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RESEARCH

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BREASTFEEDING IN PRIMARY CARE: DO THE MOTHERS PERFORM THIS PRACTICE?

Amamentação na atenção básica: as mães realizam essa prática?

Lactancia materna en atención primaria: ¿realizan las madres esta práctica?

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ABSTRACT

Objective: to identify how mothers living in the coverage areas of two family health strategies in a municipality in southern Minas Gerais performed breastfeeding. **Method:** cross-sectional study with a quantitative descriptive and retrospective approach. **Results**: 120 nursing mothers participated in the study. It is observed that they are young (71% from 20 to 25 years old), with good education (67% complete high school), had their first pregnancy in their youth (66% between 15 and 19 years old), and most have two children (44 %). Of the births 90% had one child and 10% had twins. The prevalence of cesarean deliveries (66%) was found. Breastfeeding began in rooming-in (60%); and the mixed one was predominant (73%), highlighting this practice for previous children (88%). **Conclusion:** the practice of breastfeeding is associated with family culture and there is no appreciation of exclusive breastfeeding.
DESCRIPTORS: Breastfeeding; Culture; Primary health care.

RESUMO

Objetivo: identificar como as mães que residem nas áreas de cobertura de duas estratégias de saúde da família de um município do sul de Minas Gerais realizaram a amamentação. **Método**: estudo transversal, com abordagem quantitativa de natureza descritiva e retrospectivo. **Resultados**: participaram do estudo 120 nutrizes. Observa-se que são jovens (71% de 20 a 25 anos), com boa escolaridade (67% ensino médio completo), tiveram a primeira gestação na juventude (66% entre 15 e 19 anos), e a maioria possui dois filhos (44%). Dos nascimentos 90% tiveram um filho e 10% tiveram gêmeos. Constatou-se a prevalência de partos cesáreos (66%). O aleitamento teve início no alojamento conjunto (60%); e o misto foi predominante (73%), destacando-se essa prática para os filhos anteriores (88%). **Conclusão**: a prática da amamentação está associada à cultura familiar e não há valorização da amamentação exclusiva.
DESCRITORES: Aleitamento materno; Cultura; Atenção primária à saúde.

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Breastfeeding in primary care: do the mothers perform this practice?

RESUMEN

Objetivo: identificar cómo las madres que viven en las áreas de cobertura de dos estrategias de salud familiar en un municipio en el sur de Minas Gerais realizaron la lactancia materna. **Método:** estudio transversal con enfoque cuantitativo descriptivo y retrospectivo. **Resultados:** 120 madres lactantes participaron en el estudio. Se observa que son jóvenes (71% de 20 a 25 años), con buena educación (67% completaron la escuela secundaria), tuvieron su primer embarazo en su juventud (66% entre 15 y 19 años), y la mayoría tiene dos hijos (44 %). De los nacimientos, el 90% tenía un hijo y el 10% tenía gemelos. Se encontró la prevalencia de partos por cesárea (66%). La lactancia materna comenzó en alojamiento conjunto (60%); y el mixto fue predominante (73%), destacando esta práctica para niños anteriores (88%). **Conclusión:** la práctica de la lactancia materna está asociada con la cultura familiar y no se aprecia la lactancia materna exclusiva.

DESCRITORES: Lactancia materna; Cultura; Atención primaria de salud.

INTRODUCTION

Historically in Brazil the child began to receive prominence due to high morbidity and mortality rates, and for this reason, the country over the years has sought to implement policies and actions to improve this scenario. The first actions of programs targeting children began in the late 1960s, when the Ministério da Saúde (MS) created the Maternal and Child Health Program, with the objective of reducing the morbidity and mortality of children and mothers.[1]

In 1981, the Programa Nacional de Incentivo ao Aleitamento Materno (PNIAM) was implemented to encourage actions to promote, protect and support breastfeeding, and in 1984, the Programa de Assistência Integral à Saúde da Criança (PAISC) as a strategy to combat adversities in the health conditions of the child population, specifically with regard to their survival.[1]

In order to strengthen exclusive breastfeeding, in 1991 the World Health Organization (WHO) and the Fundo das Nações Unidas para Infância (UNICEF) launched the Iniciativa Hospital Amigo da Criança (IHAC). This initiative brings the Ten Steps to Successful Breastfeeding, which establish norms, routines, and behaviors favorable to the practice of breastfeeding.[2]

In 1999, with the purpose of strengthening actions to encourage breastfeeding in hospital care and qualify neonatal care, favoring the development of the child and the creation of the family bond, the Standard of Humanized Attention of the Newborn with Low Weight - the Kangaroo Method - was created. This strategy was inserted in the country as part of the public policy of humanization of premature baby care.[3]

In 2008, aiming to establish a national strategy for the promotion, protection and support of breastfeeding, the Amamenta Brasil Network was launched, determining the critical-reflexive education of health professionals in the Basic Health Units and Family Health Strategy.[4]

In the following year, Ministerial Ordinance nº 2,395/2009 instituted the Healthy Brazilians Strategy, which in addition to prioritizing the integral care of children and their mothers at birth, emphasizes the quality of life of Brazilian children.[5]

In 2011, the Stork Network was implemented, consisting of a network of care that aims to ensure women safety and quality of care throughout their reproductive cycle, as well as to guarantee the child the right to full care at birth, growth and development.[6] Currently the General Coordination of Child Health and Breastfeeding of the Ministry of Health is the area responsible for proposing and coordinating government policies for the health care of Brazilian children from pregnancy to nine years of age. Among the main actions is the promotion, protection and support to breastfeeding. In 2015 the Política Nacional de Atenção Integral à Saúde da Criança was introduced (PNAISN).[7]

In view of these policies and actions, it becomes evident that over the years breast milk has been considered the ideal source of nutrition for infants up to six months of life. It is composed of vitamins, proteins, carbohydrates, fats, mineral salts, water, antibodies (especially IgA secretion), macrophages cells, lymphocytes and other substances (bifid factor and lactoferrin), generating protection to the newborn against possible infections. It is easy to absorb and its nutrients are essential for the child to fully develop.[8-9]

The breastfeeding is a strategy of increasing bonding, affectivity, protection and nutrition of the child, allows positive impact on the promotion of health of both baby and mother. To have a correct development of the child, the insertion of a balanced and healthy diet at the right time is of extreme importance.[9-10]

Understanding the breastfeeding process beyond its hormonal and physiological determinations and evaluating its success not only by the purely technical aspects, such as handling and milking, is a current challenge. The paradigm of breastfeeding needs to be modified, as it is anchored in a biologicist vision. It is necessary to seek answers to some questions, such as why such a recognized practice of excellence has not been adopted in its fullness by families? What has happened in this family scenario? How does the family experience the process of breastfeeding?

In an attempt to answer these questions, this study was developed with the objective of identifying how mothers who live in the coverage areas of two family health strategies in a city in the south of Minas Gerais performed breastfeeding.

METHOD

It is a transversal study, with a quantitative approach of a descriptive nature and as to temporality, retrospective. In the quantitative study, the research design presents the strategies that the researcher plans to adopt to develop accurate and interpretable information.[11] Descriptive research has the fundamental objective of describing the characteristics of

a given population or phenomena and the establishment of relationships among variables, also provides a new view of the problem.[12] The data were collected by the instruments called the Breastfeeding Home Visit Form; Questionnaire; and, the United Nations Children's Fund (UNICEF) Breastfeeding Observation Form.

The study began in October 2016 and was conducted in a city in southern Minas Gerais, in two areas covered by two Equipes de Saúde da Famílias (ESF). The study population were mothers of newborn children over six months of age, who lived in the areas assigned to the Teams.

For the collection of data, the Home Visit (DV) was carried out on the date and time of the mother's choice through previous contact with ESF. Three stages were carried out during this visit. The first stage was the completion of the Home Visit Form for Maternal Breastfeeding, being this semi-structured, divided into sociodemographic data; obstetric data; data on the nurse; and, data on the baby. In the second stage, the Questionnaire was applied, consisting of closed questions and data on the infant; initiation of breastfeeding; duration of breastfeeding; breastfeeding complications; and in the third stage, the UNICEF Breastfeeding Observation Form was used to evaluate breastfeeding.[13] For each item of each instrument used, sections were prepared in tables, with the help of the Microsoft Excel 2010 application, and the data were evaluated in terms of their prevalence and numerical percentage.

The survey was approved on May 30, 2016, with Opinion under number 1,566,407 and CAAE 55713016,1,0000,5142. The mothers were only part of the research when they agreed to participate in the study, after the explanations about its origin and objective, by signing the Free and Informed Consent Term in accordance with resolution 466/12 of the National Health Council.

RESULTS

The study included 120 nurturers, 60 of them from the Estratégia de Saúde da Família 1 (ESF1) and 60 from Estratégia de Saúde da Família 2 (ESF2). The data collection period was from October to December 2016, and from April to June 2017, totaling six months. For each participant, an average of three home visits were made, totaling 360 visits.

Table 1 shows the data related to the sociodemographic profile of the nutresses in this study.

Table 1 - Sociodemographic profile of the nutresses. Municipality of the South of Minas Gerais, Brazil, 2017

Maternal characteristic	n= 120	%
Age group		
18 and 25 years	85	71%
25 and 30 years	35	29%
Civil Status		
Married	53	44%
Single and Mature	50	42%
Divorced	17	14%
Schooling		
High School	80	67%
Elementary school	40	33%
Intestinal habit		
Normal	120	100%
Sleep		
Smooth	67	56%
Agitated	26	22%
Lack of rest	27	22%
Leisure activities		
They practice	80	67%
Do not practice	40	33%
Weight		
Increased weight during pregnancy	120	100%
Weight reduction after delivery	120	100%
Family interaction		
Five people living in the house	36	30%
Seven people living in the house	27	22%
Four people living in the house	14	12%
Eight and nine people living in the house	29	24%
Responsible for family income		
Partner	105	88%
Nursing mothers	15	12%

Source: Elaborated by the authors.

It can be observed that 85(71%) of the nurturing women are between 20 and 25 years old, 80(67%) have completed high school, 53(44%) are married, 120(100%) have a normal intestinal habit; and 120(100%) have gained weight in pregnancy and lost it, respectively; 67(56%) have quiet sleep; 80(67%) practice a leisure activity. It was observed that 36(30%) live with five people, being these parents and children. As for the family income for 105(88%) it is the responsibility of the partner.

Table 2 contains the obstetric profile of the nutresses in this study.

Table 2 - Obstetrics profile of the nutresses. Municipality of the South of Minas Gerais, Brazil, 2017

Maternal characteristic	n= 120	%
1st Pregnancy Age Group		
15 and 19 years	80	66%
19 and 22 years	40	34%
Number of children		
A Child	26	22%
Two children	53	44%
Three children	26	22%
Four children	15	12%
Prenatal Consultation		
8 to 10 consultations	120	100%
Place of pre-natal		
ESF	67	56%
Private practice	53	44%
Type of delivery		
Cesarean	80	66%
Normal Birth	40	34%
Number of births		
A child	110	90%
Twins	10	10%

Source: Elaborated by the authors.

Regarding pregnancy, it was identified that 80(66%) had their first pregnancy between 15 and 19 years; 53(44%) have two children; 120(100%) had 8 to 10 prenatal consultations, and for 67(56%) it was in the ESF of origin. Regarding the type of delivery, 80(66%) were cesarean sections; for 110(90%) it was one child.

Table 3 shows the profile of newborns and breastfeeding.

Table 3 - Characteristics of newborns and breastfeeding. Municipality of the South of Minas Gerais, Brazil, 2017

Characteristic of Newborn	n= 130	%
Apgar		
Apgar 9'9	115	88%
Apgar 9'10	10	8%
Apgar 8'9	5	4%
Weight and development		
Weight Gain and Development	130	100%
Newborn care		
For the mothers	86	66%
For the grandparents	44	34%
Sleep		
Regular	73	56%
They wake up to breastfeed during the night	29	22%
Irregular	14	11%
Change day for night	14	11%
Crying		
Frequent crying	57	44%
Weeping to suck	57	44%
Sporadically crying	16	12%
Beginning of breastfeeding		
Joint accommodation	78	60%
After hospital discharge	26	20%
In the delivery room	13	10%
There was no beginning	13	10%
Type of breastfeeding		
Mixed	95	73%
Exclusive	35	27%
Breastfeeding time		
20 minutes	47	36%
15 minutes	55	42%
10 minutes	28	22%
Nipple pain when breastfeeding		
Feel pain	52	40%
Do not feel pain	78	60%
Breastfeeding compared to the previous child		
Mixed	114	88%
Exclusive	16	12%

Source: Elaborated by the authors.

As for the characteristics of newborns 115(88%) obtained Apgar 9'9'; all 130(100%) developed after birth. In the care of the baby 86(66%) of the mothers perform. As for the babies' sleep, 73(56%) sleep regularly; however 57(44%) cried frequently and 57(44%) cried to suckle, respectively. It was found that the beginning of breastfeeding for 78(60%) was in the joint housing. Regarding the type of breastfeeding, for 95(73%) it was mixed breastfeeding, and for 55(42%) the duration of each feed was 15 minutes, and for 78(60%) there was no pain in breastfeeding. For 114(88%) of the nurturers stated that the type of breastfeeding practiced with their previous children was mixed breastfeeding.

DISCUSSION

The nurturers of this study are young, had their first pregnancy in adolescence, but the sociodemographic profile is considered good. And this is a very important factor, because it can influence the way a woman understands breastfeeding, that is, women who have a higher social level and schooling tend to breastfeed for a time closer to what is recommended.[14-15]

Mother's milk brings many benefits to the child and the mother. For the woman who breastfeeds, its practice provides the fastest return of weight before pregnancy, promotes uterine involution, is a great contraceptive method to avoid a new pregnancy in the first six months of postpartum, and also reduces the chance of developing breast and uterus cancer.[15]

With the arrival of the baby, the affective bonds tend to be strengthened, bonding and attachment are created, but there is still little participation of the father. Changes in the political, cultural, economic and scientific fields have made the concept of fatherhood undergo changes in recent years. Culturally, the man has assumed the role of responsible for family support, and now, in today's society, he presents new functions as partner, protector and caregiver. Some men present anxiety, jealousy, rejection, and sexual difficulty after the birth of their partner, and these behaviors interfere negatively in the practice of breastfeeding and make women feel lonely and unsupported. Therefore, it is essential to extend the welcome to the whole family nucleus and to value the paternal participation from the prenatal period, destroying the barriers of adaptation and care to the mother and child binomial.[16-17] However, in this study the care of the baby is exclusively carried out by the mothers.

Prenatal consultations are essential to ensure comprehensive care throughout a woman's entire pregnant cycle. ESF has become a privileged space for activities directed to the AM, in order to welcome, listen, and offer answers to the community's health problems.[18]

Even with an ideal number of prenatal appointments, there was a high incidence of cesarean section. The cesarean section presents itself as a difficult factor for the stablishment of breastfeeding, for being a surgical procedure, it can lead to the appearance of pains and discomfort, make difficult the correct positioning of the child, interfere in the mothers' disposition and in the delay for the descent of the milk. During the whole breastfeeding process it is essential that the health professional has the knowledge and skills to intervene in the face of the difficulties related to breastfeeding.[18]

The presence of frequent crying in babies is among the main reasons for weaning. Crying can be related to the baby's hunger and the difficulties associated with low milk production. Some occurrences of insufficient milk production are due to the physiology of production, an example is when there is blockage of the lactiferous ducts in a certain area of the breast, which for some reason is not properly drained. This can happen when the correct emptying of the breast does not occur, such as when breastfeeding is not frequent or when the child has inadequate suction.[10]

The care exercised only by mothers leads us to affirm that in this culture only women have the parental role. The practice of breastfeeding is built according to the stories experienced and experienced by women, through the knowledge obtained since childhood, the assistance received during pregnancy and puerperium, and the help received from family and society. The influence of grandmothers in the breastfeeding process has been reported in the literature, as some studies have found that they stimulate the introduction of water, teas, and other types of milk into the infant's diet, and that the reduced contact between mothers and grandmothers favors increased breastfeeding.[15,19]

The practice of breastfeeding in the delivery room, right after birth, is still far below ideal and, as seen in this study, it was in the joint housing that the beginning of breastfeeding had the highest prevalence. The joint housing is certainly a form of incentive to breastfeeding, where the mother has the possibility to breastfeed her child whenever it shows signs of hunger. Providing assistance to the mother in this environment is essential for the promotion of breastfeeding, because in this period the mother and child go through several adaptations, that is, the mother begins to learn how to breastfeed and the baby begins its learning process.20 According to WHO, the stimulus to breastfeeding should be initiated in the first hour of life, because it is at this moment that the newborn has greater ability to spontaneously seek the nipple-areolar region and start breastfeeding, and this will favor that the breastfeeding happens exclusively.[21]

It is noteworthy that in this study mixed breastfeeding is predominant and was in the previous children. In Exclusive Breastfeeding the child is fed exclusively with breast milk, milked or from another source. Breast milk is the ideal source for the growth of the child, it should be the only food offered to the child until it is six months old, and it can be supplemented up to two years or more. When the infant receives other foods in addition to maternal milk, with the objective of complementing it and not replacing it, we call it Complementary Breastfeeding, and in Mixed Breastfeeding, in addition to maternal milk, the infant receives other types of milk during the course of the feeding.[9,22]

The presence of pain in the nipple when breastfeeding may indicate an important difficulty in this process, especially if its origin is due to a breast trauma. Faced with this situation, many mothers end up offering baby bottles to their children, in order to space the feeds, which can cause a decrease in milk production, facilitating early weaning.[10]

As the breastfeeding process has great complexity, besides the myths and family culture, many intercurrences can occur, such as cracks, mastitis, ingurgitation and breast abscess. The presence of these breast lesions is mainly due to the incorrect technique of breastfeeding, which causes maternal suffering during this practice. In view of this, the nurse professional needs to pay attention to the presence of these intercurrences, in order to establish effective and resolutive interventions.[19-20]

Breastfeeding is a physiological act that must be stimulated from the beginning of pregnancy. The pregnant woman receives a lot of information about breastfeeding and, not always, this information is reliable. Several myths and customs regarding breastfeeding are perpetuated in families, such as the use of foods considered as human milk producers, massages and nipple care to prevent cracks, among others.[20,23]

Breastfeeding is a personal decision of the woman and is subject to many influences resulting from the socialization of each one. Many women cannot answer why they decided to breastfeed, but these women probably grew up in an environment called a breastfeeding environment,

> "an environment where breastfeeding was practiced in a natural way, without the question of how to feed the babies being asked; probably these women had been breastfed by their mothers and had seen other mothers breastfeed their babies, thus having had positive experiences related to breastfeeding".[24]

When assisting a child, we cannot approach him/her as an isolated being, but as a member of a family with its own cultural characteristics and functioning. We must recognize how the family accepts the child and prepares for their arrival. It is the responsibility of every professional to understand and guide the parents towards bonding and the development of parenting. Through the actions of care for the baby the family provides feelings of belonging and love, which are essential for the full development of the child.

It is the responsibility of the nurse who acts in Basic Care to closely follow the beginning and maintenance of breastfeeding in families under his responsibility. From the beginning of prenatal care, the bond should be formed between professional, pregnant woman, partner and family, so that their actions are truly meaningful to all those involved in this process of breastfeeding.

Breastfeeding must be understood beyond the biological question, that is, it must encompass the social and cultural issues of each family.

CONCLUSION

The practice of breastfeeding is carried out by the nurturers, but it is linked to family culture. The mothers take care of the baby, but mixed breastfeeding is predominant. The home space is a privileged environment for nursing interventions, and through the use of light technologies the professional can favor the movement of relationships, qualified listening, bonding and welcoming in the practice of breastfeeding. For this, it is indispensable that all the professionals of the Family Health Teams are committed to breastfeeding, seeking to build a new look that values exclusive breastfeeding, promoting better living conditions and development of children.

REFERENCES

1. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Política nacional de atenção integral à saúde da criança: orientações para implementação. 1. ed. Brasília: Ministério da Saúde; 2018 [acesso em 23 de agosto 2020]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2015/prt1130_05_08_2015.html.
2. Jesus PC, Oliveira MIC, Moraes JR. Capacitação de profissionais de saúde em aleitamento materno e sua associação com conhecimentos, habilidades e práticas. Ciênc. Saúde Colet. [Internet]. 2017 [acesso em 23 de março 2018]; 22(1). Disponível em: http://dx.doi.org/10.1590/1413-81232017221.17292015.
3. Aires LCP, Santos EKA, Costa R, Borck M, Custódio ZAO. Seguimento do bebê na atenção básica: interface com a terceira etapa do método canguru. Rev. gaúch. enferm. [Internet]. 2015 [acesso em 3 de março 2018]. Disponível em: http://dx.doi.org/10.1590/1983-1447.2015.esp.56805.
4. Venancio SI, Giugliani ERJ, Silva OLO, Stefanello J, Benicio MHD, Reis MCG, et al. Associação entre o grau de implantação da Rede Amamenta Brasil e indicadores de amamentação. Cad. Saúde Pública (Online). [Internet]. 2016 [acesso em 20 de novembro 2018]; 32(3). Disponível em: https://www.scielosp.org/pdf/csp/2016.v32n3/e00010315/pt.
5. Branquinho ID, Lanza FM. Saúde da criança na atenção primária: evolução das políticas brasileiras e a atuação do enfermeiro. Rev. enferm. Cent.-Oeste Min. [Internet]. 2018 [acesso em 2 de fevereiro 2019]; 8. Disponível em: http://dx.doi.org/10.19175/recom.v8i0.2753.
6. Maia VKV, Lima EFA, Leite FMC, Sousa AI, Primo CC. Avaliação dos indicadores de processo do Programa de Humanização no Pré-Natal e Nascimento e da Rede Cegonha. Rev. Pesqui. (Univ. Fed. Estado Rio J., Online). [Internet]. 2017 [acesso em 12 de dezembro 2019]; 9(4). Disponível em: http://dx.doi.org/10.9789/2175-5361.2017.v9i4.1055-1060.
7. Fernandes VMB, Santos EKA, Zampieri MFM, Gregório VRP, Hernandes MJ, Ribeiro LC. Condutas de gestores relacionadas ao apoio ao aleitamento materno nos locais de trabalho. Texto & contexto enferm. [Internet]. 2018 [acesso em 22 de setembro 2018]; 27(3). Disponível em: http://dx.doi.org/10.1590/0104-070720180002560016.
8. Ramos AE, Ramos CV, Santos MM, Almeida CAPL, Martins MCC. Conhecimentos sobre aleitamento materno e alimentação complementar dos profissionais de saúde. Rev. bras. enferm. [Internet]. 2018 [acesso em 3 de abril 2019]; 71(6). Disponível em: http://dx.doi.org/10.1590/0034-7167-2017-0494.
9. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Saúde da Criança: Nutrição Infantil. Aleitamento Materno e Alimentação Complementar. 2. ed. Brasília: Ministério da Saúde; 2015 [acesso em 23 de agosto 2020]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/saude_crianca_aleitamento_materno_cab23.pdf.
10. Moura LP, Oliveira JM, Noronha DD, Torres JDRV, Oliveira KCF, Teles MAB. Percepção de mães cadastradas em uma estratégia saúde da família sobre aleitamento materno exclusivo. Rev. enferm. UFPE on line. [Internet]. 2017 [acesso em 22 de novembro 2018]; 11(3). Disponível em: http://dx.doi.org/10.5205/reuol.10263-91568-1-RV.1103sup201712.
11. Polit DF, Beck CT. Fundamentos de pesquisa em enfermagem: avaliação de evidências para a prática da enfermagem. 7. ed. Porto Alegre: Artmed; 2011.
12. Gil AC. Métodos e técnicas de pesquisa social. 6. ed. São Paulo: Atlas; 2008.
13. Fundo das nações unidas para a infância (UNICEF). Iniciativa hospital amigo da criança. Promovendo e incentivando a amamentação em um hospital amigo da criança. Brasília: Ministério da Saúde. 2009.
14. Vasquez J, Dumith SC, Susin LRO. Aleitamento materno: estudo comparativo sobre o conhecimento e o manejo dos profissionais da Estratégia Saúde da Família e do Modelo Tradicional. Rev. Bras. Saúde Mater. Infant. (Online). [Internet]. 2015 [acesso em 4 de novembro 2018]; 15(2). Disponível em: http://dx.doi.org/10.1590/S1519-38292015000200004.
15. Nascimento CIM, Teodoro LPP, Vidal ECF, Pinto AGA. Concepções e práticas para o aleitamento materno: revisão integrativa. Rev. enferm. UFPE on line. [Internet]. 2017 [acesso em 7 de junho 2019]; 11(3). Disponível em: http://dx.doi.org/10.5205/reuol.10263-91568-1-RV.1103sup2017256.
16. Fialho FA, Lopes AM, Dias IMA, Salvador M. Fatores Associados ao desmame precoce do aleitamento materno. rev. cuid. (Bucaramanga. 2010). [Internet]. 2014 [acesso em 5 de abril 2019]; 5(91). Disponível em: http://www.scielo.org.co/pdf/cuid/v5n1/v5n1a11.pdf.
17. Rêgo RMV, Souza AMA, Rocha TNA, Alves MDS. Paternidade e amamentação: mediação da enfermeira. Acta Paul. Enferm. (Online). [Internet]. 2016 [acesso em 12 de agosto 2019]; 29(4). Disponível em: http://dx.doi.org/10.1590/1982-0194201600052.
18. Torquato RC, Silva VMGN, Lopes APA, Rodrigues LN, Silva WCP, Chaves EMC. Perfil de nutrizes e lactentes atendidos na Unidade de Atenção Primária de Saúde. Esc. Anna Nery Rev. Enferm. [Internet]. 2018 [acesso em 12 de abril 2019]; 22(1). Disponível em: http://dx.doi.org/10.1590/2177-9465-EAN-2017-0212.
19. Monteschio CAC, Gaíva MAM, Moreira MDS. O enfermeiro frente ao desmame precoce na consulta de enfermagem à criança. Rev. bras. enferm. [Internet]. 2015 [acesso em 7 de junho 2019]; 68(5). Disponível em: http://dx.doi.org/10.1590/0034-7167.2015680515i.
20. Ribeiro PM. Aleitamento materno: como incentivar. São Paulo, SP: Scortecci; 2010.

21. Esteves TMB, Daumas RP, Oliveira MIC, Andrade CAF, Leite IC. Fatores associados à amamentação na primeira hora de vida: revisão sistemática. Rev. saúde pública. [Internet]. 2014 [acesso em 6 de junho 2019]; 4(4). Disponível em: http://dx.doi.org/10.1590/S0034-8910.2014048005278.

22. Costa EFG, Alves VH, Souza RMP, Rodrigues DP, Santos MV, Oliveira FL. Nursing practice in clinical management of breastfeeding: strategies for breastfeeding. Rev. Pesqui. (Univ. Fed. Estado Rio J., Online). [Internet]. 2018 [cited 2019 ago 6]; 10(1). Available from: http://dx.doi.org/ 10.9789/2175-5361.2018.v10i1.217-223.

23. Mariani Neto C. Manual de aleitamento materno. 3. ed. São Paulo: Federação Brasileira das Associações de Ginecologia e Obstetrícia (FEBRASGO); 2015.

24. Levy L; Bértolo H. Manual de aleitamento materno. Lisboa: Comité Português para a UNICEF; 2012.

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