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REVIEW

Current Approach in the Breastfeeding Process: Lactation Management Model

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Abstract

Breastfeeding behavior requires a comprehensive process. In studies, care and support practices for breastfeeding are discussed separately, and it is stated that these practices affect breastfeeding process positively. It is thought that there is no significant change in the national and international data due to the fact that these practices cannot be generalized, and women are not supported sufficiently from the pregnancy period to the end of the breastfeeding period in terms of initiating lactation. With this model, it is aimed to prolong the breastfeeding period and to provide breastfeeding only. When the literature is examined thematically, it was determined that care and support practices for breastfeeding were not handled as a whole and continuity was not ensured. Accordingly, a model including maintenance and support applications was developed. It was thought that there was a need for a model that includes comprehensive service, care, and support about breastfeeding, and this developed model was first used for mothers undergoing cesarean section. This model, which was developed for mothers after cesarean section, has made positive contribution to the breastfeeding criteria.

Keywords: Breastfeeding, lactation management, model

Introduction

Breastfeeding behavior requires a highly comprehensive process. The messages to be given about breastfeeding should focus on early initiation of breastfeeding, prolongation of breastfeeding duration, and effective breastfeeding (AAP, 2012).

The postpartum period is an important process in which the mother and infant try to adapt to each other. It is important to prepare the mother for the breastfeeding process physically and mentally (Boran, 2020). It is stated that mothers experience concerns and difficulties about breastfeeding such as low self-efficacy perception, pain, insufficient amount of milk, and confusion about information (Francis et al., 2020). Expectations of mothers about only breastfeeding, continuation of breastfeeding, and duration of breastfeeding cannot be met for various reasons (Santacruz-Salas et al., 2020).

All over the world, 41% of infants under 6 months are only given breast milk (UNICEF, 2019). In studies, care and support practices for breastfeeding (breast massage, warm compress, skin-to-skin contact, etc.) are discussed separately, and it is stated that these practices affect breastfeeding, breastfeeding amount, and breastfeeding duration positively (Anderson et al., 2016; Becker et al., 2016). In the systematic review conducted by Becker et al. (2016), it is stated that interventions such as resting, music, warm compress, massage, starting to use a breast pump, and increasing its frequency increase the amount of milk significantly. In international guidelines, it is emphasized that skin-to-skin contact, education, support, and early breastfeeding positively affect the breastfeeding process (NICE, 2015; WHO, 2017).

It is stated that the support and guidance provided to mothers by the hospital or primary healthcare personnel and their families contribute to them in terms of sustaining breastfeeding longer. In addition, the support of healthcare personnel is very important (Cleminson et al., 2015).

Background

In the early postpartum period, it is important to enable and maintain a holistic approach to ensure adequate lactation and appropriate breastfeeding (Pinar et al., 2009). It is thought that there is no significant change in the national and international data due to the fact that these practices cannot be generalized, and women are not supported

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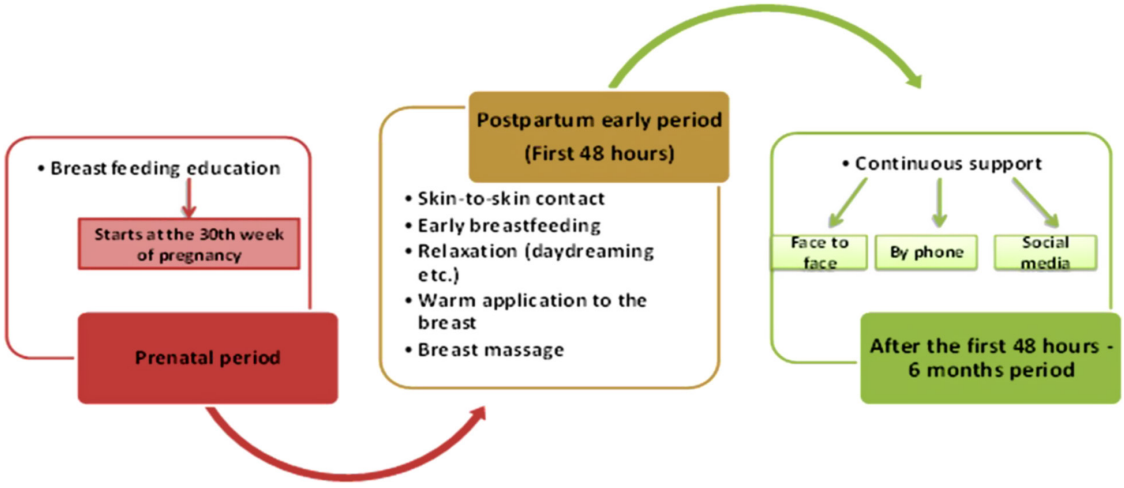

Figure 1.
Lactation management model (LMM).

sufficiently from the pregnancy period to the end of the breastfeeding period in terms of initiating lactation.

It was thought that there was a need for a model that includes comprehensive service and care and support for breastfeeding, and this developed model was first used for mothers undergoing cesarean section. The "Lactation Management Model" developed by Eker and Aslan (2019) (Figure 1) is very important in terms of covering care and support practices.

Theories and Models Used to Form the Lactation Management Model

Breastfeeding interventions will help overcome barriers to breastfeeding. Models and theories allow designing detailed plans to perform the behavior in the light of theoretical knowledge and enable women to better practice and maintain behaviors (Fawcett, 2005).

Lactation Management Model is based on the following models and theories and includes a series of care and practices with a holistic approach.

The Health Belief Model (HBM)

The Health Belief Model (HBM) is used to explain the change and maintenance of health-related behaviors and to support interventions aimed at changing health behavior (Champion and Skinner, 2008). A study conducted among breastfeeding women reveals that environmental factors activate the individual and the HBM is effective in realizing the desired behavior (Ogwezzy-Ndisika and Oloruntoba, 2016). It is also stated that the model stimulates lactation in mothers with premature infants (Liu et al., 2018).

Main Points

- A holistic view is needed to improve breastfeeding data.
- This model includes follow-up and a series of applications for 6 months postpartum starting from the pregnancy process.
- This model developed to provide lactation management and support breastfeeding is the first in the literature.
- It was used within the scope of the doctoral thesis and the breastfeeding results were found to be positive.

The Health Promotion Model (HPM)

The Health Promotion Model (HPM) model encourages healthcare professionals to enable positive resources to help people to reach behavioral changes. Practices that are carried out to increase health are discussed within the scope of HPM. Breastfeeding is a process that improves the health of the mother and the infant, and the Breastfeeding Motivation Program, which was developed based on HPM, is used to support breastfeeding (Khoshnood et al., 2018). It has been found that women participating in this program initiate breastfeeding earlier, have less problems with breastfeeding, and give less complementary food (formula) (Cangöl and Şahin, 2017).

The Behavioral Affective Associations Model

The Behavioral Affective Associations Model is a decision-making model, and this model states that the exhibited behaviors play an important role in behavior prediction and emphasizes that it should include a program designed to encourage behaviors and impact measures (Kiviniemi et al., 2007). Evaluation of emotional associations is quite effective in adopting the behavior. It has been detected that the mother's previous emotional experience with breastfeeding is largely related to her next breastfeeding behavior. Behavioral and affective relationships are associated with the duration and frequency of breastfeeding, and behavioral affective relationships explain the breastfeeding behavior (Pettis, 2010).

The Theory of Reasoned Planned Action Behavior (TRA) and Theory of Planned Behavior (TPB)

The Theory of Reasoned Planned Action Behavior (TRA) states that it is possible to explain why some behaviors are exhibited, the reasons for behaviors that are not exhibited, and to explain behaviors with the intentions that lead to the behavior of the person. It explains behavioral intention as "a

set of behaviors or actions that are necessary to complete an objective" (Al-Suqri and Al-Kharusi, 2015). The Theory of Planned Behavior (TPB) suggests that most of the behaviors are not fully under the voluntary control of the individual; therefore, it adds an additional component to TRA (perceived behavioral control) (Montaño and Kasprzyk, 2008). The Theory of Planned Behavior and TRA make positive contributions to the breastfeeding process. A previous study states that socio-cognitive factors measured by TPN significantly predict the breastfeeding intention and behavior in different time periods and emphasizes that the breastfeeding experience is more positive in terms of subjective norms (Swanson and Power, 2005).

The Theories of Behavioral Motivation and Implementation

This general theory named the theories of behavioral motivation and implementation, which provides an opportunity to plan ahead about possible problems that may develop and their solutions, can lead to the success of the objectives determined about breastfeeding (Gollwitzer, 1999). As a result of the study, it was determined that theories of behavioral motivation and implementation supported breastfeeding and positively affected the breastfeeding process (Pettis, 2010).

The Self-Efficacy Theory and Breastfeeding Self-Efficacy Theory

Self-efficacy theory associates the individual's status of performing a behavior as desired with the feeling that the individuals feel eligible or ineligible to perform that action. In the theory, it is stated that those who feel themselves eligible are more likely to perform the action and those who think they are ineligible are unlikely to perform the action. In this case, the individual's self-belief is highly important. Regardless of the theory type, the state of mind changes the level and strength of self-efficacy (Bandura, 1977). Influenced by Bandura's concept of self-efficacy, Cindy-Lee Dennis (1999) developed the "Breastfeeding Self-Efficacy Theory." Defining the sources of breastfeeding self-efficacy perception and the factors affecting it, Dennis states that mothers with high self-efficacy have no difficulty in finding solutions and encourage themselves by providing intrinsic motivation with positive thinking (Dennis, 1999). Breastfeeding self-efficacy is influenced by the previous experiences of the mother breastfeeding, the examples she sees from others, the support of the environment for breastfeeding, and the psychological state of the mother for breastfeeding (Blyth et al., 2002; Dennis, 1999). Social support is very important for the initiation, continuation, and prolongation of the duration of breastfeeding. Previous studies have revealed that breastfeeding self-efficacy increases as social support increases (Maleki-Saghooni et al., 2019; Ngo et al., 2019).

The Components of the Lactation Management Model

Face-to-Face Breastfeeding Training

Breastfeeding training is very important. The information to be given to the mother to learn breastfeeding appropriately does not contain complex messages (Fraser et al., 2019). The support given by healthcare professionals in the postpartum period and training these professionals according to international standards are very important. It is emphasized that this affects the woman's initiation of breastfeeding and the decision to continue breastfeeding at home (Burgio et al., 2016). Mothers receiving various trainings and consultancy during the pregnancy and postpartum period positively affect the breastfeeding process, and the consultancy support helps mothers to overcome breastfeeding problems (Francis et al., 2020; Rosen-Carole et al., 2019). In this context, within the scope of the model, face-to-face individual training is provided to mothers with the training material prepared in a computer environment (by using demonstration, question-answer, and discussion technique) accompanied by a breast milk and breastfeeding training booklet prepared in line with the literature. Before discharge from the hospital, the content of the breast milk and breastfeeding booklet is explained and given to the family in order to provide guidance at home.

Relaxation technique

Oxytocin release is significantly affected by psychological state and senses (Buckley, 2015). Techniques affecting the mind and soul such as hypnotism and yoga enable relaxation and increase breast milk production by stimulating prolactin and oxytocin secretion (Dini et al., 2017; Sari et al., 2017; Wildan and Primasari, 2017). Accordingly, within the scope of the model, since it provides psychological relaxation, the dreaming technique can be taught to mothers and applied before breastfeeding (3 minutes postop 0: 12 $\times$ 1, when sleeping 4 $\times$ 1, postop 1: 8 $\times$ 1, postop 2: 4 $\times$ 1). In order to provide relaxation, a quiet and dim environment is provided, the woman is asked to take the position that she is most comfortable with, and relaxation is enabled with the following sentences: "Close your eyes, relax your whole body, think that all your muscles starting from your toes to your head are relaxed. Imagine yourself in a peaceful and quiet place where you want to be."

Skin-to-skin contact

It is known that providing skin-to-skin contact increases the success of breastfeeding and affects the time of the first breastfeeding, the arrival of breast milk after birth, the situation of having problems in breastfeeding, giving the baby food other than breast milk, and the frequency of breastfeeding (Karimi et al., 2019). Early (immediately after birth, if possible) skin-to-skin contact increases the rate of early breastfeeding and is useful in prolonging the duration of breastfeeding (Lau et al., 2018; Moore et al., 2016). Women, who apply skin-to-skin contact after cesarean section, have a high rate of effective breastfeeding (Moore et al., 2016). Accordingly, skin-to-skin contact is started in the operating room within the scope of the model, and the mother is expected to continue this practice with the support of the family in the next process. In the operating room, skin-to-skin contact is performed immediately after the baby is born, as soon as the umbilical cord is cut, as naked, by placing the baby on the mother's bare skin (tummy/breast), and the baby stays there

until at least the first breastfeeding is finished. A towel or blanket is covered on the back of the baby to prevent temperature loss.

Early breastfeeding

It is emphasized that initiating breastfeeding in the postpartum first hour has positive effects, and all mothers should be supported to initiate breastfeeding in the early period (WHO, 2017). Initiating early breastfeeding increases the rates of continuous and long-term breastfeeding, and initiating breastfeeding is associated with starting early complementary food and shortening the breastfeeding period (Engstrom et al., 2013). The desire to suck in healthy-born infants is evident within the first 15–20 minutes after birth, but in the following minutes, sucking becomes difficult by entering into the state of sleep (WHO, 2017). Accordingly, within the scope of the model, all mothers in the operating room start skin-to-skin contact with the infant immediately after the birth, and it is ensured that they realize breastfeeding (in the first half an hour). In order to ensure early breastfeeding, the most comfortable position for the mother and the infant is provided, and the breastfeeding process is supported by the nurse by leaving it to its natural process without much intervention.

Breast massage

Breast massage during breastfeeding helps to relax, reduces pain and tension, stimulates the let-down reflex, increases milk production, and increases some substances (protein, lipid, saccharide, and trace nutrients) in milk (Anderson et al., 2016; Cho et al., 2012; Foda et al., 2004). In this context, within the scope of the model, the breast massage technique is taught to the mother and the supporting family member, and before each breastfeeding, this technique is applied (5 minutes hand milking, 2 minutes nipple stimulation, and 3 minutes effleurage). Massage frequency is as follows: 12×1 when awake and 4×1 when sleeping on the day of surgery, 8×1 on the first postoperative day, and 4×1 on the second postoperative day. The performance of the practices is followed, and support is provided when necessary.

Warm compress

A warm compress supports the flow of milk. Ready-to-apply warm compresses, a heated towel, a hot wet cloth, or a hot shower can be used for this application (Kent et al., 2011). Accordingly, within the scope of the model, the mother and the supportive family member are taught how to perform a warm compress, and the mother is asked to perform this application before each breastfeeding. Hot application is applied to all breast tissue with the nipple exposed. With 39°C gel pads whose temperature is measured with a barbecue thermometer, it is applied for 5 minutes as 12×1 on the day of the operation and 4×1 when sleeping, 8×1 on the first postoperative day, and 4×1 on the second postoperative day. The performance of the practices is followed, and support is provided when necessary.

Breastfeeding support

In order for breastfeeding rates to be at the desired level, mothers should be encouraged and supported about breastfeeding (Evidence level A) (NICE, 2015). It is stated that the sources of support affecting the process are the spouse, family and professional breastfeeding consultant. Initiation of breastfeeding, giving only breast milk, and continuing breastfeeding appropriately for at least 6 months are very important (Dasheka and Rala, 2020). Support provided at the hospital and subsequent professional consultation over the phone lead to higher rates of breastfeeding and enable the continuation of the process (Daou et al., 2020). Within the scope of this model, breastfeeding support is initiated in the operating room and provided until discharge from the hospital (the first 48 hours) and then the mother is called on the first day after discharge, she is called to the clinic on the 9th day after birth, and is called by the nurse once a month for 6 months. In addition, it is ensured that the mother gets in contact with the nurse whenever she needs (face-to-face, by phone, and via social media).

Conclusion

It was thought that there was a need for a model that included comprehensive service and care and support for breastfeeding, and this developed model was first used for mothers who had a cesarean section. As a result of the study, it was determined that the lactation management model made significant contributions to breastfeeding (Eker and Aslan, 2019). It is recommended that the model should be initiated from the pregnancy period, be tested in different sample groups, and actively used in the field.

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