%, n = 42) and 33.3% (n = 15) had children. In this group, totally female, 93.3% (n = 14) breastfed their children.

### 3.2 Report of the professionals versus observations – What they say and what they do

In this section, we compare the findings from the report of the participants in the questionnaires with those obtained by observations. We describe the observations made during the breastfeeding promotion activities, with a view to a more profound analysis of Registered Nurses' role in breastfeeding promotion.

#### 3.2.1 Groups for pregnant and breastfeeding mothers

##### 1) What they say...

Twenty-seven (60.0%) Registered Nurses said that they used to participate in the health education groups and 24 (88.9%) of them indicated that they provided breastfeeding orientations during almost all meetings.

##### 2) What they do...

Meetings of health education groups for pregnant and breastfeeding women took the form of lectures and prescriptive lessons about pregnancy, childbirth and newborn care, including the approach of breastfeeding. No reflective orientations were explored, with little information exchange and participation among women. Although 60.0 % of the Registered Nurses affirmed that they participated in the groups for pregnant and breastfeeding women, this was not observed in practice, as professionals from only four family health units actually participated in these activities.

#### 3.2.2 Postpartum home visit

##### 1) What they say...

Forty (88.9%) Registered Nurses said that they used to make home visits to women in the postpartum period. It is noteworthy that 38 of them (95.0%) reported breastfeeding guidance during almost these visits.

## 2) What they do...

During the four months of data collection, the Registered Nurses made only two home visits to women in the postpartum period. Based on the observation of this two home visits, at the second month after birth, we identified a nursing practice based on a biological model and prescriptive conducts. Women were not considered against their family, social, cultural and economic background. Professionals observed a feeding session and their orientations focused on the breastfeeding technique, complications, contraception, exclusive breastfeeding, complementary feeding, physical examination and growth and development monitoring.

### 3.2.3 Prenatal consultations

#### 1) What they say...

Thirty-six (80.0%) Registered Nurses said that they were active in prenatal consultations and 33 (91.7%) indicated that breastfeeding guidance was provided to pregnant women during almost all consultations.

#### 2) What they do...

Although most Registered Nurses claimed that they offered prenatal nursing consultations and provided breastfeeding orientations during these meetings, it was observed that they could not put this care in practice, as only five professionals actually held prenatal consultations at the family health units. When observing these moments, we found that the consultations were individual, without the presence of companions, based on complaints and conducts, short obstetric examination, interpretation or request of exams, checking the vaccination and medication delivery. The care was based on a biomedical model, in which women are not heard, and their family, health and work background are not considered. The breastfeeding approach was prescriptive, with closed questions and few orientations, which were limited to care of the breasts, such as sun exposure and use of loose bra straps, moisturizers and oils. Another orientation was about the contraindication of breastfeeding in the event of another pregnancy. As regards the examination of the breasts, only one professional performed this during the prenatal consultations. Moreover, one of the five Registered Nurses did a pre-consultation and subsequently forwarded the women for medical evaluation.

### 3.2.4 Children consultations

#### 1) What they say...

Forty-two (93.3%) Registered Nurses said that they used to perform children consultations at their family health units. Of these, 41 (97.6%) mentioned counseling about the benefits and importance of breastfeeding and inquiries about the progress of breastfeeding during almost all the consultations.

#### 2) What they do...

The observations revealed that, among the total number of Registered Nurses who reported doing children consultations, only three actually did this in practice and focused on complaints, growth and development assessment and vaccination checking. The orientations were prescriptive and based on childcare. The approach of breastfeeding was restricted to guidance on the importance of exclusive breastfeeding until the age of six months. Only one professional observed a feeding session and none examined the breasts or advised the mother about the prevention and/or treatment of breast problems. Moreover, one of the three Registered Nurses did a pre-consultation and subsequently forwarded the child and mother to see the doctor.

A comparison of the findings from the report of the participants with those obtained by observations is displayed in Table 1.

**Table 1.** Comparison of the Findings from the Report of the Participants (questionnaires) with those Obtained by observations. Uberaba, MG, 2010.

Activities	Questionnaires(Orientation frequencies*)				Observations	
	During almost all meetings		During some meetings		n	%
	n	%	n	%		
Educational group for pregnant (n=27)	24	88.9	3	11.1	4	16.7
Postpartum home visits (n=40)	38	95.0	2	5.0	2	5.0
Prenatal consultations (n=36)	33	91.7	3	8.3	5	13.9
Children consultations (n=42) <sup>#</sup>	41	97.6	-	-	3	7.3

\*The category "rarely" on orientation frequency have not been signed

<sup>#</sup>One (2.4%) participant did not give information on the frequency

## 4 Discussion

Little consistency was found between most Registered Nurses' assertions about breastfeeding promotion activities and practice, as only few of them actually worked in this regard. Moreover, actions were not in accordance with the health promotion proposal to go beyond the biological dimension of breastfeeding, but instead focused on the individual, curative and prescriptive approach.

The Family Health Strategy enhanced people's access to basic health services and approximated professionals and users. However, it has not generated a change in the way professionals act though, as care remains fragmented and focused on disease and medical consultations <sup>[12]</sup>.

Current breastfeeding promotion strategies are part of a hygienist health care model, partially maintaining the biological reductionism that was typical of the 1980s. The vertical orientation of health professionals' actions assumes that breastfeeding is an instinctive act, reducing it to a natural and biological attribute. These actions aim to inform mothers about the advantages of breastfeeding and blame them for its failure or success, early weaning and negative consequences for their children's health <sup>[13]</sup>.

### 4.1 Groups for pregnant and breastfeeding mothers

Professionals theoretically acknowledge the need and importance of breastfeeding promotion groups. This does not extend to practice though, as professional from only four units developed this activity, consistent with the reductionist model.

This may be due to users' low adherence levels, lack of adequate infrastructure and ambiance, as well as to professionals' lack of involvement or knowledge.

Health education, characterized by information, training, inspection and enforcement, is still present in health care, focusing on changing behaviours and bodily practices, in order to adapt them to hygienic precepts <sup>[26]</sup>. The reason for low adherence to group education activities stems from a lack of activity planning, which do not meet users' needs but professional interests. In this sense, the results of these groups may be worse than expected <sup>[27]</sup>.

For proper planning of educational activities in group, the context of the population needs to be in line with the team's goals and set in a physical structure that permits collective wellbeing, with adequate lighting, sufficient air circulation and privacy. The absence of these factors can cause a lack of motivation in professionals and users <sup>[28]</sup>.

Most of the units investigated in this study did not have enough physical space for the development of group activities. Such limitations should not impede the execution of group activities though. It is possible to use outdoor environments of health facilities, within its coverage area, as an alternative to facilitate the community's access and adherence to and connection with group activities <sup>[28]</sup>.

Health education considers the other as a subject with knowledge instead of a mere information receiver, since the process of mutual interaction and openness to one another's knowledge enhances the shared construction of knowledge and different care forms <sup>[29]</sup>. The role of health professionals in the group is to welcome the participants and listen to their experiences and questions, so as to enable them to explain their self-care difficulties, identify the resources they have to face them and link knowledge, information and experiences, strengthening the bond with the health teams <sup>[30]</sup>.

## 4.2 Postpartum home visit

Despite the observations of the two home visits do not allow us to draw appropriate conclusions about the practice of Registered Nurses of the Family Health Strategy, they revealed that biological and prescriptive practice still impregnates those moments, considering the absence of concern with contextualizing the women in their family environment, where breastfeeding practice becomes a complex experience, determined by factors that go beyond the biological determinism of lactation. We emphasize that these two visits were made in the second month after birth.

From these findings we suggest a gap in nursing care for women in the postpartum period at the primary health care. The current national policy directed to maternal/child population recommends a home visit in the first week postpartum, since the main situations of maternal and neonatal morbidity/mortality, largely happen in this period <sup>[31]</sup>.

The expansion and strengthening of home care value the health-disease process and the influence of the life context and family dynamics on child and maternal health, and also facilitate the entry of health professionals into the home. The objective of this insertion is to observe and work with the development of both mother and child within their environmental, cultural and family context <sup>[32-33]</sup>.

Home visits in the postpartum period, performed by nurse practitioners in primary care, include assistance to both mother and son child, guidance on baby care and self-care, family planning, breastfeeding support and referral to specialized services if necessary. This strategy is particularly important in view of the reduced stay at the maternity ward, limiting the support and education received during hospitalization <sup>[34]</sup>.

The most vulnerable period of breastfeeding covers the first two weeks postpartum. An initial enjoyable and efficient process is the ideal way to establish breastfeeding, while the opposite leads to failure, even in women who were originally willing to breastfeed <sup>[35]</sup>. Support for breastfeeding mothers in the first days postpartum is essential for the maintenance of lactation and helps to prevent the most common problems in this period <sup>[36]</sup>.

Evidence indicates that successful postpartum visits lead to increasing exclusive breastfeeding rates <sup>[37]</sup>. This strategy, however, is most effective when visits happen frequently and in conjunction with other interventions <sup>[38]</sup>. The experience of a nurse home visiting programme has brought positive results to various aspects of the life of mother and child, specifically the duration of breastfeeding <sup>[39]</sup>.

## 4.3 Prenatal consultations

Registered Nurses were unable to put in practice prenatal care as, of all professionals who indicated doing prenatal consultations in their daily work, only five actually did. Observation of these moments revealed that consultations were based on the biomedical model.

Qualified and humanized prenatal care is essential for maternal and child health. A new understanding of the health-disease process is needed, which includes the person as a whole and considers his/her social, economic, cultural and physical context <sup>[40-42]</sup>. Knowing the aspects related to breastfeeding practice is essential to allow mother and child to live this experience effectively and smoothly, getting necessary and appropriate health professional's orientations during pregnancy <sup>[40]</sup>.

Prenatal care is considered an important opportunity to encourage breastfeeding, when professionals are responsible for stimulating a woman's ability to breastfeed<sup>[43]</sup>. The promotion of this practice during prenatal care increases exclusive breastfeeding rates during the first months, with a great effect in developing countries<sup>[44]</sup>.

We question why, in the context of the Family Health Strategy, Registered Nurses behave as adjuvants, as they should contribute to quality care, promoting health and providing support and confidence to pregnant women<sup>[45]</sup>. The quality of care is related to these aspects minimally valued by the population and by nurses, who associate professional qualification with autonomy to prescribe drugs and request tests, restricting the consultations to interventionism, in detriment of preventive and health education aspects, which mark nursing practice<sup>[46]</sup>.

#### 4.4 Children consultations

In the group of Registered Nurses who claimed offering children consultations, only three did this in practice, based on complaints and conducts.

Despite the importance of child growth and development assessment, children consultations should go beyond purely assistentialist and biologic actions, prioritizing health promotion, health education and valuing the socioeconomic and cultural context of each child<sup>[47]</sup>. Listening, bonding and the optimization of various knowledge sources should guide professional conduct, through dialogue, awareness and sensitivity to the needs of each child and family<sup>[48]</sup>.

The children consultation is one way to promote breastfeeding and permits emphasize the importance of this practice for both mother and child, preventing the early introduction of other liquids and foods in the infants' diet, offering orientations and answering mothers' questions, thus consolidating their knowledge on the subject and eliminating factors that might hinder its consolidation. Periodic evaluation of the child allows breastfeeding promotion to happen fully, provided that adequate knowledge about infant feeding is inherent to this practice<sup>[49]</sup>.

Children consultation is being developed in a non-integrated form, with fragmented orientations that are based on complaints, which compromises the valuation of the child as a developing human being. It is essential, therefore, to rethink child health practices, particularly emphasizing breastfeeding promotion, human resource training, family participation in care and guidance to mothers, with a view to holistic health care. In this sense, despite the countless difficulties met in everyday Family Health Strategy care, such as nursing staff's lack of awareness about the importance of their transformative role, change is necessary, not only through technical or scientific development, but also through respect for people, relationships and their subjectivities, rupturing with the biomedical model established in the reality of health services<sup>[50]</sup>.

Integrated work among all health professionals, especially nursing staff, since the start of prenatal care and throughout the child's monitoring in children consultations, is a decisive factor to establish and maintain extended breastfeeding<sup>[49]</sup>. In addition, nursing consultations combined with home visits are a strategy to provide education and care with a view to enhancing children's nutritional health, provided that they do not take narrow, interventionist and vertical forms. Professionals need sensitivity, however, to go beyond what one sees and hears, from the perspective of respect of social and cultural determinants<sup>[48]</sup>.

This difficulty of the Family Health Strategy to confront the traditional biomedical model and implement a new health care logic in Brazil is due to the fact that professionals have not yet assimilated the perspective of a new care model as an innovative strategy to restructure health actions, repelling the broader view of the health-disease process<sup>[51]</sup>.

Impairments resulting from this traditional "health production" form are challenging and a critical point to overcome this situation is human resource training for the SUS, considering that these professionals' education profile is still based on a fragmented, individual and cure-focused care logic<sup>[52]</sup>.



In this sense, curriculum changes in professional health education are required to go beyond the services' current reality<sup>[51]</sup>. Besides highlighting the importance of vocational training to change the health care model, it is essential to find ways to confront the current situation of professionals working in the system, with a view to mitigating the damage of inadequate and insufficient previous education and guaranteeing practices that are consistent with a holistic care model<sup>[52]</sup>. Breastfeeding support will only be a priority when managers invest in care organization, resource allocation and continuing education of human resources<sup>[53]</sup>.

#### 4.5 Limitations of the study

Despite concerns about the methodological rigor of observations, the possibility of bias during this stage is always present because it is based on subjective informations and data. Moreover, although it offers the possibility of a closer study and the exploration of reality, in this method of data collection the observer is visible to subjects being observed, which can cause changes in how they conduct their normal activities.

The study did not aim to question pregnant and breastfeeding women about the guidance and support received. Such information could be compared to those of health professionals, which would enrich the results.

We hope the results of this study will fill gaps in the scientific literature and create new pathways towards enhancing and encouraging the performance of nursing professionals of the Family Health Strategy in the promotion of breastfeeding.

### 5 Conclusions

Most Registered nurses' assertions about the development of breastfeeding promotion activities were not very consistent with practice, but nevertheless indicated awareness and intention. Their practical performance, however, was not consistent with the proposal of health promotion to go beyond the biological dimension of breastfeeding.

This discrepancy between what the professionals stated in the questionnaires and what they used to do in their practice in health services contradict the assumptions of the Family Health Strategy and provide opportunity for further studies to clarify this gap. Due to the burden of functions performed; managers' charge to perform a certain volume of procedures; staff turnover at the services; the lack of an education program and protocol for breastfeeding action; lack of partnerships with community groups for breastfeeding support and continuing health education and little knowledge on the subject figure among the motives why the existing potential in primary care services is not fully explored.

An implication for practice is the importance of further research to investigate the reasons why breastfeeding promotion activities are not accomplished. This will unveil this gap and permit the proposal of interventions to remedy nursing professionals' non-compliance / lack of interest in relation to this practice.

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