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The practice of the fourth step of the baby friendly hospital initiative[a]

A prática do quarto passo da iniciativa hospital amigo da criança

La práctica de la cuarta etapa de la iniciativa hospital amigo del niño

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Abstract

Objective: Analyze the factors involved in the practice of the fourth step of the Baby Friendly Hospital Initiative, from the experience of postpartum women admitted to a Baby Friendly Hospital. **Methods:** This is a descriptive, exploratory study, in which a qualitative approach was used. Data was collected from November 2011 to January 2012, through systematic observation of non-participating deliveries and semi-structured interviews with 16 subjects. For the data treatment, the thematic modality content analysis was applied. **Results:** The main obstacles to the realization of the fourth step were the priority given to routine care after birth, cesarean delivery and the different work process promoted by the determinations of the Baby Friendly Hospital Initiative. **Conclusion:** We conclude that reflection upon, and (re)construction of, knowledge and practices concerning this step are necessary.

Keywords: Mother-Child Relations; Breast Feeding; Humanization of Assistance; Nursing; Professional Practice.

Resumo

O objetivo deste estudo foi analisar os fatores envolvidos na prática do quarto passo da Iniciativa Hospital Amigo da Criança, a partir da vivência das puérperas internadas em um Hospital Amigo da Criança. **Métodos:** Trata-se de um estudo descritivo, exploratório, com abordagem qualitativa. A coleta de dados foi realizada de novembro de 2011 a janeiro de 2012, por meio de observação sistemática não participante dos partos, e entrevista semiestruturada com 16 sujeitos. Para o tratamento dos dados, foi aplicada a análise de conteúdo modalidade temática. **Resultados:** Os principais obstáculos para a efetivação do quarto passo foram a prioridade dada aos cuidados de rotina após o nascimento, o parto cesáreo e o processo de trabalho díspar das determinações da Iniciativa Hospital Amigo da Criança. **Conclusão:** Conclui-se ser necessária a (re)construção e a reflexão de saberes e práticas acerca deste passo.

Palavras-chave: Interação mãe-filho; Aleitamento materno; Humanização da assistência; Enfermagem; Prática profissional.

Resumen

Objetivo: Analizar los factores implicados en la práctica de la cuarta etapa de la Iniciativa Hospital Amigo del Niño a partir de la experiencia de las puérperas internadas. **Métodos:** Se trata de un estudio descriptivo, exploratorio, con abordaje cualitativo. La recolección de datos fue realizada de noviembre de 2011 a enero de 2012, por medio de la observación sistemática no participante de los partos, apuntes de diario de campo y entrevista semiestructurada con 16 sujetos. Para el tratamiento de los datos, fue aplicado el análisis de contenido modalidad temática. **Resultados:** Los principales obstáculos para la realización del cuarto paso fueron la prioridad dada a los cuidados de rutina tras el nacimiento, el parto por cesárea y el proceso de trabajo dispar de las determinaciones de la Iniciativa Hospital Amigo del Niño. **Conclusión:** Se concluye que es necesaria la (re)construcción y reflexión de saberes y prácticas acerca de esa etapa.

Palabras-clave: Interacción Madre-Hijo; Lactancia Materna; Humanización de la Asistencia; Enfermería; Práctica Profesional.

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INTRODUCTION

Contact and breastfeeding soon after birth are recommended by the World Health Organization (WHO) and the United Nations Fund for Children (UNICEF), and correspond to the fourth step of the Baby Friendly Hospital Initiative (BFHI), which states that accredited hospitals must "put babies in skin-to-skin contact with their mothers immediately after birth for at least an hour and encourage mothers to recognize when their babies are ready to breastfeed, offering help if needed"[1:135].

The skin-to-skin contact immediately after birth helps to establish the mother-child bond, leading to physical and psychological benefits for both. With this contact, the baby is kept warm by the heat of the mother's body, avoiding hypothermia; it also assists in the adaptation of the fetal-neonatal transition and encourages the colonization of the intestine of the newborn (NB) by microorganisms from the maternal skin flora, which gives the neonate greater immunity. Moreover, the mother provides the NB with efficient and effective suction, which results in an increase in the prevalence and duration of lactation, and a decreased neonatal mortality rate[2-4].

The hormone production triggered by the stimulation of this contact also affects the woman's health, since it facilitates the physiological exchange from the pregnant to postpartum condition and helps to deliver the placenta in less time, by the action of oxytocin and the movements that the NB performs with his feet in the womb, which leads to a decreased risk of postpartum hemorrhage, in addition to providing a lower risk of breast cancer as a result of breastfeeding[4,5].

Given this scientific evidence, other studies depict the superiority of the benefits of skin-to-skin contact immediately after birth, compared to the contact that occurs when the NB is wrapped in swaddling blankets or clothes. However, we also noticed that contact with the baby, wrapped in cloths or clothes soon after its birth, also proves to be significant and valuable for the mother-child relationship[6].

When the interaction between mother and child is initiated soon after birth, the humanization and improvement to the quality of the assistance provided to women and newborns occur. Therefore the purpose of this assistance is to keep the women and newborns healthy, with a minimum of medical intervention, in order to ensure the safety of both[7].

Although these benefits are scientifically proven, studies show that the practice of the fourth step is not yet fully consolidated in the services provided to women and children, and this reality results from the fragmentation of care, inadequate knowledge of women and professionals on the subject, inappropriate records of the information, the type of delivery, and the lack of professionals, among other reasons. All these issues deserve to be better explored, mainly from the perspective of women, who experience these actions and their consequences[5,8,9].

In view of the above, this study aims to analyze the factors involved in the practice of the fourth BFHI step from the experience of postpartum women admitted into a Baby Friendly Hospital (BFH), since, by understanding these factors, we can act in order to promote early contact and breastfeeding, which are practices considered essential for the mother-child relationship.

METHODOLOGY

This is a descriptive, exploratory study, in which a qualitative approach was used. The study took place from November 2011 to January 2012 in a university hospital in southern Paraná, which has been a BFH since 2003. This hospital is a referral center for high-risk pregnant women from the participating municipalities of the 15th Regional Health Department. According to the internal register, on average, 28 normal deliveries and 41 caesarean sections are performed each month. In 2011, 339 normal deliveries and 491 caesarean sections were carried out.

This institution has the ability to accommodate fifteen hospitalizations for women in the department of Gynecology and Obstetrics (GO), where mother and child are conducted after delivery, in the Adjacent Lodgings (AL), until the time for discharge (except in cases in which there is a contraindication or inability for this relationship).

In this context, they are assisted by a multidisciplinary team. As part of this team, the nursing staff, constantly accompanying both mother and child, consists of a nurse and two nursing technicians every shift. Given the reality portrayed, the inclusion criteria established for the selection of the study subjects were: women aged 18 years or more, who were able to perform contact and breastfeeding after birth, admitted to the GO Clinic of the field study Hospital after delivery at the AL.

Exclusion criteria were: women who presented disability and/or inability to establish early contact and breastfeeding (BF), due to pathologies or childbirth complications, fetal deaths, early neonatal or maternal death, and the women who refused to participate in the research.

Therefore, given the above determinations, 16 postpartum women took part in the research. The number of individuals was determined by the objectives to be achieved, taking into account that the feasibility for pointing out subjects lies in their capability to concretize the object empirically, in all its dimensions, since in the qualitative search, the investigator should worry less about generalizations and more about the depth, scope, and diversity in the process of understanding the group being investigated[10].

Data collection was performed by systematic non-participant observation in intra- and post-partum, which followed a script in which we recorded the start time and end time of birth, the beginning of breastfeeding and how the contact occurred, the general condition of the mother and baby, and the reason for termination of the contact.

It is noteworthy that, as part of the observation, in addition to the implementation of the script, notes were taken in a field journal that included information on practices and attitudes of women and professionals involved in this context. These notes were associated with early contact and breastfeeding, thus providing further elements to the analysis of the concerned phenomenon.

In the case of normal labor, observation began in the expulsive phase of labor, and in the case of a cesarean section,

at the time of anesthesia, followed by further observation the instant the mother and newborn were in the AL of the GO. Thus, the observation occurred at the surgical center (SC) and the AL; however, in the last room, observation lasted no more than 15 minutes, since puerperal women were shown to be constrained in interacting with their children and families in the presence of an observer, in which circumstances the observation was finished. The minimum and maximum time durations of the observation were 28 and 108 minutes respectively, and the total time of observations was 954 minutes.

For data collection, semi-structured interviews were also performed with the mothers. These interviews happened after childbirth, respecting the mother's recovery period. The guiding question of the study was: "What are the factors involved in the practice of early contact and breastfeeding among mothers who had their children in the context of a BFH?". To this end, we used an instrument containing questions relating to the description of how childbirth was, as well as where, how and when the contact and breastfeeding occurred, and which professionals or companions helped at that time.

For the interpretation of the information obtained, both by means of interviews, and by non-participant observation and field diary notes, we used the analysis of thematic content, which can be divided into three phases: pre-analysis; exploration of the material and; the treatment of results, inference and interpretation[10].

In the first phase, the complete transcription of the floating reading data and the material was performed. Subsequently we established extensive contact with the material. The second phase involved the selection of record units, by selecting and coding information through convergence with the phenomenon investigated. Thus, thematic units were distributed based on a set of similar information; that is to say, the data were categorized.

In the last phase, information proved to be significant and valid because, as we had the organized data at our disposal, we could deal with and understand the phenomenon under investigation, as well as contrast it with, and bring it closer to, the scientific studies and government determinations in the area. Thus, the analysis fell into two categories: 1) childbirth care practice and its implications toward the fourth step, and 2) the work process and its relation to the fourth step.

To maintain the anonymity of the interviewees, it was decided to identify them by the abbreviations I1, I2, I3, etc., sequentially. The numeric indicator was assigned according to the progression of the interviews, by which I1 was the first respondent and I16 the last. The study was undertaken in line with the guidelines of Resolution 196/96 of the National Council for Health, and was approved by the Committee For Ethics Involving Human Beings of the State University of Maringá (Opinion 509/2009).

RESULTS

The study participants were aged between 18 and 34 years, with an average age of 26.06 years. Regarding marital status, only two women did not have a partner: one of these was a widow and the other one was single. Schooling was heterogeneous, since the group included women whose education ranged from elementary school to university.

Regarding the obstetric characteristics of participants, eleven had a history of childbirth prior to the study. Gestational age ranged between 37 and 40 weeks, with an average of 39.06 weeks, characterizing the newborns as born in good time. With regard to the type of deliveries, ten were normal childbirths. Knowledge of these features serves to help us understand the reality of the subject designated by them more deeply. For this, it is also necessary to contextualize the practices related to the fourth step of the BFHI of the study field institution, which are described below.

Usually, once the baby is born, it is received by the obstetrician, who then delivers it to the pediatric team, which delivers it to the heated crib, thence performing the routine care (RC), which involves drying, aspiring, evaluating, recording, identifying and administering Vitamin K to the baby, and in cases of normal deliveries, administering 1% Silver Nitrate eye drops.

After such care, the pediatric team takes the NB, wrapped in blankets, to the mother, providing the first contact between both of them. Generally, in normal births, the baby is handed to the woman at this moment and it stays with her until they arrive at the AL. In the case of cesarean section, this does not happen. The NB returns to the heated crib or stays on its father's lap, in the event that the father is present.

With the completion of delivery, the newborn is sent along with his mother to the AL of the GO. Commonly, mother and child leave the SC together in the gurney, except in cases of maternal or NB complications or in cases of episodes in which the baby is handed to the relatives of the puerperal woman when leaving the SC.

When referred to the clinic GO to reach the department, mother and child are often separated, so that the nursing staff can transfer the puerperal woman from the stretcher to the bed. At this time, the nursing professionals perform the specific RC for that department, which consists of a brief physical examination of the mother and the NB. They dress the baby and then hand it to the puerperal woman, who is encouraged and guided to breastfeed.

Delivery care practice and its implications in terms of the fourth step

Table 1 shows the elapsed time from birth to the completion of physical contact (PC) and the BF between mother and NB, as well as the duration and reason for the termination of PC. The PC was considered to be any interaction that led to touch, from a kiss to skin-to-skin contact.

The elapsed time from birth to the onset of PC ranged from 0 to 99 minutes. In the cesarean deliveries, the newborn was never left with the mother as soon as it was born, but it was handed to her only at the end of surgery. The interviewed mothers say that, soon after delivery, care was provided to the newborn, even before the baby was brought to them.

Table 1. Establishment of early contact and breastfeeding. Maringá, PR, 2011

Subject	Type of delivery	PC Start T	PC Duration T	BF Start t	Grounds for termination of PC
I1	N	0'	1'	17'	The obstetrician hands the infant to the pediatrician so he could perform the routine care in the SC.
I2	C	99'	14'	99'	Nurse ceases contact saying that the NB was getting "cold".
I3	C	6'	< 1'	71'	Medical student, after presenting the NB to the mother, takes it to the heated crib in the SC.
I4	C	6'	< 1'	80'	Medical student who, after presenting the NB to the mother, takes it to the heated crib in SC.
I5	N	8'	4'	48'	The NB is handed to the grandmother, so that the puerperal woman can be transferred to the stretcher.
I6	C	5'	< 1'	68'	Medical student, after presenting the NB to the mother, takes it to the heated crib in the SC.
I7	C	55'	07'	55'	Nurses separate mother and child to allocate the mother a bed in the AL and perform a physical examination on the NB and mother.
I8	N	23'	9'	23'	Nurses separate mother and child to allocate the mother a bed in the AL and perform a physical examination in the newborn and mother.
I9	N	34'	11'	34'	Nurses separate mother and child to allocate the mother a bed in the AL and perform a physical examination in the newborn and mother.
I10	N	8'	3'	8'	Nurses separate mother and child, telling the NB that the mother is tired.
I11	N	10'	16'	45'	Nurses separate mother and child to allocate the mother a bed in the AL and perform a physical examination in the NB and mother.
I12	N	6'	9'	33'	Nurses separate mother and child to take the NB to the father, who was outside of the SC.
I13	N	8'	7'	8'	The mother asks somebody to hold the NB.
I14	N	8'	7'	68'	The mother asks to take the NB away.
I15	N	0'	< 1'	12'	The obstetrician delivers the NB to the pediatrician so the routine care could be performed in the SC.
I16	C	57'	8'	87'	Nurses separate mother and son to hand the NB to his father so he could hold him.

PC: Physical contact; BF: Breastfeeding; SC: Surgical center; AL: Adjacent lodging; N: Normal birth; C: Cesarean delivery and; ' Time in minutes.

[...] First they cleaned her a bit and brought her so I could see her. The nurse was still working on my stitches. She was totally wrapped in a blanket. (I9).

[...] First they took him to the pediatrician to evaluate him, but then he brought me and stayed a little while there. I think they gave him a vaccine, something like that, and then the nurse brought him back (I10).

PC occurred immediately after the delivery in only two cases of normal delivery, in which the newborn was given immediately to the mother after emerging from the womb. In both cases, the mother's nightgown was closed on the front side; therefore no skin-to-skin contact occurred. In these cases of PC, there was no skin-to-skin contact and contact lasted just a few seconds:

In childbirth, I mean, by the time I gave birth. Soon after, they put him on top of me, but they didn't left me breastfeeding him at the time. They could have let me breastfeed him. [...] He had just been born, was warm, very bloody, naked, nothing (I1).

When the baby is born, the obstetrics resident puts it immediately on the mother's abdomen, who despite being a bit tired, shows happiness. In less than a minute, both are separated and the neonate is forwarded to the heated crib, where the RC is started (Notes field diary - I16).

In the case in which 99 minutes of waiting were required before the beginning of the PC, there was no need for immediate attention to the mother and/or the NB to justify this delay, since both were active and responsive to interaction. Through non-participant observation, it was identified that this delay in initiating the PC was related to the attitude of professionals in maintaining the NB in the crib until the end of the procedure and referring the mother to the AL, as well as relating to the type of delivery (cesarean section).

Moreover, in this case, the fact that the patient was obese influenced the time required for transferring the woman to a stretcher after the surgical procedure, which required more than one professional for this assistance to be performed safely. This was not feasible at the moment, because the other employees were involved in other activities.

When finished the procedures, the woman remains on the operating table awaiting her transfer to the stretcher and the AL. Meanwhile, the child is in a heated crib. While nursing technicians clean and tidy the room, they heads to the puerperal woman and explains to her that she is waiting for another professional to help her transfer her (the mother) and the baby (field diary notes - I2).

Another factor that contributed to delaying the onset of PC in this episode was the fact that, at the time when the mother was removed from the operating room, which is the time when babies are routinely given to their mothers, the practical nurse preferred to leave the baby between the mother's legs, which he considered safer. This was due to the fact that the professional felt afraid that the NB would not be safe with the mother, considering that the stretcher was too narrow for both of them. In addition to this issue, the woman was still under the influence of anesthetic action, which compromised her mobility. Thus, the PC only occurred in the AL.

Although the situations mentioned have all been related to this particular case, these factors were also noted in other situations observed during the study and were relevant to the delay to the beginning of PC. Thus, the delay to the start of the PC between the woman and NB, as well as its short duration in those cases in which it occurred soon after birth, were the result of the continuous monitoring of the patient and the use of anesthesia in cesarean deliveries, in addition to the priority given to the RC, which ultimately compromised the motor actions of the woman. These facts can generate a fear of leaving the NB with the mother, on the part of the team.

Regarding the time elapsed from birth to the first sucking start, a range from 8 to 99 minutes was observed and, in ten cases, there was breastfeeding/suction within the first hour of birth. The duration of the first BF was not marked because, in half the cases, this practice began only in the AL, where the presence of the observer constrained participants; therefore, in these cases, data collection was terminated. Even though BF occurred within the first hour after delivery in most of the interactions, as observed, it was found that in ten cases the PC was not followed by breastfeeding/sucking.

Even as part of the practice of birth assistance, it was also found that the reasons for the separation of mother and child after the first PC were different, as shown in Table 1, ranging from the removal of the baby for the RC, to the request of the woman herself, because it didn't feel safe.

[...] as soon as she was born and the nurse cut her umbilical cord, she (the nurse) put her on my tummy; afterwards she took the baby to take care of her; for the weighing procedures, I think, and her eyes... (I15).

[...] The mother asks someone to hold the baby, because she is in pain and afraid to drop him (field diary notes - I13).

The working process and its relation to the fourth step

Although health professionals have not become objects of this study, it was impossible to separate them from the patient in the care context because both complemented each other, creating interdependency in the care relationship.

In most cases, the dynamics of the healthcare team's working process regarding the fourth step presented a fragmented care, in which the medical team showed its predominantly curative performance. It is concerned with maintaining the biological health and stability of the child and the mother, as well as the nursing staff, in practical, assistantial and managerial terms, for providing care to the basic human needs of both after birth.

Despite the focus of the nursing team's efforts on holistic care, regardless of the specificity of each sector, we note that the nursing work process developed both in SC, and in the GO clinic, had different service focus.

The allocation of the care function of early contact and breastfeeding, most of the time, was left to the GO team: that is, when mother and child arrived at the AL. Therefore, this practice was not always valued or prioritized by the SC team.

Mother and child are forwarded to the hallway. At this time, the NB is not placed to be breastfed. The NB is on the mother's lap, he makes noise with his mouth and the mother imitates him and talks to him saying: do you want to breastfeed? Are you hungry? The nurse who remains

beside the mother, observes, but does not encourage breastfeeding. The nurse says: feed him at the hospital afterwards. While the nurse looks at me and the mother, she says: there should be a way to make the mother more comfortable. It's complicated to breastfeed in the lying position and it is complicated because this is not a maternity hospital; it is an SC. It's bad because the woman is exposed (Notes field diary - I14).

Even if the service is not being provided in accordance with the determinations of the MOH, and by all the staff soon after birth, the nursing staff were outstanding in terms of care, even if it was not directly related to the fourth step, which was confirmed by the reports of the participants and the field diary notes:

[...] Breast suction was immediate. We came to the room; I sat down, then the nurse came, put him on my lap and we already started this interaction over breastfeeding (I10).

My husband helped. The nurse taught him, then we went... (E2).

The nursing staff was present during the whole labor. She was the one who mostly interacted with the patient and was responsible for the forwarding and care for mother and child at the time of transfer and reception between the GO and SC sectors (Field diary notes).

Whereas the work process includes not only the human aspects, but the environment in which the individual is, it was also found that the lack or non-use of some hospital equipment, which could facilitate the delivery, and the limited availability of some health professionals to assist mother and child, were some factors that may interfere with the practice of early contact and breastfeeding.

There are balls; there is a special chair and a birth stool. But I think the SC still needs a bit of structure. Because there is only that gynecological table. And it doesn't provide much support for you to have humanized care (I10).

The nursing technician covers mother and child, and observes the mother who is attempting to breastfeed. Then she says that the contact the mother has with her baby is very important. She also says that, if she lets the NB touch the nipple with his mouth, it is enough for the baby to catch her breast. Then, without helping the woman, the technician just leaves the room. The mother continues trying to breastfeed her child and she says: don't cry, Mommy is going to feed you (Notes field diary - E1).

Given these facts, despite the importance of managing this process towards a more humane working practice and focusing on the real needs of mother and child, the labor process proved, at times, to have its system influenced by intrinsic and extrinsic factors:

After the baby's birth, the nursing staff is informed that a normal delivery from the emergency care is coming. A pediatrics resident gets concerned, because she is alone in the SC and left to carry out both the reception and provide care to the newborns. There is a pediatrician at the NEO ICU, but if she cannot come, the resident will have to attend both NBs. The obstetrician calms the mother down, who has overheard the conversation: it's okay, Mom. What a big baby! We have another delivery coming in, so I can't show him to you for a long time, but now you go listening to him. The resident performs the RCs quickly... moments later, a warning that the pediatrician has already started the other delivery. The resident, more calmly, completes the care toward the newborn, and at 15:35 she takes the NB to the mother, puts him very close to the woman's face, which smiles thrilled. The woman quietly talks with her son and kisses him on the forehead (Notes field diary - E6).

DISCUSSION

The results show that care practice show that there are still some discrepancies between extant care practice and the determinations imposed by the BFHI and the humanization policies for childbirth. This reality is demonstrated by the analysis of Table 1, the statements and the field diary notes. This data provides evidence of how the factors are involved in the practice of the fourth step, the cultural, practical and theoretical aspects of professionals and the physical and political aspects of the institution, as well as the priority given to RCs and the type of delivery.

The socio-cultural aspects related to the fourth step of the BFHI, albeit indirectly portrayed, demonstrate influence over the practice of early contact and breastfeeding. Women were shown to value contact and breastfeeding soon after birth, but they still show themselves committed to the biomedical model, just like the professionals. There was no opposition from either party regarding the priority given to the RCs.

This relationship was also demonstrated in a study developed in Thailand, where women from a certain community value the practice of breastfeeding, but do not practice it immediately after delivery nor perform the skin-to-skin contact, since care to the NB immediately after birth is often prioritized and the child is delivered to the mother totally wrapped in cloths. The population and professionals believe that keeping babies wrapped in tissues promotes a feeling of safety to the neonates, and protects them from evil spirits[11].

Despite the individuality, values and beliefs of each group, studies of various nationalities emphasize the importance and benefits of early contact, because when it occurs, it generates a more effective and lasting breastfeeding, as well as the satisfaction afforded to women from the mother-child proximity[6,11,12].

Regarding the type of delivery, a cesarean section was seen as a factor that contributed to the postponement of contact and first feeding. Although this finding is not likely to be widespread due to the number of subjects in this study, other national and international research has showed statistically that there is a significant relationship between instances of skin-to-skin contact and cesarean delivery, in which case this relation is inversely proportional[13,14].

Cesarean section is perceived as a risk factor for the achievement of the fourth step, in that it interferes with the mother's ability to move, from the situation and positioning resulting from the surgical procedure, and due to the effect of anesthesia, which in turn may interfere with the alertness of the mother and baby[8].

In this study, we observed as a relevant factor for the success of early contact and breastfeeding, the availability of qualified professionals to provide psychobiological support to women at the time of this first meeting. Birth is an event of great emotional and physical range, in which physiological, social, cultural and psychological factors interact; this therefore makes the monitoring of, and assistance to, women necessary[12,15].

This whole process depends on continuous, dynamic and integrated action between health professionals, and it is necessary for them to be empowered and involved with the institutional and political purposes advocated by the BFHI and defended by the hospital in question. Such a situation was also observed in a cross-sectional cohort study involving 1,309 mother-child pairs[8]. The preparation and awareness of health professionals, including the nursing staff that provides constant and direct assistance to patients, is important for this.

Situations in which professionals were in insufficient number to assist women properly in the SC interfered negatively in the proper practice of the fourth step, since the stretcher was narrow and there was a lack of support and guidance from professionals at certain moments. These occurrences were also portrayed in a Brazilian study that argues that skin-to-skin contact does not justify the difficulties described preventing the fourth step from occurring, since it is a simple technique. Early contact and breastfeeding are, therefore, essential, inexpensive and easy-to-apply measures[5].

Taking into account the recommendations aimed at humanizing and improving the quality of care to mother and child, it was observed that, in two cases of normal delivery, there was contact immediately after birth, an outcome that is consistent with the determinations of the BFHI. However, even though the interaction was established promptly, it was brief and without skin-to-skin contact, which must be rethought, since a study conducted in southern California proves that, in addition to the early onset, the duration of skin-to-skin contact is crucial to the effectiveness of breastfeeding and prevalence of exclusive breastfeeding[14].

When establishing the skin-to-skin contact for at least an hour, there is the possibility of triggering behavioral actions for pre-breastfeeding in the NB. These actions - such as bringing the hands to the mouth; making suction attempts; making sounds and touching the nipple with his hand; focusing the dark area of the breast; moving toward the breast and looking for it; and finding the nipple area and picking it up with an open mouth[7] - are described as a brief rest on alert so the NB can adapt to the new environment. This finding may explain the fact that in ten of the cases followed, breastfeeding did not occur immediately after FC, since the babies were handed to their mothers, most of the time wrapped in cloths, which may compromise behavioral actions of pre-breastfeeding in NBs, described previously.

Even if BF had not been triggered by skin-to-skin contact in the delivery room, it was observed that, in ten cases, the first meeting between the newborn and the mother occurred within the first hour after birth, which is a period described as "sensitive" and extremely important for early BF, since newborns are more sensitive to tactile, thermal and odor stimuli, in which the catecholamine levels are elevated, favoring actions that are relevant and beneficial to the initiation of breastfeeding[16].

A Thai study argues that, even if initiated after the care provided to the NB, encouraging breastfeeding as soon as possible may extend/enhance its duration and prevalence, thereby mitigating the consequences of the absence of skin-to-skin contact and breastfeeding soon after birth[11].

As observed in the results, the reasons given for the separation of the mother and child immediately after delivery were various, being, in most cases, related to RCs and, at times, upon the request of the woman. Before all the issues until this moment, these justifications do not seem to be primary needs, especially because both the mother and neonate were active and receptive to this meeting without imminent risk of death. For this reason, the care provided to the NB could have been delayed, but also measures of comfort, support and guidance implemented, to avoid the postponement of contact between mother and child.

In this scenario, in which all elements presented result directly and indirectly in the work process, it became important to discuss this matter. The working process is characterized as the interaction between humans and nature, and was presented as the transformation of a given object to a given product, by means of human actions[17].

As noted in the study, the dynamics of care proved to be fragmented, both in relation to teamwork and in departmental issues. This discrepancy resulted in an attitude of caution that was not always continuous and consistent with the determinations of the BFHI. Thus, the obstacles to early contact and breastfeeding coincide with the findings of another study, which also shows that there is a lack of continuity in the transition of care between nurses, lagged postpartum care, inadequate hospital policies and limited education of nursing professionals[9].

Seeking to correct this deficit, we need to rethink a new care model in user-centered health, for which it is fundamental to reframe the work process. This redefinition requires changing the purpose of this process, which happens to be the production of care, in view of the autonomy of the subject, guided by the principle of completeness and requiring the following tools:

interdisciplinarity; intersectionality; teamwork; humanizing services; and the creation of a bond between user, professional and healthcare team[18].

Relations with the outside world and the determinants of the organizational identity influence the evolution, changes and development of organizations[16]. This fact was presented in one of the deliveries, which demonstrated that there are times that are inherent to the will and pre-established systematics. However, in these situations, it is appropriate for the team to plan and organize itself in the best possible way, adapting to emerging factors in order to develop measures of care consistent with the precepts of the BFHI.

Thus, it is essential to (re)think practices, their relationship with the theoretical and scientific background, the uniqueness of each individual, the institutional policies established and professional training. Only then is it possible to devise strategies that will fill the gaps that prevent or hinder the realization of the measures imposed by the BFHI, especially with regard to the fourth step.

CONCLUSION

The study revealed that the practice of the fourth step is subject to personal, cultural and emotional factors affected by both mothers and professionals involved in this context, in addition to the structural and organizational elements of the institution. Within this context, the main obstacles to the realization of the fourth step were the priority given to RCs, cesarean delivery and the unique work process of the BFHI determinations.

The discussion regarding childbirth care practices and work processes gave us a perspective on the main barriers and pathways to the development and the consolidation of activities consistent with the effective realization of the fourth step.

The involvement of various sectors of the service, especially the SC and GO, and the professional turnover in the care given to mother and child, resulted in a fragmented and discontinuous care, which eventually postponed and/or interrupted the early contact and breastfeeding. Given these circumstances, it is pertinent to develop actions that promote the training of all professionals who assist these women in the importance of early contact and breastfeeding, as well as in the impact of an immediate and quality care on the health of mother and child, in order to set up a continuous, comprehensive and holistic care to mother and child.

Moreover, it is worth mentioning the importance of the team and the continuous work of the professionals at the SC and GO assisting these women, as well as organizational, instrumental and institutional realignment focused on the determinations of the BFHI, and the development of practices consistent with scientific evidence. Such measures may influence the short- and long-term quality of care, contributing to the consolidation and/or realization of the fourth step of the BFHI.

Therefore, based on the results of this research and its considerations, we can say that we have a long way to go, with many challenges to overcome, considering that, for the consolidation of the fourth step, it is necessary to go beyond a purely technical approach, as these challenges involve the specific socio-cultural characteristics of patients, professionals, institutions and society. To alter such a reality, we need to invest in the discussion of ideas related to the BFHI and, above all, to create opportunities for these ideas to become effective and be experienced, in order to search for courses of action that materialize the precepts advocated by this humanizing initiative of healthcare toward mother and child.

The limitations of the research include the fact that the number of subjects studied is not amenable to generalizations. However, the survey data are valid because they instigate critical-reflective thinking from the professionals on the importance of changes in practices and knowledge that will modulate attention in the phenomena investigated. Thus, the study is relevant in that health professionals may be sensitive to it, and share and contribute to it, so that the fourth step of the BFHI might become a consolidated fact.

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