Esc Anna Nery 2022;26:e20210056

EXPERIENCE REPORT | RELATO DE EXPERIÊNCIA

www.scielo.br/EAN

Lactation induction in women who never got pregnant: experience report

Indução da lactação em mulheres nuligestas: relato de experiência

Inducción de la lactancia en mujeres nuligestas: informe de experiencia

Luciane Cristina Rodrigues Fernandes[1]
Clara Fróes de Oliveira Sanfelice[1]
Elenice Valentim Carmona[1]

1. Universidade Estadual de Campinas, Faculdade de Enfermagem. Campinas, SP, Brasil.

Abstract

Objective: to report the experience of lactation induction in women who never got pregnant by a lactation consultant nurse. **Method:** experience report. The process of lactation induction was performed with three women due to surrogate pregnancy and homosexual relationships. **Results:** all noticed an increase in the size and sensitivity of the breasts, as well as milk secretion. However, the continuity of breastfeeding was different between them. The first did not receive support from health professionals in the postpartum hospital setting, nor at home, and did not continue breastfeeding. The second received support from the hospital staff and her partner, breastfeeding for three months. The third, with the support of her partner, breastfed for two months, but stopped because she felt inhibited by family members. **Conclusion and implications for practice:** the induction technique is capable of triggering milk production. However, the breastfeeding process was only established through the association with the support network, the reception, the encouragement of the health team, and the comprehensive view of the woman and her family. Thus, nursing care in lactation induction should not focus only on the management of induction, but transcend the technical aspect, which is essential for the protection, establishment, and continuity of breastfeeding.

Keywords: Lactation; Breast Feeding; Sexual and Gender Minorities; Homosexuality, Female; Surrogate Mothers.

Resumo

Objetivo: relatar a experiência de indução da lactação em nuligestas realizada por enfermeira consultora em aleitamento. **Método:** relato de experiência. O processo de indução láctea foi realizado com três mulheres por motivo de gestação em útero de substituição e relacionamento homoafetivo. **Resultados:** todas perceberam o aumento de tamanho e a sensibilidade nas mamas, bem como apresentaram secreção láctea. No entanto, a continuidade da amamentação foi diferenciada entre elas. A primeira não recebeu apoio de profissionais de saúde no contexto de pós-parto hospitalar, nem em casa, e não deu continuidade à amamentação. A segunda recebeu apoio da equipe do hospital e da parceira, amamentando por três meses. A terceira, com o apoio da parceira, amamentou por dois meses, mas interrompeu por sentir-se inibida por familiares. **Conclusão e implicações para a prática:** a técnica de indução é capaz de desencadear a produção láctea. Já o processo de amamentação só se estabeleceu mediante a associação com a rede de apoio, o acolhimento, o incentivo da equipe de saúde e o olhar integral à mulher e sua família. Dessa forma, o cuidado de Enfermagem na indução láctea não deve focar apenas no manejo da indução, mas transcender o aspecto técnico, o que se mostra como fundamental para a proteção, o estabelecimento e a continuidade da amamentação.

Palavras-chave: Lactação; Aleitamento materno; Minorias sexuais e de gênero; Homossexuais femininas; Mães substitutas.

Resumen

Objetivo: reportar la experiencia de inducir la lactancia en nuligestas realizada por una consultora de enfermería en lactancia materna. **Método:** relato de experiencia. El proceso de inducción de la leche se realizó con tres mujeres por embarazo en útero de reemplazo y relación homoafectiva. **Resultados:** todas notaron el aumento de tamaño y la sensibilidad en las mamas, además de presentar secreción de leche. Sin embargo, la continuidad de la lactancia materna se diferencia entre ellos. La primera no recibió apoyo de los profesionales de la salud en el contexto posparto hospitalario, ni en el domicilio, y no continuó con la lactancia. La segunda recibió apoyo del personal del hospital y su pareja, amamantando durante tres meses. La tercera, con el apoyo de su pareja, amamantó durante dos meses, pero la interrumpió porque se sentía inhibida por familiares. **Conclusión e implicaciones para la práctica:** la técnica de inducción es capaz de desencadenar la producción de leche. El proceso de lactancia materna, en cambio, solo se estableció a través de la asociación con la red de apoyo, la acogida, el estímulo del equipo de salud y la mirada integral a la mujer y su familia. Así, el cuidado de Enfermería en la inducción de la leche no debe enfocarse solo en el manejo de la inducción, sino trascender el aspecto técnico, que se muestra fundamental para la protección, el establecimiento y la continuidad de la lactancia materna.

Palabras clave: Lactancia; Amamantamiento; Minorías sexuales y de género; Homosexuales femeninas; Madres sustitutas.

Corresponding author:
Luciane Cristina Rodrigues Fernandes.
E-mail: fernandeslcr@gmail.com

Submitted on 03/17/2021.
Accepted on 10/27/2021.

DOI:https://doi.org/10.1590/2177-9465-EAN-2021-0056

INTRODUCTION

Breastfeeding is more than the act of feeding. It is a dynamic process of mother-baby interaction that provides food security, promotes health and well-being, in the short and long term, and is able to impact the cognitive and emotional development of both[1-4].

Lactation Induction (LI) is a process by which a non-puerperal woman is stimulated so that her breasts are physiologically suitable for lactation. This technique is used by women who wish to breastfeed an adopted baby or in the case of babies generated by so-called surrogate pregnancy, which in Brazil is also known as surrogate uterus[5]. In other words, a situation in which an agreement is established in which a woman becomes pregnant and gives birth to a child that will be assumed as a child by another person or couple. Another possibility is breastfeeding by women who have had their children conceived by their partners[6] in homo-affective relationships.

Surrogate pregnancy is an assisted reproduction technique that involves the temporary donation of a uterus by another woman when pregnancy is not possible[7]. The woman who chooses to become a mother via surrogacy pregnancy will not be exposed to the lactogenic hormones of pregnancy, thus the mother-child dyad may not enjoy the benefits of breastfeeding after birth. However, due to the successful induction of lactation in surrogate mothers[6,8], there has been interest in testing the feasibility of this intervention in surrogate mothers[7].

In addition to physiological aspects, the establishment and continuation of breastfeeding is influenced by several factors such as maternal age, education, emotional aspects, cultural and economic factors, as well as the support of family members, friends, and health professionals[2]. These factors can interfere with the mother's attitudes and knowledge about breastfeeding, as well as her self-confidence, influencing the continuation[9].

The act of breastfeeding is considered natural and physiological, but it is influenced by several factors, as mentioned. In addition, it depends on the learning that mother and child develop together. Thus, difficulties may be experienced, especially in the first days[9]. In this sense, the journey to breastfeeding through induced lactation is also full of challenges and fears[5].

Among health professionals, nursing professionals are those with the greatest opportunity to interact with and influence mother and child. There are numerous ways in which members of the nursing team can offer support to women in the breastfeeding process, which is not limited to just helping the baby feed through the breast[10]. Also essential are: an educational process on the importance of breastfeeding; strategies for maintaining milk production; information on manual milk extraction or using a breast pump; the provision of educational brochures, as well as the identification of people in the family who can help the woman[11].

Thus, it is urgent that the Nursing team and all health professionals who work in rooming-in and in the various contexts where breastfeeding occurs acquire theoretical and practical knowledge in order to provide effective support for successful breastfeeding[9], including the LI process.

By understanding that breastfeeding is a multifactorial practice, the training of professionals working in the area is necessary, as well as the sharing of experiences on topics that have not yet been investigated with robust research methods. From this perspective, the objective of this paper is to report the experience of lactation induction, carried out by an obstetric nurse, a breastfeeding consultant, with three women in different contexts. It is expected to contribute to reflections on the theme, understanding that it is not enough to provide guidance on the technique, but to contemplate the individual welcoming, the integral view of the woman and her family, as well as the establishment of a support network.

DESCRIPTION OF THE EXPERIENCE

This experience report addresses cases of three women who underwent LI. The first case (Case A) concerns the LI in a woman who became a mother via surrogate uterus; while the second (Case B) and third (Case C) refer to the induction in mothers who had their children conceived by their partners in homosexual relationships, and in one of the cases, the pregnancy was twin. Since this is an experience report, it was not submitted to the evaluation of the Research Ethics Committee. However, the ethical precepts present in the norms of scientific research involving human beings were respected and the confidentiality of the identity of those involved was assured.

For all three women, the lactation induction protocol developed by Newman and Goldfarb was applied[12]. In the first and second cases, the follow-up occurred for three months prior to the birth of the babies and the regular LI protocol was used (Figure 1). In the third, the follow-up was for only one month with the baby already born five months ago. Therefore, the accelerated protocol was used (Figure 2).

These protocols use combined progesterone and estrogen pills, galactogogens (domperidone), and manual or pumped breast stimulation. For all cases, an obstetrician was involved as responsible for prescribing the drugs.

The **regular protocol** of LI is applied when there is enough time for its execution. It shows better results, being associated with a greater possibility of exclusive breastfeeding compared to accelerated[12].

When considering the accelerated LI protocol, milk production is generally lower compared to the regular protocol, but may play a significant role for milk production in cases where there is not enough time for the regular protocol to be applied[12].

The three cases were seen by the same obstetric nurse, and they were three women who had never been pregnant and, therefore, had no history of breastfeeding. At the end of the protocol, all noticed an increase in the size of their breasts, greater breast sensitivity, and presented milk secretion. The experiences with Cases A, B and C are described below.

As for the induction in Case A, the visits occurred in the doctor's office every two weeks for guidance and monitoring of the evolution. The woman used a bilateral electric breast pump, provided by the nurse who accompanied her, for breast stimulation,

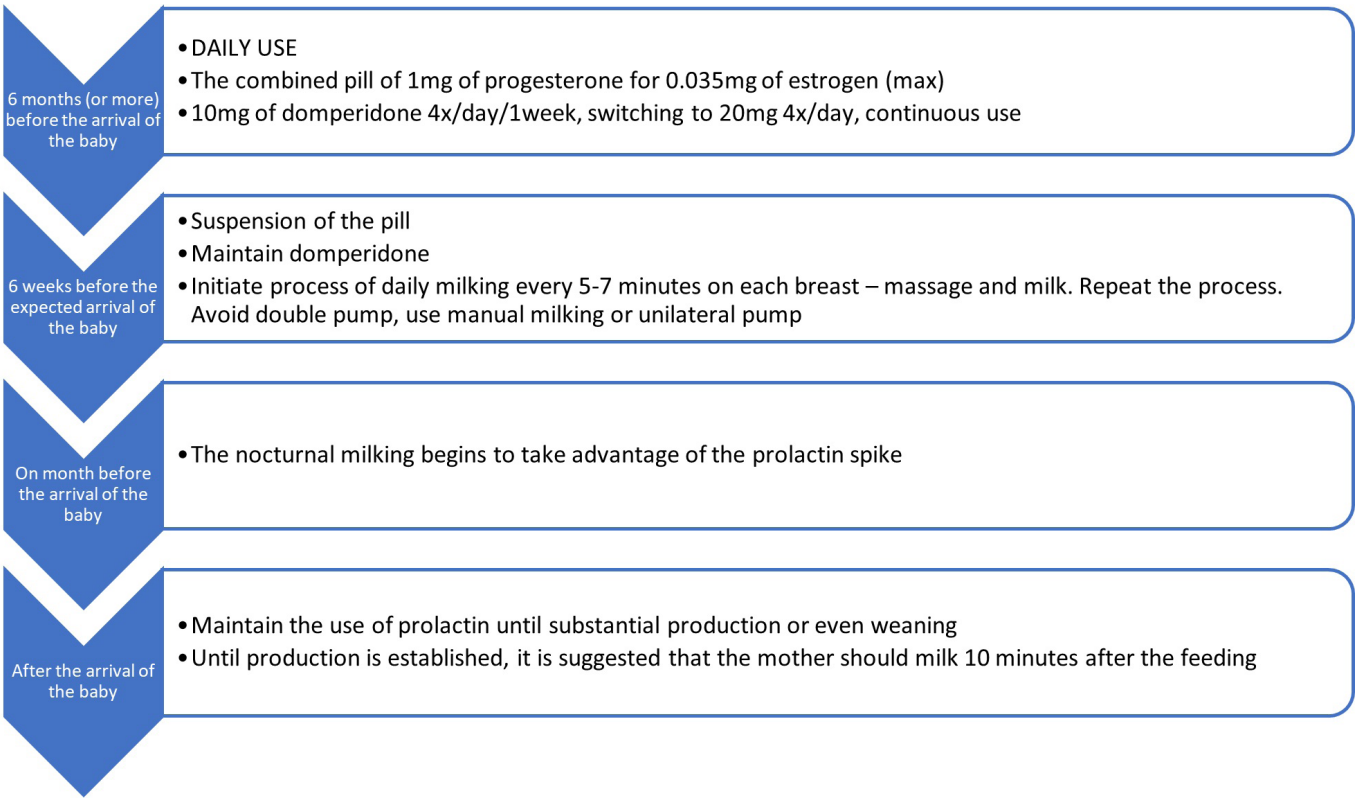

Figure 1. Regular lactation induction protocol[12].

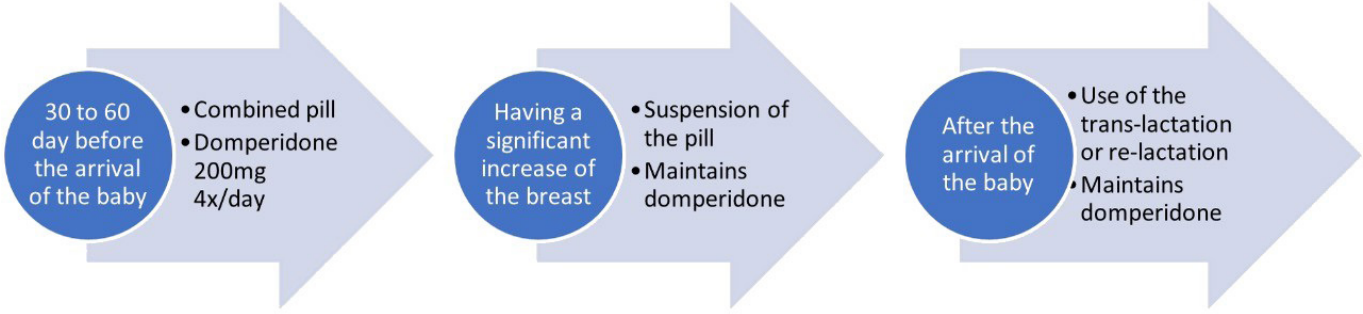

Figure 2. Accelerated lactation induction protocol[12].

which was done every three to four hours throughout the day, plus twice in the morning when she woke up. She had medical follow-up for the use of galactagogue (domperidone) and the hormonal pill according to the protocol mentioned. This process was followed up for three months. The technique for using the breast pump was oriented and supervised by the nurse during its first use. In the first two weeks, the woman complained of breast sensitivity, especially in the areolomammary region. At this moment, new orientation and supervision were done regarding the use of the electric pump. Despite the reported discomfort, the woman had good acceptance of the suggested protocol and followed it, showing good compliance to the proposed protocol. At no time, she presented complaints related to the side effects of the medications.

Case B, like the previous one, was followed up in the office every two weeks, using the same model of breast pump, also provided by the professional who accompanied her. As in the previous case, this process was also monitored for three months. The technique for using the breast pump was also oriented and supervised. In this case, the woman had great sensitivity in the areola-mammary region during the use of the pump. There was supervision and new instructions were given regarding the use

of the electric pump. Due to the high sensitivity, the frequency of stimulation of the breasts was three to four times during the day and only once in the morning. This woman experienced sensations that she described as "premenstrual tension" and that she felt pregnant and hormonally unstable like her partner. She referred to joy in feeling this way, as she could share, with her partner, the sensation of hormonal oscillations. The frequency of breast stimulation did not strictly follow the proposed protocol, but she used the medications as proposed.

In Case C, the mother decided to induce lactation when her daughter was already almost five months old and, for this case, home visits were made weekly and this mother chose not to use hormonal pills, only maintaining breast stimulation, with the same model of breast pump provided by the nurse who accompanied her, four times during the day, once or twice during the night, in addition to the use of the galactagogue (domperidone) according to the protocol mentioned. The pregnant mother would return to work when her daughter was six months old and this was the main reason that led her to seek the LI. Given the limited time, the "accelerated protocol" was chosen, as shown in figure 2. In common with the other women, this one also presented breast tenderness, especially in the areola-mammary region. The use of the breast pump was oriented and supervised. With the presence of the sensibility complaint, a new approach to the technique and reorientation about it were made. Due to the sensitivity, the woman chose to decrease the number of stimuli throughout the day. The choice for not using hormone was based on negative experiences lived.

In cases A and B, the women showed drops of milk secretion when using the breast pump at the end of the first month of induction. By the end of the second month it was possible to see more volume drained, and before the third month of follow-up the volume increased significantly. There was no specific pattern in the volume of milk they extracted, and it varied from ten to 30 ml at different times over the days. In Case C, the woman presented milk drops during the use of the breast pump three weeks after the beginning of the LI. Since the daughter was already breastfeeding her biological mother, she stopped using the breast pump and started to offer the breast directly to the baby at times when she wanted stimulation or when the daughter sought non-nutritive sucking.

The continuity of the breastfeeding process suffered the interference of multifactorial aspects that were not addressed during the LI assistance process. In Case A, due to the particularity of gestation by surrogate uterus, the woman was always followed up psychologically during the entire process. She was present at the birth of her child; however, she did not have skin-to-skin contact or breastfeeding during the first hour of life, since the hospital staff did not make this experience possible. In rooming-in, she stayed with her son, but reported that, again, breastfeeding was not stimulated. In addition, she received guidance on bottle-feeding with infant formula and was not offered the possibility of performing trans-lactation. During the entire hospitalization period, according to her perception, the team did not provide breastfeeding assistance. The woman mentioned that she tried to put the baby in the breast by herself, with difficulty and without help. She also reported that, after hospital discharge, she received no family support and was discouraged by her partner to seek professional attention to mediate the situation.

In Case B, before the birth, the mothers constructed a birth and breastfeeding plan describing their intentions about the birth and the postpartum period, as well as the encouragement of breastfeeding. This document was previously presented to the hospital before the birth of the twin daughters. In it, both mothers stated their desire to have skin-to-skin contact and to breastfeed within the first hour of life. It was also agreed between the two mothers that breastfeeding would also be performed by the non-biological mother. To support this request, the plan included photographic records of the milk extraction and the serological tests that proved the eligibility of both mothers to breastfeed.

On the day of birth, the birth plan was respected. In rooming-in, formula was prescribed, but the mothers chose to offer it only after breastfeeding on the mother's breast. At home, the family had a structured support network that helped and supported breastfeeding; the mother who induced lactation, breastfed for three months. Weaning occurred due to persistent breast lesions, which is one of the factors indicated in the literature as a possible cause of weaning[13,14].

In Case C, the mother (non-biological) started breastfeeding after the baby was six months old, interspersing breastfeeding with her partner, especially during periods of absence of the biological mother. The amount of milk was known to be less than that of her partner, but breastfeeding was initiated along with the introduction of food and successfully established after meals and for the baby's comfort. In this case, breastfeeding occurred for a period of two months and was interrupted due to the mother receiving the LI not feeling comfortable to breastfeed in public or in the presence of family members.

EXPERIENCE ANALYSIS

Technique for LI

The follow-up of these three cases confirms that the technical approach, without the integral reception of the woman and her family members, can lead to milk excretion, but does not contemplate all that is necessary for the establishment and continuity of breastfeeding.

Health systems, many of which have an innovative vision of public health, should develop a simple, low-cost model for equipping staff to provide breastfeeding support, which would raise the health status of the population by promoting the provision of better food to infants, as well as increase the satisfaction of breastfeeding families by achieving their goals. In addition, it would result in greater satisfaction of the team with their work, since they aim to provide adequate information and care, but do not always do so due to the work process, staffing, and lack of continuing education on breastfeeding[15].

It is of utmost importance that health professionals involved in obstetric and perinatal care develop technical knowledge and skills to act in support, promotion and protection of breastfeeding, which includes knowledge about the possibility of LI for women who have not given birth to their children.

This experience report denotes such fragility of the assistance, which needs to be changed in order to contemplate all women who will need LI. Moreover, it is verified that the professionals' personal beliefs about how successful or unsuccessful a woman will be in establishing and continuing breastfeeding are limiting for the success of this process, preventing families from receiving proper care. Moreover, the experiences described show that the health team is not yet prepared to meet the new family conformations. Thus, these are issues that should be further addressed in the training of professionals and in continuing education strategies.

Support network and knowledge of women's rights

The practice of breastfeeding and early weaning reflect the conjunction of biological determination and socio-cultural, economic, and political conditioning[4]. When investigating the factors that hinder the increase in the rates of Exclusive Breastfeeding (EBF) and lead to early weaning, the literature pointed out the following factors: lack of preparation of health professionals to welcome breastfeeding within the hospital routine; early introduction of milk formula; pain while breastfeeding or presence of breast lesion; maternal insecurity or negative past experience and lack of family support. In addition, there are special situations, such as prematurity and other health conditions that separate the mother from the newborn[13].

As exposed in the cases described, different factors led to the interruption of breastfeeding. In Case A, the lack of preparation of professionals and the absence of respect for women's rights in the puerperium and good practices in birth care culminated in the lack of opportunity for the mother to place her child close to the breast and experience skin to skin and breastfeeding in the first hour of her child's life. These events have been proven to favor the success of breastfeeding[1,16].

A systematic review pointed to recommendations that constitute a set of effective measures to encourage in-hospital EBF: early skin-to-skin contact; mother and child staying in a room together; intervention in breast pain during breastfeeding; restriction of the use of supplementary feeding for infants; breastfeeding on demand; and educational interventions through individual and/or group support during hospitalization[13]. Thus, in addition to the orientation about the technique of LI, the woman needs to know and have access to facilitators of the process of establishing, promoting and protecting breastfeeding.

The birth plan is the documentation of the couple's decisions regarding labor and birth. These decisions are based on safe possibilities for care. Thus, the birth plan is recommended by the World Health Organization (WHO) as one of the strategies to improve the level of care for women and newborns[16]. In it, it can be expressed the will of the permanence of a companion in accordance with the Federal Law No. 11.108/2005: guarantees to the parturient women the right to a companion during all labor, delivery and postpartum, in the Unified Health System (UHS), in the own or associated network, as well as the possibility to request that the State Law (SP) No. 15.759/2015 be applied, which ensures the right to humanized childbirth in public health facilities in the State and other provisions, encompassing the good practices for labor and birth[16].

In this context, the birth plan is much more used focusing on issues related to labor and delivery than on breastfeeding. This experience report demonstrates the urgency for professionals and women to know the relevance of it also being used to determine issues related to breastfeeding. In addition, it was found that women who presented a birth plan had more autonomy during hospital care than those who did not, which may encompass the LI. The women's understanding of this issue can decrease the risk of malpractice related to labor and birth, as well as ensure their protagonism in the birth and care of their child, as was experienced by the women in Case B.

Social Paradigms

LI makes it possible for mothers who have not given birth to their children to breastfeed. Thus, with the increased dissemination of this technique, a greater number of women who adopt and homo-affective women will be able to take advantage of this worldwide recommended practice, which is also relevant so that more children can benefit from the numerous advantages of human milk for their growth and development, in addition to the affective aspects.

For this to happen more naturally and for the wishes of the mother (or mothers) to be respected, both health professionals and society will need to revisit and understand the definition of the term "cross-feeding". Cross-feeding refers to the practice of feeding a baby through the breast of a woman other than the mother. By understanding that a woman who adopts a baby is its mother, just as the two women in a homosexual couple are mothers of the same baby, there will be no harm or risk to the child if it is breastfed by the mother, whether or not she is the mother of the baby.

The imposition of some social models may prevent the continuation of breastfeeding with consequent misfortune to infant health. Such models are related to the greater appreciation of milk formula and the devaluation of breastfeeding. Moreover, they are also related to the non-acceptance of the mother's wishes, to the imposition of norms as to what is expected from the female behavior and the supremacy of the heterosexual relationship, aiming to suppress or ignore the freedom of women and the existence of homosexual relationships. This imposition, for example, made the woman in Case C feel extremely uncomfortable breastfeeding her daughter in places where she could be exposed to social judgment.

By understanding that breast milk is the best food a baby can receive and that breastfeeding involves much more than nutrition, it is essential to be more welcoming and change the paradigms imposed by a consumerist and hetero-normative culture.

Comprehensive care: Glimpsing beyond the technical

Each woman and family has particularities that need to be understood in order to offer individualized assistance that contemplates integral care and articulates actions for the promotion, protection, and support of breastfeeding. The established care plan must be understood and make sense to the woman and her family, but mainly to the woman. In addition, strategies should be established to prevent problems that lead to weaning, such as care for nipple and neck lesions, among other needs[3]. Health Care Networks, regardless of the agent providing the care or the place of service provision, should be linked to the recovery of breastfeeding-related practices so that obstacles are removed and appropriate breastfeeding practices are disseminated[3]. Here, the urgency of the preparation of professionals to receive women undergoing or in need of breastfeeding is emphasized, providing support for the maintenance of breastfeeding. However, as already described, there are still many barriers for women to enjoy a support network that is strengthened and prepared to facilitate breastfeeding. The monitoring of the woman and her child by a breastfeeding consultant, from the moment of discharge, may be one of the possible solutions[17]. When thinking about women who cannot afford this specialized care, professionals must be prepared to perform this role in primary care.

Thus, another relevant aspect is that the skills and knowledge on breastfeeding cannot be exclusive to specialists, considering the relevance of its impact on the population's health. Thus, by perpetuating a disparate access to health care, only the families with greater purchasing power will have the support of this type of specialist because they can afford to hire him/her. Therefore, the training of health professionals should aim to ensure that the promotion and support for breastfeeding are guaranteed in prenatal care, hospital care for labor, birth, and puerperium, and in the continuity of care in primary health care in all establishments linked to UHS. These professionals should be trained in breastfeeding to provide equitable care. It is considered that raising breastfeeding rates is a simple and low-cost public health strategy that provides a higher level of satisfaction to families, helping them to value this health care and achieve their breastfeeding goals[15].

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

The experience of the three women showed that breastfeeding in women who had never been pregnant is feasible and should not be seen only as the application of techniques and protocols to stimulate breast tissue. Milk excretion does not define satisfaction or success in the breastfeeding process in these women, but the process as a whole. It is emphasized the relevance of offering clarification on the concepts related to breastfeeding and the rights of breastfeeding women, as well as the importance of professionals investigating their needs in an individualized manner. In addition, the professionals must also identify their limitations of knowledge, beliefs, and values that may negatively interfere in the assistance and rates of breastfeeding.

The monitoring of the LI process in these women showed that breastfeeding transcends the action of nurturing, and its continuity is influenced by issues of multifactorial origin that must be considered and included in the care plan. Health professionals must take ownership of the LI strategies, going beyond the technical aspect of induction, considering the subjectivity of those involved, contemplating scenarios that are becoming increasingly present, such as adoptive mothers, surrogate wombs, and homosexual couples.

From this perspective, basic professional training and continuing education should cover the LI not only in its technical management, but also help women overcome their fears, face challenges, and structure a support network so that breastfeeding becomes a satisfactory experience for the woman, the baby, and the family. Given the positive impact of breastfeeding on the population's health and on the establishment of the bond between mother and child, it is hoped to inspire other professionals to develop individualized strategies to promote it.

AUTHORS' CONTRIBUTIONS

Experience Report Design. Luciane Cristina Rodrigues Fernandes. Clara Fróes de Oliveira Sanfelice. Elenice Valentim Carmona

Information collection. Luciane Cristina Rodrigues Fernandes.

Experience Analysis. Luciane Cristina Rodrigues Fernandes. Clara Fróes de Oliveira Sanfelice. Elenice Valentim Carmona

Interpretation. Luciane Cristina Rodrigues Fernandes. Clara Fróes de Oliveira Sanfelice. Elenice Valentim Carmona

Writing and critical revision of the manuscript. Luciane Cristina Rodrigues Fernandes. Clara Fróes de Oliveira Sanfelice. Elenice Valentim Carmona

Approval of the final version of the article. Luciane Cristina Rodrigues Fernandes. Clara Fróes de Oliveira Sanfelice. Elenice Valentim Carmona

Responsibility for all aspects of the content and integrity of the published article. Luciane Cristina Rodrigues Fernandes. Clara Fróes de Oliveira Sanfelice. Elenice Valentim Carmona

ASSOCIATED EDITOR

Beatriz Rosana Gonçalves de Oliveira Toso

SCIENTIFIC EDITOR

Ivone Evangelista Cabral

REFERENCES

1. Victora CG, Horta BL, de Mola CL, Quevedo L, Pinheiro RT, Gigante DP et al. Association between breastfeeding and intelligence, educational attainment, and income at 30 years of age: a prospective birth cohort study from Brazil. Lancet Glob Health. 2015;3(4):e199-205. http://dx.doi.org/10.1016/S2214-109X(15)70002-1. PMid:25794674.

2. Victora CG, Bahl R, Barros AJ, França GV, Horton S, Krasevec J et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. Lancet. 2016;387(10017):475-90. http://dx.doi.org/10.1016/S0140-6736(15)01024-7. PMid:26869575.
3. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Bases para a discussão da política nacional de promoção, proteção e apoio ao aleitamento materno [Internet]. Brasília: Ministério da Saúde; 2017 [citado 2021 jan 10]. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/bases_discussao_politica_aleitamento_materno.pdf
4. Venancio SI, Toma TS. Promoção, proteção e apoio ao aleitamento materno: evidências científicas e experiências de implementação [Internet] São Paulo: Instituto de Saúde; 2019 [citado 2021 jan 10]. Disponível em: http://www.saude.sp.gov.br/resources/instituto-de-saude/homepage/pdfs/49082001internetbx.pdf
5. Farhadi R, Philip RK. Induction of lactation in the biological mother after gestational surrogacy of twins: A novel approach and review of literature. Breastfeed Med. 2017;12(6):373-6. http://dx.doi.org/10.1089/bfm.2016.0112. PMid:28631931.
6. Wahlert L, Fiester A. Induced lactation for the nongestating mother in a lesbian couple. Virtual Mentor. 2013;15(9):753-6. http://dx.doi.org/10.1001/virtualmentor.2013.15.9.ecas2-1309. PMid:24021102.
7. Zingler E, Amato AA, Zanatta A, Vogt MF, Wanderley MD, Mariani Neto C et al. Lactation induction in a commissioned mother by surrogacy: effects on prolactin levels, milk secretion and mother satisfaction. Rev Bras Ginecol Obstet. 2017;39(2):86-9. http://dx.doi.org/10.1055/s-0037-1598641. PMid:28257588.
8. Wilson E, Perrin M, Fogleman A, Chetwynd E. The intricacies of induced lactation for same-sex mothers of an adopted child. J Hum Lact. 2015;31(1):64-7. http://dx.doi.org/10.1177/0890334414553934. PMid:25311827.
9. Carvalho MR, Gomes CF. Amamentação: bases científicas. 4ª ed. Rio de Janeiro: Guanabara Koogan; 2017. 554 p.
10. Emídio SCD, Oliveira VRRF, Carmona EV. Mapeamento das intervenções de enfermagem no estabelecimento da amamentação em uma unidade de internação neonatal. Rev Eletr Enferm. 2020;22. http://dx.doi.org/10.5216/ree.v22.61840.
11. Shattnawi KK. Healthcare professionals' attitudes and practices in supporting and promoting the breastfeeding of preterm infants in NICUs. Adv Neonatal Care. 2017;17(5):390-9. http://dx.doi.org/10.1097/ANC.0000000000000421. PMid:28787301.
12. Newman J, Goldfarb L. Introduction to the protocols for induced lactation Canadian [Internet]. Quebec: Canadian Breastfeeding Foundation; 2000 [citado 2021 jan 10]. Disponível em: https://www.canadianbreastfeedingfoundation.org/induced/regular_protocol.shtml
13. Coca KP, Amir LH, Alves MRS, Barbieri M, Marcacine KO, Abrão ACF. Measurement tools and intensity of nipple pain among women with or without damaged nipples: a quantitative systematic review. J Adv Nurs. 2019;75(6):1162-72. http://dx.doi.org/10.1111/jan.13908. PMid:30407654.
14. Berens P, Eglash A, Malloy M, Steube AM. ABM clinical protocol: persistent pain with breastfeeding. Breastfeed Med. 2016;11(2):46-53. http://dx.doi.org/10.1089/bfm.2016.29002.pjb. PMid:26881962.
15. Eglash A. An alternative strategy to solve the problem of the discontinuity of breastfeeding care. Breastfeed Med. 2016;11(3):153. http://dx.doi.org/10.1089/bfm.2016.0028. PMid:26982551.
16. Ministério da Saúde (BR), Secretaria de Ciência, Tecnologia e Insumos Estratégicos, Departamento de Gestão e Incorporação de Tecnologias em Saúde. Diretrizes nacionais de assistência ao parto normal: versão resumida [Internet]. Brasília: Ministério da Saúde; 2017 [citado 2021 jan 10]. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/diretrizes_nacionais_assistencia_parto_normal.pdf
17. Garner CD, Ratcliff SL, Thornburg LL, Wethington E, Howard CR, Rasmussen KM. Discontinuity of breastfeeding care: "there's no captain of the ship. Breastfeed Med. 2016;11(1):32-9. http://dx.doi.org/10.1089/bfm.2015.0142. PMid:26566010.