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Training and experiences of speech therapy in breastfeeding: a descriptive study

Formação e vivências da fonoaudiologia no aleitamento materno: um estudo descritivo

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ABSTRACT

Purpose: To investigate the training and experiences of speech therapy in breastfeeding in Brazil. **Methods:** This is a qualitative descriptive study that assessed 39 speech-language pathologists through semi-structured interviews. The interviews were recorded and transcribed. Thematic content analysis was used to identify thematic axes. **Results:** Professionals with experience in the field ranging from five to 28 years from six Brazilian states participated in this study. Three thematic axes were identified: "The participant's training journey in breastfeeding," where interviewees stated that the scientific basis provided during the speech therapy course, in all its disciplines, supports the clinical practice in the field. The integration of knowledge with the mother-infant dyad facilitates the development of a pleasant and efficient feeding process; "Workplaces in breastfeeding: reflections on the daily practice," highlighting the role of speech-language pathologists in hospital settings with both healthy and at-risk infants, and their interactions with the multidisciplinary team; "Challenges in the practice of speech-language pathologists in breastfeeding," which highlighted a lack of understanding about the role of speech-language pathologists in breastfeeding among parents and other healthcare professionals, delaying the start of speech-language pathologist intervention. **Conclusion:** Breastfeeding training was linked to public services, the Brazilian National Health System (SUS), and graduate courses in speech therapy. The role of speech-language pathologists in breastfeeding has evolved synchronously with national public policies and the demands of the places where they work.

Keywords: Breast feeding; Speech, language and hearing sciences; Maternal and child health; Interview; Public policy

RESUMO

Objetivo: investigar a formação e as vivências da Fonoaudiologia em aleitamento materno no país. **Métodos:** estudo descritivo e qualitativo. Realizou-se entrevista semiestruturada, de forma remota, com 39 fonoaudiólogas. As entrevistas foram gravadas e transcritas. Realizou-se análise de conteúdo, modalidade temática. **Resultados:** participaram profissionais de seis estados brasileiros, com tempo de atuação na temática variando de cinco a 28 anos. Construíram-se três eixos temáticos: "O percurso formativo das participantes no aleitamento materno", em que as entrevistadas afirmaram que o embasamento científico transmitido durante o curso de Fonoaudiologia, nas diversas disciplinas, sustenta a prática fonoaudiológica no tema. O entrelaçamento dos saberes, junto com a díade mãe-bebê, possibilita a construção de um processo alimentar prazeroso e eficiente; "Locais de atuação no aleitamento materno: reflexões sobre o cotidiano", com destaque para a atuação no ambiente hospitalar, com bebês saudáveis e de risco, bem como as relações do fonoaudiólogo com a equipe multidisciplinar; "Os desafios da atuação do fonoaudiólogo no aleitamento materno", que evidenciou a falta de conhecimento quanto ao papel do fonoaudiólogo no aleitamento materno, por parte dos pais e dos profissionais que os assistem, o que atrasa o início do trabalho fonoaudiológico. **Conclusão:** a formação em aleitamento foi vinculada aos serviços públicos ligados ao Sistema Único de Saúde, ou em cursos de pós-graduação em Fonoaudiologia. A atuação do fonoaudiólogo no aleitamento materno se transformou de forma síncrona com as políticas públicas nacionais e com as demandas dos locais de atuação.

Palavras-chave: Aleitamento materno; Fonoaudiologia; Saúde materno-infantil; Entrevista; Política pública

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INTRODUCTION

Breastfeeding (BF) is the best feeding practice recommended by the World Health Organization (WHO) as the exclusive feeding method up to six months of age and as a complementary feeding method up to two years of age or older. It has multiple positive effects on the health of the baby and the mother, as well as benefits for the family and the planet[1].

In Brazil, the 1980s had important advances due to the implementation of public policies to promote BF. In this sense, in the 1990s and early 2000s, the Baby-Friendly Hospital Initiative (BFHI) was a milestone, because it provides ten steps for successful BF[2]. Despite all efforts, the prevalence of BF remains below the recommendation of the WHO[1].

Speech therapy addresses general aspects of BF management, as do other professionals in contact with the mother-baby dyad in the breastfeeding process. However, in addition to this general work, it contributes to the adaptation of the baby's oral functions to facilitate suction and expression of breast milk and promote prolonged BF[3,4].

Speech therapy in BF involves assessment, intervention, guidance, and discussion with the multidisciplinary team. Throughout its history, it has built a set of approaches that use techniques to adjust the infant's oral sensorimotor system and assist in safe swallowing. This work includes home care with healthy babies and babies in the neonatal intensive care unit (NICU) who are at risk of death[3,4].

Speech therapy is focused on the perception of physiological and organic aspects of breastfeeding. Despite the relevance of such aspects, it is believed that breastfeeding also has a hybrid conception involving aspects of nature and culture[5]. Then, although it is a natural practice of mammals, with physiological and anatomical aspects, breastfeeding is intrinsically linked to cultural aspects regarding personal knowledge and beliefs.

Historically, there is no specific training in breastfeeding in the curriculum of the speech therapy course. In general, this training is distributed across different curriculum disciplines and/or programs, and does not occur in a systematic manner. Due to the relevance of speech therapy in breastfeeding, this study aimed to investigate the training and experiences of speech therapy in breastfeeding in Brazil.

METHODS

This study was approved by the Research Ethics Committee of Universidade Estadual de Campinas (UNICAMP) under report nº 5.196.603 and CAAE: 52456221.3.0000.5404. All volunteers received information about the content of the study and signed the informed consent form.

This is a qualitative descriptive study that assessed participants through semi-structured interviews. The script contained the following predefined questions: In which state of Brazil do you work as a speech-language pathologist?; What is your specific training in BF?; When you graduated, did you feel you were prepared to work with BF? How did you seek to improve?; How many years have you worked with BF? Tell me a little about your career in BF; Where do you work now?; Do you work with a team? Who are these professionals?; What is the teamwork like?" Do they collaborate with speech therapy procedures?; Tell me about your work in breastfeeding; What techniques do you use?; Describe your assessment of breastfeeding with patients; What is the assessment and flow of care when there is a change in the lingual frenulum?; Do you work with pregnant women? Tell me how it works.; Do you provide follow-up after breastfeeding? Until when?; Do you refer the dyad to other professionals for complementary techniques?; What criteria do you establish for the first breastfeeding care?; If you work in a hospital, does it have the BFHI program?; Do you work with breastfeeding in the public and private networks? If so, do you see any difference in demands between the different networks? Does your work change depending on the network you serve?; Do the age group and education of the parents make a difference in your work? Why?; What protocols do you use and why?; Is there a protocol that you do not identify with and prefer not to use? Why?; Based on your experiences, do you feel that are able to act and resolve all speech-language pathology demands that are referred to you? Tell me a little about that.; What are the challenges that you see in your professional practice? What do you do in these cases?

This study used snowball sampling, which is a qualitative approach used in hard-to-reach groups[6]. Then, the selected professionals were contacted through a messaging application, when the objectives of this study were explained and an interview was scheduled, on a day chosen by the participant.

The interview was conducted through the Google Meet platform and lasted up to two hours. It addressed aspects related to training, career in BF, information about current work, assessment and treatment techniques, application of protocols, among others. Some data were selected for analysis and discussion of the results. All interviews were recorded (audio and video), stored in Google Drive, with access only by the speech therapists responsible for the study, ensuring the confidentiality of all information and the interviewees.

The inclusion criteria for participation in this study were: speech-language pathologists who have worked with BF for at least five years, who agreed to participate in the study by providing self-reported answers, after fully understanding the procedures and objectives informed, and who consented by voluntarily signing the ICF. Speech-language pathologists of different age groups and from different states of Brazil were invited to participate. Those who refused to participate were excluded.

Data from this study were submitted to a qualitative analysis, without the aid of a software tool, based on content analysis[(7)], since the elements of communication allow the researcher to make a variety of interpretations. The interviews were transcribed and then the main ideas and general meanings were captured in a global manner. Next, the excerpts were selected, with an interest in thematic analysis. Finally, the analyzed units were categorized to express important meanings and ideas that met the study objective[(7)].

Data collection ended when data saturation was reached, totaling 39 speech-language pathologists, all female (Chart 1), from six Brazilian states: 18 from Rio de Janeiro, 13 from São Paulo, 3 from Paraná, 3 from Minas Gerais, 1 from Alagoas, and 1 from Paraíba. The time since graduation ranged from 5 to 28 years, with mean and median of 16 years (SD=6.23).

Chart 1. Characterization of participants by state where they work and breastfeeding training (public or private service).

Participant	State where participant works	BF training (public or private service)
1	SP	Public
2	MG	Public
3	RJ	Public
4	PR	Public
5	RJ	Public
6	RJ	Public
7	PR	Private
8	RJ	Public
9	RJ	Public
10	SP	Public
11	SP	Public
12	RJ	Public
13	SP	Private
14	RJ	Public
15	RJ	Public
16	RJ	Public
17	SP	Private
18	PB	Public
19	SP	Private
20	SP	Private
21	RJ	Public
22	PR	Public
23	RJ	Public
24	SP	Private
25	RJ	Public
26	MG	Private
27	MG	Public
28	RJ	Public
29	AL	Public
30	SP	Private
31	SP	Private
32	RJ	Public
33	RJ	Public
34	RJ	Public
35	RJ	Private
36	SP	Private
37	RJ	Public
38	SP	Private
39	SP	Private

Source: Developed by the author.

RESULTS

The data set consisted of interviews with the study participants. The reports were based on the experiences of the interviewees, who highlighted their training process in BF, their work environments, and the challenges they encountered along the way. The empirical material showed three axes of analysis, based on the most recurrent themes identified in the statements of participants.

The training journey in BF of participants

The interviewees believe in the importance of the training process for assertive performance in BF, but they pointed out the challenges in training, as observed in the following excerpts:

Participant #4: "Twenty-six years ago, I had BF in the OM (Orofacial Motricity) discipline, as BF promoted optimal craniofacial growth in the baby and prevented future malocclusion changes, with a subsequent impact on speech development, but it did not address it in clinical management, it did not address this issue of OM related to BF."

Participant #25: "I completed my course 14 years ago and my degree only had theory, no Neonatal practice at all, for this reason I took an advanced training in Neonatology."

The excerpts above show the reality of the training that existed around two decades ago, in the late 1990s and early 2000s, when public policies in BF were implemented in Brazil. At that time, speech therapists were part of the team of professionals involved in promoting breastfeeding, mainly linked to the BFHI. As a result, breastfeeding was gradually included in the curriculum of speech therapy courses.

The practice of breastfeeding in extracurricular programs was an enriching experience for the interviewees who had this opportunity during their academic training. It is clear in a participant's speech, as she talks about her experience in another environment.

Participant #8: "I was a scholarship student in the city hall program (mentions the name of maternity hospital), and it was a very strong maternity hospital, with a very strong and very active BF committee. It was a great school. I stayed there for a year as a scholarship student."

The speech-language pathologists who were working in BFHI hospitals, or in services with BFHI program, completed their training in BF training courses promoted by the Ministry of Health.

Participant #8: "My BF training was in the city hall internship. We had frequent BFHI courses, I was always attending these classes, we had groups of mothers, they were very active."

Participant #37: "I took courses during the residency, especially because it was a BFHI hospital."

Also, in the perspective of the training process, the participants who were not involved in services linked to the Brazilian National Health System (SUS) or the BFHI felt they had to take graduate courses on the subject, with specializations in OM and hospital speech therapy as the most cited, as can be seen below:

Participant #33: "I went to college, then I specialized in OM; at the time there was no specific course in neonatal (…) I took refresher courses in this area, more focused on dysphagia and pediatrics."

Due to the lack of specific courses in breastfeeding related to speech therapy in this context in the 2000s, breastfeeding consulting courses and preparatory courses for the International Board Certified Lactation Consultant® (IBCLC) certificate were cited by the participants, as illustrated in the following excerpt:

Participant #11: "After graduation, I took a professional development course; at the time it was very focused on breastfeeding, because it was provided at a BFHI hospital (…) it took two years and then I continued, I took other courses, today I have a specialization in maternal and child health and I am an international consultant, I took the IBCLC exam and I continued on that path."

The following excerpts mention another learning path in breastfeeding, in which the participants were immediately inserted into the work environment after graduation.

Participant #21: "Although I had contact with breastfeeding in the last period of graduation, it was a short time, only for us to have a basic understanding. But we actually learn with

practice, we gradually improve. As you work, as you see each case and get to know each family, interact with the team, and build clinical reasoning. I believe that no course gives you this experience like practice can provide you."

Participant #35: "During my undergraduate studies, I learned the basic guidance. Then I started getting some jobs, working in the NICU, working in the hospital, and I learned a lot from the people at the milk bank (...)."

These statements show that the scientific basis taught during the speech therapy course, in several disciplines such as OM, language, dysphagia, among others, supports the practice in BF. However, the work is complemented by the experience built in daily practice and the transfer of knowledge with other health sciences.

To conclude the data set for this first axis, the excerpt from the speech of participant #1 showed that adequate training, linked with reflective practice, helps build skills in practice. It should be noted that speech therapy has several training elements that synergistically support the work in breastfeeding.

Participant #1: "What do I call successful breastfeeding? (...) For me, successful breastfeeding is when the mother feels well when feeding her child, connecting with her baby, and enjoying breastfeeding."

In the participant's view, the work is not limited to establishing breastfeeding. It should be taken into account that breastfeeding is a process involving the mother-baby dyad and different speech-language knowledge elements, which, together, allow building a pleasurable and efficient feeding process.

Places of work in breastfeeding: reflections on the daily routine

The information below addresses the different areas of activity that speech therapy has involved, according to the statements of participants.

Hospital settings were highlighted in the statements, with their several spaces and different speech therapy demands, as explained below:

Participant #32: "I work in the NICU and in the Intermediate Nursery. In the first years at this hospital, I worked in the rooming-in service and the contact with breastfeeding is from a different perspective when compared to the NICU. It is an environment that strongly promotes breastfeeding, we are in constant contact with mothers (…) And then, at the end of 2015, I went to the NICU and I had contact with breastfeeding in premature babies or babies who had problems during pregnancy or at birth, with some pathology, heart disease or neuropathy. And this is another context, they are often infants with dysphagia, and the mother is very distressed and cannot maintain breastfeeding during this period."

The excerpt above clearly shows that in neonatal intensive care units (NICUs), speech therapy work with at-risk babies may have to handle immaturity and/or the presence of dysphagia, not allowing the immediate establishment of breastfeeding. This context creates the need for speech therapy work, since issues related to oral functions are one of the competencies of speech therapy. Then, specialized work is required to stimulate the baby and help the mother maintain lactation and manage her emotional demands.

In addition, it is clear that work with mother-baby dyads allocated in the rooming-in service can only take place when the multidisciplinary team requests a speech therapy opinion after considering it a difficult case, as seen in the speech of participant #37: "The rooming-in service sometimes requested an opinion; when the milk bank had some problem, they contacted us."

This situation shows that breastfeeding in this environment has actions from the multidisciplinary team without due emphasis on speech therapy, with speech therapy present only in cases with difficulties or oral dysfunctions[8]. Then, the lack of speech therapy professionals working in the rooming-in service remains implicit, considering the existing demand, as well as the failure of the neonatal team to understand the role of the speech therapist as a promoter of breastfeeding.

Regarding the criteria for the first speech therapy appointment in the NICU, the statements indicated that there is no consensus regarding the exact moment for it to happen, as observed in the following excerpts:

Participant #32: "We don't use a single, specific milestone. What we do (referring to the NICU team) is observe the baby's clinical condition, observe the baby's level of readiness and alertness throughout the day. So, if the baby is clinically stable but very immature and doesn't have the conditions or energy to remain alert to suck or interact, we wait and observe. It's not linked to weight or gestational age. It's much more linked to the baby's behavior and clinical stability."

Participant #39: "At the neonatal service, it was like this: if the baby was stable, especially from a respiratory point of view, if the baby was stable from a clinical point of view and had the minimum weight, which from what I remember was one kilo, we would start to intervene."

Participant #34: "In our protocol, we used 33-34 weeks. There was no ideal weight, we observed the baby's readiness to suck and clinical stability. The doctors would request it or we would ask if it was okay to put the baby on the breast."

These statements clearly show that, in the most serious cases of babies admitted to the NICU, the clinical condition is essential for the first evaluation and that, in some contexts, medical authorization is required for the speech-language pathologist to be included in the case. Corrected gestational age and weight are also taken into consideration in some services.

When referring to the initial work with low-risk babies, we observed more autonomy of the speech-language pathologist, as revealed by participant #12: "In the NICU (neonatal intermediate care unit), it doesn't depend on the doctor's request. If we see that there is a condition and readiness, we start to stimulate. In the NICU, however, we only do it with a request for the doctor's opinion."

Also in the perspective of work in hospital settings, data showed the existence of the multidisciplinary team and their partnership relationships and/or disagreements regarding speech therapy procedures. Speech therapy in the NICU has a solid history of practices based on scientific evidence, but often unknown to the other members of the team. It was clearly seen in the following statement:

Participant #29: "There are doctors, nurses, physical therapists, nutritionists, but there is no occupational therapy (…) The physical therapy, psychology, and nursing professionals help a lot. What we sometimes face as a barrier is the medical team, because sometimes we want to perform a different approach, let's say 'translactation,' and today's doctor agrees, but tomorrow's doctor doesn't agree, and then our approach changes."

The participant's statement showed that dialogue with the medical team is essential for the constant understanding and

maintenance of the approach in breastfeeding. It is important that doctors understand the clinical reasoning that the speech therapist has outlined for the baby, so that there is an agreement between all the professionals involved and breastfeeding can be fully implemented.

The statement also revealed concern about the lack of continuity in speech therapy, however, the speech therapist's work schedule at the hospital does not include a 24-hour routine, that is, the baby's needs can change at any time, especially at-risk babies. Therefore, the constant presence of a speech therapist in the NICU is required to avoid changes in the approach in his/her absence.

Finally, regarding speech therapy in breastfeeding in hospital settings, participants mentioned the differences between working in private and public services.

Participant #5: "The institution itself (referring to a SUS institution) offered several training courses to the teams. So, I took courses on the BFHI, the Kangaroo method, a course to be a Kangaroo method tutor, BF counseling, several courses."

Participant #19: "Because it is a private NICU, there is the reality of having to rotate beds. So, unfortunately, we won't have a high number of BF cases because of that."

Participant #12: "It doesn't depend on the doctor, in the public sector (referring to the speech therapist's work). In the private service where I work, it can only be with a doctor's request because of the health insurance plan."

These statements clearly show that there are differences between the two service realities. The SUS, by complying with public policies of breastfeeding, can ensure its promotion, protection, and support with more engagement. The private service management, on the other hand, involves other principles, which do not necessarily include breastfeeding as one of the focuses of care for the mother-baby dyad.

During the interviews, other scenarios of speech therapy work in breastfeeding were mentioned in the statements, as can be seen in the following excerpts:

Participant #3: "Today I'm 100% dedicated to private care. I work in two offices and I also do several home visits."

Participant #22: "I'm currently a supervising professor at (name of hospital and location), where we provide care in both the rooming-in service and the NICU."

Participant #17: "Today I only work in the office (...) and I think it's important to say that I make a living from this. It's a job that allows me to live off my work (...) I think it's important to say that it can be a financially viable job option for speech therapists."

These excerpts from speech therapists show the possibility of working with private home visits and/or in offices. They clearly show that there is a demand for this type of work and the participants stated that financial stability is viable when providing BF care. In addition, it is worth highlighting the opportunities for speech therapists in teaching undergraduate or graduate courses.

Given the reality of the COVID-19 pandemic, remote speech therapy support has become another option, as observed in the statement of Participant #17:

Participant #17: "The pandemic taught us how to work online. Of course, there are many things you can't do online, but I work with weaning, I work with return to work, I work with induced lactation in non-pregnant women, I work with pregnant women. We can do all these things online."

Online services were eventually provided before the pandemic; however, the participants clearly showed the pandemic helped normalize this type of service, due to social contact restrictions. This way, the Federal Council of Speech Therapy regulated the remote speech therapy service as a practice of this profession, using communication technologies for promotion, prevention, evaluation, diagnosis, and intervention in some areas of speech therapy[9].

In another moment in the interview, the participants reported referral of the mother-baby dyad to other professionals:

Participant #1: "I've referred them to pediatricians, pediatric pulmonologists, pediatric gastroenterologists, allergists, osteopaths, pediatric dentists, otolaryngologists, and nutritionists."

In addition to issues related to the work options and referrals, the interviewees highlighted the need to meet demands that go beyond the issues involved in OM. The assessment and use of speech therapy techniques should be more comprehensive and take into account the family history and its representations for the baby, which are so important for the development of the subjects and linked to the development of language, as explained in the following statement:

Participant #10: "It turns out that in teaching and in what I provide in my care, there is a lot of counseling, listening, support, personalizing that story, about what's going on there, more than how the baby will breastfeed, the weight the baby will gain, the utensil to be used, so it's the motherhood happening, there's parenthood, there's this family being formed, that human being is much more than what, when or how the baby eats. So, I believe that breastfeeding is a wonderful and very powerful way for a human being to bond with his or her mother. Therefore, our role as a health promoter, not just a breastfeeding promoter, is to understand the particularities of each story."

Regarding these aspects, we can say speech therapists must act broadly, considering the baby's development as a whole, offering care that integrates the various areas of speech therapy, including OM, dysphagia, language, and audiology. In addition, one of the intrinsic characteristics of speech therapy is qualified listening, in which the woman finds space to be a protagonist in the breastfeeding process.

Challenges of the speech therapist's work in breastfeeding

One of the challenges highlighted was the lack of preparation of healthcare professionals regarding breastfeeding, whether in maternity wards or clinics, to support the mother-baby dyad at the beginning of the feeding process, as seen in the following excerpt:

Participant #27: "I think that if I could list the number one issue, it would be the care received in maternity wards. The professionals who work in maternity wards don't know how to work with breastfeeding. They know how to prescribe infant formula, they know how to identify the need to gain weight, pee and poop, that's it. They don't know how to manage breastfeeding and I think it's very serious (…) mothers should leave the hospital with a contact for help if they need it and not with a prescription for infant formula."

Maternity wards are the place where breastfeeding will happen for the first time and will likely involve doubts and insecurities that must be supported by the healthcare professionals who are

there; then, all healthcare team must be prepared to manage breastfeeding.

Mothers who leave the maternity ward without trusting the professionals who assisted them, or who leave without a contact to rely on when faced with obstacles that may arise, can make use of information on social media, which is often divergent and doesn't provide technical support.

BF is a field where different types of professionals can work. The first professionals who come into contact with the mother-baby dyad are not necessarily speech therapists. Then, the late search for a speech therapist may lead to a challenge in their work, as highlighted in the following statements:

Participant #15: "When they come to us, unfortunately, most of them already have breast injuries (…) they often don't seek us if they don't have breast injury or if they aren't having problems."

Participant #22: "My biggest problem is that they don't know that a speech therapist can help them resolve BF issues. Most people come to the speech therapist as a last resort. They seek a consultant, a nurse, and never a speech therapist. It takes a long time to contact us."

These excerpts show that the search for a speech therapist often occurs when the eating disorder has already set in, so that establishing exclusive breastfeeding (EBF) becomes more challenging. The statements also highlight the importance that other professionals have right after birth (nurses and/or breastfeeding consultants). The fact is that these professionals are contacted first, and it may happen due to a lack of knowledge about the role of the speech therapist in BF by the parents and the professionals who assist them.

Delay in starting speech therapy focused on temporary dysphagia rehabilitation[10] may lead mothers to introduce complementary feeding too early and cause that much-feared early weaning. This situation could easily be managed with specialized care from a speech therapist, whose intervention would be much more effective when performed at the beginning of the BF process. In other words, mother-baby dyads could benefit from the work of a speech therapist, who provides specialized clinical management of BF. However, they end up needing rehabilitation due to iatrogenic situations caused by a lack of knowledge about the risk factors involved.

Participant #15: "When they come for a doctor's appointment, the baby hasn't gained weight, the mother gets desperate and starts feeding with a bottle. It's much harder to reverse that."

Participant #22: "They arrive with a bottle, without a feeding tube, which makes the job much more difficult."

Another challenge mentioned by the participants was the high demand of patients and the reduced number of speech therapists in the hospital setting, both in the public and private services.

Participant #30: "Our demand is very high. For example, today we have 26 babies in a unit and 18 of them need speech therapy. So we created a priority protocol. Priority one babies are those closest to discharge or those whose mothers are having more issues; priority two refers to moderate cases; priority three refers to babies who are not yet heavy enough to start breastfeeding, those who are in screening and observation."

Participant #12: "The health insurance only pays for one appointment per day and I need to see all the babies during that feeding time."

Another aspect addressed in the interviews regarding the hospital setting was the conditions for the provision of care to mothers.

Participant #37: "For NICU mothers, we have a space called the postpartum mother's house, where the mother can sleep, take a shower, rest, but in order to stay there she must have an interview with a social worker. However, there are only six beds and the NICU has 20."

Participant #5: "One issue is the accommodation for the mothers. The hospital should have accommodation for the mothers to stay. The mother goes home, takes the bus to the hospital, and just had a surgery, and then returns home with all the violence out there, sometimes leaving at night to stay with the baby (…) if you want to promote breastfeeding, you must provide the conditions to mothers so they can stay in the hospital."

The barrier of physical distance between the mother and baby directly influences the progress of breastfeeding.

DISCUSSION

In Brazil, there are several public policies to promote breastfeeding and, in general, all professionals involved in maternal and child health receive general breastfeeding training. However, mother-baby dyads may require more specialized practices that can only be offered by speech-language pathology[4].

Training in speech-language pathology allows a highly synergistic approach, due to the interface that breastfeeding creates with several fields, offering the mother-baby dyad a completely differentiated care. In the context of a healthy baby, breastfeeding is expected to involve clinical management linked to a physiological process, mainly involving actions of support and encouragement in response to the needs of the dyad. However, even in this context, it should be noted that a large number of births in Brazil are by elective cesarean section, a fact that may affect the baby's maturity and development[11]. It may mask the presence of functional dysphagia[10], which requires temporary specialized care to avoid exposing the baby to health risks or even leading to early weaning[12]. This is an important gap in neonatal care and highlights the need for further studies to demonstrate the role of speech-language pathologists and their impact on breastfeeding as a process.

Breastfeeding should be considered the first stage of the feeding process. Then, the role of the speech-language pathologist has not only organic and physiological aspects, but also knowledge of health and development, considering the promotion of care at its various levels. Therefore, health care should be understood as a dimension that goes beyond technical interventions, as a territory where subjects meet and, through the exchange of experiences, welcome each other and create bonds[13].

Speech-language pathologists are health professionals who enable and rehabilitate orofacial functions, including breastfeeding. In this sense, recognition of their work was expected both from other professionals and families. However, in general, it is clear that dyads with breastfeeding issues take a long time to seek speech therapy.

Speech therapy work in hospitals has improved and contributed to the development of public policies, such as proposed laws/laws. In the hospital setting, the approaches cover diagnosis, rehabilitation, health promotion and protection[14]. A significant number of the interviewees reported that they work in hospitals/maternity wards. In these environments, speech therapy work produces positive effects on breastfeeding, by building maternal knowledge, improving the mother-baby relationship, and

providing an intervention in the baby's orofacial functions, which may lead to reduced hospital length of stay[15].

Although the objectives of the speech therapy work are the same, speech therapy approaches vary according to the demands of the different hospital environments. Rooming-in is a system that allows dedication to the mother and baby, as it facilitates the healthcare professional and dyad meeting for exams and exchange of information. Speech therapists contribute to the identification and intervention in orofacial alterations[16]; however, they are considered a professional category that may be necessary in care, but not as a mandatory resource in the team[17]. In addition, they are still strongly associated with speech issues, not as a promoter of maternal and child health[16].

In the NICU, the service must be equipped with technical and support structures suitable for the care of newborns with severe or potentially severe conditions. According to the guidelines of the SUS, there must be at least one speech therapist in the team[18]. According to several aspects, the diagnostic profile of prematurity and respiratory syndromes prevail in newborns in the NICU[19]. Therefore, the speech therapist's work goes even further, as these professionals can deal with the immaturity of babies, who benefit from stimulation to coordinate the functions of sucking, swallowing, and breathing (SSB), which supports the maturation of oral reflexes and favors the transition from the alternative feeding route to the oral route, weight gain, and reduced hospital length of stay[20].

Patient care must be shared, in any hospital environment, through the articulation of actions and exchange of knowledge between the members of the multidisciplinary team. Also, effective communication with mothers is important so that interventions with babies occur at the right time, favoring their growth and development, even if it requires minimal handling[21].

The interviewees clearly stated that the baby's clinical condition is a key factor to start the intervention and that weight and gestational age are also considered. However, as a promoter of BF, speech-language pathologists can begin their intervention with the mother by providing guidance on how to maintain lactation while the baby is still unable to suck the mother's breast, ensuring active and qualified listening, as this is probably a time of vulnerability for the family[22].

BF is a moment of connection between mother and child, with a positive impact on the physical and mental health of both. Although incipient, there is an intense interest of speech therapy in understanding parental issues related to BF, which, although it is a biologically determined process, is also made up of emotional and sociocultural issues[5]. The childhood and family background of the parents, especially of the mother, and their representations of the baby, are closely related to the care they provide to the baby and influence expectations and behaviors during breastfeeding. Professionals should observe the physical and visual contact between mother and baby, the maternal dedication, the mother's current social role, and the new self and the needs of the newborn who now fully depends on the mother[23], promoting positive developments of the bond that is being built.

In preterm babies, studies suggest that interventions for the transition from the alternative feeding route to the oral route should begin between week 32 and 34 of corrected gestational age, to coincide with the sucking pattern of the full-term baby who, at this age, develops coordination of SSB functions[20]. However, the readiness and guarantee of the oral route are linked to factors other than just the gestational age and weight of the baby, which also include clinical stability, muscle tone, oral motor skills, presence of oral reflexes, behavioral organization, and aspects of non-nutritive sucking, that is, the oral sensorimotor performance of preterm babies[24].

The beginning of speech therapy intervention for the transition to the oral route in the baby must be shared with the members of the multidisciplinary team. Since it is the second vital function, which directly affects the hospital length of stay[20], feeding the baby is of interest to all caregivers. Therefore, speech therapists should share the findings of their assessment and explain to the team their objectives and therapeutic plan for each case to ensure continuity in the speech therapy approach, even in the absence of this professional.

Another factor that directly affects the maintenance of speech therapy practice, especially in cases of EBF, is the accommodation for mothers so that they are present full-time with their children, ensuring a place to rest, clean themselves, and eat. When the baby is hospitalized, parents need to adjust their routine and, in many cases, do not have the means to financially support demands such as food and transportation, in addition to emotional needs[22].

In Brazil, most hospitals and maternity wards with care that prioritizes breastfeeding, such as hospitals with the Baby-Friendly Hospital Initiative (BFHI) or that have implemented the Kangaroo Method, have a public or philanthropic nature. This fact confirms the speech of the participants in this study who reported differences in speech therapy practice between the public and private services, as these policies advocate that all professionals in the health team must be trained and qualified to implement the breastfeeding standards, generating some autonomy for everyone in the team while approaching the mother-baby dyad. Therefore, speech therapists, supported by these policies, can have work recognition, particularly in cases where speech therapy interventions are required for BF to occur[25].

Besides the undeniable importance of speech-language pathologists in hospitals and maternity wards as promoters, protectors and supporters of BF, they should also provide post-discharge follow-up, whether in risk and high-risk outpatient clinics, in offices, clinics, at home, and even remotely. Although some dyads are discharged from the EBF service, many infants are weaned in the first weeks after hospital discharge and the lack of support from a trained professional may be one of the reasons[25,26].

The interviewees highlighted the need to often refer mother-baby dyads to complementary specialties. Supporting BF also means identifying issues related to this practice, since they directly impact its prevalence. Therefore, it is important that speech-language pathologists know how to recognize that each specialty has specific attributions and the articulation of these skills, when necessary, by requesting the opinion of another health professional, so that the maternal and child health can benefit from different professional qualities[27].

Today, BF is still seen by parturient women and their families as an instinctive practice and, when faced with issues, they may consider themselves insufficient to feed their babies. Therefore, health professionals must be aware of breastfeeding techniques, enabling the exchange of information and encouraging women to breastfeed[25]. Professional unpreparedness is closely related to their training with theoretical knowledge and technical skills related to BF[26]. Just as trained professionals can promote BF, unprepared professionals can favor early weaning.

Contemporaneity and the influence of social media encourage the search for information about motherhood and BF. Technological tools provide information and advice related to the exercise of motherhood in an unlimited and unregulated manner. Although these virtual spaces provide support for maternal issues, it is important to identify limits so that women are not passively taught to be mothers through the authority of others who transmit the ideals of motherhood[28]. Also, motherhood presented on social media is often unrealistic and unattainable, which can lead women to feelings of failure, guilt, and helplessness.

The challenge of a late search for a speech-language pathologist may be related to the gap that occurs in the prenatal period, an ideal time to support pregnant women by directing them to the necessary services and providing guidance and disseminating the role of each professional who makes up the multidisciplinary team in interventions, leading to security in their conduct during the postnatal period and in the family's connection with the professionals[29].

CONCLUSION

The speech-language pathologists interviewed in this study had their breastfeeding training in public services, especially those who had the BFHI and/or Kangaroo Method qualification, or sought training in graduate courses, some in this field and some multidisciplinary courses.

The work of speech-language pathologists in breastfeeding has changed with national public policies, and the places where they work present challenges beyond the work in breastfeeding itself.

The scenario of breastfeeding in Brazil shows the need for the presence of speech-language pathologists, because, despite the importance of the multidisciplinary team, speech therapy can contribute in a unique way to the promotion and establishment of breastfeeding as an initial feeding process and the development of subjects in this process.

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