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Health professionals' breastfeeding practices and associated factors: a cross-sectional study

Prática de profissionais de saúde em aleitamento materno e fatores associados: estudo transversal

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ABSTRACT

Objective: To analyze primary care health professionals' breastfeeding practices and associated factors. **Method:** A cross-sectional and analytical study was carried out with all health professionals working in breastfeeding support in five primary healthcare units, through a self-administered questionnaire. The chi-square test was used with a significance level of 5% to analyze the association of categorical variables with professional practice. **Results:** Thirty-eight professionals participated. There was a statistically significant association (p=0.04597) between the variable update on breastfeeding in the last five years and the practice of implementing breastfeeding through support groups. Clinical management, guidance on maternal rights, and support for resolving difficulties in breastfeeding were less reported. **Conclusion:** The practice of health professionals showed weaknesses, highlighting the need for professionals and managers to value the breastfeeding issue through strategies that include continuous training and monitoring of breastfeeding in the primary healthcare network.
Descriptors: Breast Feeding; Health Personnel; Primary Health Care.

RESUMO

Objetivo: Analisar a prática dos profissionais da saúde da atenção básica quanto ao aleitamento materno e fatores associados. **Método:** Estudo transversal, analítico, realizado com todos os profissionais da saúde atuantes em aleitamento materno de cinco unidades da atenção básica através de questionário autoaplicável. Para análise da associação das variáveis categóricas com a prática profissional, utilizou-se teste Qui-quadrado com nível de significância de 5%. **Resultados:** Participaram 38 profissionais. Houve associação estatística significativa (p=0.04597) entre a variável atualização em aleitamento materno nos últimos cinco anos e a prática de implementação em grupos de apoio. O manejo clínico, a orientação quanto aos direitos maternos e o apoio para a resolução de dificuldades na amamentação foram menos informados. **Conclusão:** A prática dos profissionais da saúde apresentou fragilidades evidenciando a necessidade de valorização do tema por profissionais e gestores através de estratégias que incluam capacitação contínua e monitoramento do aleitamento materno na rede de atenção básica.
Descritores: Aleitamento Materno; Pessoal de Saúde; Atenção Primária à Saúde.

INTRODUCTION

The association of breastfeeding (BF) with benefits for the health of the infant and mother, in the short and long term, has been widely publicized in the scientific literature, standing out as one of the best strategies for reducing infant mortality. In Brazil, even with the increase in the prevalence of BF over the years, this practice is often interrupted early, due to a multifactorial etiology[1].

In addition to the biopsychosocial and cultural factors of mothers, fathers, and families involved in breastfeeding, the practice of health professionals can also impact early weaning. Studies[2-4] indicate an association between the practices of health professionals regarding the initiation and maintenance of BF, highlighting, as important actions, prenatal guidance, clinical management of postpartum intercurrences, and monitoring of the mother-child

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dyads in primary healthcare facilities, a context in which the pregnant/nursing mother has greater contact in the pregnancy-puerperal cycle, and professionals place the population's health needs into perspective over time.

Despite the essential role of health professionals regarding BF being well described in the scientific literature and Brazilian public health policies, the promotion of breastfeeding is still a challenging process, highlighting the lack of updates and knowledge as important aspects that influence the approach to women and the clinical management of breastfeeding[5,2].

Therefore, investigating the practice of primary care health professionals regarding BF will allow the identification of difficulties and, based on them, elaborating strategies for interventions that make it possible to qualify this practice and contribute to improving BF prevalence rates, even in a local or regional context. Thus, the study aims to analyze primary care health professionals' breastfeeding practices and associated factors.

METHOD

A cross-sectional, analytical study, guided by the STROBE tool, was conducted in five primary healthcare units (one basic unit, two polyclinics, and two family doctor units) in the city of Niterói, Rio de Janeiro, selected based on the three unit models existing, the number of attendances, the easy access, and the good receptivity to the research. A trained team collected data from November/2018 to June/2019.

Health professionals working with BF support were considered eligible. Inclusion criteria were working in centers that routinely assist pregnant women, nursing mothers, and newborns, providing prenatal care, child care, immunization, and neonatal screening, or conducting home visits to these patients. These were accounted only once for the professionals who worked in more than one of the surveyed units.

The professionals were recruited individually after signing the free and informed consent form. The professionals answered the questionnaire in a private room, before or after working hours, according to their choice. Two questionnaires were prepared according to the specificity of the professional's work, based on the scientific literature and public policies related to breastfeeding[6-9].

Graduate professionals answered a questionnaire divided into two parts: one for characterization, with the independent variables sex, age, education, time of professional experience and work in primary care, and participation in courses/training/workshops on BF in the last five years and the last year. The second part consisted of a checklist with 19 items of dependent variables on BF practice, with the items on the Likert scale as a response pattern: "never", "rarely", "often", "usually," and "always".

The community health agents (CHA) answered a questionnaire with characterization variables plus the variable length of time working in the current team, and the second part consisted of 18 questions about their practice. This study had as its main outcome the practice of primary care health professionals regarding BF. The sample consisted of all health professionals who work with BF support in the mentioned units, making this a census study.

Data were double-entered into an Excel 2010 spreadsheet. Numerical variables were represented by medians and quartiles, and categorical variables by absolute and relative frequencies. The statistical software R Core Team (2019) was used to test for associations.

The practice of graduate professionals was analyzed through the answers to the Likert items, using the sum of the frequencies of responses in each category considered correct[6-7], grouping the categories "often", "generally," and "always" for positive answers, and "never" and "rarely" for negative ones, making a score for each item. Correct answers (positive or negative) represented an adequate practice (AP).

For the statistical analyses, the practice of graduate professionals was classified as adequate (YES) and not adequate (NO) and associated with the exposure variables, length of professional experience, length of experience in primary care, and participation in BF courses/training/workshops in the last five years and the last year. The Chi-square test was used, and results that presented p values <0.05 were considered statistically significant. Descriptive statistics were used to analyze the CHA's practice[8-9].

Ethical precepts were respected per Resolution 466/2012 of the National Health Council under the approval of opinion No. 2,507,525, with confidentiality and anonymity guaranteed to participants.

RESULTS

The study included 38 health professionals (13 nurses, 9 physicians, 3 dentists, 2 speech thera-

pists, 1 nutritionist, 1 psychologist, and 9 CHA), characterized in Table 1.

Table 2 presents the individual and collective care activities performed by the graduate professionals.

Table 1 - Characterization of health professionals involved with breastfeeding (n=38). Niterói, RJ, Brazil, 2019

Variables	Graduate professionals (n=29) N (%)	CHA (n=9) N (%)
Sex		
Female	25 (86.2)	9 (100)
Male	4 (13.8)	-
Age (years)	47 (38-56)*	36 (35-44)*
Training		
Complete high school		8 (88.9)
College	27 (93.1)	1 (11.1)
Specialization	22 (81.5)	-
Master's degree	2 (6.9)	-
Professional experience time		
< 5 years	2 (6.9)	1 (11.1)
5-10 years	4 (13.8)	2 (22.2)
> 10 years	23 (79.3)	2 (22.2)
No answer	-	4 (44.4)
Time working in primary care		
< 5 years	2 (6.9)	6 (66.7)
5-10 years	12 (41.4)	3 (33.3)
> 10 years	15 (51.7)	-
Time working in the current team		
< 5 years	-	6 (66.7)
5-10 years	-	3 (33.3)
> 10 years	-	-
Participation in courses/training/workshops on breastfeeding in the last 5 years		
Yes	12 (41.4)	4 (44.4)
No	16 (55.2)	5 (55.6)
No answer	01 (3.4)	
Participation in courses/training/workshops on breastfeeding in the last year		
Yes	3 (10.3)	-
No	26 (89.7)	9 (100.0)

Source: Prepared by the authors, 2019.
Caption: *Median (first quartile – third quartile)

Table 2 – Adequate practice of higher education health professionals related to breastfeeding (n = 29). Niterói, RJ, Brazil, 2019

Statement	N (n%)	R (n%)	O (n%)	U (n%)	A (n%)	NA (n%)	AP (n%)
A1. I observe/accept advertising and donations of infant formulas, bottles, and pacifiers at the health unit.	19 (67.8)	7 (25.0)	–	2 (7.1)	–	1 (3,4)	26 (92.8)
A2. I guide pregnant/nursing mothers about their rights (maternity leave, paternity leave, job guarantee, right to daycare, etc.).	3 (10.7)	6 (21.4)	2 (7.1)	4 (14.2)	13 (46.4)	1 (3,4)	19 (67.7)
A3. I guide the father/family about their rights (maternity leave, paternity leave, guarantee of the mother's job, right to daycare, etc.).	3 (10.7)	8 (28.5)	2 (7.1)	3 (10.7)	12 (42.8)	1 (3,4)	17 (60.6)
A4.I guide mothers about the advantages/benefits of breastfeeding.	–	2 (7.1)	1 (3.5)	2 (7.1)	23 (82.1)	1 (3,4)	26 (92.7)
A5. I advise on the importance of exclusive breastfeeding in the first 6 months and supplemented until 2 years of life or more.	1 (3,4)	1 (3,4)	3 (10.3)	1 (3,4)	23 (79.3)	–	27 (93.0)
A6.I implement/participate in breastfeeding support groups accessible to all pregnant women/nursing mothers seeking to involve family members.	12 (41.3)	7 (24.1)	4 (13.7)	2 (6.8)	4 (13.7)	–	10 (34.2)
A7. I advise that early and uninterrupted skin-to-skin contact between mother and baby should be facilitated and encouraged as soon as possible after birth.	4 (14.2)	1 (3.5)	3 (10.7)	2 (7.1)	18 (64.2)	1 (3,4)	23 (82.0)
A8. I advise mothers on the importance of breastfeeding in the first hour after childbirth and staying with the baby in a rooming-in during the day and night.	7 (25.0)	1 (3.5)	2 (7.1)	5 (17.8)	13 (46.4)	1 (3,4)	20 (71.3)
A9. I advise mothers to breastfeed and maintain lactation through manual milking, even if they are temporarily separated from their children.	4 (14.8)	2 (7.4)	1 (3.7)	4 (14.8)	16 (59.2)	2 (6.8)	21 (77.7)
A10. I guide persons about the clinical management of breastfeeding (positioning, attachment, etc.) in my work sector.	4 (14.2)	1 (3.5)	1 (3.5)	4 (14.2)	18 (64.2)	1 (3,4)	23 (81.9)
A11. I assist/guide the mother individually with doubts about breastfeeding.	2 (7.1)	3 (10.7)	1 (3.5)	5 (17.8)	17 (60.7)	1 (3,4)	23 (82.0)
A12. I encourage breastfeeding on demand.	1 (3.5)	–	2 (7.1)	3 (10.7)	22 (78.5)	1 (3,4)	27 (96.3)
A13. I listen to mothers' concerns, experiences, and doubts about breastfeeding, supporting them and strengthening their self-confidence.	2 (6.8)	-	3 (10.3)	2 (6.8)	22 (75.8)	–	27 (92.9)
A14. I offer practical support to mothers to initiate and establish breastfeeding and manage their common difficulties.	3 (10.3)	3 (10.3)	5 (17.2)	2 (6.8)	16 (55.1)	–	23 (79.1)
A15. I support/orient mothers to recognize their babies' feeding, closeness, and comfort signals.	2 (6.8)	3 (10.3)	4 (13.7)	2 (6.8)	18 (62.0)	–	24 (82.5)
A16. I discourage mothers from giving any foods or liquids other than breast milk unless clinically indicated.	2 (6.8)	1 (3,4)	1 (3,4)	3 (10.3)	22 (75.8)	–	26 (89.5)
A17. I guide mothers about infant formula, bottle, and pacifier risks.	1 (3,4)	2 (6.8)	2 (6.8)	5 (17.2)	19 (65.5)	–	26 (89.5)
A18. In case of a medical prescription for breast milk or other foods/medicines, I advise mothers to use cups/cups or spoons instead of bottles to offer them.	1 (3,4)	3 (10.3)	3 (10.3)	4 (13.7)	18 (62.0)	–	25 (86.0)
A19. I guide mothers about lactational amenorrhea and other contraceptive methods suitable for breastfeeding.	7 (24.1)	4 (13.7)	1 (3,4)	7 (24.1)	10 (34.4)	–	18 (61.9)

Source: Prepared by the authors, 2019.
Caption: N: never; R: rarely; O: often; U: usually; A: always; NA: no answer; AP: adequate practice.

Table 3 presents the variables' length of professional experience and time working in primary care for higher-level professionals and their relationship with adequate practice.

Table 4 presents the results referring to courses/training/workshops attended by the graduate professionals in the last five years and the last year, and the relationship between this variable and adequate practice.

Table 3 – Association between professional experience and primary care experience with appropriate breastfeeding practice among graduate professionals (n = 29). Niterói, RJ, Brazil, 2019

AP		Professional experience in years			p-value*	Primary care experience in years			p-value*
		<5 n%	5-10 n%	>10 n%		<5 n%	5-10 n%	>10 n%	
A1 (n=28)	Yes	2(7.7)	4(15.4)	20(76.9)	1	2(7.7)	11(42.3)	13(50.0)	0.563
	No	0(0.0)	0(0.0)	2(100.0)		0(0.0)	0(0.0)	2(100.0)	
A2 (n=28)	Yes	2(10.5)	2(10.5)	15(79)	0.617	2(10.5)	8(42.1)	9(47.4)	0.582
	No	0(0.0)	2(22.2)	7(77.8)		0(0.0)	3(33.3)	6(66.7)	
A3 (n=28)	Yes	2(11.8)	1(5.9)	14(82.3)	0.252	2(11.8)	6(35.3)	9(52.9)	0.717
	No	0(0.0)	3(27.3)	8(72.7)		0(0.0)	5(45.5)	6(54.5)	
A4 (n=28)	Yes	2(7.7)	3(11.5)	21(80.8)	0.388	2(7.7)	10(38.5)	14(53.8)	1
	No	0(0.0)	1(50.0)	1(50.0)		0(0.0)	1(50.0)	1(50.0)	
A5 (n=29)	Yes	2(7.4)	4(14.8)	21(77.8)	1	2(7.5)	12(44.4)	13(48.1)	0.556
	No	0(0.0)	0(0.0)	2(100.0)		0(0.0)	0(0.0)	2(100.0)	
A6 (n=29)	Yes	0(0.0)	2(20.0)	8(80.0)	0.641	1(10.0)	6(60.0)	3(30.0)	0.215
	No	2(10.5)	2(10.5)	15(79.0)		1(5.3)	6(31.6)	12(63.1)	
A7 (n=28)	Yes	2(8.7)	3(13.0)	18(78.3)	1	2(8.7)	10(43.5)	11(47.8)	0.569
	No	0(0.0)	1(20.0)	4(80.0)		0(0.0)	1(20.0)	4(80.0)	
A8 (n=28)	Yes	2(10.0)	2(10.0)	16(80.0)	0.588	2(10.0)	9(45.0)	9(45.0)	0.840
	No	0(0.0)	2(25.0)	6(75.0)		0(0.0)	3(37.5)	5(62.5)	
A9 (n=27)	Yes	2(9.5)	3(14.3)	16(76.2)	1	2(9.5)	9(42.9)	10(47.6)	0.797
	No	0(0.0)	1(16.7)	5(83.3)		0(0.0)	2(33.3)	4(66.7)	
A10 (n=28)	Yes	2(8.7)	3(13.1)	18(78.2)	1	2(8.7)	10(43.5)	11(47.8)	0.569
	No	0(0.0)	1(20.0)	4(80.0)		0(0.0)	1(20.0)	4(80.0)	
A11 (n=28)	Yes	2(8.7)	3(13.1)	18(78.2)	1	2(8.7)	9(39.1)	12(52.2)	1
	No	0(0.0)	1(20.0)	4(80.0)		0(0.0)	2(40.0)	3(60.0)	
A12 (n=28)	Yes	2(7.4)	4(14.8)	21(77.8)	1	2(7.4)	12(44.4)	13(48.1)	1
	No	0(0.0)	0(0.0)	1(100.0)		0(0.0)	0(0.0)	1(100.0)	
A13 (n=29)	Yes	2(7.4)	4(14.8)	21(77.8)	1	2(7.5)	12(44.4)	13(48.1)	0.556
	No	0(0.0)	0(0.0)	2(100.0)		0(0.0)	0(0.0)	2(100.0)	
A14 (n=29)	Yes	2(8.7)	4(17.4)	17(73.9)	0.716	2(8.7)	11(47.8)	10(43.5)	0.266
	No	0(0.0)	0(0.0)	6(100.0)		0(0.0)	1(16.7)	5(83.3)	
A15 (n=29)	Yes	2(8.3)	3(12.5)	19(79.2)	1	2(8.3)	10(41.7)	12(50)	1
	No	0(0.0)	1(20.0)	4(80.0)		0(0.0)	2(40.0)	3(60.0)	
A16 (n=29)	Yes	2(7.7)	3(11.5)	21(80.8)	0.515	2(7.7)	11(42.3)	13(50.0)	1
	No	0(0.0)	1(33.3)	2(66.7)		0(0.0)	1(33.3)	2(66.7)	
A17 (n=29)	Yes	2(7.7)	3(11.5)	21(80.8)	0.515	2(7.7)	11(42.3)	13(50.0)	1
	No	0(0.0)	1(33.3)	2(66.7)		0(0.0)	1(33.3)	2(66.7)	
A18 (n=29)	Yes	1(4.0)	3(12.0)	21(84.0)	0.179	1(4.0)	11(44.0)	13(52.0)	0.339
	No	1(25.0)	1(25.0)	2(50.0)		1(25.0)	1(25.0)	2(50.0)	
A19 (n=29)	Yes	1(5.5)	3(16.7)	14(77.8)	1	1(5.6)	10(55.5)	7(38.9)	0.099
	No	1(9.1)	1(9.1)	9(81.8)		1(9.1)	2(18.2)	8(72.7)	

Source: Prepared by the authors, 2019.
Caption: AP: Adequate practice; * Chi-square test.

Table 4 – Distribution of variables related to the updating of graduate healthcare professionals on breastfeeding, and their correlation with adequate practice (n = 29). Niterói, RJ, Brazil, 2019

AP		Update conducted in the last 5 years		p-value	Update conducted in the last year		p-value
		Yes n%	No n%		Yes n%	No n%	
A1 (n=28)	Yes	11(42.3)	15(57.7)	1	3(11.5)	23(88.5)	1
	No	1(50.0)	1(50.0)		0(0.0)	2(100.0)	
A2 (n=28)	Yes	8(42.1)	11(57.9)	1	3(15.8)	16(84.2)	0.5302
	No	4(44.4)	5(55.6)		0(0.0)	9(100.0)	
A3 (n=28)	Yes	9(52.9)	8(47.1)	0.253	3(17.6)	14(82.4)	0.2579
	No	3(27.3)	8(72.7)		0(0.0)	11(100.0)	
A4 (n=28)	Yes	11(42.3)	15(57.7)	1	3(11.5)	23(88.5)	1
	No	1(50.0)	1(50.0)		0(0.0)	2(100.0)	
A5 (n=29)	Yes	11(40.7)	16(59.3)	1	3(11.1)	24(88.9)	1
	No	1(50.0)	1(50.0)		0(0.0)	2(100)	
A6 (n=29)	Yes	7(70.0)	3(30.0)	0.04597	2(20.0)	8(80.0)	0.2668
	No	5(26.3)	14(73.7)		1(5.3)	18(94.7)	
A7 (n=28)	Yes	12(52.2)	11(47.8)	0.0525	3(13.0)	20(87.0)	1
	No	0(0.0)	5(100.0)		0(0.0)	5(100.0)	
A8 (n=28)	Yes	10(50.0)	10(50.0)	0.09872	3(15.0)	17(85.0)	0.536
	No	1(12.5)	7(87.5)		0(0.0)	8(100.0)	
A9 (n=27)	Yes	11(52.4)	10(47.6)	0.1819	3(14.3)	18(85.7)	1
	No	1(16.7)	5(83.3)		0(0.0)	6(100.0)	
A10 (n=28)	Yes	11(47.8)	12(52.2)	0.3553	3(13.0)	20(87.0)	1
	No	1(20.0)	4(80.0)		0(0.0)	5(100.0)	
A11 (n=28)	Yes	12(52.2)	11(47.8)	0.0525	3(13.0)	20(87.0)	1
	No	0(0.0)	5(100.0)		0(0.0)	5(100.0)	
A12 (n=28)	Yes	12(44.4)	15(55.6)	1	3(11.1)	24(88.9)	1
	No	0(0.0)	1(100.0)		0(0.0)	1(100.0)	
A13 (n=29)	Yes	12(44.4)	15(55.6)	0.4975	3(11.1)	24(88.9)	1
	No	0(0.0)	2(100.0)		0(0.0)	2(100.0)	
A14 (n=29)	Yes	10(43.5)	13(56.5)	1	3(13.0)	20(87.0)	1
	No	2(33.3)	4(66.7)		0(0.0)	6(100.0)	
A15 (n=29)	Yes	11(45.8)	13(54.2)	0.3701	3(12.5)	21(87.5)	1
	No	1(20.0)	4(80.0)		0(0.0)	5(100.0)	
A16 (n=29)	Yes	12(46.2)	14(53.8)	0.2463	3(11.5)	23(88.5)	1
	No	0(0.0)	3(100.0)		0(0.0)	3(100.0)	
A17 (n=29)	Yes	11(42.3)	15(57.7)	1	3(11.5)	23(88.5)	1
	No	1(33.3)	2(66.7)		0(0.0)	3(100.0)	
A18 (n=29)	Yes	11(44.0)	14(56.0)	0.6221	3(12.0)	22(88.0)	1
	No	1(25.0)	3(75.0)		0(0.0)	4(100.0)	
A19 (n=29)	Yes	9(50.0)	9(50.0)	0.2732	3(16.7)	15(83.3)	0.2685
	No	3(27.3)	8(72.7)		0(0.0)	11(100.0)	

Source: Prepared by the authors, 2019.
Caption: AP: Adequate practice; * Chi-square test.

As for the practice of the CHAs, 44.4% reported carrying out active case-finding in the assigned area, 33.3% reported assisting women only by spontaneous demand, 22.2% both ways and 66.7% of respondents reported that home visits (HV) were the primary strategy used for active case-finding. A rate of 88.9% of respondents reported conducting a home visit (HV) after a woman gives birth to check if she has returned to the community.

Regarding the frequency of HV to mothers with children up to six months, 77.7% reported that the healthcare facility established the home visit, 44.4% reported performing HV monthly, and 33.3% weekly. A rate of 88.9% of respondents reported conducting the first home visit (HV) when the baby was between 3-7 days old, while 11.1% reported conducting it with babies aged 8-15 days old. Also, a rate of 88.9% of the professionals gave BF guidelines on the first HV, and 66.7% reported observing breastfeeding and correcting possible errors.

Regarding group participation, 77.8% reported participation in groups for pregnant women and family planning, 55.6% reported that guidance on BF is given in almost all meetings and 22.2% in just a few meetings. When asked if they considered themselves able to observe breastfeeding and guide the mother, 77.8% answered yes. The most frequent guidelines about BF provided to mothers were giving information about the non-existence of weak milk (100%), the importance of exclusive breastfeeding for up to six months (88.9%), not offering a bottle (77.7%), and not offering a pacifier (66, 7%). Mothers with breastfeeding difficulties, such as breast engorgement and mastitis, were referred to the unit by 88.9%.

Regarding qualification, 55.6% did not carry out any training/updating in BF in the last five years. Seventy-five percent of those who reported training or updating in AM obtained it through the healthcare facility where they work. In the last year, no CHAs made any updates in BF.

DISCUSSION

This study highlights weaknesses in the practices of healthcare professionals regarding BF, particularly concerning the implementation and participation of BF support groups. This issue was associated with higher-level healthcare professionals' training and professional development within the past five years. Support groups are essential for disseminating information, identifying and discussing maternal difficulties, and providing support, especially for mothers already at home and taking on the task of breastfeeding autonomously. Despite being a recommended strategy for guiding pregnant women and their families, as outlined in the 10th step for successful BF, many women do not have access to, or choose not to participate in, support groups[5].

Primary care units must take responsibility for providing updates to their professionals on different topics, procedures, care flows, and other aspects of the healthcare scenario through their managers. Studies[2,10] have indicated that better service performance is associated with, among other factors, better qualifications of professionals to develop practices that value the promotion, protection, and support of BF.

A systematic review[4] on forms of support for BF pointed out the main result: the need for professionals trained in approaching pregnant women and nursing mothers, emphasizing the importance of active listening, ways of reassuring mothers, praising them, obtaining information, and providing opportunities for women to discuss their problems. These are considered essential attributes for maintaining BF. In Brazil, the *Estratégia Amamenta e Alimenta Brasil* strategy was launched in 2012 to qualify the work process of primary care professionals within the scope of the Unified Health System. As a principle, permanent education is essential, including the training of tutors and workshops in basic health units[11].

Graduate professionals partly informed that they guide mothers, fathers, and family members regarding their rights, such as maternity leave, important protection for exclusive breastfeeding[12]. In Brazil, working mothers are legally entitled to 120-day maternity leave, yet many health professionals must-incorporate this guideline into their practice. This lack of adherence highlights a disregard for protecting maternal rights, despite the country having the necessary tools to improve breastfeeding indicators[13].

Most professionals with higher education acknowledged the importance of early skin-to-skin contact, breastfeeding in the first hour of life, and staying with the baby in rooming-in. However, it is noteworthy that a percentage reported never or rarely guiding about such themes, demonstrating that some professionals still distance themselves when the woman is under the care of the hospital network. In this sense, health professionals must understand their role in providing continuity of care. Despite this, there are still difficulties because the existing integration

mechanisms are insufficient to ensure a fully functioning reference system. Primary care still needs to be better organized to effectively become the organizer of access to the network, reflecting on care practices[14].

Most graduate professionals positively mentioned the guidelines regarding the benefits and importance of Exclusive Breastfeeding (EBF) for up to six months. Political agents and managers must disseminate robust evidence pointing to BF as a highly effective intervention for child development and maternal health at different levels of health care[5,11].

After hospital discharge, when nursing mothers assume breastfeeding at home, they need support from their partners, family, and community to maintain EBF until the baby is six months old. During this period, difficulties related to free demand, correct attachment, the interval between feedings, and learning the baby's cues to identify hunger, sleep, etc., are common. In this moment of fragility, health professionals must be open to listening to women and be available to assist them. In this sense, most higher-level professionals reported providing individual care, active listening, guidance on the clinical management of breastfeeding and free demand, and the risks of using infant formulas, bottles, and pacifiers. However, 37.8% were never or rarely guided on adequate contraceptive methods during breastfeeding. It is essential to provide guidelines that consider the context involved in the BF process, especially until the baby is six months old. A study[5] comparing the guidelines on BF offered by primary care professionals and the prevalence of EBF found that, despite the guidelines provided to mothers, it decreased by 22% for each month of the baby's life, reinforcing the importance of providing instructions with the skill to be more effective.

In terms of CHAs' qualification, 55.6% did not receive any training or updates on BF in the last five years, and none received training in the past year. A study in São Paulo involving 148 CHAs showed similar results. Another study suggested that higher education of CHAs is associated with better performance in their functions. However, having higher education does not guarantee qualification to provide guidance and monitor nursing mothers regarding breastfeeding. Multiple actions are necessary to make real progress concerning BF, including investing in the continuing education of health professionals.

One of the responsibilities of CHAs is to monitor all families and individuals under their care through HV[8]. In this study, CHAs mainly perform the first HV during the baby's first week of life, providing advice on breastfeeding and observing breastfeeding to identify and correct any difficulties. The significance of this initial moment is that mothers typically initiate breastfeeding in the hospital and receive some guidance from healthcare professionals. However, more than this may be required for some or many women, who may require ongoing support once they return home. In this context, HV during the first week presents an ideal opportunity for such assistance, considered a protective factor for EBF[16-17].

Despite this initial action, monitoring during the first two years of the child's life is essential, with EBF up to 6 months of challenging for professional practice. The CHAs mentioned that during their meetings with mothers of children up to six months old, they talk about breastfeeding and consider themselves qualified to guide them. However, when faced with difficulties, mothers are referred to the unit, which shows that these professionals may have doubts or insecurity. Some studies[9,15] have verified that CHAs who received qualification/training have greater capacity and skill in conducting BF, requiring support and continuous updates, given the high turnover of these professionals.

Most CHAs reported participating in group educational activities, with BF being addressed in almost all meetings. However, there is little feedback from these mothers to the groups after childbirth, which raises questions about whether the guidelines or how they are presented meet the mothers' needs. Interventions to promote and support BF[4,14] are generally based on the perspective of acting on modifiable behavioral factors. However, professionals need to be trained and qualified in conducting these interventions, have active listening, use accessible language, enable personal contact and interaction between mothers, and get to know their community.

Limitations of the study included using a self-administered questionnaire as a data collection instrument, which may not accurately reflect the real practices of professionals. The study was conducted in only five units, which may only represent some health professionals who work with breastfeeding.

The study's results indicate difficulties to be overcome in implementing actions open to handling specific cases or difficulties. More effective interventions are needed, including expanding of mul-

tiple strategies with families and the community to ensure exclusive breastfeeding is maintained up to six months of age. In addition, managers need to act in structuring the network, promoting the continuing education of health professionals, training tutors in breastfeeding, and periodically monitoring breastfeeding.

CONCLUSION

The practice of health professionals revealed some weaknesses, such as less guidance to pregnant women/parents/families regarding their rights and a lack of updates, especially in the last year. Graduate professionals also reported less practice in implementing BF support groups, and this practice was associated with a lack of BF qualification in the last five years. Clinical management and support for solving breastfeeding difficulties were not adequately informed by the CHAs, indicating gaps in the performance of these professionals. Therefore, it is recommended that professionals and managers value the BF topic through strategies that include continuous training, conducting more robust studies, and periodic monitoring and evaluation of BF in the city of Niterói.

CONFLICT OF INTERESTS

The authors have declared that there is no conflict of interests.

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