# Breastfeeding initiation and support: A literature review of what women value and the impact of early discharge

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## Abstract: (250 words)

### Problem

Early discharge following birth has become a worldwide phenomenon. It is likely early discharge has an impact on breastfeeding management and success.

### Objective:

To explore what women value in relation to breastfeeding initiation and support, and investigate the impact early discharge can have on these values.

### Method:

Literature search was conducted for publications since 2005 using the following databases: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medline, Scopus and PsycINFO; 21 primary articles were selected and included in the review.

### Findings:

There is no standard definition for 'early discharge' worldwide. Early discharge definitions vary from six-72 hours of birth. Seven key values in relation to breastfeeding initiation and support following early discharge were identified, namely trust and security, consistent advice, practice/active breastfeeding support, breastfeeding education, comfortable environment, positive attitudes and emotional support, and Individualised care.

### Conclusion:

The findings suggest individualised postnatal lengths of stay may be beneficial to women initiating breastfeeding. Five values were not impacted by early discharge, but rather individual midwives' practice. The literature agreed early discharge promoted a comfortable environment to support breastfeeding initiation. Wide variations in the definition of early postnatal discharge made it difficult to draw influential conclusions. Therefore, further research is required.

## Introduction:

Since the 1940s when hospitalised childbirth became the 'norm', length of postnatal stay following vaginal birth has altered dramatically [1,2]. In the 1950s, staying six to 14 days was common practice following a normal vaginal birth [1,2]. This decreased to four days in the 1970s, then to less than 48 hours in the 1990s in some settings [2,3]. In the Australian setting in 1995, 4.5 days was the average postnatal length of stay and in 2014 it had reduced to <24-48 hours following uncomplicated vaginal birth [4-6].

There are two proposed reasons for reduction in length of postnatal stay; namely, reducing health expenditure and improving women's satisfaction [2,3]. Significant health budget cuts have occurred in Australia in recent years, and reducing length of hospital stay is one way of lowering health costs [7]. Early discharge intends to improve maternal satisfaction by offering advantages such as autonomy, increased sense of belonging, promoting a feeling of responsibility and participation, and facilitating family support in a comfortable home environment [2,3,8,9].

A Cochrane review aimed to evaluate safety, effectiveness and impact of early discharge policies, in terms of health outcomes for mothers and babies, postnatal satisfaction rates, costs to health care and broader impact on families [1]. From ten trials included in the review, no significant differences of infant and maternal readmissions and breastfeeding rates following early discharge were found [1]. However, substantial variations in defining early discharge and antenatal and postnatal services proved difficult to draw compelling conclusions [1]. The World Health Organisation [10] recommend exclusively breastfeeding infants until six months of age, however the Australian breastfeeding rate at six months is only 14% [11]. Apprehension continues to exist regarding the impact of early discharge on breastfeeding

initiation, and maternal satisfaction of breastfeeding support. A significant concern is women returning home before their milk production has established, and possibly receiving inadequate support. This may lead to early cessation of breastfeeding and potential for increases in future morbidity and mortality rates [2,12, p. 64].

In South Australia, current policy promotes discharge within 24 hours following uncomplicated vaginal births [5]. Following discharge, one to three domiciliary home visits are provided [5]. The initial intent of this review was to examine literature surrounding maternal perception of breastfeeding initiation and support after early discharge within 24 hours of birth. Due to inconsistent definitions of early discharge worldwide and minimal literature using the 24-hour definition, research defining early discharge up to 72 hours postpartum is included.

The purpose of this review is to explore what women value relating to breastfeeding initiation and support, and the impact early discharge may have on these values and practices. The literature search strategy and critical appraisal approaches, collation of themes and discussion of the findings, limitations and conclusions of the review will be addressed.

## Search strategy and selection process:

A comprehensive literature search was conducted identifying publications describing breastfeeding initiation and early discharge after birth. The search was completed during August and September 2015 and included four credible electronic databases predominately used in midwifery research [13, p. 100]. The databases were: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medline, Scopus and PsycINFO. The initial search heavily focused on early discharge and breastfeeding as broad concepts. Key terms and hits from each database are detailed in Table 1. Titles and abstracts were screened for relevance,

before reading 46 full texts. This search only elicited 12 articles relevant for the review and subsequently the search was expanded.

A second search was conducted using the same four databases focusing on breastfeeding initiation and postnatal care. Key terms and hits from each database are detailed in Table 2. A similar screening process was employed with this search, involving 52 full-text examinations. Seven primary articles were added to supplement the literature review. Two further articles were coincidentally found after this, which brought the total number of articles reviewed to 21. A summary of the articles appears in Appendix one.

All languages were included and publication period of 2005-current was used, as limited relevant research was available within a five-year period. Variations of the terms 'neonatal intensive care' and 'premature' were used to exclude irrelevant research in all search strategies. All research methodologies were eligible and only primary peer-reviewed articles were used, however literature/systematic reviews were assessed for references.

## Critical appraisal:

Critical review guidelines for quantitative and qualitative studies adapted from Schneider et al [14, pp. 292, 303] were used to critically appraise the articles, to identify any strengths and weaknesses[13]. Summaries of these appraisals can be found in Appendices Two and Three.

Quantitative studies require large sample sizes to reduce sampling error, increase generalisability and establish results of statistical significance [14, p. 187]. Five of the quantitative studies were strengthened by large sample sizes, giving the results more power [14, p. 187,15-19]. Generalisability was decreased in two quantitative studies due to small sample sizes [20,21]. There was a significant discrepancy between two sample groups in Sjöström et al's [21] study,

with 300 Swedish and 91 Australian participants. The research had high response rates but was limited due to the lack of any eligibility for inclusion/exclusion criteria [21]. Both studies acknowledged the sample size as a limitation [20,21].

Four quantitative studies were strengthened by probability sampling, minimising selection bias [15-17,22]. The remaining nine studies did not randomise their samples, and hence may not be representative of the population [8,14, p. 211,18-20,23,24].

Although published within the ten-year period, four studies with outdated data were included[8,16,22,25]. Data collection period ranged from 1998-2003, and involved two longitudinal cohort studies, one randomised control trial and one grounded theory [8,16,22,25]. Despite this limitation, they were included in the review due to the value they added to the themes and discussion.

## Findings:

Usually give a brief introduction into the findings – overview the 2 sections and that themes are in women's values

What type of review is this – you have not stated the type of analysis to be done

### Defining early discharge:

What constitutes as early discharge varies from country-to-country, and even hospital-to-hospital. Hence, it is extremely difficult to define a standard length of hospital stay post birth which is known as 'early discharge' [1]. Currently there are variations in expected length of stay across Australia between different settings. For example at the Royal Women's Hospital in Melbourne women can expect to stay 48 hours, and at the Women's and Children's Hospital in Adelaide early discharge is within 24 hours of an uncomplicated vaginal birth [5,6].

It quickly became evident these variations defining early discharge not only applies to Australia, but rather exemplified there is no standard definition world-wide. Of the 12 articles discussing early discharge, only three defined it as being within 24 hours of birth [20,22,26]. Two articles were set in Sweden, and both explored the experience of mothers or parents following early discharge and investigated breastfeeding as a complex phenomenon [20,26]. The third article evaluated advantages and disadvantages of early discharge by comparing factors, including breastfeeding, between early discharge of within 24 hours and conventional length of stay, 48 hours [22]. Early discharge was defined as discharge within 36 hours of birth in another Swedish article, which explored primiparous women's experience following early discharge [9]. Similarly, the only study to define early discharge within 48 hours of birth was a phenomenological study exploring the experience of initiating breastfeeding, also set in Sweden [27]. Hence, even within Sweden the definition of early discharge varies from <24 hours up to 48 hours following birth.

A Canadian cohort study investigating impact of type and timing of postnatal services, defined early discharge as length of stay <60 hours [16]. Whereas, another longitudinal cohort study conducted in Sweden comparing postnatal programs defined early discharge as 6-72 hours post birth, however it is noted their average length of stay was 44 hours [8]. In the research by Henderson and Redshaw [15], the national survey does not explicitly define early discharge, but rather explores ranges of length of stay (between <6 hours to >6 days) in relation to clinical factors associated with breastfeeding. The national survey aimed to describe maternity care from women's perspective and identify concerns and changes in practice since 1995 [15]. A second publication derived from the same survey also included in the literature review was by Redshaw and Henderson [28]. Hjälmhult and Lomborg [29] discuss

early discharge as a concept, but provide no explicit definition, although do make reference to it as <48 hours. Two different studies defined early discharge as <72 hours [23,24]. Hence, varying definitions make drawing conclusions from the literature extremely difficult.

## Women's values in relation to breastfeeding initiation and support:

Effective support is necessary following birth, as it is a life event which changes the mother and family physically, emotionally and psychologically, and everyone copes with these changes differently [30]. It is therefore not surprising over a dozen values in relation to breastfeeding support appeared throughout the literature examined. These values were grouped into seven common values: 1. Trust and security, 2. Consistent advice, 3. Practical/active breastfeeding support, 4. Breastfeeding education, 5. Comfortable environment, 6. Positive attitudes and emotional support, and 7. Individualised care. Each of these will now be discussed.

### *1. Trust and security*

Three studies with dissimilar methodologies, all concluded women want to feel safe and secure in the postnatal period whilst establishing breastfeeding [9,20,29]. In one phenomenological study women discharged within 36 hours of birth did not receive domiciliary visits, but rather had access to an early discharge team (EDT) via telephone 24 hours a day [9]. These women valued the sense of security instilled in them by the EDT trusting their expertise. The women felt secure, demonstrated by two direct quotes "I knew I could get all the help I wanted" and "it felt good to have this extra check and a chance to ask questions. It gave me a sense of security" [9, pp. 325, 327]. They felt they could trust the support to establish breastfeeding at home from the EDT [9].

A retrospective case-control study by Askeldottir, Lam-De Jonge [20] used Parent's Postnatal Sense of Security (PPSS) Scale demonstrating women choosing early discharge and received home visits, felt more secure and had greater positive experiences of midwives in terms of breastfeeding support, practical advice, education and encouragement, than those receiving the conventional length of stay. However, it also highlighted those who did not choose early discharge had a greater sense of security in terms of decision-making [20].

It was identified in the Hjälmhult and Lomborg [29] grounded theory study, women valued security, however did not necessary feel secure during their stay at the hospital. Due to lack of support and individualised care from staff, women felt confused and insecure, breastfeeding being a significant burden [29]. Initiating breastfeeding was expressed by 'balancing the unknown' in Palme et al.'s [27] study, whereby the unknown feelings surrounding breastfeeding brought forth insecurities in the mother. Insecurity gave rise to uncertainty to whether they could produce enough breast milk, leading to questioning one's ability to succeed in motherhood [27].

### *2. Consistent advice*

New mothers need consistent information and practical advice from midwives to initiate and sustain breastfeeding [31]. One of the most significant values identified throughout the literature was receiving consistent advice about breastfeeding from midwives. This was evident in eight articles, more commonly identified as inconsistent advice provided to mothers [15,17,23,27,28,31-33]. An example of the inconsistencies in breastfeeding advice was expressed by Palme et al. [27, p. 6] as "...some of them said 'have him this way' and some said 'have him that way'...It was a little bit confusing with these opposite views all the time, especially when it is a short hospital stay...". The French observational study found

inconsistent advice was associated with 9.6% of the participants [23]. A slightly higher percentage of mothers in the conventional discharge (>72 hours) group reported this, compared to the early discharge, however these reports did not reach significance [23].

Women frequently reported midwives providing contradictory advice, in some cases impacting breastfeeding initiation rates [15,17,23,27,28,31,32]. The Walburg et al. [32] study comparing breastfeeding initiation and cessation between Germany and France, found France had significantly lower rates. Contradictory advice was suggested as one factor that could account for the disparity [32]. Inconsistent advice was also suggested as a factor associated with women having ceased breastfeeding by 10 days postpartum in another study [17]. Women associated with the greatest percentage of cessation at 10 days were women discharged between 24-96 hours [17].

### *3. Practical/Active breastfeeding support*

The most prevalent value for women found to help initiate breastfeeding was practical breastfeeding support. Ten articles described practical advice as helpful prior to hospital discharge, and dissatisfaction associated with breastfeeding support when this did not occur [9,15,17,19-21,24,28,29,31]. Lack of practical support may negatively impact on breastfeeding initiation, as demonstrated by 28% of women who reported receiving adequate practical support were exclusively breastfeeding at three months, compared to 15% of women who reported inadequate active support [15]. In a different study, one woman "...nearly gave up (breastfeeding)..." and another expressed her disappointment with the midwives' lack of "...time to sit and help me get my baby to latch-on or explain..." [28, pp. 22 & 25]. An American study exploring women's choices for not initiating breastfeeding found one reason to be lack of practical support from hospital staff to teach them to breastfeed [19].

Practical or active breastfeeding support can be an individual preference, and requires a non-threatening approach. It was noted some women did not appreciate invasive 'hands on' approaches, without permission sought to touch the woman and thus should be avoided [21,28]. As exemplified by this quote "some staff even grabbed my breast and just pushed it inside my baby's mouth. This did not teach me how to feed my baby, it was awful" [28, p. 26].

### *4. Breastfeeding education*

Breastfeeding education in the antenatal and postnatal period was shown to be valuable when attempting to establish breastfeeding. In relation to antenatal classes, one woman described it "...was crucial to read as much as possible... I thought it helped me enormously" [9, p. 325]. In the Henderson and Redshaw [15] study, the most powerful explanatory factor influencing breastfeeding was antenatal intention to breastfeed. A strong association was also found between attendance at antenatal class, breastfeeding initiation, and continuation of exclusive breastfeeding [15]. Conversely, in another study one woman found breastfeeding information to be "unrealistic" and should include honest education such as "it takes...time to establish good feeding technique" [28, p. 24]. In the Walburg, Goehlich [32] study, 96% of German mothers initiated breastfeeding at birth compared to 67% of French mothers. It was hypothesised that a lack of antenatal education and inadequate postnatal education and support was a leading cause for the substantial disparity between the two settings [32].The Hildingsson [24] study linked dissatisfaction with postnatal care to lack of education on the ward in relation to multiple issues, including breastfeeding.

A cohort study compared breastfeeding experiences of Swedish and Australian women and identified factors for breastfeeding continuation [21]. Of the Swedish women, 88.3% were still breastfeeding at two months postpartum compared to 75.8% of Australian women.

Swedish women reported receiving adequate breastfeeding information on the postnatal ward as the most important factor in continuing to breastfeed. While Australian women reported the most important factor was breastfeeding advice and support received during the initial breastfeed [21]. Both groups of women valued breastfeeding education they received in the hospital setting [21]. Opposing this view is the Hildingsson [24] study which found breastfeeding education on the wards to be lacking. Askeldottir et al. [20] reported positive experiences in relation to education in the early discharge group.

### *5. Comfortable environment*

The Australian Breastfeeding Association [34] state a private, comfortable space is a key element supporting breastfeeding. Six articles described a comfortable environment as an essential factor assisting breastfeeding initiation, whether in the hospital or home setting [9,22,24-26,28,29]. The majority of research demonstrated that women found their home a more comfortable environment compared to postnatal wards, as they were more relaxed, together with the father or family, and could start to get into their own routines [9,22,24-26,28,29]. Only two studies found the postnatal hospital environment to be positive [29]. Women whose length of stay was >48 hours enjoyed the professional breastfeeding support, and could not understand how mothers coped at home alone [29]. The Australian study with eight focus groups by Forster et al. [33] found many women, especially primiparous women, valued the hospital environment during the first few days postpartum until their milk production established. Some women feared going home early. They felt they needed constant professional support until they gained confidence breastfeeding and caring for their newborn, which many felt was better achieved in the hospital setting [33]. The article by McLachlan et al. [35] is the second publication derived from the same eight focus groups conducted in Australia[33], and henceforth details

similar findings. It was the view of many first-time mothers that a postnatal hospital stay of one night following normal vaginal birth was inadequate [35]. However, these two articles produced both positive and negative experiences of postnatal care in the hospital setting.

Women described the postnatal ward as "noisy", "unfamiliar", "chaotic", "uncomfortable", "lacks privacy" and filled with "interruptions" [25,28 pp. 25-6,33,35]. The Spanish randomised control trial by Bueno et al. [22] found significant positive satisfaction responses for care provided in the home setting. Of the early discharge (<24 hours) group, 92% of the women preferred home visits over the hospital setting [22]. The grounded theory research by Beake et al. [25] exploring women's postnatal experiences of home and hospital settings reported overwhelming support for the home environment over hospital. Women expected their hospital stay to be a time for rest and breastfeeding support however found it was not conducive and breastfeeding support was difficult to obtain. One woman explained *"I kept asking for help with feeding, but nobody would come and if they did it was like about a minute"* [25]. Similarly, some women found the hospital staff were often too busy or unavailable to adequately support them in the Forster et al. [33] study. Exemplified by this direct quote, "I got up there and they left me ... to myself. I had no idea about breastfeeding which was hurting... it took them two hours to get to me" [33, p. 6].

Those who returned home very early found the transition from birth to early parenthood easier and less stressful in their own home [25]. Some women did not understand why they were staying in the hospital at all "12 hours after he was born I just came home, I thought "I'm not staying here, I can do this better for myself at home" [25]. A different study concurred, "we wanted to go home as early as possible...", "home is best" [26, p. 133].

The studies highlight the importance of home visits [9,25,29]. Women valued and appreciated visits in the home because it was peaceful and calm, convenient and could involve the partner

and/or other family members [25,29]. Visits in the home contributed to a sense of normality in a new situation, especially to assist overcoming breastfeeding challenges [25,29]. The Goulet et al. [16] study, focusing on the impact of type and timing of postnatal services, found a correlation between increased probability to find postnatal services useful and a visit at home within 72 hours. However, this was not associated with increased breastfeeding continuation [16].

Four articles highlighted the home environment supports the new family dynamic.[24,28,29,33] Women were strongly displeased their partners did not have the opportunity to stay overnight [24,28,29,33]. In the home environment fathers could also receive advice which in turn he could utilise to support the mother with breastfeeding [29].

### *6. Positive attitudes and emotional support*

Women valued positive attitudes and emotional support from midwives. A positive, affirmative attitude towards breastfeeding support empowered women's self-confidence and reassured normality [9,27,29]. Women longed for confirmation and encouragement, as breastfeeding is a complex phenomenon, both psychological and physical [9,17,20,27,29]. Breastfeeding rates were generally higher, in the study by Henderson and Redshaw [15], when the women felt emotionally supported, treated with respect and as individuals.

### *7. Individualised length of stay*

It became apparent women wanted to be treated as individuals, and a standardised length of postnatal stay is maybe not the answer [18,24,27,28,35]. The Australian study by McLachlan et al. [35] explored the view of new parents in regards to alternate models of early postnatal care. The results showed individual women placed higher value on different aspects of postnatal care compared to other women, hence individualised, flexible care was deemed of utmost importance [35]. In general women did not respond favourably to the new postnatal care

models, with a major concern being shorter length of postnatal care. A common view was that there should be different care options offered to primiparous women compared to multiparous women [35].

The study by Palme et al. [27] highlights women's concerns relating to individualised care, including length of postnatal stay. A major theme was 'having the entire responsibility' encapsulating the sense of burden and loneliness some mothers feel when initiating breastfeeding [27]. The discussion provokes the idea not all women would enjoy being "left alone" with the responsibility of breastfeeding with a short hospital stay [27, p. 7].

Two qualitative Swedish studies both found maternal dissatisfaction was associated with postnatal length of stay either being too short (<24 hours) or too long (≥5 days) [18,24]. Those with length of stay <24 hours felt there was inadequate time for hands on breastfeeding support and encouragement to initiate breastfeeding successfully [18,24].

Similar views were echoed in the English study whereby some women preferred to leave earlier and others preferred to stay longer in the hospital [28]. Those who felt their stay was too short were concerned breastfeeding was not established, and felt they were not psychologically ready to be discharged. On the contrary, some mothers in the same study decided to go home on the day of birth due to lack of support and the standard of care being so low "...felt neglected. No help/advice given about breastfeeding/baby care" [28, p. 28]. This highlights the differing opinion on ideal length of stay.

## Discussion:

The literature highlighted early discharge does not have a standardised definition, and ranges anywhere within six to 72 hours following birth [15,24]. The literature also provided

insight into seven key values women deem essential to establish breastfeeding. The question provoked by this review is - does early discharge impact these values?

It seems several values, namely trust and security, practical/active breastfeeding support, breastfeeding education, positive attitudes and emotional support, and consistent advice, are not strongly impacted upon by early discharge policies, but rather by individual midwifery practice. In particular, instilling a sense of 'trust and security' and providing adequate 'practical/active breastfeeding support' and 'positive attitudes and emotional support' are less about discharge policies, and more about the individual midwives' attitude and approach to breastfeeding support. The midwife should possess the ability to establish rapport, empower and encourage women, in addition to the skills to effectively teach breastfeeding techniques [36]. Some women reported midwives on the postnatal ward lacked time to actively support them [28,33]. It could be hypothesised returning home sooner could improve this, as the midwife has an opportunity to spend one-on-one time with the woman, as opposed to the number of women and babies they 'juggle' on the ward.

Similarly, providing consistent breastfeeding advice is most directly impacted upon by midwifery as a profession, being informed and delivering education in a uniform manner. This is an area identified for improvement in the Australian Health Ministers' Conference [11] *Australian National Breastfeeding Strategy 2010-15*. Likewise, it could be hypothesised early discharge could improve inconsistent advice by alleviating the number of different midwives caring for women shift-to-shift, "...each change of shift saw different advice, I found this very distressing" [28, p. 24].

Antenatal breastfeeding education and promotion play a significant role in informing women and families about breastfeeding [11]. This is known to assist with maternal intention

to breastfeeding, shown to be one of the main explanatory reasons to initiate breastfeeding [11,15]. Early discharge policies are not associated with antenatal education, thus is unlikely to impact breastfeeding initiation. Only one study mentioned breastfeeding education in the context of early discharge [20]. The early discharge group (12-24 hours) compared with conventional discharge reported greater positive experiences towards midwives in relation to breastfeeding education received in the first week [20].

The value found to be most impacted upon by early discharge was 'comfortable environment'. The literature highlighted early discharge can promote a comfortable environment for women, assisting breastfeeding initiation. By discharging women home sooner, some women found greater sense of well-being and comfort, valued the breastfeeding support from midwives more, and felt the father can be more easily included in the home setting [9,24,25,28,29]. However, two studies presented an opposing view to this [33,35]. Women in these studies felt leaving hospital early was detrimental, and felt they required a longer length of stay to gain confidence with caring for the newborn and establishing breastfeeding [33,35]. The 'individualise care' value links to implications for practice. Some women wanted to leave hospital as soon as possible, and others found the thought of early discharge lonely and distressing [25-27,35]. Several studies showed maternal dissatisfaction associated with postnatal length of stay being either too short or too long [18,24,28]. These results neither promote nor negate early discharge, but rather emphasises the importance of individualising care, over allowing policies to dictate postnatal length of stay.

As with all studies there are often limitations. The lack of a consistent definition of early discharge is the main limitation of this review, as it has restricted the ability to draw conclusions. For instance, in one study women discharged within 36 hours of birth

experienced a lack of active breastfeeding support [9]. However, for the same value, the women discharged with 12-24 hours of birth in Askeldottir et al.'s [20] study were found to have positive experiences. For this reason, it is difficult to determine whether early discharge, as a concept, promotes or negates this key element for breastfeeding initiation. The second limitation is the inclusion of four studies which collected their data between 1998 and 2003, as these may be considered outdated [8,16,22,25].

## Conclusion:

The purpose of this review was to explore what women value in relation to breastfeeding initiation and support, and investigate the impact early discharge can have on these values. We found that the definition of early discharge fluctuates country-to-country, setting-to-setting, varying between six to 72 hours of birth. Seven key values in relation to breastfeeding initiation and support were identified. Of these five values were most influences by individual midwives' practice rather than early discharge. Although two hypothesises were made from this suggesting early discharge could promote the values of 'practical/active breastfeeding support' and 'consistent advice'. Most studies showed early discharge promoted a comfortable environment to support breastfeeding initiation. The literature suggests individualised postnatal lengths of stay could be beneficial. There is limited research focused on initiating breastfeeding and support following early discharge within 24 hours of birth. Further research is required to address this gap in knowledge.

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