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Exclusive breastfeeding counseling at Women and Children Friendly Institutions of Bogotá D.C., Colombia

Consejería en lactancia materna exclusiva en Instituciones Amigas de la Mujer y la Infancia de Bogotá D.C., Colombia

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Abstract

Introduction: Exclusive breastfeeding is still limited in Colombia. Despite the strategies implemented to promote it, the goal established by the World Health Organization (WHO) regarding this practice is far from being achieved.
Objective: To describe the current situation of exclusive breastfeeding counseling at Women and Children Friendly Institutions (WCFI) of Bogotá D.C., Colombia.
Materials and methods: Cross-sectional descriptive study conducted in a sample of 76 counselors from 12 WCFI institutions who were administered a semi-structured questionnaire with open and closed questions. Descriptive statistics were used to analyze the numerical and categorical variables, and the NVivo 10 software was used to analyze the answers obtained through open questions.
Results: Qualified nurses and nursing assistants had the most contact with breastfeeding mothers (84% and 42% respectively). 91% of the participants had not been trained in exclusive breastfeeding counselling according to the WHO guidelines, while 60% of the sample considered that counseling only meant teaching and providing information to mothers on how to breastfeed.
Conclusion: Breastfeeding counseling training is focused on providing information on how to breastfeed, but not on developing counseling skills. Furthermore, there is no consensus among health staff that works as breastfeeding counselors about what exclusive breastfeeding counseling is.
Keywords: Counseling; Health Facilities; Breastfeeding; Health Personnel (MeSH).

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Resumen

Introducción. En Colombia la práctica de la lactancia materna exclusiva es baja y, pese a las estrategias implementadas para promoverla, aún falta mucho para cumplir con la meta establecida por la Organización Mundial de la Salud (OMS).
Objetivo. Describir la situación actual de la consejería en lactancia materna exclusiva (CLME) en Instituciones Amigas de la Mujer y la Infancia (IAMI) de Bogotá D.C., Colombia.
Materiales y métodos. Estudio descriptivo transversal. La muestra estuvo constituida por 76 consejeros (miembros del personal en salud) de 12 IAMI, a quienes se les aplicó una encuesta semiestructurada con preguntas cerradas y abiertas. Para el análisis de las variables numéricas y categóricas se empleó estadística descriptiva y para analizar las respuestas obtenidas mediante preguntas abiertas se usó el software N-Vivo versión 10.
Resultados. Los enfermeros y los auxiliares de enfermería fueron los consejeros que tuvieron mayor contacto con las madres lactantes (84% y 42% respectivamente). El 91% de los participantes no contaba con formación en CLME según los lineamientos de la OMS, mientras que para el 60% la consejería significaba enseñar o brindar información a las madres sobre cómo lactar.
Conclusión. La formación en consejería en lactancia materna se centra en brindar información sobre cómo lactar, mas no en desarrollar habilidades de consejería; además, no hay un consenso entre el personal de salud que se desempeña como consejero en lactancia materna sobre lo que significa la CLME.
Palabras clave: Instituciones de salud; Lactancia materna; Personal de salud (DeCS).

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Introduction

According to official figures, early initiation of breastfeeding (BF) and exclusive breastfeeding (EBF) up to the 6th month of life of the baby is not common in Colombia. Furthermore, the practice of EBF is actually decreasing: the 2010 National Nutritional Status Survey[1] reported that only 57% of babies started BF in the first hour after birth; the 2010 National Demographic and Health Survey[2] established that the median time of BF went from 2.2 months in 2005 to 1.8 months in 2010; and finally, the 2010 National Nutritional Status Survey[3] showed that the prevalence of BF went from 42.8% in 2010 to 36.1% in 2015.

One of the strategies implemented to promote BF in Colombia are the so-called Women and Child Friendly Institutions (IAMI by its acronym in Spanish), which are an adaptation of the program *Hospital Amigo de los Niños* (Children's Friendly Hospital). These institutions seek to encourage the practice of BF by fulfilling the *Ten Steps to Successful Breastfeeding* proposed by UNICEF.[4,5] These steps include breastfeeding counseling (BFC), an initiative implemented in the last 20 years to promote BF,[6,7] and its effectiveness is evident in the beginning, exclusivity, and duration of BF.[8-11]

In the IAMIs, counseling is regarded as a fundamental strategy for teaching mothers about the best way to feed their children, always taking into account what they feel and respecting their beliefs and needs.[12] Therefore, the health staff of these institutions are a fundamental actor for the fulfillment of the *Ten Steps*, from prenatal check-ups to hospital discharge, in what is called exclusive breastfeeding counseling (EBFC).

Colombia has guidelines that promote, protect, and support BF.[13,14] They specifically state that counseling should involve maternal and child care; however, the definition of said concepts and the way it should be done is not clear. In 2011, the relevance of the BFC was recognized, so the Ministry of Health and Social Protection of Colombia included the EBFC within the activities of health care and declared it as mandatory; this was ratified in 2018 through Resolution 3280.[15] Nevertheless, its execution has been challenging since the implementation of the IAMI initiative in health institutions authorized to provide maternal and child care is still very limited.[12,16]

Knowing how EBFC is being carried out and how it should be carried out based on the position of the health staff who have contact with the mothers in the IAMIs of Bogotá D.C., Colombia, makes it possible to strengthen and guide this strategy. Moreover, this could facilitate the provision of effective health care for pregnant and breastfeeding women, thus helping to improve the initiation and maintenance of EBF for the recommended 6 months. Therefore, the objective of this study was to describe the current situation of EBFC from the perspective of the health staff of the IAMIs in Bogotá D.C., Colombia.

Materials and methods

This is a cross-sectional descriptive study conducted on a sample of 76 counselors (health staff members) from 12 of the 17 health institutions that were accredited as IAMI in 2014, in Bogotá D.C., who agreed to participate in the study. Participants were selected by each of the IAMI mother and child service coordination offices or nutrition offices according to the criteria described below:

Inclusion criteria: Having received training in BFC according to the WHO guidelines,[17] which were adopted by Colombia as a requirement for performing EBFC at the IAMI or having a minimum experience of 3 months as a BF counselor.

Exclusion criteria: Not serving as a BF counselor at the IAMIs at the time of the study.

Participating counselors worked in the following facilities: delivery rooms, neonatal units, maternity wards, pumping rooms, and outpatient clinics.

Data were collected at three different times through a semi-structured survey of 52 questions: between March 15 and May 30, 2015; between August 15 and October 30, 2015; and in January 2016. The instrument, which was completed by one of the researchers or self-administered by the participants in the presence of the researcher, included the following information: i) general information on the health institution and the breastfeeding counselor, ii) data on the EBFC training received by the counselor, iii) data on the methodology implemented to teach EBFC in the institution, and iv) counselor's knowledge of EBFC. The survey was designed based on the 2009 WHO Infant and Young Child Feeding Guidelines[17] and some conceptual aspects developed for the research. To validate it, a pilot test was carried out with health staff trained in BFC according to the WHO guidelines.[17]

To assess EBFC in the IAMI, both dependent and independent variables were considered. Dependent variables included the EBFC activities carried out during pregnancy, postpartum and hospital discharge; the material used in EBFC; the difficulties reported when carrying out the EBFC; and the participants' knowledge of EBFC. Independent variables included concerns and problems of the mother identified by the interviewees; information on the type of health institution and the training of the breastfeeding committee and the BF support group; and some data on the staff from the institution who provide support to breastfeeding mothers, such as type of work contract, working hours, data on training in counseling (time, topics, methodology), and time of experience as a counselor.

Once the questionnaire was administered, it was verified that it had been completed in full and clearly; then, a database was created with the collected information. The acronym of each IAMI was used to develop this database and each participating counselor's information was coded with an order number for each institution to keep the information confidential. To categorize the answers to the open questions, an analysis was made using the N-Vivo Software version 10, and to analyze the results of the numerical and categorical variables, descriptive statistics were used using averages, frequencies, and proportions.

The survey was conducted upon obtaining the informed consent from the participants. The study took into account the ethical principles for medical research on human subjects established by the Declaration of Helsinki[18] and the provisions on health research of Resolution 8430 of 1993 issued by the Colombian Ministry of Health.[19] In addition, the project was reviewed and approved by the ethics committees of the Faculty of Medicine of the Universidad Nacional de Colombia according to Minutes No. 152-15 of September 23, 2015, and of the Faculty of Sciences of the Pontificia Universidad Javeriana according to Minutes No. 089, endorsed in

Minutes No.152 and the reference document 2015/218 of December 15, 2015.

Results

EBFC in the IAMIs

Of the 17 accredited IAMIs in Bogotá D.C., only 12 accepted to participate in the study. These institutions (7 private and 5 public) provided care of different levels and served the population of both the contributory and subsidized insurance regimes. None of the participating IAMIs had a system for monitoring the practice of EBF among the mothers and only 42% (n=5) contacted some of the mothers by phone to ask whether or not they were breastfeeding; however, the information obtained in these calls was not systematized.

EBF Counselors

In total, 76 questionnaires were administered at the participants' workplaces: 43 were self-completed and 33 were administered through a structured interview.

In terms of the characteristics of the participants, it was found that 99% (n=75) were female, 34% (n=26) had graduate studies, 72% (n=55) had a permanent employment contract, 68% (n=52) worked full time and 91% (n=69) had more than one year of work experience as a counselor.

91% of counselors had not received breastfeeding counseling training according to the WHO guidelines.[17] In this regard, 51 reported they had not been trained to work as breastfeeding counselors, and among those who claimed having been trained, only 12 said they had completed the WHO breastfeeding counseling training course (40 hours)[17]; however, out of these 12 counselors, 7 reported they had received training on counseling techniques related to the practical components of the course, including topics such as "how to approach nursing mothers", "how to counsel them" and "communication skills". Similarly, it was observed that the training in both topics received by those who reported being trained in counseling and the aspects they addressed when they were in contact with mothers had in common that they focused on the conceptual aspects of BF, the benefits, and the technique.

For 60% of those interviewed, BFC means teaching or giving information to the mother about breastfeeding, which they expressed with phases such as: "it is giving advice to the mother", "it is giving a talk to the mothers", "it implies having the knowledge and practice to educate and solve concerns", "teaching the mother how to feed her children, all the benefits that breastfeeding has, teaching them the correct positions, massage techniques." Furthermore, 95% said that breastfeeding is promoted through educational activities in which information materials such as brochures and primers are provided.

The health staff who had the most contact with the mothers during the breastfeeding process were nurses and nursing assistants (84% and 42%, respectively); in contrast, dietitian nutritionists (8%), general practitioners (6.6%) and other health professionals (speech therapists) (1.4%) had very little contact. Also, 71% of the nurses and nursing assistants had contact with the same mother more than once. The mothers were most contacted in the immediate postpartum period and least contacted in the gestation period.

Finally, 9% of the health staff focused on promoting EBF until the sixth month of life, while the remaining 91% addressed the issue in a general way, that is, they promoted EBF with complementary feeding up to the second year and beyond.

How EBFC is performed

55% of the participants indicated that BF training was provided in pairs to mothers and fathers during prenatal check-ups, individually to the mother in the immediate postpartum period (38%), and individually and in groups at hospital discharge (76%). During the discharge, the counseling was done when the mother went, with her partner or a relative (especially a woman), to the health institution for the newborn check-ups.

According to the health personnel interviewed, the main doubt that mothers have regarding breastfeeding is about the insufficient production of breast milk. This doubt appears from the beginning of the prenatal check-ups and persists until hospital discharge. Also, the main problems that mothers manifest are related to the physical alterations of the breasts and nipples.

Finally, it was found that 44% of the participants identified institutional barriers to providing BFC that included lack of time (50%); insufficient human resources (26.5%); limited material resources to support the counseling process, such as didactic devices, primers, brochures, etc. (14.7%); and lack of training and support (8.8%).

Discussion

This research showed that only a small number of the staff reported that they were trained as BF counselors; in other words, very few counselors received the 40 hours of training indicated by the WHO to train health staff in knowledge and skills that would enable them to acquire BF counseling competencies.[17]

The WHO course on Infant and Young Child Feeding Counseling[17] seeks to develop primarily two sets of skills: on the one hand, listening and learning, and on the other, confidence building and support. However, the BFC training reported by staff members had a theoretical and practical component focused on the breastfeeding technique and its benefits; similarly, it barely referred to the practical component related to counseling skills. All this indicates that there is a lack of BFC training, and that emphasis is on BF knowledge acquisition instead.

It should be noted that the WHO course[17] is a world reference in the training of human talent in BFC. This course aims to develop skills related, firstly, to the facilitating attitudes proposed by the American psychologist Carl Rogers, quoted by Mereira,[20] who is considered one of the greatest exponents of the so-called humanistic psychology, and, secondly, to the characteristics that Patterson[21] states that counselors should have: *empathy*, which refers to how the client's world, in this case the mothers, is perceived and understood from their perspective; *unconditional positive acceptance,* which consists of absolute respect for the client's individuality;

and *congruence or authenticity*, which is described as the degree of correspondence between what the counselor experiences and what he or she communicates to the client.[22]

Furthermore, it is important to note that the follow-up to the participants of a counseling course is fundamental and mandatory, as implied in the WHO document.[17] Nevertheless, this study found that there was no follow-up of the counselors who claimed to be trained in BFC and that the supervision of the functions performed by these professionals is far from what is established by the WHO. Therefore, it is necessary to establish protocols that determine the expected achievements, the difficulties usually encountered, and the adjustments required in each case, so that EBFC is fully developed.[17]

The results of this study show that the counselors interviewed do not differentiate clearly an EBFC course from a BF training course since their response to the question on EBFC training was that the trainings given by the institutions permanently to health staff usually last less than 6 hours and focus on BF information. This is relevant when considering that short training courses on EBFC, in addition to not meeting the time frame for a counseling course, are focused on teaching basically the physiology of the mammary gland and the proper breastfeeding technique, and do not provide information on aspects related to the development of counseling skills as such. As mentioned above, said aspects are indispensable for the mother to gain confidence in her ability to breastfeed and to solve doubts related to the practice of breastfeeding, and thus be able to successfully carry out the practice of EBF up to the 6th month.

There may be a trend among health care staff and the health care institution to consider that people who know about BF and have contact with mothers over a long period of time are counselors. For this reason, it is necessary to understand the importance of BFC so that health personnel are trained as such and, at the same time, mothers receive this counseling as a form of care.

According to the findings, it could be said that the activities carried out by the health staff interviewed to promote EBF are not typical of EBFC,[22,23] but are more associated with specific teaching activities or information provided to the mother on breastfeeding techniques and its benefits. It was also possible to see that EBFC is not focused on promoting exclusive breastfeeding up to the sixth month of life at any of the three moments when the mother is contacted, despite the many known benefits of this practice.[24]

On the other hand, the counselor staff interviewed agrees that insufficient milk production is the main concern of mothers since they attend the prenatal check-ups until hospital discharge. This finding is consistent with what is reported in the literature, being this a factor that limits the initiation and maintenance of BF.[25,26] However, because of the way counseling is carried out in Bogotá, it is not possible to support the mother in this aspect, a situation that is also consistent with the findings of other studies.[27,28]

In the present study, the health staff reported teaching (but not counseling) BF to couples during prenatal check-ups, individually to the mother in the immediate postpartum period, and individually and as a group at hospital discharge. This type of contact with the mother is consistent with what Bueno & Teruya[29] recommend in their review article. Likewise, several studies claim that the interventions carried out during these three moments are more effective than those carried out only in one and that if several methodologies are developed to accompany the mother instead of using only one method, especially if this accompaniment is focused on the mother's needs rather than on educational activities carried out in a general way, the positive effect of counseling will be more evident.[6,10,30]

Although this study reports that counseling is done both individually and in groups during hospital discharge, the real contact occurs when mothers approach the health institution. This is evidence that home visits are not made and that the IAMIs do little or no monitoring of BF, even though mothers have the greatest need for support regarding the difficulties that arise with breastfeeding in the postpartum period.[26,31-33]

It is noteworthy that some of the counselors interviewed identified barriers to doing EBFC, the most frequent being those related to the health institution. These findings are consistent with those reported in other studies; for example, Renshaw & Henderson[27] found that staff shortages were the cause of poor care and negative attitudes toward mothers, while Hall & Hauck[34] found that elements such as absent staff, multiple contacts with different health professionals, and caregivers with inflexible attitudes make BF more difficult.

It should be noted that besides the fact that the counseling offered to mothers is based on information and explanation, the health staff recognizes that knowledge about BF and EBFC is not unified within the IAMIs. This is a barrier to overcome in these institutions, as it prevents mothers from having clear information, specific support, and consistent messages.[35-37]

Conclusions

Breastfeeding counseling training focuses on providing information on how to breastfeed but not on developing counseling skills. In addition, there is no consensus among health care workers who serve as breastfeeding counselors about what EBFC means.

The health care staff interviewed saw themselves as EBF counselors, despite having minimal training in the subject, since they do so based on the time they have spent in contact with the mothers. Therefore, it is important to establish strategies for EBFC training and propose new ways of conceiving counseling in both BF and EBF and do the corresponding training.

Conflicts of interest

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