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FACTORS ASSOCIATED WITH BREASTFEEDING IN THE FIRST HOUR OF LIFE IN A BABY-FRIENDLY HOSPITAL¹

Juliane Lima Pereira da Silva², Francisca Márcia Pereira Linhares³, Amanda de Almeida Barros⁴, Auriculara Gonçalves de Souza⁵, Danielle Santos Alves⁶, Priscyla de Oliveira Nascimento Andrade⁷

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- ² Nursing Resident in Women's Health. *Hospital das Clínicas* of UFPE. Recife, Pernambuco, Brazil. E-mail: juliane_ips@hotmail.com
- ³ PhD in Nutrition. Professor of the Nursing Faculty of UFPE. Recife, Pernambuco, Brazil. E-mail: marciapl27@gmail.com
- ⁴ Nursing Student UFPE. Recife, Pernambuco, Brazil. E-mail: amandabarros95@hotmail.com
- ⁵ Nursing Student. UFPE. Recife, Pernambuco, Brazil. E-mail: aury.kk@hotmail.com
- ⁶ M.Sc. in Health Sciences. Professor of the Nursing Faculty of UFPE. Recife, Pernambuco, Brazil. E-mail: angeldannyalves@gmail.com
- ⁷ M.Sc. in Nursing. Substitute Professor of the Nursing Faculty of UFPE. Recife, Pernambuco, Brazil. E-mail: pricila_nas@yahoo.com.br

ABSTRACT

Objective: to evaluate the factors associated with the practice of breastfeeding in the first hour after delivery.

Method: a quantitative cross-sectional study whose sample consisted of 244 postpartum women hospitalized at the Obstetric Wards and Rooming-in Wards at the *Hospital das Clínicas*, Recife, Brazil.

Results: the rate of breastfeeding in the first hour of life was 28.7%. Among sociodemographic variables, not one presented a protective factor for breastfeeding in the first hour postpartum with p-value>0.05. By adjusting the final Poisson model, it was observed that the factors associated with this practice were the presence of the nurse in the delivery room (p <0.001), the weight of the newborn being equal to or greater than three kilos (p 0.05) and skin-to-skin contact between mother and child (p 0.003).

Conclusion: in the first hour of life after delivery, the practice of breastfeeding fell short of what is recommended by the World Health Organization, despite the institution considered as a baby-friendly hospital. The main factors associated with this practice were vaginal delivery, the nurse, and skin-to-skin contact between mother and child.

DESCRIPTORS: Breast feeding. Delivery rooms. Obstetric nursing. Women's health. Milk. human

FATORES ASSOCIADOS AO ALEITAMENTO MATERNO NA PRIMEIRA HORA DE VIDA EM UM HOSPITAL AMIGO DA CRIANÇA

RESUMO

Objetivo: avaliar os fatores associados à prática do aleitamento materno na primeira hora pós-parto.

Método: trata-se de um estudo quantitativo, do tipo transversal, cuja amostra foi constituída por 244 puérperas internadas no Centro Obstétrico e Alojamento Conjunto do Hospital das Clínicas, Recife, Brasil.

Resultados: a taxa de amamentação na primeira hora de vida foi de 28,7%. Dentre as variáveis sociodemográficas, nenhuma se apresentou como fator de proteção para a amamentação na primeira hora pós-parto com p-valor>0,05. Através do ajuste do modelo de Poisson final observou-se que os fatores associados a esta prática foram a presença do enfermeiro na sala de parto (p<0,001), o peso de recém-nascido ser igual ou maior que de três quilos (p 0,05) e o contato pele a pele entre mãe e filho (p 0,003).

Conclusão: a amamentação, na primeira hora pós-parto, ficou aquém do recomendado pela Organização Mundial de Saúde, mesmo a instituição estudada sendo considerada como Hospital Amigo da Criança, e, que os principais fatores associados a esta prática foram o parto vaginal, enfermeiro prestador da assistência ao parto e o contato pele a pele entre mãe e filho.

DESCRIPTORIOS: Aleitamento materno. Salas de parto. Enfermagem obstétrica. Saúde da Mulher. Leite humano.

FACTORES ASOCIADOS AL ALCANCE MATERNO EN LA PRIMERA HORA DE VIDA EN UN HOSPITAL AMIGO DEL NIÑO

RESUMEN

Objetivo: evaluar los factores asociados a la práctica de la lactancia materna en la primera hora posparto.

Método: se trata de un estudio cuantitativo, del tipo transversal, cuya muestra fue constituida por 244 puérperas internadas en el Centro Obstétrico y Alojamiento Conjunto del Hospital de las Clínicas, Recife, Brasil.

Resultados: la tasa de lactancia en la primera hora de vida fue de 28,7%. Entre las variables sociodemográficas, ninguna se presentó como factor de protección para la lactancia en la primera hora postparto con p -valor $> 0,05$. A través del ajuste del modelo de Poisson final se observó que los factores asociados a esta práctica fueron la presencia del enfermero en la sala de parto ($p < 0,001$), el peso de recién nacido ser igual o mayor que de tres kilos ($p 0,05$) y el contacto piel a la piel entre madre e hijo ($p 0,003$).

Conclusión: la lactancia, en la primera hora postparto, quedó por debajo de lo recomendado por la Organización Mundial de la Salud, incluso la institución estudiada siendo considerada como Hospital Amigo del Niño, y que los principales factores asociados a esta práctica fueron el parto vaginal, enfermero prestador de la asistencia al parto y el contacto piel a piel entre madre e hijo.

DESCRIPTORES: Lactancia materna. Salas de parto. Enfermería obstétrica. Salud de la mujer. Leche humana.

INTRODUCTION

The Ministry of Health recommends that breastfeeding should take place exclusively from birth to six months of age and continue in association with other foods up to two years of age or older.¹⁻² This recommendation is based on the benefits that breast milk can bring to the health of the child, the woman, the family and the environment. For the child's health, breast milk has an immunological protection factor, since it contains Immunoglobulin A, which protects the newborn against intestinal infections, allergies and other conditions.³ Many strategies are being implemented by international organizations with the objective of promoting, encouraging and supporting breastfeeding. The United Nations Children's Fund together with the World Health Organization (WHO) set up the Baby-Friendly Hospital, whose initiative recommends ten steps to successful breastfeeding. Among these steps, it is worth noting the fourth step that recommends placing newborns (NBs) in contact with their mothers immediately after birth for a period of at least one hour.¹

Breastfeeding in the delivery room enables the NB to better adapt to extrauterine life, glycemic, cardiorespiratory and thermal regulation.⁴ For mothers, early attachment stimulates the pituitary gland and the production of oxytocin and prolactin, increasing breast milk production. A study carried out with 10,947 infants showed that when breast milk is given on the first day of life, 16% neonatal deaths were avoided, which could reach 22% if breastfeeding is anticipated for the first hour after childbirth.⁶

In addition, breastfeeding in the first hour of life is considered an indicator of breastfeeding excellence. The WHO ranks the percentage of adherence

to breastfeeding in the first hour of life after delivery for healthy mothers and newborns between 0 and 29% as 'very poor', between 30 and 49% as 'bad', 50-89% as 'good' and 90 to 100% as 'very good'.⁷

There are still barriers that impede the effectiveness of this fourth step and its implantation in health institutions. Thus, care for the newborn has been established as one of the practices that hinder skin-to-skin contact of the mother-baby binomial, and consequently, breastfeeding.⁸ The type of delivery also influences breastfeeding. Cesarean section is considered a risk factor for women as it performed under anesthesia, which prevents the mother from full arm movement and thus limits the contact between mother and baby.⁹

Thus, all the health care professionals who work in the delivery room are responsible for the act of early breastfeeding, among them, the nursing professional. This professional has the role of facilitator with regard to early breastfeeding, especially when providing information and assisting in the management of breastfeeding in the delivery room. The nurse must encourage the other health professionals present at the birth, to understand more about the awareness, information and integration regarding the program and support breastfeeding in the first hour of life. In order to achieve this goal, it is necessary to acquire scientific knowledge, technical ability and communication.¹⁰

This study contributes to the knowledge regarding the main factors that impede the implementation of early breastfeeding, and may be the starting point for institutions to start improving the incidence of this practice in hospital settings. This article aims to evaluate the factors associated with the practice of breastfeeding in the first hour of life after delivery.

METHOD

A transversal quantitative study. Data collection was performed at the obstetric wards and rooming in accommodation of a University Hospital accredited with the Baby-Friendly Hospital title. The research participants were hospitalized women in the immediate post-partum period, between May and September 2016.

Women who were incapacitated and/or prevented from breastfeeding due to one or more of the following characteristics were excluded from the study: NB with low birth weight (weight less than 2500g); gestational age <37 weeks (according to first-trimester ultrasonography); newborn hospitalized in the intensive care unit (ICU); mother hospitalized in the ICU; positive serostatus for HIV in the prenatal card or the rapid test performed at maternity hospital; positive for syphilis, hepatitis B and five minute apgar score less than seven. The sample calculation was performed, taking into account the number of participants which was determined by the equation of the sample calculation for the study of the proportion in finite population.

Considering a confidence level of 95%, the sample error of 5% and the number of puerperae equal to 660 (the average number of deliveries in one month was 220, so in three months the estimated number of deliveries is 660), it was shown that the required sample size was 243 mothers, thus, 244 interviews were collected. The average of deliveries was calculated using the records of the procedure book of the obstetrical center of the mentioned institution. The mothers who entered the service on the pre-defined days for collection were selected until the necessary sample size was reached. The outcome: breastfeeding in the first hour of life after delivery (yes/no) was obtained through an interview with the mother, through a 24-hour recall and by consulting the medical records. Breastfeeding in the first hour after birth was considered as offering the breast within up to sixty minutes after birth.

Independent variables were selected for analysis: personal characteristics (schooling, marital status, parity), gestational characteristics (desire to become pregnant, maternal age, support received by the partner), prenatal care (receiving information about breastfeeding, information about breastfeeding in the first hour of life after delivery, number of consultations), hospital care (type of delivery, birth weight, newborn Apgar score, neonate given to the mother after delivery, attendance in the delivery room, cord clamping and place of RN care). Subsequently, the dependent variable was questioned:

breastfeeding in the first hour of life after delivery. The completion of some variables related to delivery care (type of delivery, weight of the newborn, Apgar in the first and fifth minutes and cord clamping) were verified by consulting the medical records.

For the purpose of data analysis, a database was created using the 3.5.2 version of the EPI INFO® program, where the database was validated (double entry for later comparison and correction of divergences). After the validation, the database was exported to version 18 of the SPSS® software, where the analysis was performed. In order to evaluate the personal profile, the characteristics of gestation, the characteristics of the prenatal care, the profile of the birth and the characteristics of the NB, the percentage frequencies were calculated and their distributions were constructed. The chi-square test was used to compare the percentage found in the levels of the evaluated factors and to compare the proportion. All conclusions were made considering the significance level of 5%. For the purpose of multivariate analysis the factors that presented significance of up to 10% in the bivariate analysis were included. The Poisson model with robust variance to analyze the risk of breastfeeding of the newborn in the first hour of life after delivery was also applied. For the permanence of the factors in the model the significance level of 5% was estimated. In addition, the confidence intervals for the prevalence ratio and the Wald test were used for the comparison of the risks of breastfeeding the NB in the first hour of life after birth between the levels of the evaluated factors. The present study was approved by the ethics committee in research with humans with CAAE number 52519916.0.0000.5208 and protocol number 2,062,869. All participants in the study received the Informed Consent Form. For the mothers who were under the age of 18, their Term of Assent and the respective Informed Consent Form were conferred by their guardian.

RESULTS

The age of the post-partum women ranged from 11 to 39 years of age, with 54.1% of the women being between 20 and 29 years of age. The majority of the women attended high school (97; 39.8%), were in a civil union (143, 58.6%). Not one sociodemographic variables presented as a protective factor for breastfeeding in the first hour of life after delivery with a p-value>0.05 (Table 1).

Table 1 - Distribution of breastfeeding in the first hour of life after delivery according to age, schooling and marital status. Recife, PE, Brazil, 2016. (n = 244)

Evaluated factor	Breastfed in the first hour postpartum		p-value*
	Yes	No	
Age			
11 -19 years old	15(31.2%)	33(68.8%)	0.409
20 - 29 years old	37(28.0%)	95(72.0%)	
30 - 39 years old	15(25.4%)	44(74.6%)	
Older than 39 years old	3(60.0%)	2(40.0%)	
Schooling			
Illiterate	3(100.0%)	0(0.0%)	0.088
1st grade incomplete	17(27.0%)	46(73.0%)	
1st grade complete	20(25.6%)	58(74.4%)	
2nd grade complete	30(30.9%)	67(69.1%)	
3rd grade complete	0(0.0%)	3(100.0%)	
Marital status			
Single	14(29.8%)	33(70.2%)	0.898
Married	17(32.1%)	36(67.9%)	
Divorced	0(0.0%)	1(100.0%)	
Civil Union	39(27.3%)	104(72.7%)	

* p-value of the Fisher's exact test.

According to the study, primiparous women presented a higher prevalence of early breastfeeding (29.3%), but with very close percentages to that of multiparous and grand multiparous women, with 28.8% and 25%, respectively, and were therefore not

statistically significant (p-value > 0.05). The support received by the companion and the characteristics related to the performance of prenatal care, did not have a significant association with the outcome of the study (Table 2).

Table 2 - Distribution of breastfeeding in the first hour of life after delivery according to the gestational characteristics. Recife, PE, Brazil, 2016. (n = 244)

Evaluated factor	Breastfed in the first hour postpartum		p-value
	Yes	No	
Parity			
Primiparous	34(29.3%)	82(70.7%)	0.913*
Multiparous	30(28.8%)	74(71.2%)	
Grand multiparous	6(25.0%)	18(75.0%)	
Received support from companion			
Yes	60(27.3%)	16(72.7%)	0.139*
No	10(41.7%)	14(58.3%)	
Performed pre-natal care			
Yes	69(28.8%)	171(71.3%)	1.000†
No	1(25.0%)	3(75.0%)	
Number of pre-natal consultations			

Up to 3 consultations	3(20.0%)	12(80.0%)	0.698*
4 - 6 consultations	18(27.7%)	47(72.3%)	
More than 6 consultations	48(30.0%)	112(70.0%)	
Received orientation regarding breastfeeding during pre-natal			
Yes	45(30.4%)	103(69.6%)	0.472
No	24(26.1%)	68(73.9%)	
Received orientation regarding the importance of breastfeeding in the first hour after birth			
Yes	31(32.3%)	65(67.7%)	0.322*
No	38(26.4%)	106(73.6%)	

* p-value of the Chi-square test; † p-value of Fisher's exact test.

Among the characteristics of the delivery and the newborn, the ones that presented as protection factors for the fourth step of the Baby-Friendly Hospital Initiative (BFHI) were the type of vaginal deli-

very (p 0.009). In addition, the nurse as a caregiver (p 0.001), skin-to-skin contact between mother and child (p 0.001) and late clamping of the umbilical cord, (p.0.011) (Table 3).

Table 3 - Distribution of breastfeeding in the first hour of life after delivery according to characteristics of delivery and newborn. Recife, PE, Brazil, 2016. (n=244)

Evaluated factor	Breastfed in the first hour postpartum		p-value
	Yes	No	
Type of delivery			
Vaginal	45(35.4%)	82(64.6%)	0.009
Cesarean	23(20.2%)	91(79.8%)	
Professionals in the delivery room			
Nurse	7(77.8%)	2(22.2%)	0.003†
Doctor	63(26.8%)	172(73.2%)	
Companion present			
Yes	31(33.3%)	62(66.7%)	0.208*
No	39(25.8%)	112(74.2%)	
Newborn weight			
Less than 3000g	10(18.9%)	43(81.1%)	0.074*
3000g or more	60(31.4%)	131(68.6%)	
1st minute Apgar			
< 7	2(11.8%)	15(88.2%)	0.171†
7	2(18.2%)	9(81.8%)	
8	13(22.0%)	46(78.0%)	
9	47(33.1%)	95(66.9%)	
10	6(40.0%)	9(60.0%)	
5 minute Apgar			
8	2(11.1%)	16(88.9%)	0.058*
9	15(22.4%)	52(77.6%)	
10	53(33.3%)	106(66.7%)	
Newborn and mother skin to skin contact			

Yes	55(36.7%)	95(63.3%)	0.001*
No	15(16.0%)	79(84.0%)	
Umbilical cord clamping			
Early	24(20.9%)	91(79.1%)	0.011*
Delayed	46(35.7%)	83(64.3%)	
Place of newborn care			
In contact with the mother	2(66.7%)	1(33.3%)	0.199†
Away from the mother	68(28.2%)	173(71.8%)	

* p-value of the Chi-square test; † p-value of Fisher's exact test.

Table 4 shows the adjustment of the final Poisson model with the variables that showed significance for the breastfeeding of the NB in the first hour of life after delivery. It is observed that the Wald test was significant; indicating an increase in

the risk of the event occurring when the nurse is the professional who provides care during childbirth, when the weight of the infant is equal to or greater than 3000g and when there is skin-to-skin contact between the mother and child. (Table 4).

Table 4 - Adjusted Poisson model for newborn breastfeeding in the first hour of life after delivery. Recife, PE, Brazil, 2016. (n = 244)

Evaluated factor	PR*	CI†(95%)	p-value
Professionals in the delivery room			
Nurse	2.41	1.72 - 3.37	<0.001
Doctor	1.00	-	-
Weight of the newborn			
Less than 3000g	1.00	-	-
3000g or more	1.80	1.00 - 3.24	0.050
Newborn and mother skin to skin contact			
Yes	2.17	1.30 - 3.64	0.003
No	1.00	-	-

*RP=Prevalence Ratio; †CI= Confidence interval; p-value of the Wald statistic (if -value <0.05 the risk adhesion is significantly higher than the reference group).

DISCUSSION

The issues related to the success of breastfeeding should be seen from a variety of angles such as: culture, knowledge about the subject, family support among others.¹¹ Although breastfeeding in the first hour of life is an indicator of excellence in breastfeeding practices, being a factor of protection for the survival and development of children in the first months of life remains a recent goal, and it is understandable that their results have not been reached as expected.¹² Thus, the data analyzed in this study need to be contextualized. As the study was performed in a hospital, with a high demand for complicated obstetric cases (medium and high risk),

difficulties related to the practice of breastfeeding in the first hour post childbirth are expected.

In the present study, the rate of breastfeeding in the first hour of life was 28.7%, similar to a survey conducted in Vitória, where the rate was 30%.¹² However, the rate as lower than the studies conducted in Rio de Janeiro and Fortaleza, which indicated a prevalence of 50.8% and 63.5%, respectively.¹¹⁻¹³ The possible hypothesis for this higher rate is mentioned in the mentioned studies may be related to the greater number of beds in the rooming-in accommodation in those services.¹¹

Age, schooling and marital status were not independent determinants in this study; probably

due to their effects mediated by factors closer to the outcome. Women over the age of 39 showed increased breastfeeding in the first hour of life of the child, similar to the results of a systematic review, which showed the delayed initiation of breastfeeding in younger women, a fact that may be related to the lack of experience and confidence among these women.¹³ According to the present study, illiterate women presented higher rates of early breastfeeding related to those who had higher schooling, corroborating the event with other studies, which call attention to the accomplishment of the procedure of the cesarean section, which may explain the delay of this practice in women with higher levels of education,¹³⁻¹⁴ being aware that in the present study the relationship between schooling and the type of delivery was not analysed. According to a study in Rio de Janeiro, married women were more likely to initiate breastfeeding in the delivery room. It is worth emphasizing that support from social networks may be a relevant factor in the explanation of the higher prevalence of early breastfeeding.¹⁴

It was observed that the primiparous women had a higher rate of early breastfeeding, different from another previous study, where multiparity was shown to be a protective factor, since these women already had previous experience with breastfeeding and, consequently, they had less doubts and insecurities about this practice.¹⁴

Prenatal care in this study was not associated with the outcome, which differs from previous research, where women were heavily protected regarding breastfeeding their children in the first hour of life after delivery. Prenatal care should encompass comprehensive care (promotion, prevention of illness and recovery of health) and as well receiving information on breastfeeding, allowing the mother to be prepared for this act in the delivery room.¹⁴⁻¹⁵

The type of delivery had a significant association (p-value 0.009) with the outcome; and vaginal delivery was considered a protective factor. This finding confirms the results of other studies, where there is agreement that in vaginal delivery, the woman is able to participate more actively and is more likely to put the newborn in direct contact with her body, and be able to recognize when the child is ready to breastfeed.¹³⁻¹⁵

Caesarean section was seen as an obstacle to the initiation of breastfeeding due to the effect of anaesthesia, since women do not have an adequate position to support the child, in addition to the postoperative care routine, which delays skin-to-skin contact between mother and child.¹³ It is also

known that this type of delivery delays the woman's journey to the rooming-in accommodation.¹¹ The proportion of caesarean sections from the current research was 46.7%; (10 to 15%).¹⁶ Although this type of delivery is associated with maternal death, infections and prematurity, its occurrence remains high and is of worldwide concern.¹³

In this study, the presence of a companion in the delivery room was also not relevant in the significant association with breastfeeding in the first hour of life after delivery. The presence of a companion in the delivery room is understood as a strategy to reduce the time of the first breastfeeding,¹⁴ however, this practice remains scarce, especially in surgical deliveries, due to the professionals not allowing the companions to enter, justifying their decisions because of the risk of infection; even if the rights of these women are assured by the Companion Law Number 2.418 of December 2, 2005.¹⁷

The presence of nurses in the delivery room, as a protective factor for early breastfeeding, concurs with a study carried out in Teresina, whose objective was to describe the perception of the new mother regarding the promotion of breastfeeding in the first hour of life after delivery by the professionals of nursing. The aforementioned study confirms that the nurse is the professional who ensures the accomplishment of the fourth step of the BFHI, since they play an essential role in the preparation of the new mothers, helping them to breastfeed and overcome the adversities that comes with this practice.¹⁸

Nursing care, in this first contact with breastfeeding, is advisable because the professional acts as a facilitator, demystifying beliefs, myths and taboos surrounding the act of breastfeeding. The nurse is considered the professional who becomes the closest with the woman, having an important role in health education, encouraging and supporting the act of breastfeeding through her actions, giving mothers confidence in their ability to breastfeed. The commitment of nursing becomes a determining factor to consolidate the right to breastfeed in the first hour of the child's life. Nursing is responsible for humanized care, reducing discomforts and making the breastfeeding experience pleasant for the dyad.¹⁸

Skin-to-skin contact is advocated by WHO, and act facilitates breastfeeding in the first hour of life, is helps the neonate to be alert, and thus, can suck more effectively. Therefore, the NB creates a bond with the mother, they are warmed and receive the colostrum which serves as the first type of immunization. This contact should be encouraged as, in addition to the benefits for the child, this moment

is also of prime importance to the woman as it will be remembered as a positive experience.¹⁸ The present study also agrees with another study, which demonstrated a positive association between joint accommodation with early breastfeeding, as skin-to-skin contact is more easily done in this type of accommodation. Mothers who were put in the same room as their baby were nine times more likely to feed their baby in the first hour of life.¹²

The weight of the NB being equal to or greater than 3000 grams was also positively associated with the outcome of breastfeeding in the first hour of life after delivery. A survey conducted in Rio de Janeiro found similar findings and showed that low-weight babies were less likely to breast-feed compared to children of adequate weight. The need for special care could justify these results, however, it is important to note that unnecessary practices are performed in the hospital environment, making it difficult to comply with the fourth step of BFHI, and neonates with health problems were excluded from the sample in this study.¹⁴

The limitation of this study is the lack of observation of the studied phenomenon, and that the study was based on the memory of the post-partum woman.

CONCLUSION

The protective factors of the practice of breastfeeding in the first hour of life were the presence of the nurse professional in the delivery room, the weight of the RN being equal to or greater than 3000 grams and the skin-to-skin contact between mother and son. Therefore, it is concluded, that breastfeeding in the first hour of life after delivery was below the WHO recommendation, despite that the institution is certified as a Baby-Friendly Hospital. It must be emphasized that this action needs to be maximized only when it is possible and safe. Precautionary factors such as delayed release of the HIV test result should be monitored. The results also showed the importance of an adequate indication for caesarean section delivery and the encouragement of vaginal delivery by institutions, as the rates for caesarean section were high compared to the WHO recommendations.

Educational actions aimed at guiding and sensitizing the professionals who attend women during childbirth should be a practice instituted by the health services. Although there is scientific evidence and recommendations regarding mother and baby proximity directly after delivery, this

routine still encounters several barriers that need to be overcome. Thus, it is recommended that future studies consider the use of direct observation of the practice of breastfeeding in the first hour of life within the delivery room.

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Correspondence: Juliane Lima Pereira da Silva
Rua Indianópolis, 116
54768-190 - Timbi, Camaragibe, Pernambuco, Brasil
E-mail: juliane_lps@hotmail.com

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