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Profile of Exclusive Breastfeeding in a Public Maternity Hospital in Southern Brazil

Perfil do aleitamento materno exclusivo em uma maternidade pública do sul do Brasil

***Edna Ribeiro de Jesus*[1*], *Eduardo Manoel Pereira*[2], *Danielle Cristina Alves Rigo*[3], *Luana Claudia dos Passos Aires*[4]**

[1] Master in Nursing from the Graduate Program in Nursing, Federal University of Santa Catarina (UFSC), Santa Catarina (SC), Brazil. [2] Master in Pharmacology from the Federal University of Paraná (UFPR). University of the Region of Joinville, Joinville, SC, Brazil. [3] Master in Dental Clinics from the Federal University of Goiás (UFG), Goiânia (GO), Brazil. [4] Doctor in Nursing from the Graduate Program in Nursing, Federal University of Santa Catarina. Faculty member of the Nursing Department at the Federal Institute of Santa Catarina (IFSC), Santa Catarina (SC), Brazil.

***Corresponding author**: Edna Ribeiro de Jesus – Email: ednaenfa25@gmail.com

ABSTRACT
To describe the profile of exclusive breastfeeding at a maternity hospital in the northern region of Santa Catarina, Brazil. This observational, descriptive, and prospective study gathered sociodemographic data and information regarding childbirth and lactation through interviews in the maternity ward, medical records, and telephone contacts at 7 and 15 days post-discharge. A total of 297 postpartum women participated. The average age was 26.2 ± 6.3 years. Most were of white ethnicity, married, with an income between one and five minimum wages, smokers, and had skin-to-skin contact within the first hour of their baby's life. The first bath predominantly occurred between 6 and 15 hours after birth, and over 84% of the postpartum women maintained exclusive breastfeeding at 7 and 15 days. A high prevalence of exclusive breastfeeding was observed, underscoring its benefits and highlighting the need for healthcare teams to adopt breastfeeding promotion strategies.

Keywords: Breast Feeding. Health Education. Milk, Human. Maternal and Child Health. Nursing Care.

RESUMO
Descrever o perfil do aleitamento materno exclusivo em uma maternidade do norte de Santa Catarina. Pesquisa observacional, descritiva e prospectiva, cujos dados sociodemográficos e referentes ao parto e lactação foram obtidos por entrevista no alojamento conjunto, prontuários e contato telefônico aos 7 e 15 dias após alta. participaram 297 puérperas. A média de idade foi de 26,2 ± 6,3 anos. A maioria era de etnia branca, casada, com renda entre 1-5 salários-mínimos, tabagista e teve contato pele a pele na primeira hora de vida de seu bebê, com primeiro banho predominantemente entre 6 e 15 horas após nascidos e mais de 84% das puérperas mantiveram o aleitamento materno exclusivo aos 7 e 15 dias. Foi observada alta prevalência do aleitamento exclusivo e seus benefícios devem posicionar a equipe de saúde na adoção de estratégias de incentivo à amamentação.

Palavras-chave: Aleitamento Materno. Cuidado de Enfermagem. Educação em Saúde. Leite Humano. Saúde Materno-Infantil.

INTRODUCTION

Breastfeeding is the best, most complete, and safest form of food for young children[1,2]. Despite this, low breastfeeding rates persist in Brazil and globally, influenced by myths, taboos, and the strong culture of weaning promoted by the food industry. Health professionals strive to foster exclusive breastfeeding from birth to six months and supplemented breastfeeding for up to two years or more, as recommended by the Brazilian Ministry of Health (MS). However, numerous challenges remain, such as low milk secretion, delayed milk letdown, flat or inverted nipples, mastitis or nipple pain, milk stasis, and difficulty in the baby's suction[2,3].

It is estimated that globally, only two out of every five newborns are breastfed within the first hour of life, and only 40% of children are exclusively breastfed up to six months of age3. The global goal is that, by 2025, at least 50% of children will be exclusively breastfed until the sixth month of life[4].

Breastfeeding is vital because of its numerous benefits. It reduces infant mortality by 13% and lowers the risk of obesity, diabetes, and other systemic and psychosocial diseases. It also supports intestinal colonization of newborn and reduces opportunistic infections. In oral health, breastfeeding is a protective factor against harmful oral habits such as pacifier use. Infants breastfed within the first 30 min after birth have a 25% lower risk of needing a pacifier during their first year. Thus, breastfeeding not only fosters maternal-infant bonding but also serves as a cost-effective strategy for families and society, presenting an effective approach for multidisciplinary health promotion[5].

The breastfeeding promotion actions recommended by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), which aim to extend the breastfeeding period and reduce infant mortality, have led to a gradual increase in the duration of exclusive breastfeeding during the first six months—from 31% to 41% between 1975 and 2008. The average duration of breastfeeding, which was 25 months in 1974-1975, increased to 5.5 months in 1989, to 9.9 months in 1999, and to 11.3 months in 2008. According to the global breastfeeding initiative by WHO and UNICEF, the worldwide rate of exclusive breastfeeding for infants up to six months of age reached 48%, reflecting a ten-percentage-point increase over the previous decade, demonstrating that significant progress is achievable[5,6].

The report from the United States Centers for Disease Control and Prevention indicated that exclusive breastfeeding in 2019 had a prevalence of 62.6% immediately after birth, which decreased to 45.3% by the third month and 24.9% by the sixth month. In Europe, breastfeeding rates are far from WHO recommendations, with significant differences between countries. For example, the prevalence of breastfeeding within the first hour after birth was 78.1% in Austria (2006), 42.9% in Albania (2008-2009), and only 4.6% in Bulgaria (2010). UNICEF data also show substantial variations in breastfeeding prevalence between 2005 and 2015: Eastern and Southeastern Africa reached 69%, while West and Central Africa had a prevalence of 41%, and Southern Africa only 39%. In South Asia, a prevalence of 60% was recorded, with 36% in Central Asia, and 41% in East Asia[7,8].

To overcome the challenges associated with breastfeeding, rooming-in provides comprehensive health care for the woman and the newborn, recognizes the child's needs, and clarifies questions with the team. This practice is mandated by the Child and Adolescent Statute (ECA), MS/GM Ordinance No. 1016/2003, the Child-Friendly Hospital Initiative (IHAC), and the National Policy for Comprehensive Child Health Care (PNAISC)[8]. Rooming-in facilitates and stimulates the initiation of breastfeeding on demand and offers the advantages of promoting early and continuous mother-child bonding[9].

However, some studies focus on exclusive breastfeeding from the first to the sixth month of

the baby's life, with investigations after 7 and 15 days of birth being less described. Additionally, the variability in the adoption of public policies and breastfeeding practices, along with the proportion of Child-Friendly Hospitals, is a factor that influences the prevalence of breastfeeding. Therefore, understanding the profile of a specific region is important to strategically plan effective interventions that sustain breastfeeding[9].

Thus, considering the benefits and importance of breastfeeding and the role of the nursing team and other health professionals in monitoring and supporting pregnant women and nursing mothers, there is a significant opportunity to promote breastfeeding and its short and long-term benefits. Therefore, this study aimed to describe the profile of exclusive breastfeeding in a maternity hospital in the north of Santa Catarina after 7 and 15 days from birth.

METHODS

STUDY DESIGN

This is an observational, descriptive, prospective study with a quantitative approach, following the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) initiative[10].

STUDY SETTING AND PERIOD

The study was conducted at a public maternity hospital in the city of Joinville, state of Santa Catarina, which exclusively serves the Unified Health System (SUS). This maternity hospital has institutionalized various routines that are part of the humanization ideology: childbirth preparation courses, the right of the parturient to a companion of her choice throughout the birthing process, the option of squatting birth, rooming-in, encouragement of mechanical pain relief techniques (massages, baths, walking), cautious use of intravenous induction (oxytocin), analgesia, and episiotomy, as well as abolishing the application of enemas and shaving.

According to the Maternity Comptroller, there were 6,065 births in 2017, with 325 by natural birth and 180 by cesarean section per month. Data collection occurred from April 5 to May 5, 2019, from Monday to Sunday.

POPULATION AND SELECTION CRITERIA

The population consisted of parturients from the researched maternity hospital, with no age limit, residing in the city of Joinville or neighboring cities, with pregnancies classified as usual risk. Excluded from the study were postpartum women with clinical conditions that prevented breastfeeding (retroviral disease); preterm newborns who were in the neonatal unit; maternal use of medications and/or substances that contraindicate breastfeeding, as per the breastfeeding guide and the MS manual[11]; and those who did not have a contact phone number for follow-up.

SAMPLE DEFINITION

Convenience sampling was utilized; thus, all pregnant women who consented to participate and met the inclusion criteria were selected.

INSTRUMENTS AND DATA COLLECTION

A questionnaire featuring open-ended questions on sociodemographic information, childbirth conditions, and aspects of maternal and newborn health was administered. Additionally, a questionnaire with closed-ended questions focused on the monitoring of breastfeeding was employed. A table was also compiled containing the telephone numbers of the postpartum women, the identification of the participants, and details including the date and time of birth and the records from the electronic health record.

Twelve volunteers, thoroughly trained to conduct interviews, participated in the data collection. Among these, 11 were nursing interns and one was a nursing resident at the institution. All followed a predefined research conduct schedule to ensure standardization of the interview procedure.

Before data collection commenced, a pilot study was executed with the volunteer team to identify potential inconsistencies or biases during the interviews. Data collection began only after confirming the absence of any irregularities related to understanding and interpreting the information to be collected.

All postpartum women were personally invited by the team to participate in the study. During this invitation, the characteristics of the study were explained and the Informed Consent Form (ICF) was provided for signature. When adolescents were involved, they signed the Assent Form (AF), and their legal guardians signed the ICF. Data collection commenced following the signing of these forms.

The data collection process was conducted in two phases. In the first phase, face-to-face interviews were held with the mothers in the rooming-in facility, where they were asked about their sociodemographic characteristics, childbirth conditions, and health-related issues concerning themselves and their babies. Data from the patients' electronic health records were also gathered. The researchers ensured a private setting with minimal interference during this stage. The second phase of the study occurred after hospital discharge, involving telephone contact with the postpartum women. At this time, a questionnaire focusing on the characteristics of breastfeeding on the seventh and fifteenth day of the newborns' lives was administered. To minimize loss to follow-up, three attempts to contact each participant were made using both phone calls and the messaging app WhatsApp®.

STUDY VARIABLES

The sociodemographic categorical variables considered for this study included age group (<18 years; 19-25 years; 26-35 years; 36-45 years; 46-55 years; 56-65 years), ethnicity (white, black, brown, indigenous, or none), marital status (married or single), education (none, elementary, secondary, or higher education, complete or incomplete), employment type (formal or informal), family income (< one minimum wage, one minimum wage, two or more minimum wages, or over five minimum wages), classification of gestational risk (usual or high risk), and previous diseases (diabetes mellitus, gestational hypertension, chronic hypertension, epilepsy, depression, and human immunodeficiency virus infection). Variables related to lactation follow-up included the maintenance of exclusive breastfeeding, the introduction of formula or a combination of both (mixed), and any complications that occurred during breastfeeding.

DATA TREATMENT AND ANALYSIS

The survey data were tabulated using Excel® software, and the results were presented through descriptive statistics, including absolute and relative distributions (n-%), as well as measures of central tendency (mean and median) and variability (standard deviation) for each researched parameter.

ETHICAL ASPECTS

Data collection was conducted after receiving approval from the Research Ethics Committee of the Hans Dieter Schmidt Regional Hospital/State Health Department of Santa Catarina, under opinion number 3,215,785 issued on 03/22/2019. The research was conducted within the guidelines of Resolution 480/2018.

RESULTS

The average age found was 26.2 ± 6.3 years (absolute values for each age group are presented in Table 1). The predominant age group was 18-35 years, accounting for just over 90.2% of the sample, while less than 6% were adolescent postpartum women. Regarding ethnicities, most were white at 75.5%, followed by mixed race, and less than 6% of the sample included participants of black or indigenous ethnicity. The characterization of the sample composition is detailed in Figure 1.

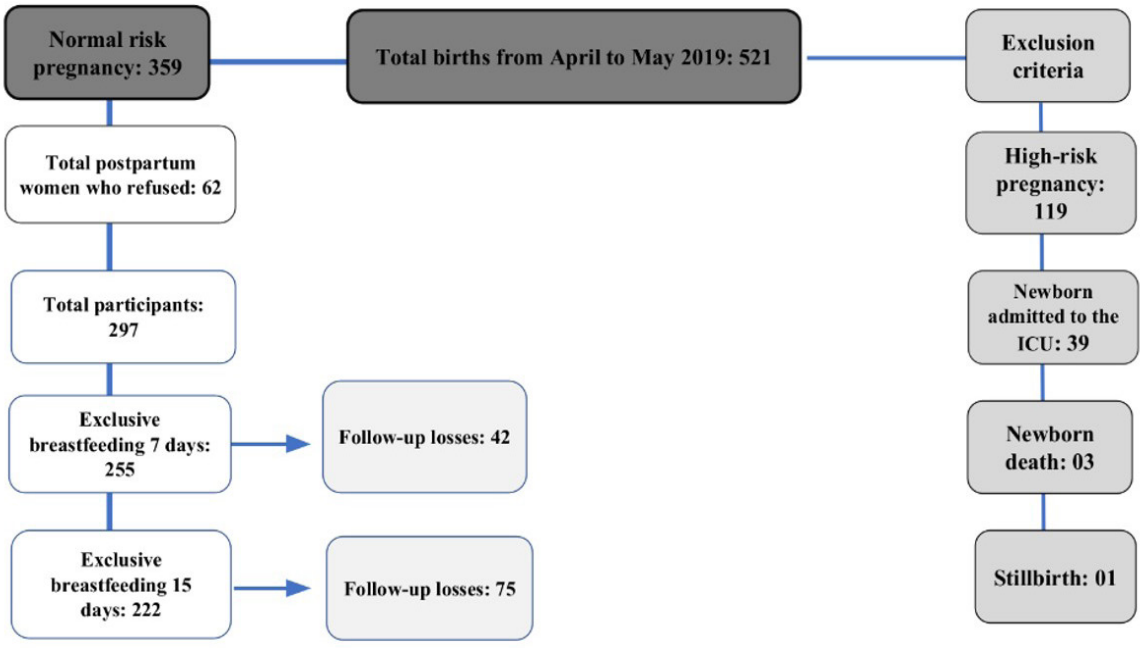


Figure 1. Flowchart of the research sample collection. Joinville, SC, Brazil, 2019.
Source: the authors (2019).

The most prevalent educational level was complete secondary education, reported by 131 (44.1%) participants, followed by incomplete secondary education. Regarding marital status, 264 (88.8%) women were married, and the remaining 33 (11.1%) were single. Of the participants, 157 (52.8%) lived in their own homes and the remaining 140 (47.1%) in rented houses. It was noted that 38.0% of the participants had formal employment; nearly half of the participants were domestic workers, and less than 17.1% of the pregnant women interviewed worked in informal sectors (Table 1).

Table 1. Sociodemographic Characteristics of Postpartum Women, n=297, Joinville, SC, Brazil, 2019

Variable	(N=297)	%
Age		
<18 years	18	6.0%
18-25 years	131	**44.1%**
26-35 years	119	40.0%
36-53 years	29	9.7%
Ethnicity		
White	224	**75.4%**
Brown	56	18.8%
Indigenous	1	0.3%
Black	16	5.3%
Education		
Completed elementary education	36	12.1%
Incomplete elementary education	37	12.4%
Completed secondary education	131	**44.1%**
Incomplete secondary education	41	13.8%
Completed higher education	26	8.7%
Incomplete higher education	24	8.0%
Unknown	**2**	0.6%
Employment		
Formal	113	**38.0%**
Informal	51	17.1%
Unemployed	133	**44.7%**

Source: Research data, 2019

Family per capita income at one minimum wage was reported by 15 (5.0%) participants, two or more minimum wages by 267 (89.8%), over five minimum wages by 12 (4.0%), and income below the minimum wage by three (1.0%).

Of the postpartum women, 194 (65.3%) were smokers, and 103 (34.6%) non-smokers. Although only seven (2.3%) were illicit drug users (marijuana or cocaine), the identified cases were reported to the responsible doctors so that the postpartum women could be referred to adhere to the protocol recommended by the MS regarding breastfeeding (2.8). As for their partners, 71 (23.9%) were smokers, 194 (65.3%) declared they did not smoke, and 32 (10.7%) did not respond to the question.

All interviewed postpartum women underwent prenatal examinations; however, only 107 (36.0%) had planned their pregnancies. Among the participants, 261 (87.8%) had skin-to-skin contact with their babies at birth, 33 (11.1%) reported not having performed it, and three (1.0%) were unsure how to respond.

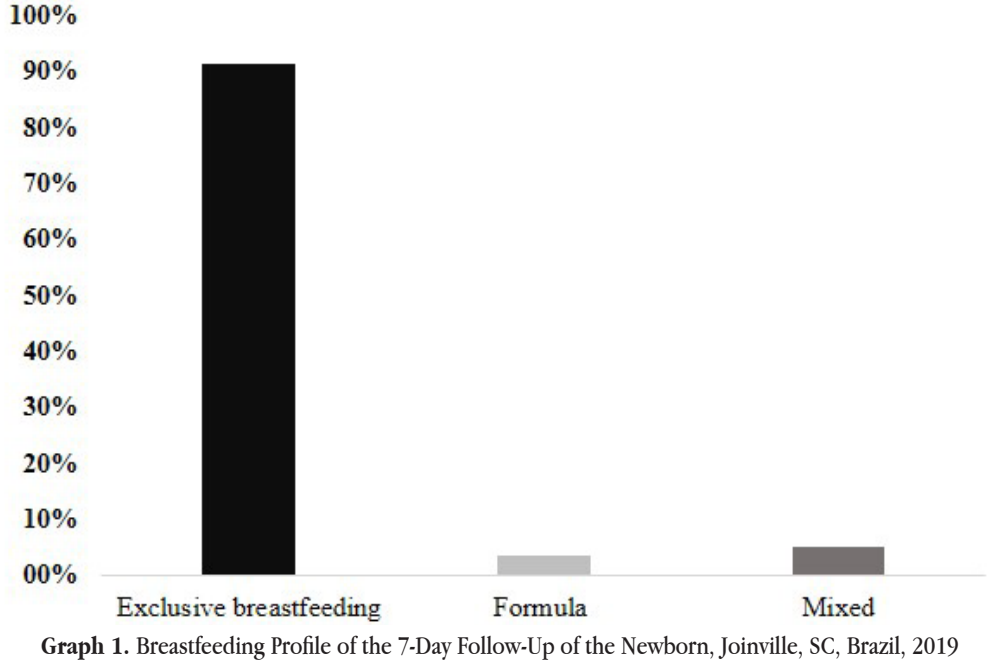
The first bath for the newborns occurred between one and five hours after birth in 25 (8.4%) cases, between six and fifteen hours in 183 (61.6%) of the babies, and between sixteen and twenty-four hours in 73 (24.5%) cases. Only nine

(3.0%) newborns took their first bath between 25 and 30 hours, and for seven (2.3%) cases, this information was unavailable.

Regarding their own newborn feeding experiences, 31 (10.4%) postpartum women stated they were not breastfed, 252 (84.8%) were breastfed, and 14 (4.7%) did not know. Concerning the desire to breastfeed their current child, only two (0.6%) reported a lack of desire, while the remaining 295 (99.3%) expressed a desire to breastfeed.

Among the participants, 179 (60.2%) had previous breastfeeding experience, while 118 (39.7%) were first-time mothers. The duration of breastfeeding varied among those who had previously breastfed: 61 (20.5%) breastfed for 0-6 months; 35 (11.7%) for 1-2 years; 37 (12.4%) for 3-5 years; and 46 (15.4%) were unsure.

There was a loss to follow-up of 42 (14.1%) lactating women on the seventh day (the first phone contact) and 75 (25.2%) on the fifteenth day (the second contact). Among the original 297 participants, 255 were interviewed after seven days (Graph 1). Of this total, 233 (91.3%) stated they continued to exclusively breastfeed, 17 (6.6%) used formulas, 45 (17.6%) introduced pacifiers, and 18 (7.0%) used silicone nipples. Additionally, seven (2.7%) started offering herbal teas (chamomile or lemon balm) and one (0.3%) introduced water.



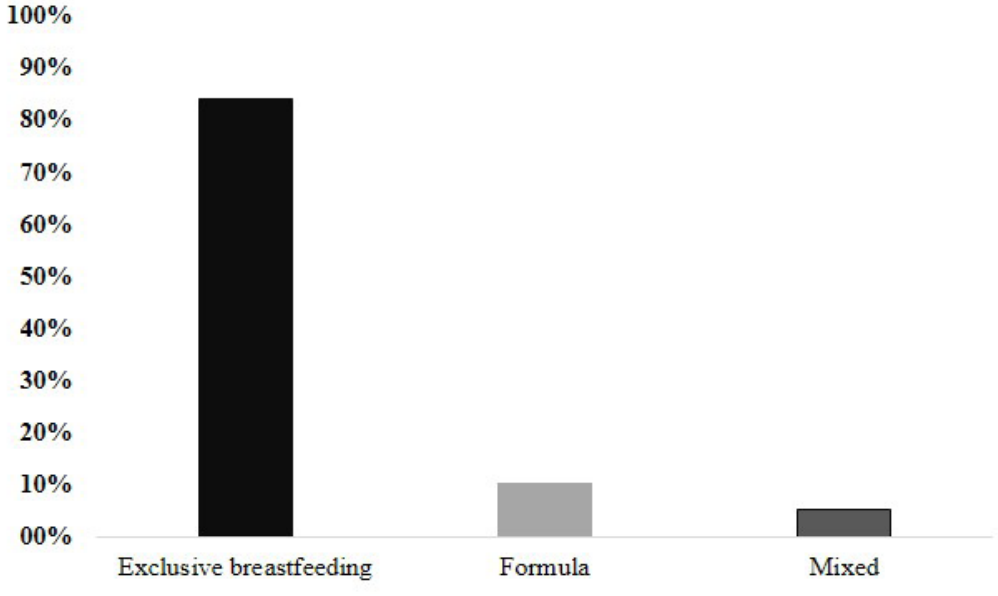
Graph 1. Breastfeeding Profile of the 7-Day Follow-Up of the Newborn, Joinville, SC, Brazil, 2019

Source: Survey data, 2019

Among the complications related to breastfeeding, seven (2.7%) lactating women experienced mastitis, sought help from the milk bank, and independently introduced formula before seeking assistance from the reference maternity hospital. Out of the participants, 14 (5.4%) reported difficulties with latching; 37 (14.5%) described nipple cracks; four (1.5%) had low milk secretion; six (2.3%) experienced engorgement; and one (0.3%) had a tongue-tie (case referred for evaluation and corrective surgery by a pediatrician).

Of the postpartum women who reported problems at seven days postpartum, the following interventions were implemented: 6 (2.3%) were referred to the milk bank, 29 (11.3%) received guidance by phone, 18 (7.0%) used their breast milk, 7 (2.7%) applied lanolin ointment, 3 (1.1%) performed breast milk extraction, and one (0.3%) used a pump to empty the breasts.

After 15 days post-hospital discharge, of the 222 participants who responded to the questionnaire, 187 (84.2%) declared they were exclusively breastfeeding (Graph 2). Among those who reported they were not breastfeeding, 23 (10.3%) were using formula; four (1.8%) simply stated they were not breastfeeding; eight (3.6%) developed mastitis; two (0.9%) did not produce milk (they sought help from the maternity milk bank and began medications to stimulate milk secretion, and the newborn received supplements); and one (0.4%) participant presented with acute renal infection.



Graph 2. Breastfeeding Profile of the 15-Day Follow-Up of the Newborn, Joinville, SC, Brazil, 2019
Source: Survey data, 2019

In response to the challenges encountered in breastfeeding during the first 15 days of the newborn's life, the following measures were implemented: seven (3.1%) received guidance by phone, four (1.8%) were referred to the milk bank, one (0.4%) dropped out, one (0.4%) offered formula, one (0.4%) performed breast milk extraction, 61 (27.3%) mothers introduced a pacifier, six (2.6%) used a silicone nipple, and eleven (4.9%) utilized herbal teas.

DISCUSSION

This study highlighted a high prevalence of exclusive breastfeeding in the first two weeks after birth (91.3% and 84.2% at 7 and 15 days, respectively). Breastfeeding offers undeniable benefits for both the mother and the baby. Breast milk provides all the nutrients a baby needs in the first six months of life, protects against diarrhea and other community diseases such as pneumonia, and reduces the risk of overweight and obesity in childhood and adolescence while promoting bonding for the mother-child dyad[12].

In the current study, there was a predominance of white ethnicity, possibly linked to the historical colonization of the region by Caucasian peoples. There was significant adherence to exclusive breastfeeding, possibly because of an awareness of its importance and the marital stability of the participants. This finding is supported by a study conducted from 2004 to 2016 at a specialized clinic that identified similar sociodemographic characteristics, such as average maternal age and educational level,

which contribute to breastfeeding by providing a more favorable emotional and logistical context for lactating women compared to single mothers, thus underscoring the importance of understanding these characteristics[13,14].

Regarding employment, half of the participants reported having jobs, corroborating a study conducted in Porto Alegre with 261 mothers, which identified an exclusive breastfeeding rate of 41%. Just over half (61.3%) of the mothers returned to work six months after giving birth or had not worked postpartum. Returning to work before six months reduced the likelihood of exclusive breastfeeding by 68%[15]. Approximately 25% of the economically active Brazilian population includes women with children under six months old; therefore, adherence to labor laws is crucial for protecting breastfeeding[16], including the provision of maternity leave and workday breaks, as well as breastfeeding facilities at workplaces[17].

An early return to work often necessitates the introduction of other foods and weaning, as many women work far from home, endure long hours with little scheduling flexibility, and must balance occupational duties with household chores. Additionally, when women are employed informally to supplement family income, they are unlikely to benefit from legally mandated protections, making the reconciliation of work and breastfeeding more challenging[18].

A cross-sectional survey of 334 women who received prenatal care at Basic Health Units showed that the prevalence of exclusive breastfeeding at six months was 30.0%, with 60.8% of these women earning up to two minimum wages—a factor identified as contributing to early weaning[19]. Other studies have also found a statistically significant relationship between family income and early weaning[20,21].

Regarding income, most women reported earning between one and five minimum wages. Notably, exclusive breastfeeding is a cost-effective strategy that reduces expenses, providing yet another incentive to support the practice. Higher family income also enables women to delay returning to work, as the need to supplement income is less urgent than in lower-income populations. This study found that just over half of the mothers lived in their own homes, with 62.3% of mothers (n = 99) in this situation. Homeownership can offer financial benefits such as living security, predictable costs, increased wealth, freedom to make modifications, and elimination of rental expenses[22,23].

Additionally, 9.3% of the pregnant women were smokers. This is significant because children of smoking mothers are more likely to be born with low weight. After birth, these children may experience increased allergies like rhinitis and asthma, triggering of chronic respiratory conditions, more frequent and severe upper and lower airway infections, and higher rates of hospital admissions. Harmful components transferred through breast milk, such as cyanide, aluminum, arsenic, ammonia, formaldehyde, benzene, lead, monoxide, dioxide, and nicotine, can alter the taste of milk and reduce basal prolactin secretion, thereby contributing to early weaning[24].

Prenatal care is crucial for monitoring fetal and maternal development, as it enables the detection of discrepancies during pregnancy. In this regard, the study data are highly satisfactory, as it was observed that all participants received prenatal care, although comprehensive monitoring does not guarantee the success of breastfeeding[25]. Notably, the fact that 64% of the participants had unplanned pregnancies is significant for guiding the development of strategic measures aimed at enhancing sexual and reproductive health at the primary care level.

In this context, it is essential to implement breastfeeding support actions that engage professionals and families from prenatal care, through pre-delivery and birth, to immunizations and returning for postpartum consultation. A supportive team that listens,

alleviates concerns, clarifies doubts, and fosters the exchange of experiences has the potential to successfully promote breastfeeding by addressing challenges and humanizing maternal and child care[26]. Additionally, it is important to consider the use of communication methods that extend beyond traditional health services, such as follow-up telephone contacts (as done in this study), and the use of social networks. These are identified as important tools for protecting breastfeeding, although they are still used as an informal practice, and can be incorporated into the routines of health professionals[27].

Regarding skin-to-skin contact within the first hour of birth, a significant majority (87.8%) of the postpartum women in our study confirmed engaging in this practice. In contrast, a rate of 60.1% was found for immediate post-birth skin-to-skin contact[28]. Early skin-to-skin contact between mother and child is crucial for initiating breastfeeding within the baby's first hour of life and is endorsed by WHO and UNICEF as a key component of the IHAC for successful breastfeeding. This practice aids the lactating mother in recognizing and responding to her baby's cues, facilitating an optimal start to breastfeeding[29].

Despite common beliefs that the first bath of a newborn should occur as soon as possible to clean blood and secretions, delaying this procedure can be beneficial. Postponing the first bath allows for proper thermoregulation, hydration, reduced skin peeling, decreased incidence of neonatal toxic erythema, improved wound healing, and cutaneous colonization by nonpathogenic bacteria[30]. Therefore, it is recommended to avoid separating the baby from the mother during the first hour to facilitate skin-to-skin contact. The first bath can be delayed for newborns with a normal respiratory rhythm and tone and without meconium fluid[31]. Supporting this, data[32,33] indicate that most newborns who received their first bath within the first two hours of life experienced neonatal hypothermia. In contrast, this study found that most newborns received their first bath between six and fifteen hours after birth, adhering to practices that prioritize early skin-to-skin contact and a later first bath.

Nearly all postpartum women expressed a desire to breastfeed and reported having been breastfed by their mothers. The fact that only two women reported a lack of desire to breastfeed suggests potential response bias, as participants might have provided answers they believed were expected by health professionals. Notably, 15.4% of respondents were unsure how long they had breastfed their previous children, underlining the significance of this information in the context of maternal care.

Experiencing and observing the challenges and developments of other children can mitigate tensions and concerns, underscoring the self-perceived benefits of breastfeeding. Previous breastfeeding experience is positively correlated with its prolongation and maintenance, possibly affecting breastfeeding duration more significantly than maternal age. Experiences in prior pregnancies are also positively associated with extended periods of breastfeeding[34].

Several factors contribute to early weaning: low secretion of breast milk, frequent crying of the baby, lack of knowledge, and consequently, supplementation with formulas and other liquids (water, teas) that interfere with nutritional satisfaction. These factors can lead to decreased suction and present challenges such as breast engorgement or nipple injury, potentially resulting in early weaning[35]. Additionally, interruptions in breastfeeding because of breast abscesses caused by methicillin-resistant *Staphylococcus aureus* (28/260 – 10.8%) or methicillin-sensitive strains (63/962 – 6.5%) were observed[36].

Despite these challenges, the factors described were infrequent among the postpartum women in this study, allowing for the maintenance of exclusive breastfeeding by

the majority. However, it is important to highlight notable occurrences of nipple cracks and the use of pacifiers. Using artificial nipples can lead to "nipple confusion," risking improper latching on the maternal breast, causing cracks, and potentially leading to early weaning[36].

The limitations of this study include its observational and prospective nature. Some data relied on the self-perception of the postpartum women, potentially introducing memory bias. Conflicts of interest that could suggest negligence by the postpartum women include data regarding smoking or other drug use, as well as claims of disinterest in breastfeeding or the early introduction of liquids other than breast milk.

Nevertheless, the data collected are highly relevant, as there are few published studies with such a significant sample size. This study provides a detailed snapshot of the sociodemographic characteristics and factors that contribute to reducing the prevalence of exclusive breastfeeding in the first 15 days after delivery.

CONCLUSION

This study observed a high prevalence of exclusive breastfeeding at 7 and 15 days postpartum, with a low rate of complications, aligning with the Baby-Friendly Hospital Initiative's guidelines, which encourage measures that support breastfeeding. Research involving larger populations across different regions and with extended follow-up periods will enhance our understanding of the sociodemographic and psychosocial variables that influence the maintenance of exclusive breastfeeding. Such studies enable a deeper reflection on the critical intervention points for healthcare teams, whose professionals play a crucial role in addressing factors associated with early weaning. This knowledge is instrumental in guiding health professionals to promote breastfeeding effectively and assist women during the initial phase of motherhood to mitigate and resolve any lactation-related complications.

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