



Promotion and support of breastfeeding directed to mothers in the Rede Mãe Paranaense

Promoção e apoio ao aleitamento materno direcionados às puérperas na Rede Mãe Paranaense

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ABSTRACT

To identify the practices of promoting and supporting breastfeeding in maternity hospitals of three health regions of Paraná, Brazil. Cross-sectional study, with 1,270 puerperal women, between 2017 and 2018, using an instrument that included prenatal, delivery and postpartum care. The Chi-Square test was performed in the program XLSTAT, Version 2017. In prenatal care, 27.1% of pregnant women received guidance on breastfeeding and 44.5% prepared for breastfeeding. Skin-to-skin contact occurred in 45.1%, with contact time less than 15 minutes (65.2%) and breastfeeding in the first half hour of life in 61.8%. In the joint housing, 88.6% received support and guidance and 93.9% practiced free demand. There were no guidelines to persist with lactation (47.3%), there was the use of cups or cups to offer breast milk (38.1%), and 47.1% donated breast milk. Factors that promote breastfeeding were identified, but not in an integral way.

Keywords: Breast feeding. Lactation. Maternal and child health. Milk banks. Postpartum period.

RESUMO

Identificar as práticas de promoção e apoio ao aleitamento materno em maternidades de três Regionais de Saúde do Paraná, Brasil. Pesquisa transversal, com 1.270 puérperas, entre 2017 e 2018, utilizando um instrumento que contemplou o pré-natal, parto e pós-parto. Foi realizado o teste qui-quadrado no programa XLSTAT Versão 2017. No pré-natal, 27,1% das gestantes receberam orientações sobre aleitamento, e 44,5% se prepararam para amamentação. O contato pele a pele ocorreu em 45,1%, com tempo de contato menor que 15 minutos (65,2%) e amamentação na primeira meia hora de vida em 61,8%. No alojamento conjunto, 88,6% receberam apoio e orientações, e 93,9% praticaram a livre demanda. Não houve orientações para persistir com a lactação (47,3%), ocorreu o uso de xícaras ou copos para oferta de leite materno em 38,1%, e 47,1% realizaram doação de leite materno. Foram identificados fatores que promovem o aleitamento materno, mas não de forma integral.

Palavras-chave: Aleitamento materno. Bancos de leite. Lactação. Período pós-parto. Saúde materno-infantil.

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INTRODUCTION

Breastfeeding has countless benefits to the health and wellbeing of children,

protecting them against gastrointestinal, cutaneous, and respiratory infections, diabetes, and sudden death syndrome. This protection reduces the likelihood of

diseases, hospitalizations, and drug dependence¹.

According to the World Health Organization (WHO), in 2019, 41% of the children in the world received exclusive breastfeeding (EB) up to their six months of age.² The main obstacles to breastfeeding are the job of the mother, insufficient maternity leave, lack of a support network, maternal insecurity, unpreparedness of health workers, among others¹⁻³.

To improve the access and quality of mother-child health, the Health Secretariat of the State of Paraná implanted, in 2012, the *Rede Mãe Paranaense* (RMP - the Network for Mothers in Paraná)⁴⁻⁵. Ever since, there was an increase in the use of strategies such as actions to encourage breastfeeding (as prescribed by the WHO) and to guarantee human milk for children at risk in the state⁶.

However, research carried out in Paraná two years after the RMP was implanted showed that health workers did not have good knowledge regarding breastfeeding and the planning of integral actions to improve the child health indicators in the region⁷.

Although EB is recommended by the WHO and the Ministry of Health (MS) until the sixth month of life of the child, the RMP prescribes that all mothers should provide EB until the fourth month of life. However, even this indicator has not been met in the state⁵.

It should be noted that the obstacles to breastfeeding can be associated with the scarcity of information on its advantages

and benefits, as well as to the lack of professional follow up in the process of breastfeeding⁷⁻⁸.

Therefore, it is paramount to verify how the EB has been promoted for women in the RMP during prenatal care, delivery, and in the immediate postpartum. Timely orientations from a qualified health team were the elements indicated by a Brazilian study as practices for the success of the EB⁷. Adequate communication has also been an indicator to strengthen the bond between users and health workers, corroborating decisions and trust for the practice of breastfeeding⁷.

This context raises the following question: What are the actions developed in the prenatal, delivery, and puerperium to promote and support breastfeeding in maternity wards in the RMP? Therefore, the goal of this study was to identify the practices of promotion and support to breastfeeding in maternity wards from three Sanitary Regions (SR) in Paraná, Brazil.

METHOD

Descriptive and cross-sectional quantitative research carried out in three Sanitary Regions (SR) in the state of Paraná, Brazil: Foz do Iguaçu (9th SR), Cascavel (10th SR), and Londrina (17th SR).

The sample of the study was formed by women users of the referral maternity wards of the RMP in the three SR who are in high-risk (HR), usual risk (UR), or intermediary risk (IR) pregnancies.

A sample calculation was carried out, stratified per SR and based on the number of births in 2015, with the variables: **N** - population size (number of elements); **n** - sample size (number of elements); **n⁰** - first approximate sample size; **E0** - acceptable sampling error⁹.

$$n0 = 1 / E0^2 (5\% = 400)$$

Knowing the population size, we can correct the calculations above:

$$n = N . n0 / N + n0$$

We also considered a margin of error of 5%, a confidence level of 95%, and, since this is a follow up study, it was determined that 10% should be added as a margin of safety. The total sample included 1,270 participants.

Mothers from nine maternity wards, in their puerperium, were included. In the 9th SR, the interviews were carried out in three maternity wards: Foz do Iguaçu, Medianeira, and Matelândia. Only the Foz do Iguaçu one is certified by the *Iniciativa Hospital Amigo da Criança* (IHAC - the Child Friendly Hospital Initiative). In the 10th SR, the interviews took place in a maternity in Cascavel, the only one with IHAC certification. In the 17th SR, the interviews were carried out in two maternity wards in Londrina, both IHAC certified, in addition to three maternities in other cities in the same SR: one in Cambé; one in Ibiporã; and one in Rolândia; none of these had IHAC certification.

Women whose newborns were alive in joint accommodation with the mother, including those with premature babies (after 33 weeks, since babies whose gestational age was below this value were in intensive care); attended RMP maternity wards, regardless of the age of the mother. Mothers with mental health issues in their records were excluded, as were those whose babies were hospitalized in intensive care or who lived in the other countries that share the triple border with Brazil (Argentina and Paraguay) and use Brazilian services.

Data collection took place in 2017 and 2018 in the joint accommodations of the maternity wards 24 hours after the birth of the baby. It was carried out by students in the 5th year of the nursing course and students from the post-graduation nursing course from three public teaching institutions. They were previously trained to carry out the collection. The interview with the participants was carried out in a private location without the participation of the family or health workers. The women who accepted participating in the research signed the Free and Informed Consent Form (FICF). It should be highlighted that, for mothers younger than 18 years old, a tutor of legal age authorized their participation and signed a Consent Form.

The data collection instrument, based on the guidelines of the RMP, was created by two nurses from each SR who participated, who are experts in mother-child health. To adjust and validate the instrument, six pilot tests, two in each SR, were carried out. These tests allowed us to

assess, experimentally, without statistical testing, the applicability of the instrument, and whether it would be able to answer our initial questions. After the pilot test in each SR, small failures could be corrected in order to illuminate the study object.

The instrument included several types of variables, including: i) socioeconomic and obstetric: age, ethnicity, marital status, educational level, the job of the mother, number of children, and prenatal location; ii) breastfeeding: the desire to breastfeed, skin-to-skin contact between mother and baby, time of skin-to-skin contact, reasons to bring the baby away from maternal contact, and breast suction in the delivery room; iii) guidance: preparing for breastfeeding, participating in groups of pregnant women, exclusive breastfeeding, breastfeeding on demand, holding correctly, breastfeeding without suction, avoiding artificial pacifiers or baby bottles, using cups or complements, using artificial milk, and donating milk. Continuous variables were categorized.

Data were analyzed using the chi-squared test to verify whether the values found in the categories of a variable were proportionally equal or different one from the other. As a complement, an adjusted residue analysis was carried out. The analyses were carried out in the software XLStat Version 2017.

This study was approved by the Research Ethics Committee at Universidade Estadual de Londrina, under CAAE 67574517.1.1001.5231 and Opinion 2.053.304, in accordance with the norms from Resolutions 466/2012 and 510/2016 from the Ministry of Health for research involving human beings.

RESULTS

The research included 1,270 women, 397 (31.2%) from the SR Foz do Iguaçu, 385 (30.3%) from Cascavel, and 488 (38.4%) from Londrina. Table 1 shows the profile of the participants from the three SRs studied.

Table 1. Frequency distribution of the variables related with the profile of the mothers attended by the *Rede Mãe Paranaense* - Paraná, Brazil, 2017-2018

Variables (n)	Frequency	%	*P-value
Age (in years) (1,267)			
≤15 ^d	18	1.4	
From 16 to 15 ^a	650	51.3	< 0.001
From 26 to 35 ^b	486	38.4	
≥36 ^c	113	8.9	
Ethnicity (1,242)			
White ^a	734	59.1	
Black ^c	93	7.5	< 0.001
Asian ^d	6	0.5	
Brown ^b	401	32.3	
Native ^d	8	0.6	

Marital status (1,263)				
Has a partner ^a	1.130	89.5		< 0.001
Does not have a partner ^b	133	10.5		
Mother's educational level (1,265)				
Complete elementary school ^c	144	11.4		< 0.001
Incomplete elementary school ^b	266	21.0		
Complete high school ^a	457	36.1		
Incomplete high school ^b	252	19.9		
Complete higher education ^d	79	6.2		
Incomplete higher education ^d	60	4.7		
No educational level ^c	7	0.6		
Mother's job (1,258)				
Paid ^b	573	45.5		< 0.001
Unpaid ^a	685	54.5		
Family income in R\$ (1,183)				
≤1,000 ^b	198	16.7		< 0.001
From 1.000 to 3.000 ^a	831	70.2		
From 3.001 to 4.000 ^c	84	7.1		
≥4,001 ^c	57	4.8		
Absent or unstable income ^d	13	1.1		
Number of children (1,265)				
One ^a	531	42.0		< 0.001
Two ^b	404	31.9		
Three ^c	200	15.8		
Four ^d	86	6.8		
Five or more ^c	44	3.5		

*Chi-squared for equal expected proportions

Different letters indicate that the categories have statistically distinct frequencies.

Source: The author (2019).

Regarding the profile of the mothers, a few more than 50% were from 16 to 25 years old (51.3%), most were white (59.1%), followed by brown (32.3%), and 89.5% had a partner.

Most women had completed high school (36.1%) Regarding their financial situation, 45.5% had unpaid jobs and 70.2%

had a family income from R\$ 1,001 to R\$ 3,000. Most women declared to have only one child (42%) and to have been through a prenatal in the Primary Care Unit (UBS, in the Brazilian Portuguese acronym) (81.3%). It stands out that all characteristics presented a statistical difference ($p < 0.001$).

Table 2. Frequency distribution of variables related with the practices of promotion and support to breastfeeding during the gestation period, provided to the mothers attended by the *Rede Mãe Paranaense* - Paraná, Brazil, 2017-2018

Variables (n)	Frequency	%	*P-value
Desire to breastfeed (1,263)			
Yes	1,213	96.0	< 0,001
No	50	4.0	
Guidance to breastfeed (630)			
Yes	171	27.1	< 0,001
No	459	72.9	
Prepared for breastfeeding (1,259)			
Yes	560	44.5	< 0,001
No	699	55.5	
Participated in groups of expecting mothers (1,260)			
Yes	221	17.5	< 0,001
No	1,039	82.5	

*Chi-squared for equal expected proportions
Source: The author (2019).

96% of interviewees reported that they wished to breastfeed, but 72.9% received no guidance, and 55.5% did not prepare for the moment (Table 2). In addition, 82.5% were not part of any group

of expecting mothers, even though guidance is mostly provided during courses in these groups, as Table 3 shows (all variables had $p < 0.001$).

Table 3. Frequency distribution of the prenatal and the place of prenatal for women attended in the *Rede Mãe Paranaense-Paraná*, Brazil, 2017-2018

Variables (n)	Frequency	%	*P-value
Prenatal (1269)			
Yes ^a	1,260	99.3	< 0.001
No ^b	9	0.7	
Place of the prenatal (1265)			
Primary Health Care Unit (UBS) ^a	1,029	81.3	< 0.001
Outpatient clinic ^c	23	1.8	
Insurance/private ^d	3	0.2	
UBS + insurance/private ^c	27	2.1	
UBS+outpatient clinic ^b	175	13.8	
Other ^{cd}	8	0.6	

*Chi-squared for equal expected proportions
Different letters indicate that the categories have statistically distinct frequencies.
Source: The author (2019).

Regarding practices of breastfeeding promotion and support in the delivery room, there was a statistical difference between the number of newborns who were on skin-to-skin touch with the

mother (45.1%), whereas in 31.8% of cases the baby was placed with the mother, despite having no skin-to-skin contact (Table 4).

Table 4. Practices of breastfeeding promotion and support in the delivery room to parturient women attended by the *Rede Mãe Paranaense-Paraná*, Brazil, 2017-2018

Variables (n)	Frequency	%	*P-value
Skin-to-skin mother-baby contact (1,263)			
Baby placed in skin-to-skin contact ^a	570	45.1	
Baby placed with no skin-to-skin contact ^b	402	31.8	< 0.001
Baby was not placed with the mother ^c	291	23.0	
Time of mother-baby contact (1,071)			
≤ 15 minutes ^a	698	65.2	
From 16 minutes to 1 hour ^b	236	22.0	< 0.001
> 1 h ^d	14	1.3	
There was no contact ^c	123	11.5	
Reason to interrupt mother-baby contact (1,014)			
The mother asked ^c	11	1.1	
The mother had a complication ^c	13	1.3	< 0.001
The baby was taken away - routine/procedures ^a	898	88.6	
The baby had a complication ^b	57	5.6	
Other ^b	35	3.5	
The breast was suckled immediately after birth (1,124)			
In the first half hour ^a	695	61.8	
From half hour to one hour ^b	262	23.3	< 0.001
From one to two hours ^c	167	14.9	

*Chi-squared for equal expected proportions

Different letters indicate that the categories have statistically distinct frequencies.

Source: The author (2019).

Regarding the duration of the contact with the child, still in Table 3, 65.2% of babies remained with their mothers for less than 15 minutes, with the second most common situation being a time from 16 to 60 minutes (22%). The baby was removed from contact with the mother, in most cases, for routine procedures (88.6%). Regarding suckling in the immediate postpartum, 61.8% of babies were encouraged to do so in the first 30 minutes of life ($p < 0.001$).

Considering the promotion of breastfeeding in joint accommodations, 88.6% of mothers received support and guidance about breastfeeding, and 70.1% of them received guidance about the advantages of EB. On-demand breastfeeding was reported by 93.9% of mothers. 85.2% of them were evaluated during breastfeeding, and 83.8% held the baby correctly (Table 5).

Table 5. Practices of breastfeeding promotion and support in the joint accommodations in *Rede Mãe Paranaense* - Paraná, Brazil, 2017-2018

Variables (n)	Frequency	%	*P-value
Guidance and support (1,262)			
Yes	1,118	88.6	< 0.001
No	144	11.4	
Guidance about the advantages of exclusive breastfeeding (1,258)			
Yes	882	70.1	< 0.001
No	376	29.9	
Guidance about on-demand breastfeeding (1,260)			
Yes	1,183	93.9	< 0.001
No	77	6.1	
Breastfeeding evaluation (1,246)			
Yes	1,062	85.2	< 0.001
No	184	14.8	
Guidance for continued lactation (1,001)			
Yes	473	47.3	0.087
No	528	52.7	
Guidance about holding the baby correctly (1,258)			
Yes	1,054	83.8	< 0.001
No	204	16.2	
Avoidance of baby bottles or pacifiers (1,260)			
Yes	637	50.6	0.714
No	623	49.4	
Use of cups or glasses (1,231)			
Yes	469	38.1	< 0.001
No	762	61.9	
Did the baby receive any complements (1,242)			
Yes	327	26.3	< 0.001
No	915	73.7	
Encouragement to milk donation (1,233)			
Yes	581	47.1	0.046
No	652	52.9	

*Chi-squared for equal expected proportions

Source: The author (2019).

Still according with Table 5, 79.7% of newborns were not offered complementary milk, 61.9% of mothers did not receive guidance on the use of cups/glasses as an alternative way to offer breast milk ($p < 0.001$), and 52.9% were not

encouraged to donate milk ($p < 0.05$). Regarding guidance about maintaining lactation and avoiding the use of baby bottles and pacifiers, there was no statistically significant difference.

DISCUSSION

This study revealed the actions to promote breastfeeding in maternity wards from three SRs from the RMP. Practices for the success of breastfeeding, with statistical evidence, were observed. They took place in the delivery room, in the postpartum, and in the joint accommodations.

An important indicator of mother-health quality is the access to the prenatal in the first trimester of pregnancy, which corroborates a study in which most participants went through prenatal consultations¹⁰. This moment is relevant to develop actions to promote, protect, and support breastfeeding⁷.

Factors such as legal age and educational level, higher number of children, and receiving guidance in the pre- and postpartum stages are connected with longer periods breastfeeding¹¹. Early weaning can take place due to going back to work, lack of information about breastfeeding benefits, the use of baby bottles and pacifiers, among other factors¹.

According to the MS,³ the women's knowledge about the benefits of breastfeeding is often superficial and limited. Educational actions during pregnancy and postpartum period are essential to empower pregnant women and

improve the levels of adherence to breastfeeding¹². Although most women in this study reported that they wanted to breastfeed, many of them did not go to groups of expecting women, nor did they seek information about caring for the newborn, the delivery, and breastfeeding¹².

In regard to hospital care, most babies were put in touch with the mother in the delivery room, but skin-to-skin contact was not always encouraged¹³. According with literature, one of the actions for successful breastfeeding is the skin-to-skin contact with the mother immediately after birth^{7,13}.

The mothers were encouraged to having the baby suckle in the first half hour. However, in most cases, this took place in the obstetric recovery room¹⁴. Having this contact with the baby during their first hour of life is essential, since the newborn is awake and can suckle more efficiently¹⁴.

The separation of mother and baby after birth is characteristic of the 20th century. It diverges from the historical evolution where the survival of the newborn is favored by an approximation and contact with the mother^{15,16}. Throughout the years, the hospital routine of birth assistance has given priority to the first care to be provided to the newborn, that is, the babies are separated from the mother in the first minutes of lives for routine procedures such as weighing and physical examination. Then, they are placed in a warm crib and enveloped in a sterile field, and go back to the mother's arms, where they stay for one hour¹⁶.

It is noteworthy that the interventions from health workers in the delivery room are given priority over the contact between baby and mother. This is worrisome, since separating the mother from the baby in the first minutes leads to less successful breastfeeding¹⁷. Thus, it is essential to immediately place the baby on the mothers arms, as this will promote a better transition from fetal life into the extra-uterine environment¹⁶.

It should also be noted that recommendations from the MS for EB can strengthen the physical and mental health of mother and baby, preventing child morbidity and mortality. Embracing and guiding the woman in this period promotes self-trust and increases adherence to breastfeeding^{8,18,19}. Nevertheless, in low- and medium-income countries, only 37% of children under six months receive exclusive breastfeeding¹⁷.

Most participants in this study received guidance about breastfeeding in their puerperium, support to provide on-demand breastfeeding, and were evaluated as they breastfed, corroborating other research where the importance of this practice to continue EB until the sixth month was demonstrated^{11,19}. Furthermore, complementary milk was offered for a small number of newborns.

Guidance about maintaining lactation, how to offer complementary milk in cups/glasses, using baby bottles/pacifiers, and donating human milk can prevent early weaning,^{14,19} but were not explored in depth in this study. This is why

issues regarding the success of breastfeeding should be reevaluated, as it involves biological, social, cultural, and emotional aspects from both the woman and the baby^{3,20}.

Support from trained professionals can have significant effects, leading to longer and exclusive breastfeeding^{3,21}. Therefore, the RMP encourages EB and instrumentalizes the health workers to prepare women who are expecting to breastfeed and continue doing so after hospital discharge, through home visits and consultations for the child^{6,22}.

Entering the family environment and discovering doubts, difficulties and preoccupations in follow up consultations can strengthen, in the workers, the compromise of providing quality care, considering health promotion and damage control^{11,20-22}.

Actions to promote and support breastfeeding in the hospital can also be developed by establishing norms for human milk banks, implementing IHAC, and interrupting the use of artificial formulas¹⁴. The strategies supported by the RMP include the increase of actions to encourage breastfeeding and the guarantee of human milk for all children at risk⁶. It should be highlighted that all SRs have at least one maternity ward with IHAC certification.

Also, literature highlights that liquids and foods are generally introduced earlier than recommended, in the third or fourth month of life of the baby, due to the mother going back to work, low weight gain, or medical guidance¹¹. Nonetheless,

the use of formulae is not recommended for low-risk newborns, which is accordance with this study, where only a small number of babies received complements.

A limitation of this study is the fact that it took place in a single Brazilian state, which has its specific mother-child policy - the RMP -, which can impair the possibility of generalizing the data or comparing it with that from other regions in the country. Nevertheless, the study provides subsidies to improve actions and strategies during the pregnancy/puerperium cycle in regard to EB and its benefits for babies and families, one of the main instruments for the promotion of child health.

CONCLUSION

Although most mothers wanted to breastfeed, more than half received no guidance in this regard, did not participate in groups for expecting mothers, and was not prepared for breastfeeding. Practices to promote and support breastfeeding, on the other hand, were considered to be very frequent in the joint accommodations. Contact with the mother immediately after birth took place for most participants, however, many of them did not get skin-to-skin touch with their children, or had it for less than 15 minutes, after what it was interrupted for delivery room interventions.

The guidance about breastfeeding was provided in the postpartum period, but measures such as discouraging the use of baby bottles and pacifiers, continuing lactation even without suction, encouraging

milk donation, and discouraging the use of complementary milk, were not sufficient.

This study highlights importance of educational actions to guide and raise the awareness of health workers that attend women during pregnancy and delivery, reiterating the practices instituted, especially for maternity wards that have the IHAC certification, since the knowledge about the efficacy of health programs provides subsidies to improve the quality of the service. Finally, we recommend that further studies should be carried out to guarantee integral care and promote attention to the health of the woman and the child in an efficient way, encouraging breastfeeding.

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