revista de pesquisa ISSN 2175-5361

CUIDADO É FUNDAMENTAL

Escola de Enfermagem Alfredo Pinto – UNIRIO

ORIGINAL ARTICLE *DOI: 10.9789/2175-5361.rpcfo.v17.13811*

THE PERCEPTION OF HEALTH MANAGERS ON THE 4TH STEP OF THE BABY-FRIENDLY HOSPITAL INITIATIVE IN THE MUNICIPAL MATERNITY HOSPITAL OF MANAUS

A percepção de gestores de saúde sobre o 4º passo da iniciativa hospital amigo da criança na maternidade pública municipal de manaus

Percepción de los gestores de salud sobre el 4º paso de la iniciativa hospital amigo del niño en la maternidad municipal de manaus

Suellen Oliveira Couto[1]
Valdecyr Herdy Alves[2]
Diego Pereira Rodrigues[3]
Elielza Guerreiro Menezes[4]
Bianca Dargam Gomes Vieira[5]
Márcia Vieira doa Santos[6]

RESUMO

Objetivo: analisar as percepções dos gestores em saúde acerca das fragilidades e potencialidades na execução do 4º Passo da iniciativa hospital amigo da criança. **Método:** trata-se de um estudo descritivo e qualitativo, com 10 gestores de saúde da secretaria municipal de Manaus, atuantes na Maternidade Moura Tapajoz. Os gestores realizaram entrevista semiestruturada em novembro de 2023, com a gravação e transcrição na íntegra e com a análise de conteúdo no tratamento dos dados. **Resultados:** os profissionais de saúde. Entretanto, necessita-se de uma gestão participativa e colaborativa para atenuar as fragilidades e os obstáculos, especialmente na realização do 4º passo. O modelo colaborativo com a equipe multiprofissional permite uma

[1] Municipal Health Secretariat of Manaus, Amazonas, Brazil.
[2,3,5]Fluminense Federal University, Niterói, Rio de Janeiro, Brazil.
[4]Amazonas State University, Manaus, Brazil.
[6]State Servants Hospital, Rio de Janeiro, Brazil.

Received: 19/02/2025. **Accepted:** 08/05/2025

CORRESPONDING AUTHOR: Diego Pereira Rodrigues
Email: diego.pereira.rodrigues@gmail.com

How to cite this article: Couto SO, Alves VH, Rodrigues DP, Menezes EG, Vieira BDG, Santos MV. The perception of health managers on the 4th step of the baby-friendly hospital initiative in the municipal maternity hospital of Manaus. R Pesq Cuid Fundam (Online). [Internet]. 2025 [cited year month day];17:e13811. Available from: https://doi.org/10.9789/2175-5361.rpcfo.v17.13811.

maior integração, participação ativa, sensibilização dos profissionais de saúde. **Conclusão:** a percepção dos gestores mostra que o cuidado compartilhado, com foco na equipe multiprofissional, torna-se essencial para garantir a efetividade do 4° passo na iniciativa hospital amigo da criança.

DESCRITORES: Aleitamento materno; Gestor de saúde; Serviços de saúde materno-infantil; Capacitação profissional.

ABSTRACT

Objective: to analyze health managers' perceptions of the strengths and weaknesses of implementing the fourth step of the baby-friendly Hospital Initiative. **Method:** this descriptive qualitative study examined ten health managers from the Municipal Secretariat of Health in Manaus who work at the Moura Tapajoz Maternity Hospital. In November 2023, the managers were given semi-structured interviews, which were recorded and transcribed in full. The data were processed using content analysis. **Results:** health professionals identified several weaknesses and potentialities in implementing the 4th step. However, participatory and collaborative management is needed to mitigate weaknesses and obstacles, especially when carrying out this step. A collaborative model with a multidisciplinary team allows for greater integration, active participation, and sensitization of health professionals. **Conclusion:** the managers' perceptions show that shared care with a focus on a multidisciplinary team is essential to ensure the effectiveness of the fourth step of the baby-friendly hospital initiative.

DESCRIPTORS: Breast feeding; Health manager; Maternal-child health services; Professional training.

RESUMEN

Objetivo: analizar la percepción de los gestores de salud sobre las debilidades y potencialidades en la implementación de la Etapa 4 de la iniciativa hospital amigo del niño. **Método:** se trata de un estudio descriptivo y cualitativo con 10 gestores de salud del departamento municipal de Manaus que trabajan en la Maternidad Moura Tapajoz. Los gestores fueron sometidos a entrevistas semiestructuradas en noviembre de 2023, que fueron grabadas y transcritas íntegramente, y los datos se procesaron mediante análisis de contenido. **Resultados:** profesionales sanitarios. Sin embargo, es necesaria una gestión participativa y colaborativa para mitigar las debilidades y obstáculos, especialmente a la hora de llevar a cabo el paso 4. El modelo colaborativo con el equipo multiprofesional permite una mayor integración, participación activa y sensibilización de los profesionales sanitarios. **Conclusión:** la percepción de los gestores muestra que la atención compartida, centrada en el equipo multiprofesional, es esencial para garantizar la eficacia del Paso 4 en la iniciativa del hospital amigo de la infancia.

DESCRIPTORES: Lactancia materna; Gestor de salud; Servicios de salud materno-infantil; Capacitación profesional.

INTRODUCTION

Launched in 1990, the Baby-Friendly Hospital Initiative is supported by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). The initiative establishes hospital policies that mobilize health professionals and hospital and maternity staff to promote breastfeeding and prevent early hospital weaning.[1-2]

Brazil was one of the first countries to encourage this practice by creating the National Breastfeeding Promotion Policy of the Ministry of Health, which aims to increase the prevalence and duration of breastfeeding. The fourth step of the BFHI stands out, which WHO/UNICEF currently interprets as placing babies in skin-to-skin contact with their mothers immediately after delivery for at least half an hour, encouraging mothers to recognize when their babies are ready to breastfeed, and offering help from the professionals if necessary.[3]

According to the Pan American Health Organization (PAHO), Brazil is a world leader in breastfeeding, with a prevalence rate of 41%. Brazil surpasses countries such as the United States, the United Kingdom, and China with twice the rates of exclusive breastfeeding up to six and 12 months of age.[1]

However, a 2009 study entitled "2nd Survey of Prevalence of Breastfeeding", carried out in Brazilian capitals and the Federal District evidenced the encouraging panorama of breastfeeding within the first hour of life in all regions of the country, especially in São Luís, which had the highest breastfeeding percentage (83.5%). In the northern region, Palmas (79.6%) and Manaus (71.9%) ranked second to last, only surpassing Rio Branco (74.3%). It is worth mentioning that, at the time, Salvador had the lowest percentage (58.5%) of all the state capitals. The prevalence of breastfeeding within the first hour of life is approximately 67.7%.[4]

A recent National Study of Child Food and Nutrition, commissioned by the Ministry of Health, shows that half of Brazilian children are breastfed for more than one year and four months, and almost all Brazilian children have been breastfed at some point (96.2%), with two out of three babies being breastfed within the first hour of life (62.4%).[5] Furthermore, a 5.3% decline in breastfeeding within the first hour of life was observed when comparing the two studies conducted within a ten-year period. This decline indicates the necessity of interventions involving health professionals to enhance these indicators.[5]

In this context, it is emphasized that health professionals are important agents in implementing the Ten Steps of Breastfeeding. Those working in the delivery room especially should act positively on issues involving breastfeeding. It is also essential that they apply their knowledge and skills related to the technical aspects of lactation in an attentive, comprehensive, and sensitive manner when approaching postpartum women, immediately promoting skin-to-skin contact regardless of the mode of delivery. Therefore, it is essential to reduce procedures performed on low-risk babies in the immediate postpartum period to avoid separation between mother and child.[6-7]

Additionally, it is important to note that this contact between mother and newborn reduces hypothermia and sepsis, shortens hospital stays, and decreases the risk of mortality at discharge.[8] From this perspective, it is crucial to support strategies that improve institutional indicators, particularly those that involve training the multidisciplinary team and organizing or adapting their work processes to the institutional reality and the need to comply with the Ten Steps of the Baby-Friendly Hospital Initiative.[1-2]

During the work in the prepartum, delivery, and postpartum (PDP) units, as well as in the surgical center, it was possible to observe numerous health professionals not complying with the fourth step, skin-to-skin contact. This is even though it is a safe, inexpensive procedure with proven short- and long-term benefits.[9]

In 2019, the Moura Tapajoz Maternity Hospital underwent the first re-assessment to maintain its Baby-Friendly Hospital Initiative qualification. One of the findings from this assessment was that the professionals did not comply with the fourth step. It was observed that skin-to-skin contact is rarely practiced, especially during cesarean deliveries. One of the strategies adopted by management was to raise awareness among the healthcare team. However, approximately four years ago, after the first reassessment, implementing skin-to-skin contact remained a significant challenge. Working directly in childbirth care, I observe professionals performing interventions that prioritize their needs over the well-being of the mother and the baby.

This study adopted the following guiding question: How do managers perceive the weaknesses and potentialities of complying with the fourth step (skin-to-skin contact) of the BFHI, as well as its impact on breastfeeding indicators?

The study aimed to analyze health managers' perceptions of the weaknesses and potentialities in executing the fourth step of the Baby-Friendly Hospital Initiative.

METHOD

This is a descriptive and exploratory study with a qualitative approach. It is characterized by a subjective analysis of the collected information, aiming to understand people's behavior, opinions, attitudes, beliefs, and fears. It is also related to the meaning people attribute to their experiences and how they understand the world.[10]

The study took place at the Moura Tapajoz Maternity Hospital, which is located in the West Zone of the Compensa 2 neighborhood on Avenida Brasil in Manaus, the capital of the state of Amazonas. It is the only municipal maternity hospital in the usual risk network. The unit has 75 obstetric and neonatal beds and performs approximately three thousand deliveries per year. It operates under participatory management through a management collegiate. Since 2010, it has been certified as a Baby-Friendly Hospital, undergoing reevaluation in 2019 and 2023 as per Ordinance No. 1153 of May 22, 2014. It was observed that there was no practice of skin-to-skin contact during C-sections. The medical team's awareness of this step must be intensified to implement the Skin-to-Skin Contact Protocol.

The participants were ten managers from the Moura Tapajoz Maternity Hospital of the Manaus Municipal Health Department. They worked in the following positions: department manager, nursing manager, coordinator of the Permanent Education Center, and medical and nursing coordinators of the human milk collection station.

Inclusion criteria for the study included having worked in a management position for at least six months and working at the central and/or local level in a supervisory role. Managers on sick leave or away from their duties for health, vacation, or other reasons were excluded.

The first contact with the health manager, who was selected as a possible participant in the research for convenience, was through the sending of an individual invitation. Later, the researcher explained the project, the risks and benefits of the

study, data collection techniques, and other relevant points in a didactic way. After acceptance, the eligibility criteria were applied. According to the participant's convenience, the date, time, and place of the interview were scheduled once eligibility was confirmed.

To ensure privacy and confidentiality regarding the collected data, participants were identified by the letter G (the initial of the word "manager" in portuguese), followed by Arabic numerals (G1, G2, G3, G4, G5, G6, G7, G8, G9, G10) in the order that the interviews were conducted. This identification system was adopted to safeguard the participants' identities.

The interviews were interrupted based on the criterion of theoretical saturation, which is used in qualitative research. This criterion considers that when data are collected, psychocultural meanings are transferred from the original environment of individuals or groups to the environment of the researcher. Data is considered saturated when no new elements are found, new meanings become convergent, and a chain of discourse meanings emerges, providing insight into the core of the studied phenomenon.[11] Thus, the study had five participants when data collection was interrupted.

Data collection was carried out through semi-structured interviews with open and closed questions. These interviews were scheduled individually with each participant in a reserved room at their workplace. Third parties were not present; only the researcher and the participant were present. The script was developed based on the study's objectives and structured around the themes of identification, academic and professional profiles.

Data was collected via voice recording with the participant's authorization. The recordings and their respective transcriptions will be stored for at least five years under the responsibility of the researcher. After this period, they will be deleted, as provided for in Resolution No. 466/12 of the National Health Council, which establishes guidelines and regulatory standards for research involving human beings.[12]

The research was submitted to the Research Ethics Committee of the Faculty of Medicine of the Antonio Pedro University Hospital, affiliated with Fluminense Federal University, for consideration and approval as recommended by Resolution No. 466/12 of the National Health Council. The research was approved in accordance with Opinion No. 6,425,756 of October 13, 2023 (CAAE: 71119923.5.0000.5243).

Interviews were conducted after REC approval and the participant's signature on the Informed Consent Form, expressing agreement to participate in the research. The participant was given clarification on the data collection procedures, risks, benefits, and other issues related to the research.

Since this is qualitative research, content analysis was used to analyze and interpret the collected data thematically because this technique allows for an understanding of data of psychological and social significance.[13] Content analysis is a set of techniques for objective analysis and description of the content of messages, allowing for reflection on the phenomena that communication addresses, as well as on the subjects that produce them. This analysis seeks to discover the central aspects that construct the meaning of the statements and contextualize them to the moment and circumstance in which they were uttered.[13]

To achieve the research objectives, the content analysis revealed and exposed the nucleus of meaning through three chronological phases. In the first phase, a preliminary reading of each interview was conducted to familiarize them with the content. Several readings were carried out to select representative elements. The second phase involved exploring the material and constructing coding interventions relating to the transcribed testimonies of the participants for categorization purposes.[13]

In this phase, a chart of units of meaning was assembled. After applying organizational strategies, an enlarged spreadsheet was chosen using colorimetry with markings in different colors in Microsoft Word®. A legend was established for the meaning of each color, and the related units were grouped together to provide an overview. After grouping the coding units, we evaluated their percentage and regrouped those that demonstrated meaning, forming themes for each group.

Thus, the following registration units were identified: The course as a qualification process, communication as a means of integrating the 4th step, norms and routines for the 4th step, live protocol, the multiprofessional team and care management, the 4th step in daily life, and the BFHI in management.

These registration units enabled the construction of the thematic nucleus, "Shared Gestation for the Success of the BFHI," which contributed to the formulation of two categories: 1) Teaching-service integration: The 4th step of the BFHI as an integrated protocol, and 2) The multiprofessional team's active incorporation of the 4th step/BFHI through employee participation in decision-making.

RESULTS

Regarding the profile of the study participants, there are six females and four males. Eight are over 40 years old, and two are between 30 and 40. Seven are Protestant and three are Catholic. Two are married, one is in a stable relationship, and seven are single.

Six participants studied nursing and four studied medicine. Four participants graduated from a public institution, and six graduated from a private institution. All participants took postgraduate courses, and the specializations include hospital administration, pediatrics and neonatology, and obstetric nursing.

All participants underwent BFHI evaluations in the maternity ward and took improvement courses on the fourth step of the BFHI. Four courses are held every three months, and one is held every six months for this purpose.

The fourth step of the BFHI is an integrated protocol of teaching-service integration.

The maternity hospital frequently promotes integration between teaching and service by training health professionals to promote the stages of the BFHI, especially the fourth step. Thus, a foundation is established for everyone to participate in ensuring the BFHI reaccreditation processes, as demonstrated by the following statements:

> *Motherhood often brings about positive changes. It does. We had the biggest gain in visibility issues with the doctor when she came in, even with the course issues. Continuing education has its role, but it is inactive at the moment. It is not active. The boss said he wants nothing less than approval. (G1)*

> *These training courses are offered to comply with the ten steps. During my time here, I believe they were offered once a month, more or less. So, it's monthly. (G3)*

According to the following statements, the perceptions of the maternity managers show the importance of continuing education for all professionals, with the aim of improving the quality of care and supporting the re-accreditation of units considering the BFHI:

> *It's very complicated. However, motherhood has frequently been promoted in these courses in recent years. In the last year, for example. Every time we get close to completing the BFHI courses, which are mandatory and only valid for two years, we have to start over. Continuing education must determine who has and hasn't taken the course, and we help these people take it again. The courses were held online, in person, and on site. More than 45 courses were held. In a year and a month. We managed to reach 80% of the group. For the BFHI, this is the minimum. Now that we are experiencing all this, it is important to note that. (G2)*

> *We are continuing our education through activities such as discussing cases with the professional team. These activities show, talk about, and address the many benefits. They demonstrate that the difficulties or obstacles that people think they have do not prevent them from achieving their goals. (G4)*

One weakness is the management process with health professionals. Integrated management aligned with the health unit's objectives guarantees better results through its collaborative role in processes. The collaboration model aims to reduce damage and weaknesses to ensure the realization of potential, especially with the BFHI steps, as indicated in the following statements:

> *I think fragility is related to management. Management needs to be more active with this category. If management arrives and [...] makes itself present in the charges, we can reduce the current issues. You told me about this. Do you think it has to come from above? Also, from top to bottom. Since someone is not fulfilling their role, the demand must be greater. Just because we are public servants does not mean that we should not be charged for our service. Is there an action plan today for implementing this fourth step? Yes. There is an action plan with guidelines for the three categories of direction: Administrative, technical management, and nursing management. However, this does not address the issue of consecutively increasing bills. This implies the financial aspect. Employees are called in individually to discuss the situation and what has stopped being done. The agency has already issued warnings to professionals who did not comply. (G5)*

> *It's not impossible, but we have different schedules, people, and teams. I think the lack of supervision in the sector at night impacts things a lot. Is there anything else you would like to add from what we discussed? You'll only have a productive team if you stay close to them. (G6)*

Among the difficulties encountered during the work process at the maternity hospital is the implementation of the fourth step of the Baby Friendly Hospital Initiative (BFHI) for women who have undergone a cesarean section. Although surgical delivery poses a minor challenge, trained professionals can overcome this obstacle and promote full breastfeeding within the first hour of a newborn's life, as demonstrated by the following statements:

> *The first challenge for me is cesarean delivery. The biggest challenge is getting professionals to understand the importance of skin-to-skin contact. It's a very natural process. When we put the baby there and leave him there,*

he physiologically seeks the mother's breast. I think the team lacks understanding. They should reinforce this concept more, and I think creating a specific protocol for the fourth step would be a good idea. (G7)

The operating room was much more complicated. To this day, there are several restrictions on professionals in general, in all categories. However, we have been working. Inside the operating room, especially in the PAR, it is guaranteed. However, inside the operating room, it is more difficult. (G8)

There is a growing need to establish work processes that contribute to successful breastfeeding. The absence of a protocol for the fourth step of the BFHI contributes to its ineffectiveness in the maternity ward and noncompliance with the specificities for skin-to-skin contact:

There is no specific protocol for the fourth step. It has a policy. There is a policy, but not a protocol. A protocol would guide and monitor. There is no specific protocol for the fourth step. It basically applies to a routine so that it becomes institutionalized and is really part of each professional's routine. (G9)

The protocols at the maternity hospital and its sectors are posted on notices and stickers on the wall. There is also a QR code strategy: a flyer with a QR code has been put on the wall so that anyone who wants to have the protocol on their cell phone can access it. However, there is no specific protocol for the fourth step. (G10)

The multiprofessional team is actively incorporating step 4 of the BFHI, which involves decision-making through employee participation

The multiprofessional team is more actively involved in the fourth step of the BFHI to ensure the resolution of future problems with the newborn (NB). Implementing the fourth step reduces damage to the newborn's health and feeding process, as described below:

No, because if you do a 100% count, I think about 30% is done with skin-to-skin contact. I think it's very little. If skin-to-skin contact and help were offered in the PDP sector, we would not have so many problems. Like fissures. Requests for supplements. Babies with hypoglycemia. If all of this were done, as the history of breastfeeding dictates, and if the baby were placed on the breast for skin-to-skin contact, even if he does not breastfeed, it would benefit us. (G1)

There are many more professionals on the team. I think some of the teams are outsourced and not integrated into the routines of the maternity hospital. I think the anesthesia department is really impaired, and there is a lack of responsibility from all the professionals involved in cesarean delivery. Everyone involved must participate in this process so they can establish early contact with the mother. Perhaps more effective communication with the team and the companion is missing. (G3)

There must be better communication with the multidisciplinary team at the maternity hospital to ensure greater commitment and awareness among the health professionals working there, with the goal of providing higher quality care, as indicated in the following statements:

The team is committed. I think what people lack is a sense of professionalism. Of all classes. It's not just nursing. If the doctor allows skin-to-skin contact, the nurse and the obstetrician can play their roles, and the technician can help because he needs to. They need to take a stand without talking because they are more numerous. What about the perception of professionals working in the operating room who initiate skin-to-skin contact? If 30% of PDPs occur in the operating room, then breastfeeding in the first hour of life is even less common. I think the number is even smaller because there are fewer employees. Without their commitment, I'm going to focus on the number of people and the key commitment. However, it's useless to have ten people on the roster if none of them are committed to the service. As I'm telling you, today we have greater engagement. In the final stretch, we had greater engagement from nurses. I believe that if we continue to be more available and respond to demand, we will be able to avoid the rush in the next evaluation. (G2)

The doctor will be able to do his job. We need this type of professional. He needs to be able to argue with the doctor and make a case for such a step. Today, we are not. I still see myself hooked up to the fourth step, but it was much worse. It's impressive how much worse it has been. Today, we have some professionals who accept the issue of skin contact. (G4)

The collaborative model, with the application of the BFHI steps, especially the fourth step, is essential to providing effective care to women and newborns. This approach aims to improve health through breastfeeding, as demonstrated by the following statements:

The challenge is to make it happen. The doctor needs to accept that he is not the main one and that the mother and baby are. They need time, and there is no need to rush. Of course, one or the other will pass, but if you have ten births a day, eight is a big number. The challenge is getting them to do it so they can breastfeed and need less formula. The challenge is to implement the fourth step: the baby looks for the breast and gets there. This mother doesn't stay for three

or four days, which leads to a crisis. If he doesn't do that, then it's formula directly. I don't have breast milk to give to everyone, pasteurized. (G5)

This group of seven people is the first time we have done a bedside approach one by one and making the employees do their job. We go from person to person, talking about skin-to-skin contact, its importance, and how it will be done in the operating room. When a patient leaves or arrives, we approach them and ask, "Did you receive any guidance?" This is the first time we have this type of flow. Is this what we want? We want this to be done by more than one group and to be part of each person's routine. (G7)

The clinical signs of the newborn, such as hunger cues, are an important strategy for the multidisciplinary team to interact and provide specialized care. This care is intended to guide the woman and promote breastfeeding within the first hour of the child's life, as indicated in the following statements:

Baby hunger signals. Exactly. About the breastfeeding process. The main clinical observation we can make is that, at birth, the baby will sleep and relax. Then, he will become familiar with the place and open his mouth. We must show the mother the signs of hunger and how the baby searches. We must also guide the mother on how to bring the baby closer to her to see if he will latch on properly. If the mother has any doubts about the latch or position, we must guide her. (G2)

Skin-to-skin contact, as referenced in the 4th step of the BFHI, fosters a connection between mother and newborn. This bond is essential for integrating those involved in the relationship, which is built on countless feelings surrounding the birth of a child and the care process. As mentioned in the following statements:

Of course, it is paramount. Skin-to-skin contact is simply bonding. If you bond with your baby, you will want to take care of him and give him your milk. It's completely different from a child you just put in a crib, give a bottle, change the diaper, and put back in the crib. It's different. (G8)

The baby needs this contact to become familiar with his mother, and the mother needs this contact to increase her bond with her baby. According to my perception, this contact generates a stronger emotional bond between mother and baby. There are better breastfeeding rates because the baby is here and seeks breastfeeding. We can improve breastfeeding rates by teaching mothers what a milk patch is, what colostrum is, and what hunger signals are. We can also teach them that breastfeeding should be done on demand and is guided by the baby. These are fundamental guidelines with great potential to improve the maternal-child bond. Improve the breastfeeding rate and the mother-child bond. It allows the baby to come into contact with the maternal microbiota earlier. This provides short- and long-term protection for the baby's healthy life. We reduce the world's spending. This is achieved by decreasing the use of infant formula. (G10)

DISCUSSION

WHO and UNICEF mention that skin-to-skin contact positively influences mother-baby interaction, increasing bonding and attachment behaviors. Practicing this in the first hour after birth alleviates post-traumatic stress in women who have had challenging birth experiences and decreases the risk of early maternal depression and bonding issues. It also decreases maternal anxiety. Skin-to-skin contact reduces the risk of early death and increases the likelihood of successful breastfeeding and exclusive breastfeeding. It also promotes positive latching and sucking behaviors.[14] Thus, skin-to-skin contact produces maternal and neonatal benefits, favoring the health of women and children.

There is a constant need for professional development to promote knowledge sharing and improve practical care. Monitoring units with the BFHI seal shows that 96% of institutions comply with the fourth step.[15] Therefore, engaging, sensitizing, and training the entire health team is necessary for the care process. However, the rate of skin-to-skin contact in the northern region of the country is only 27.9%. This indicator demonstrates the effectiveness of the fourth step of the BFHI in promoting successful breastfeeding.

The Ministry of Health introduced Permanent Education in Health (PEH) as a health policy in Brazil through Ordinances No. 198/2004 and No. 1,996/2007. PEH aims to guide the training and qualification of professionals in public health services. The goal is to transform professional practices, and the organization of work based on the needs and difficulties of the system.[17] Thus, PEH must be implemented to ensure compliance with all BFHI steps, especially the fourth step.

As a consequence, professionals should share a living protocol based on scientific recommendations for skin-to-skin contact within the first hour of life, as recommended by the WHO. It should also be based on the empowerment of service users, resulting in principles for their health and that of their children. This should apply to at least 80% of women who have undergone vaginal delivery or a cesarean section without general anesthesia. This initiative is essential for consolidating the Baby-Friendly Hospital Initiative (BFHI).[18]

However, there are weaknesses in incorporating this meaning into daily work life, especially in relation to

management. The interprofessional collaborative model illustrates the interaction between different areas in favor of a common goal: the implementation of skin-to-skin contact. Health professionals and managers must understand the importance of this to ensure better institutional indicators in the context of BFHI and breastfeeding and reduce operational costs resulting from breastfeeding failures.

This collaborative unit requires professionals from different areas to work together to provide the best healthcare for patients. At the same time, they must recognize their own interests and desire for autonomy. They should seek to reduce competition and replace it with interprofessional partnerships and collective responsibility.[19]

Therefore, management must be more committed to educating all health professionals through the supervision of work processes to promote shared, integrated care focused on skin-to-skin contact between mother and baby. This will reduce possible weaknesses in achieving the common institutional goal.

One difficulty associated with skin-to-skin contact involves women who have undergone a cesarean section. Thus, women who had a vaginal delivery have higher skin-to-skin contact rates than those who had a C-section. The lower occurrence of skin-to-skin contact may be related to health professionals' practices when carrying out protocols for maternal and neonatal care. These protocols do not initially focus on promoting this contact between mother and baby during the first hour of life.[18]

Despite knowledge of the process for skin-to-skin contact, operational obstacles arise from a practice that does not value the fourth step of the Baby-Friendly Hospital Initiative (BFHI). Therefore, a protocol implemented in the obstetric and surgical centers within the first hour of life is crucial to ensure compliance with institutional objectives regarding skin-to-skin contact and breastfeeding. However, according to the discourse, maternity management is committed to the training process; yet the service is still fragile with low incorporation of the instituted protocols. Thus, this study is relevant because it promotes the use of the standard operating procedure for skin-to-skin contact and establishes processes within the maternity ward.

Management recognizes individualized work centered on the health professional rather than on the collaborative process with an egalitarian approach based on the best scientific evidence rather than on individual knowledge. Thus, collective work through the multidisciplinary team is essential to promoting skin-to-skin contact in the first hour of life.

Deficiencies occur in the implementation of skin-to-skin contact, and management requires greater monitoring, especially in providing guidance to women and promoting decision-making. Many women do not receive guidance on the benefits of skin-to-skin contact and breastfeeding. This may increase the likelihood of breast problems and lower the rate of exclusive breastfeeding.[20] Consequently, management should be articulated with multiprofessional knowledge and the collective of different forms of knowledge to guarantee skin-to-skin contact between mother and baby.

It is necessary to have greater engagement from health professionals. Through active participation in the work process, professionals can demonstrate their commitment to the objectives of the BFHI, especially the fourth step. This commitment includes caring for women and newborns based on scientific evidence.

Skin-to-skin contact and breastfeeding are practices that should be encouraged during the first hour after birth, known as "the golden hour." During this period, all routines should be postponed due to skin-to-skin contact. This practice provides physiological stability for the mother-baby dyad, increases attachment behavior, protects against the negative effects of separation, supports optimal NB development, and promotes breastfeeding stimulation. It is the responsibility of the entire healthcare team, not just one professional or category.[20]

Therefore, professionals working in obstetric care are essential to facilitating early contact between mother and baby. However, health professionals often promote the separation of mothers and babies due to institutional barriers, such as the demands of hospital routines.[21] Thus, management must work with health professionals who have the proper awareness and institutional guidelines to ensure skin-to-skin contact within the first hour of life.

The search for agility in hospital routines, the dynamization of work shifts, and high productivity often lead professionals to provide fragmented, mechanistic care. This distances them from the precepts established by the Baby-Friendly Hospital Initiative (BFHI) and the Ministry of Health.[21]

There is a need to incorporate collective knowledge as a product of scientific research to align and strengthen breastfeeding care, especially in the 4th step of the Baby-Friendly Hospital Initiative (BFHI), which highlights the scientifically proven benefits of skin-to-skin contact between mother and baby, such as bonding, latching on, breastfeeding, cardiorespiratory stability, reduced energy and heat loss, and metabolic adaptation, among others.[1-3,6-8,14-20]

Health professionals and managers should establish practices that promote, protect, and support breastfeeding.

These practices should help women cope with possible difficulties and include identifying the baby's hunger cues with the help of a multidisciplinary team. When skin-to-skin contact is encouraged and health professionals advise on clinical signs of hunger, women are more likely to initiate it within the first hour, promoting the early onset of exclusive breastfeeding.[22]

WHO and UNICEF recommend skin-to-skin contact because it strengthens the bond between mother and baby, among other benefits. However, this practice needs to become a clinical routine because it is a low-cost strategy that brings several benefits to the mother-baby dyad and promotes healthcare in a more sensitive and humanized way.[23] With institutional support for skin-to-skin contact, management favors an early bond between the mother and her child through a feeling inherent to motherhood.

Thus, a multidisciplinary team working with management and sharing similar objectives promotes skin-to-skin contact between mother and baby as an institutional policy, ensuring this practice is included in clinical routines and protocols. However, it is important to mention that even with instituted protocols, it is necessary to incorporate collective practices that promote institutional changes based on the objectives of the Baby-Friendly Hospital Initiative (BFHI).

CONCLUSION

The present study aimed to analyze health managers' perceptions of the strengths and weaknesses in executing the fourth step of the Baby-Friendly Hospital Initiative, as well as the facilitators and hindrances of the process for maternal and child care at the Moura Tapajós Maternity Hospital.

The managers demonstrated knowledge of the benefits of skin-to-skin contact between mother and baby and provided this information to all health professionals through improvement courses and permanent health education at the institution. Therefore, knowledge about the importance of skin-to-skin contact for women and children is offered, which can positively impact the maternity, municipal, and state breastfeeding indicators.

However, there is a need for greater team integration as an effective protocol for women's and children's health within the scope of the fourth step of the Baby-Friendly Hospital Initiative. With effective collective and collaborative work, skin-to-skin contact should not be attributed to a specific professional or category, but rather to everyone involved in the institutional objective of promoting the health of mothers and babies.

In this sense, the study contributes to the understanding of the fourth step of the Baby-Friendly Hospital Initiative among maternity managers, with the goal of improving the practice of skin-to-skin contact and initiating breastfeeding in the delivery room.

The small number of managers who participated in the study is noted as a limitation; however, it is understood that qualitative research does not aim to generalize a phenomenon, but rather to provide context for discussion.

REFERENCES

1. Fundo das Nações Unidas para a Infância. Iniciativa Hospital Amigo da Criança: revista atualizada e amplada para o cuidado integrado: módulo I. Histórico e implementação. Brasília: Ministério da Saúde, 2008 [cited 2025 jan 25]. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/iniciativa_hospital_amigo_crianca_modulo1.pd.

2. Lamounier JA, Chaves RG, Rego MAS, Bouzada MCF. Iniciativa hospital amigo da criança: 25 anos de experiência no Brasil. Rev Paul Pediatr. [Internet]. 2019 [cited 2025 jan 25]; 37(4). Available from: https://doi.org/10.1590/1984-0462/;2019;37;4;00004.

3. Antunes MB, Demitto MO, Soares LG, Radovanovic GAT, Higarashi IH, Ichisato SMT, et al. Amamentação na primeira hora de vida: conhecimento e prática da equipe multiprofissional. Av Enferm. [Internet]. 2017 [cited 2025 jan 25];35(1). Available from: https://doi.org/10.15446/av.enferm.v35n1.43682.

4. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Ações Programáticas e Estratégicas. II Pesquisa de Prevalência de Aleitamento Materno nas Capitais Brasileiras e Distrito Federal. Brasília: Editora do Ministério da Saúde, 2009 [cited 2025 jan 25]. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/pesquisa_prevalencia_aleitamento_materno.pdf.

5. Santos NHA, Vasconcellos MTL, Silva PLN, Castro IRR, Boccolini CS, Kac G. Plano amostral do Estudo Nacional de Alimentação e Nutrição Infantil (ENANI-2019): inquérito domiciliar de base populacional. Cad Saúde Pública. [Internet]. 2021 [cited 2025 jan 25];37(8): e00037221. Available from: http://dx.doi.org/10.1590/0102-311X00037221.

6. Lopes SS, Laignier MR, Primo CC, Leite FM. Iniciativa Hospital Amigo da Criança: avaliação dos Dez Passos para o Sucesso do Aleitamento Materno. Rev Paul Pediatr. [Internet]. 2013 [cited 2025 jan 25];31(4). Available from: https://doi.org/10.1590/S0103-05822013000400011.

7. Rodrigues DP, Alves VH, Paula CC, Vieira BDG, Pereira AV, Reis LC, et al. Humanized childbirth: the values of health professionals in daily obstetric care. Rev Bras Enferm. [Internet]. 2022 [cited 2025 jan 25];75(2):e20210052. Available from: 10.1590/0034-7167-2021-0052.

8. Sampaio ÁRR, Bousquat A, Claudia B. Contato pele a pele ao nascer: um desafio para a promoção do aleitamento materno. Epidemiol Serv Saúde. [Internet]. 2016 [cited 2025 jan 25];25(2). Available from: http://dx.doi.org/10.5123/S1679-49742016000200007.

9. Ministério da Saúde (BR). Portaria nº 569 de 1 de junho de 2000. Instituir o Programa de Humanização no Pré-natal e Nascimento, no âmbito do Sistema Único de Saúde. Brasília: Ministério da Saúde, 2000 [cited 2025 jan 25]; Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2000/prt0569_01_06_2000_rep.html.

10. Vieira S, Hossne WS. Metodologia Científica para a Área de Saúde. 3º ed. Rio de Janeiro: Guanabara Koogan, 2021.

11. Nascimento LCN, Souza TV, Oliveira ICS, Moraes JRMM, Aguiar RCB, et al. Saturação teórica em pesquisa qualitativa: relato de experiência na entrevista com escolares. Rev Bras Enferm. [Internet]. 2018 [cited 2025 jan 25];71(1). Available from: https://doi.org/10.1590/0034-7167-2016-0616.

12. Ministério da Saúde (BR). Resolução nº 466, de 12 de dezembro de 2012. Dispõe sobre diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Brasília: Ministério da Saúde, 2012 [cited 2025 jan 25]; Available from: https://bvsms.saude.gov.br/bvs/saudelegis/cns/2013/res0466_12_12_2012.html.

13. Bardin L. Análise de Conteúdo. 4ª edição. Lisboa: Edições 70 LDA; 2011.

14. Brimdyr K, Stevens J, Svensson K, Blair A, Turner-Maffei C, Grady J, et al. Skin-to-skin contact after birth: Developing a research and practice guideline. Acta Paediatr. [Internet]. 2023 [cited 2025 jan 25];112(8). Available from: https://doi.org/10.1111/apa.16842.

15. Kuamoto RS, Bueno M, Riesco ML. Contato pele a pele entre mãe e recém-nascido a termo no parto normal: estudo transversal. Rev Bras Enferm. [Internet]. 2021 [cited 2025 jan 25];74(Suppl 4): e20200026. Available from: http://dx.doi.org/10.1590/0034-7167-2020-0026.

16. Moreira MEL, Gama SGN, Pereira APE, Silva AAM, Lansky S, Pinheiro RS, et al. Clinical practices in the hospital care of healthy newborn infant in Brazil. Cad Saúde Pública. [Internet]. 2014 [cited 2025 jan 25];30(1):S128-S139. Available from: https://doi.org/10.1590/0102-311x00145213.

17. Ferreira L, Barbosa JSA, Espotil CDD, Cruz MM. Educação Permanente em Saúde na atenção primária: uma revisão integrativa da literatura. Saúde debate. [Internet]. 2019 [cited 2025 jan 25];43(120). Available from: https://doi.org/10.1590/0103-1104201912017.

18. Ayres LF, Cnossen RE, Passos CM, Lima VD, Prado MRMC, Beirigo BA. Fatores associados ao contato pele a pele imediato em uma maternidade. Esc Anna Nery. [Internet]. 2021 [cited 2025 jan 25];25(2): e20200116. Available from: https://doi.org/10.1590/2177-9465-EAN-2020-0116.

19. Peduzzi M, Agreli HF. Trabalho em equipe e prática colaborativa na Atenção Primária à Saúde. Interface (Botucatu). [Internet]. 2018 [cited 2025 jan 25];22(Supl. 2). Available from: https://doi.org/10.1590/1807-57622017.0827.

20. Campos PM, Gouveia HG, Strada JKR, Moraes BA. Contato pele a pele e aleitamento materno de recém-nascidos em um hospital universitário. Rev Gaúcha Enferm. [Internet]. 2020 [cited 2025 jan 25];41(esp):e20190154. Available from: https://doi.org/10.1590/1983-1447.2020.20190154.

21. Souza HLR, Fernandes FECV, Pereira RCLF, Melo RA. Compreensão da enfermagem sobre o contato pele a pele entre mãe/bebê na sala de parto. Rev Enferm UFSM. [Internet]. 2020 [cited 2025 jan 25];10:e93. Available from: https://doi.org/10.5902/2179769242729.

22. Vargas PB, Vieira BDG, Queiroz ABA, Alves VH, Aguiar RCB, Rodrigues DP. Experiências de puérperas na identificação de sinais de fome do recém-nascido. Rev Baiana Enferm. [Internet]. 2016 [cited 2025 jan 25];30(1). Available from: https://doi.org/10.18471/rbe.v1i1.12011.

23. Lotto CR, Linhares MBM. Contato "pele a pele" na prevenção de dor em bebês prematuros: revisão sistemática da literatura. Trends Psychol. [Internet]. 2018 [cited 2025 jan 25];26(4). Available from: https://doi.org/10.9788/TP2018.4-01Pt.