



“Successful breastfeeding is multifactorial. Healthcare professionals must continuously support mothers throughout their in-hospital journeys (birth to breastfeeding), adjusting practices that best meet their needs and expectations.”

# Carlos Carlomagno

Neonatologist  
Albert Einstein Hospital, Brazil

## Biography

I graduated from Medical School at Universidad de Monterrey, in Mexico and specialized in Pediatrics and Neonatology at Universidade de São Paulo, Brazil. I am a medical staff member at the Neonatology Department at Albert Einstein Hospital (Brazil) and I am currently studying for a master's degree in Health Science.

# Birth and in-hospital perinatal practices that ensure successful breastfeeding

The success of short- and long-term breastfeeding is multifactorial. It is unquestionable that a mother's milk contains the most appropriate nutritional and immunological composition for a baby's immediate and long-term health (including, higher cognitive development, as well as protection against sudden infant death syndrome, otitis, diarrhea, asthma, atopic dermatitis, and obesity)<sup>1</sup>. This is well established by the 1000 days nutrition program, as well as recommendations by the World Health Organization (WHO) and the UNICEF to breastfeed exclusively during the first 6 months of age<sup>2-3</sup>. Breastfeeding also benefits moms, who are more likely to undergo faster uterine involution, and increase fat deposits catabolism. Furthermore, this practice also increases the bond between mothers and their babies<sup>1</sup>.

But despite of all this knowledge, breastfeeding rates are still quite low worldwide. According to the Global Breastfeeding Scorecard, out of the 194 evaluated nations, only 23 (11,9%) rate above 60% of exclusive breastfeeding at 6 months<sup>4</sup>.

Guaranteeing the success of breastfeeding begins during pre-natal care and may also depend on several perinatal and in-hospital factors. Cochrane has conducted several meta-analysis over recent years to try to determine the impact of different practices on breastfeeding rates. Their evidence, however, are mostly moderate- to low-impact, due to inherent methodological limitations.

Healthcare professional-led education (midwives + nurses + doctors) in formal settings (promotion campaigns and counselling) improves rates of breastfeeding initiation compared to standard care (RR 1.53, 95% CI 1.07-1.92)<sup>5</sup>. Furthermore, all forms of organized support increased length of time women continued to breastfeed exclusively. Such help showed better results when scheduled (predictable), and may be provided by trained volunteers, doctors, and/or nurses (RR 0.91, 95% CI 0.88-0.96)<sup>6</sup>.

Continuous support by a person of the woman's choice (midwife, nurse, family or friend) is perceived as humanized and enhances woman confidence in their own strength and ability to give vaginal birth with lesser obstetric intervention (RR 1.08, 95% CI 1.04-1.12)<sup>7</sup>. However, it showed no difference whether babies were breastfed at 8 weeks of age (RR 1.05, 95% CI 0.96-1.16)<sup>7</sup>.

Hospital birth centers increase likelihood of no intrapartum analgesia/anesthesia, spontaneous vaginal birth (RR 0.88, 95% CI 0.78-1.00)<sup>8</sup>, and very positive feelings of care. But again, showed no difference whether babies remained breastfeeding at 6-8 weeks of age (RR 1.04, 95% CI 1.02-1.06)<sup>8</sup>.

Skin-to-skin contact, placing a newborn naked on mother's bare chest immediately (first 10 minutes of age) or soon after birth (from 10 minutes to 24 hours of age), increases chances of breastfeeding at 1-4 months after discharge (RR 1.24, 95% CI 1.07-1.43)<sup>9</sup>.

Rooming-in, keeping mothers and babies together throughout hospitalization, showed higher exclusive breastfeeding rates before hospital discharge (RR 1.92, 95% CI 1.34-2.76)<sup>10</sup>, but no difference between proportion of infants receiving any breastfeeding at 6 months of age (RR 0.84, 95% CI 0.51-1.39)<sup>10</sup>.

Kangaroo mother care during babies (usually premature) stay at neonatal intensive or semi-intensive care units found to increase breastfeeding at discharge (RR 1.16, 95% CI 1.07-1.25)<sup>11</sup> and at 1 to 3 months (RR 1.20, 95% CI 1.01-1.43)<sup>11</sup>.

Use of dextrose gel for treating hypoglycemia did not improve breastfeeding rates at 6 weeks of age (RR 1.06, 95% CI 0.88-1.29)<sup>12</sup>. Frenotomy in tongue-tied babies showed no consistent positive effect on infant breastfeeding performance assessed by validated scales (MD -0.07, 95% CI -0.63 to 0.48)<sup>13</sup>.

Breastfeeding has many positive benefits for both, babies and their moms. Despite WHO and UNICEF recommendations to maintain it exclusively until 6 months of age, and to continue until 2 years or beyond, breastfeeding rates globally low. Current literature shows mostly low- to moderate-quality evidence on what can be done during pre-natal and throughout hospital admission to stimulate such act. This is a challenge that requires active participation of engaged and enthusiastic multi-professional teams.

**References:** See page 30