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ORIGINAL

First hour of life and COVID-19 from the view of obstetric nurses: a descriptive study

Primeira hora de vida e COVID-19 a partir da visão de enfermeiras obstétricas: estudo descritivo

Primera hora de vida y COVID-19 a partir de la visión de enfermeras obstétricas: estudio descriptivo

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RESUMO

Objetivo: analisar como ocorria o contato pele a pele em maternidade municipal, na região metropolitana II do estado do Rio de Janeiro, Brasil, durante o início da pandemia da COVID-19, a partir da visão de enfermeiras obstétricas. Método: estudo qualitativo, descritivo-exploratório, realizado com sete enfermeiras obstétricas. As informações foram coletadas via Google Formulários® e tratadas pela análise temática proposta por Bardin. Resultados: emergiram duas categorias: "manutenção do contato pele a pele e influência da decisão médica" e "avaliação de síndromes gripais e COVID-19, no início da pandemia, que interferiram no processo do contato pele a pele". Conclusão: a manutenção do contato pele a pele ocorria atrelada às recomendações de protocolos oficiais. O poder da medicina influenciava o trabalho em equipe, direcionado pelo uso de procedimentos, durante o parto e nascimento que, de certa forma, limitava a respectiva prática, em casos suspeitos para COVID-19.

Descritores: Enfermagem Obstétrica; Relações Mãe-filho; Pandemias; Infecções por Coronavírus.

ABSTRACT

Objective: to analyze how skin-to-skin contact occurred in a municipal maternity hospital in Metropolitan Region II of the state of Rio de Janeiro, Brazil, at the beginning of the COVID-19 pandemic, from the perspective of obstetric nurses. Method: a qualitative, descriptive, and exploratory study with seven obstetric nurses. The information was collected via Google Forms® and subjected to the thematic analysis proposed by Bardin. Results: two categories emerged: "maintenance of skin-to-skin contact and medical decision influence" and "evaluation of flu syndromes and COVID-19 at the beginning of the pandemic, interfering in the process of skin-to-skin contact". Conclusion: the maintenance of skin-to-skin contact was linked to the recommendations of official protocols. The power of medicine influenced teamwork, directed by the use of procedures, during labor and birth, which, in a way, limited the respective practice in suspected cases for COVID-19.

Descriptors: Obstetric Nursing; Mother-Child Relations; Pandemics; Coronavirus Infections.

RESUMEN

Objetivo: analizar cómo se produce el contacto piel a piel en maternidad municipal, en la región metropolitana II del Estado de Río de Janeiro, Brasil, durante el inicio de la pandemia de COVID-19, a partir de la visión de enfermeras obstétricas. Método: estudio cualitativo, descriptivo-exploratorio, realizado con siete enfermeras obstétricas. Las informaciones se recabaron con Google Formularios® y analizadas por el análisis temático propuesto por Bardin. Resultados: emergieron dos categorías: "mantenimiento del contacto piel a piel e influencia de la decisión médica" y "evaluación de síndromes gripales y COVID-19, en el inicio de la pandemia, que interfirieron en el proceso de contacto piel a piel". Conclusión: el mantenimiento del contacto piel a piel se verificaba relacionado a las recomendaciones de los protocolos oficiales. El poder de la medicina influía el trabajo en equipo, dirigido por el empleo de procedimientos, durante el parto y nacimiento que, de cierta forma, limitaba la respectiva práctica, en casos de sospecha de COVID-19.

Descriptores: Enfermería Obstétrica; Relaciones Madre-hijo; Pandemias; Infecciones por Coronavirus.

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INTRODUCTION

The World Health Organization (WHO) declared a COVID-19 pandemic on March 11, 2020[1]. As this disease is currently harmful to human health and a rapidly spreading virus, research has been developed during the pandemic. As a result, many doubts arose and persisted about specific issues associated with the disease, such as breastfeeding.

In Brazil, breastfeeding by women with COVID-19 is not contraindicated, regardless of the woman's serological status, as, in addition to the lack of information on COVID-19 transmission through breast milk, its benefits outweigh the possible risks[2]. However, it is suggested that nursing mothers follow the precautions recommended by the scientific community, such as using masks during feedings and rigorously washing their hands before and after holding the baby[3].

It is emphasized that, according to the WHO, the fourth of the ten recommendations of the Baby-Friendly Hospital Initiative (BFHI) in promoting the breastfeeding process is skin-to-skin contact between mother and baby in the first hour of life. This step must be understood as keeping the newborn's skin in contact with the mother's skin and encouraging the woman to recognize when the child is ready to be breastfed[4].

The positive effects of this practice involve low cost, early initiation of breastfeeding, and the creation of a bond between the mother-infant dyad promoting understanding of the baby's needs and encouragement to perform the maternal role[5,6]. Skin-to-skin contact is not recommended if the mother is infected by the new coronavirus or needs diagnostic clarification[3].

Despite the benefits of this practice in the first hour of life, the implementation involves the need for the health professional to have theoretical and practical knowledge, awareness, and constant updating, due to the current period of a health emergency, when information and guidance from health agencies constantly change. Thus, it is opportune to rescue the importance of training as a tool to update knowledge and promote qualified care based on the best scientific evidence available[6].

In this context, the presence of Obstetric Nurses (ON), as a professional category, has proved to be very important, nationally, and internationally. The WHO recommends encouraging the training of ON, a group of specialized professionals able to carry out the practices they are responsible for, according to the health recommendations regarding the pregnancy-puerperal cycle. In addition, they are essential members of the interprofessional obstetric team, which offers qualified care to the woman and newborn, based on scientific evidence[7,8].

Thus, given the COVID-19 pandemic that reconfigures the work processes related to delivery and birth, the care of women and babies should be the object of study, aiming at reorganizing obstetric services, of great value to health managers, the assistant professionals, and the population served. Therefore, the guiding question has emerged: how did skin-to-skin contact between mother and baby occur, in the first hour of life, during the onset of the COVID-19 pandemic, in a municipal maternity hospital in the metropolitan region II of the state of Rio de Janeiro, from the perspective of obstetric nurses?

This study aims to analyze how skin-to-skin contact occurred in a municipal maternity hospital in Metropolitan Region II of the state of Rio de Janeiro, Brazil, at the beginning of the COVID-19 pandemic, from the perspective of obstetric nurses.

METHOD

This study is related to the research project entitled "Qualification and intervention in the field of labor and birth: interprofessional improvement in obstetrics", carried out within the scope of the Mother, Women and Child's Health Research Group. The study protocol was submitted to the Faculty of Medicine's Research Ethics Committee and approved, according to opinion No. 3.913.573 and certificate of presentation for ethical appreciation No. 12127619.80000.524330.

This is a qualitative study with a descriptive-exploratory approach. The instrument Consolidated Criteria for Reporting Qualitative Research (COREQ)[9] recommended in qualitative studies in health, was adopted.

The scenario was a public maternity hospital at usual risk, located in the metropolitan region II of Rio de Janeiro, Brazil, a reference in the performance of obstetric nurses in the care of pregnant women in situations of usual risk, especially concerning humanized normal birth. The sector of interest for this study was the Obstetric Center, characterized as a delivery and birth environment in which skin-to-skin contact and breastfeeding

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occur in the first hour of life, also known as the golden hour[6].

Seven obstetric nurses from the hospital mentioned above participated in the study, using the following inclusion criterion: being an obstetric nurse with activities focused on delivery and birth, and the following exclusion criterion: being away from work on vacation or sick leave.

Given the pandemic context, we decided not to collect face-to-face data. Thus, the nursing coordinator of the hospital provided the obstetric nurses' telephone numbers after informing them about the development of this study. The WhatsApp® messaging application was used to maintain a dialogue with the professionals and invite them to participate in the study using Google Forms®, answering the following question: "Describe how skin-to-skin contact has been carried out in the maternity ward, during the COVID-19 pandemic."

This method was chosen given the pandemic context and the workload professionals face in their routine, allowing greater convenience, and maintaining anonymity and confidentiality. Data collection took place from March to September 2020, followed by the analytical process.

The convenience sampling procedure was used. Obstetric nurses were recruited and invited to participate in the study by manifesting availability and interest and meeting the inclusion criteria.

The data obtained will be kept confidential, under the responsibility and care of the main researcher. Alphanumeric coding (e.g., P1, P2, P3, …, P7) was used to distinguish the participants and ensure secrecy, anonymity, and reliability. Voluntary participation was also guaranteed through the Consent Form.

The content analysis was carried out using the thematic technique[10], established into the following phases: 1) pre-analysis of statements, 2) exploration of the material and treatment of results, 3) inference and interpretation[10].

The material was coded using simple computerized resources, including colorimetry in Microsoft Word®, which allowed the election of the following Registration Units (RU): "skin-to-skin contact", "COVID-19", "pandemic", "delivery and birth procedure", "medical power", "risk assessment", and the Thematic Unit: "Maintenance of skin-to-skin contact and medical decision influence and uncertainties caused by the COVID-19 pandemic". These RU supported the construction of the following categories: 1) Maintenance of skin-to-skin contact and medical decision influence, and 2) Evaluation of flu syndromes and COVID-19 at the beginning of the pandemic, interfering in the process of skin-to-skin contact.

RESULTS

Maintenance of skin-to-skin contact and medical decision influence

According to the statements, skin-to-skin contact and breastfeeding at birth continued to be carried out at the beginning of the pandemic. Even under specific circumstances caused by the pandemic, this practice had continuity, in agreement with the processes previously implemented in the institution. In this context, the need on the part of the obstetric team to use procedures in delivery and birth, such as cesarean section and interventions considered necessary for the immediate care of newborns, were identified as impediments to ensure, in a comprehensive way, the practice of skin-to-skin contact and breastfeeding.

> *We had no confirmed cases of COVID in the maternity ward, and, in my shift, there was a suspicion that the only case was referred directly to a cesarean. No skin-to-skin contact is being given after cesarians. So the practice has not changed much. (P2)*

> *I have observed no changes concerning skin-to-skin contact during the pandemic. (P5)*

> *Skin-to-skin contact has remained normal, and there were no changes in this process during normal delivery. In cesarean, skin-to-skin contact is not given, regardless of COVID. (P7)*

Difficulties in ensuring skin-to-skin contact existed before the pandemic, especially regarding the post-cesarean section. Thus, the centrality of the medical decision-making in the statements was evidenced, influencing the work processes in the institution, a factor that makes skin-to-skin contact/breastfeeding impossible at birth, in some situations. Thus, the findings demonstrate the existence of possible obstacles to guaranteeing routines that fully ensure skin-to-skin contact and breastfeeding in the first hour of life. The statements signaled how much the need for

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assessment, assistance, and interventions determines the moment the baby is taken away to the nursery.

> *Therefore, clamping can never be longer than 3 minutes, and skin-to-skin contact is done according to what the pediatrician on duty allows. Mothers rarely have the right to experience the Golden Hour. (P2)*

> *Currently, skin-to-skin contact is allowed; however, the time is limited because the pediatrician on duty takes the newborn for routine care procedures. (P6)*

Based on the reports, the resolving power was observed, often concentrated in being a doctor, which directly influences the context of birth. However, the speech of an ON stands out as she mentions the role of interprofessional teamwork when promoting skin-to-skin contact/golden hour.

> *[...] skin-to-skin contact continues to be prioritized in the first hour of life due to maternal desire. It has been offered by the team of obstetricians, doctors, and pediatricians, and the mother can keep her newborn with her in the first hour of life, as long as the Apgar is normal, and the baby is comfortable. (P1)*

From the statement above, it is observed that, in the same health institution, there may be different modes of action, as a situation in which skin-to-skin contact and obstetric interprofessional work was prioritized was pointed.

Evaluation of flu syndromes and COVID-19 at the beginning of the pandemic, interfering in the process of skin-to-skin contact

The assessment of flu syndromes/COVID-19, at the beginning of the pandemic, was carried out based on the maternity risk classification, and, in a way, this concern influenced the process of skin-to-skin contact.

> *Given the current pandemic scenario, we have a patient screening in our reception, where we assess the potential risk! After this analysis and the recommended care are conducted, we allow skin-to-skin contact, as we know its importance. (P4)*

In the case of asymptomatic parturient women, skin-to-skin contact occurred according to institutional routines. On the other hand, the process of skin-to-skin contact/breastfeeding was altered in the presence of flu symptoms, cold, or confirmed Sars-CoV-2 infection, not taking place in its entirety, as recommended.

> *[...] before the pandemic, we already used the golden hour, and, at this moment, we continue to prioritize the skin-to-skin contact in the first hour unless this mother has a respiratory complaint, flu, or a cold. But so far, we did not need to reduce skin-to-skin contact time due to the coronavirus, and it already worked that way before. (P1)*

> *[...] skin-to-skin contact has happened with asymptomatic mothers, the baby is still put in contact with the mother at birth, and breastfeeding has also been maintained in the first hour, the golden hour; it has happened at this moment of pandemic. Unless the mother has COVID. In this case, we do not make skin-to-skin contact. (P3)*

From the speeches presented above, there was a change in the dynamics of reception in the maternity hospital. Through the risk classification, the protocols that will be followed are determined according to the recommendations of the international scientific community. It was evident that skin-to-skin contact was valued, and health professionals acknowledge the importance of this practice, according to the individuality of each patient.

DISCUSSION

Regardless of the suspicion or confirmation of infection by Sars-CoV-2, the possibility of skin-to-skin contact and breastfeeding at birth were shown to be conditioned, above all, on the type of delivery, with cesarean being identified as one of the obstacles to maintaining this practices, corroborating findings in the literature[11-14].

It is noticeable that certain factors can directly influence the continuity of skin-to-skin contact and the guarantee of the golden hour. In the obstetric center environment, many elements make it difficult to maintain the golden hour, such as instability of the mother's clinical conditions, discomfort during the closing of the surgical in-

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cision, lethargic effects of anesthetics, nausea, and unpreparedness of the obstetric team[11]. In addition to these, other factors, such as first care, exams, teamwork, and institutional routines, can interfere with skin-to-skin contact[14].

Despite the above, guidance and efforts are needed so that skin-to-skin contact is encouraged during the first hour of life, also in cases of cesarean sections, considering the specificities faced during the pandemic, as this process brings both benefits to the woman and the newborn. Furthermore, it provides an intimate moment, with comfort for both mother and child, generates heat stimuli for better adaptation, prevention of pain, healthy development of the baby, and aid in the interaction and creation of a bond between mother and child, a factor that is harmed by cesarean section, since oxytocin, prolactin, adrenaline and noradrenaline hormones, which facilitate this relationship, are not released in the same way that occurs in a vaginal delivery[11-16].

Another factor interfering with skin-to-skin contact/breastfeeding at birth is the centrality of medical decision-making power, predominant in the biomedical model that still occurs in many health institutions, especially hospitals. In this context, the skin-to-skin contact time can be influenced, based on the medical decision-making power of the pediatrician on duty in some situations. Thus, it can be observed that the need for assessment, care, and interventions, according to the newborn's clinical conditions, determines the moment when the pediatrician is asked to provide routine care procedures.

As this process is influenced by the medical conduct, some interventions are justified according to the clinical assessment required at each moment, hampering, to some extent, actions that should be carried out based on the health team's collective assessments. This movement induces the guarantee of routines that ensure skin-to-skin contact and breastfeeding at birth, as indicated in the scientific literature[6-12].

Thus, it can be highlighted that the guarantee of skin-to-skin contact and breastfeeding at birth depends heavily on institutional routines and the involvement and relationship between the various obstetric professionals. In this study, the statements show that the great influence of medical decisions is closely associated with this process.

This symbolic power attributed to the medical profession is linked to historical factors, also permeating class, gender, and race/ethnicity issues. Medicine has still been seen as a liberal and intellectual profession, while nursing has occupied the space of a subsidiary and auxiliary profession with a technical representation involved, the "manual work". In turn, this process of historical tensions, to some extent, has contributed, so far, to reinforce weaknesses, interfering with teamwork[17].

However, the speech of an ON who mentioned the role of interprofessional teamwork when promoting skin-to-skin contact stands out. The possibility of carrying out activities that characterize different ways of organizing the work process in the same institution, complementing and configuring a collaborative work, with a focus on women's health safety, makes it possible to observe that there are convergent points in the relationship between nursing and medicine; this, in one hand may cause tension, but in the other hand stimulate balance in power relationships[18].

The WHO recommends encouraging the training and qualification of obstetric nurses due to the importance of this profession in interprofessional teams working in hospitals and maternity hospitals, prepared to assist in the pregnancy-puerperal cycle[7,8]. Thus, it is necessary to emphasize that the ON has a significant role in assisting parturient women, as, in addition to knowing the physiological process of childbirth, recognizes the individuality of each woman, respects, guide, and welcome her, answer questions, and detect complications during labor and concerning skin-to-skin contact and breastfeeding at birth[7,8,18].

Currently, the presence of the ON has been highly valued by women and health institutions, as among the various aspects that involve the care provided by these professionals is that of guaranteeing the rights of mothers and newborns in the process of delivery and birth. This point can be expressed by ensuring the companion's presence and the family's involvement at the time of parturition and respect for the woman's privacy, in addition to the implementation of evidence-based practices that contribute to avoiding interventions considered unnecessary, and the encouragement of actions aimed at health promotion and education carried out to encourage female autonomy during labor and birth[19].

The humanization of labor and birth is one of the different actions that make up the National Humanization Policy (NHP) developed by the WHO, whose premise is the humanization of services provided by the Unified Health System to reduce the rates of cesarean sections and ma-

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ternal mortality. In humanized care, emphasizing skin-to-skin contact and breastfeeding at birth, the interprofessional team must ensure greater participation of the parturient in decisions about their health, thus ensuring woman and baby's wellbeing[19].

Thus, evidence-based practices must be part of the routine of all health professionals so that the focus of health care is no longer on professionals and is directed towards the needs of women and newborns[19].

In this study, the exercise of the participating obstetric nurses in ensuring assessment and control measures for cases of Sars-CoV-2 infection was under the recommendations of public health institutions, societies, and professional bodies[20], including the indications of the Brazilian Society of Pediatrics[2], which guides the observation of the woman's clinical history and prenatal care, with analysis of the present situation concerning contact with a respiratory symptomatic person, compatible with the flu-like illness.

In addition, it is also recommended that skin-to-skin contact should be temporarily suspended for symptomatic parturient women or those who have had home contact with people with flu-like illness, or tested positive for COVID-19, until the development of contamination prevention actions. Skin-to-skin contact and breastfeeding should only be initiated after performing hygiene and measures to prevent contamination of the newborn, such as bathing the mother, changing the mask, cap, nightgown, and sheets. For infected but clinically stable women and asymptomatic babies, rooming-in must be maintained, as well as breastfeeding, but in isolation and with the following conditions: two meters of distance between the mother's bed and the newborn's crib, and reinforcement of the necessary preventive measures, such as using a mask and performing hand hygiene, properly, before and after having contact with the baby[2].

It is emphasized that each woman must be evaluated individually and, in the case of interruption of skin-to-skin contact/breastfeeding at birth, obstetric professionals must be aware of the safety measures in force at the time[20].

Thus, it is noted that the pandemic, to some extent, interfered in the process of performing skin-to-skin contact and breastfeeding in the first hour of life. Even though it was possible to identify that, in the investigated hospital, there were difficulties to fully guarantee the golden hour. The pandemic moment has contributed to the need to retake and maintain the awareness regarding the infection control and prevention actions in defense of life. Therefore, this historical moment raises greater vigilance from health professionals regarding the current use of scientific evidence to promote a safe and high-quality health care.

As a limitation of this study, the impossibility of consulting the data produced by the ON's records at the hospital is highlighted due to the recommendation of isolation and social distancing during the pandemic.

As an implication of advances in scientific knowledge in health and nursing, it is opportune to encourage and invest in research on this topic to enable reflections and updated production of information related to breastfeeding and skin-to-skin contact, even in pandemic times. In addition, updated reflections on the relationship of interprofessional work between nurses and physicians, in the context of labor and birth, are indicated to stimulate the intellectual debate related to scientific production in health.

CONCLUSION

When considering the experiences reported in this study, it was identified that the pandemic raised awareness of the need to review institutional work processes. In the case of skin-to-skin contact/breastfeeding at birth, there were also concerns on the part of health professionals regarding the predominance of new information about COVID-19, including the possibility of rapid changes that, in a way, influenced routines and the work processes.

In this case, the medical power that historically centralizes decisions in the work process in hospital institutions, especially concerning the assessment of procedures, such as cesarean section and immediate care for the newborn, during the pandemic, has found artifacts that justify making decisions that interfere, for example, in maintaining skin-to-skin contact. However, even if in a focused way, the interdependence between professionals and the existence of actions that involve obstetric nurses stands out, and actions have been carried out based on agreements between the obstetric teams, whose practices were based on safety and up-to-date scientific evidence.

As COVID-19 is a disease with high transmissibility and lethality, a concern was revealed in following the guidelines of official health agencies guaranteeing the lives of women and newborns, from

the evaluation of criteria and risk classification, from the entrance to the maternity ward, limiting skin-to-skin contact in suspected or confirmed cases of infection.

Furthermore, the importance of the obstetric nurse in the dynamics of the interprofessional work related to delivery and birth care for operationalizing skin-to-skin contact and breastfeeding was highlighted. The reinforcement of the fundamental role of each member of the obstetric team in the performance of a collaborative practice, which adds quality and safety to the care process, has been an invitation to the possibility of causing changes in the work processes in health institutions.

In the same way, the importance of permanent improvement in health is reinforced, especially in pandemic times, promoting humanized care in labor and birth, encouraging breastfeeding and skin-to-skin contact, and reducing maternal and neonatal morbidity and mortality rates.

In short, given the possibility of permanence of the COVID-19 pandemic, globally, it is reiterated that the findings regarding the theme investigated in this study can be stimuli for future research, supporting the qualification and safety of care, as well as the need to strengthen public health policies committed to encouraging breastfeeding and defending the lives of women and newborns, during and after the pandemic.

CONFLICT OF INTEREST

The authors have declared that there is no conflict of interest.

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REFERENCES

1. World Health Organization (WHO). Coronavirus disease (COVID-19) pandemic [Internet]. Geneva: WHO; 2020 [cited 2021 Mar 31]. Available from: https://www.who.int/emergencies/diseases/novel-coronavirus2019
2. Sociedade de Pediatria. Departamento Científico de Aleitamento Materno. O aleitamento materno em tempos de COVID-19. Nota de alerta nº 9 [Internet]. 2020 [cited 2020 Nov 9]. Available from: https://www.sbp.com.br/fileadmin/user_upload/22393cNota_de_Alerta_sobe_Aleitam_Materno_nos_Tempos_COVID-19.pdf
3. Fundação Oswaldo Cruz. Rede Brasileira de Bancos de Leite Humano da Fiocruz. Recomendação técnica nº 01/20.170320 [Internet]. Brasília: Ministério da Saúde; 2020 [cited 2021 Mar 31]. Available from: https://rblh.fiocruz.br/sites/rblh.fiocruz.br/files/usuario/80/rblh_recomendacao_01020_170320.pdf.
4. Lamounier JA, Chaves RG, Rego MAS, Bouzada MCF. Baby friendly hospital initiative: 25 years of experience in Brazil. Rev Paul Pediatr. 2019;37(4):486-93. http://dx.doi.org/10.1590/1984-0462/;2019;37;4;00004. PMid:31241692.
5. Ministério da Saúde (BR). Atenção Humanizada ao Recém-Nascido. Método Canguru. Diretrizes do Cuidado [Internet]. Brasília: Ministério da Saúde; 2019. 80 p. [cited 2021 May 21]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/metodo_canguru_diretrizes_cuidado_revisada.pdf
6. Fundação Oswaldo Cruz. Instituto Nacional de Saúde da Mulher, da Criança e do Adolescente Fernandes Figueira. Portal de Boas Práticas em Saúde da Mulher, Criança e Adolescente. Principais questões sobre contato pele a pele ao nascer [Internet]. Brasília: Ministério da Saúde; 2019 [cited 2021 May 21]. Available from: https://portaldeboaspraticas.iff.fiocruz.br/atencao-recem-nascido/principais-questoes-sobre-contato-pele-a-pele-ao-nascer/#:~:text=Nesse%20sentido%2C%20o%20contato%20pele,o%20nascimento%20do%20seu%20filho
7. Alves VH, Pereira AV, Dulfe PAM, Vieira BDG, Silva LA, Fontoura AMT, et al. Preceptorship in nursing-midwifery: a training-intervention in health work. Rev Bras Enferm. 2020;73(Suppl. 6):e20190661. http://dx.doi.org/10.1590/0034-7167-2019-0661. PMid:33338134.
8. International Confederation of Midwives. Essential competencies for midwifery prac-

tice [Internet]. 2019 [cited 2021 Mar 31]. Available from: https://www.internationalmidwives.org/assets/files/general-files/2019/02/icm-competencies_english_final_jan-2019-update_final-web_v1.0.pdf

9. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349-57. http://dx.doi.org/10.1093/intqhc/mzm042. PMid:17872937.

10. Urquiza MA, Marques DB. Análise de conteúdo em termos de Bardin aplicada à comunicação corporativa sob o signo de uma abordagem teórico-empírica. Entretextos. 2016;16(1):115-44. http://dx.doi.org/10.5433/1519-5392.2016v16n1p115.

11. Ferrari AP, Almeida MAM, Carvalhães ABL, Parada MGL. Effects of elective cesarean sections on perinatal outcomes and care practices. Rev Bras Saúde Mater Infant. 2020;20(3):879-88. http://dx.doi.org/10.1590/1806-93042020000300012.

12. Saco MC, Coca KP, Marcine KO, Abuchaim ESV, Abrão ACFV. Skin-to-skin contact followed by breastfeeding in the first hour of life: associated factors and influences on exclusive breastfeeding. Texto Contexto Enferm. 2019;28:e20180260. http://dx.doi.org/10.1590/1980-265x-tce-2018-0260.

13. Ayres LFA, Cnossen RE, Passos CM, Lima VD, Prado MRMC, Beirigo BA. Factors associated with early skin-to-skin contact in a maternity hospital. Esc Anna Nery. 2021;25(2):1-8. http://dx.doi.org/10.1590/2177-9465-EAN-2020-0116.

14. 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. 2020;41(spe):e20190154. http://dx.doi.org/10.1590/1983-1447.2020.20190154. PMid:32401893.

15. Lotto CR, Linhares MBM. Contato pele a pele na prevenção de dor em bebês prematuros: revisão sistemática da literatura. Trends Psychol. 2018;26(4):1699-713. http://dx.doi.org/10.9788/TP2018.4-01Pt.

16. Oakley L, Benova L, Macleod D, Lynch CA, Campbell OMR. Early breastfeeding practices: descriptive analysis of recent demographic and health surveys. Matern Child Nutr. 2018;14(2):e12535. http://dx.doi.org/10.1111/mcn.12535. PMid:29034551.

17. Gonçalves LAP, Medonça ALO, Camargo KR Jr. The interaction between doctors and nurses in the context of a hospital ward. Cien Saude Colet. 2019;24(3):683-92. http://dx.doi.org/10.1590/1413-81232018243.32162016. PMid:30892491.

18. Silva TWM, Velosso ISC, Araújo MT, Fernandes ARK. Configuration of power relations in physicians and nurses' professional practices. Rev Bras Enferm. 2020;73(Suppl. 1): e20180629. http://dx.doi.org/10.1590/0034-7167-2018-0629.

19. Oliveira SB, Batista GS, Valcarenghi RV, Mattos ARS, Correia JBB, Hoffmann ACOS. Contato precoce pele a pele entre mãe e recém-nascido: contribuições da enfermagem em uma Maternidade de São José/SC. Estácio Saúde [Internet]. 2020 [cited 2021 Mar 31];9(1):8-16. Available from: http://periodicos.estacio.br/index.php/saudesantacatarina/article/viewFile/6034/47966442

20. Rio de Janeiro. Secretaria de Estado de Saúde. Nota Técnica nº 27/2020. Recomendações para a atenção ao período gravídico-puerperal frente à pandemia do novo coronavírus (COVID-19) [Internet]. Rio de Janeiro; 2020 [cited 2021 Mar 21]. Available from: https://www.saude.rj.gov.br/comum/code/MostrarArquivo.php?C=MzI2Njg%2C

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