RESEARCH

INFLUENCE OF THE EXTENSION OF MATERNITY LEAVE TO SIX MONTHS ON THE DURATION OF EXCLUSIVE BREASTFEEDING

INFLUÊNCIA DA PRORROGAÇÃO DA LICENÇA MATERNIDADE PARA SEIS MESES NA DURAÇÃO DO ALEITAMENTO MATERNO EXCLUSIVO

INFLUENCIA DE LA AMPLIACIÓN DE LA LICENCIA POR MATERNIDAD PARA SEIS MESES EN LA DURACIÓN DE LA LACTANCIA MATERNA EXCLUSIVA

Gabriela Ramos Ferreira [1]
Eloana Ferreira D'Artibale [2]
Luciana Olga Bercini [3]

[1] Nurse. Resident of the Neonatal Nursing Course, Universidade Estadual de Londrina – UEL (Londrina State University – UEL). Londrina, PR – Brazil.
[2] Nurse. MsN, Nursing Graduate Program Enfermagem (PSE), Universidade Estadual de Maringá (Maringá State University – UEM). Maringá, PR – Brazil.
[3] Nurse. Associate Professor at the Nursing Department, PSE/UEM. Maringá, PR – Brazil.

Corresponding Author: Eloana Ferreira D´Artibale. E-mail: eloana_dartibale@hotmail.com
Submitted on: 08/17/2012 Approved on: 02/26/2013

ABSTRACT

This article aimed to analyze the influence of the maternity license extension from four to six months on the length of exclusive breastfeeding (EBF) of mothers whose children attended a Childhood Educational Center (CEC). This is a descriptive exploratory research with a quali-quantitative approach, conducted with 20 mothers that returned to work after a 180-day maternity leave, whose children attended the CEC of the State University of Maringá in 2010. Data collection was performed through a semi-structured questionnaire containing closed- and open-ended questions. The closed-ended questions were tabulated and analyzed into Excel spreadsheets and the statements were evaluated through content analysis. The results showed that the population studied presented favorable factors towards breastfeeding. The maternity leave extension allowed mothers to exclusively breastfeed their babies for a longer period. The return to work was, then, the main reason for the discontinuation of exclusive breastfeeding. Thereby, the study suggests that efforts should be made by the CEC health team in order to orientate these working mothers, during all the stages of the pregnancy and childbirth cycles, on the importance of exclusive breastfeeding on the baby's first six months. Moreover, they should enact breastfeeding management, so that when mothers return to work, they will be still breastfeeding their children.
Keywords: Breastfeeding; Child Health; Maternity Leave; Women's Health; Nursing.

RESUMO

Este estudo objetivou analisar a influência da prorrogação da licença maternidade para seis meses na duração do aleitamento materno exclusivo (AME) das mães usuárias de um Centro de Educação Infantil (CEI). Trata-se de uma pesquisa descritiva, exploratória de abordagem quantiqualitativa, realizada com 20 mães que, após o retorno da licença maternidade de 180 dias, retornaram aos seus respectivos serviços e ingressaram com seus bebês no CEI da Universidade Estadual de Maringá, em 2010. A coleta de dados foi realizada por meio de um instrumento semiestruturado contendo questões fechadas e abertas. As questões fechadas foram tabuladas e analisadas em planilhas no programa Excel e os depoimentos avaliados por meio da análise de conteúdo. Os resultados mostraram que a população estudada apresentava fatores favoráveis à amamentação. A prorrogação da licença maternidade possibilitou que as mães amamentassem exclusivamente por um tempo mais longo, sendo o retorno ao trabalho o principal motivo para a interrupção do AME. Destarte, o estudo informa que esforços devem ser feitos pela equipe de saúde do CEI no sentido de orientar essas mães trabalhadoras, em todas as etapas do ciclo gravídico-puerperal, sobre a importância do AME até os seis meses, além de atuar no manejo do aleitamento materno para que, quando elas retornarem ao trabalho, ainda estejam amamentando seus filhos.
Palavras-chave: *Aleitamento Materno; Saúde da Criança; Licença Maternidade; Saúde da Mulher; Enfermagem.*

RESUMEN

El objetivo de este artículo es analizar la influencia de la prorrogación de la licencia por maternidad de las madres usuarias de un Centro de Educación Infantil (CEI) para seis meses, durante el período de lactancia exclusiva o amamantación exclusiva (AME). Se trata de una investigación descriptiva, exploratoria de enfoque cualitativo cuantitativo, realizada con 20 madres que, trás el término de la licencia por maternidad de 180 días, han vuelto a sus respectivas actividades laborales e ingresaron con sus bebés en el CEI de la Universidad Estatal de Maringá, en 2010. La recogida de datos se realizó por medio de un instrumento semi-estructurado compuesto por preguntas cerradas y abiertas. Las preguntas cerradas fueron tabuladas y analizadas en planillas con el programa Excel y las declaraciones fueron evaluadas por medio del análisis de contenido. Los resultados demostraron que el grupo estudiado presentaba factores favorables a la amamantación. La prorrogación de la licencia por maternidad posibilitó que las madres amamantasen exclusivamente por un tiempo mayor; el regreso al trabajo fue el principal motivo para la interrupción de la AME. El estudio indica que el equipo de salud del CEI debe hacer esfuerzos para orientar a estas madres trabajadoras, en todas las etapas del ciclo gravídico

puerperal, sobre la importancia de la AME hasta los seis meses, además de ayudar en la administración de la lactancia, para que cuando ellas vuelvan al trabajo aún estén amamantando a sus hijos.

Palabras clave: *Lactancia Materna; Salud del Niño; Licencia de Maternidad; Salud de la Mujer; Enfermería.*

INTRODUCTION

Breastfeeding (BF) is a natural strategy of bonding, affection, protection and nutrition for children and the most sensitive, economical and effective intervention for the reduction of infant morbidity and mortality, recommended by the World Health Organization (WHO) exclusively during the first six months of life and supplemented until two years of age or older.[1]

The process of BF is complex and socially conditioned, in addition to being biologically defined; it is an act embedded in ideologies and determinants resulting from concrete conditions of life.[2,3]

Therefore, several factors have been considered determinants of early weaning, among them low maternal educational and socioeconomic level, early motherhood, parity, attention of health professionals in prenatal consultations, and being employed.[4,5]

Being employed stands out as a risk factor for interruption of BF.[4-7] A study developed in Rio de Janeiro evidenced that the frequency of exclusive breastfeeding (EBF) among children of women who did not have a job was twice as high compared to mothers who had any occupational activity.[5]

In this context, maternity leave constitutes an important mechanism for the continuity of EBF, since women can provide their newborns with care and free demand breast milk full time during this period. Maternal jobs without maternity leave increase the risk of EBF interruption, because women often need to be absent to resume work, due to their direct contribution to family income.[6,7]

The absence of the mother due to the triple role that she starts playing (mother, housewife and paid employee) may favor the insertion of complementary food before six months of age, and thereby early weaning.[8,9]

Brazilian women employed in the formal labor market legally possess four months of paid maternity leave and two half-hour intervals during the workday when they return to work to breastfeed their babies until they are six month-old. Companies that employ 30 women must have a suitable place to take care of the children during the BF period inside the company itself or through agreements with appropriate institutions.[10]

In addition to these benefits offered to employed women, Law 11770 was enacted on September 9, 2008, in order to increase the prevalence of BF, which extends the length of maternity leave under clause XVIII of the *caput* of article 7 of the Constitution for 60 days, without job and salary disadvantages, for federal employees. States, municipalities and private companies have the prerogative of adopting this Law.[11]

The state of Paraná, in line with the Law above, enacted Law 16176 in 2009, which extended maternity leave of the public servants in Paraná for 180 days, and the maternity leave must be requested by the employee.[12] Such extension of maternity leave can be a determining factor for increasing the length of BF, as it is more likely that mothers who returned to work after the fifth month post-partum continued breastfeeding for more than four months.[13] In addition, studies have shown that the extension of maternity leave may favor the prevalence and length of BF, and hence, mother-child health.[6,7]

The Childhood Educational Center (CEC) from the *Universidade Estadual de Maringá* (State University of Maringá – UEM), as part of a public institution located in the state of Paraná, abides by Law 16176/2009, benefiting its employees with the extension of maternity leave. This center provides welcoming and care to children of the employees of UEM during their workday, in addition to promoting ways to keep the mother-child bond, and allowing BF at regular times.

In this context, this study aimed to analyze the influence of the extension of maternity leave to six months on the length of EBF of mothers from the CEC, UEM.

Therefore, this study was guided by the following question: "what is the influence of the extension of maternity leave to six months on the length of exclusive breastfeeding of children attending the CEC/UEM?".

METHODS

This was a descriptive, exploratory study with a quanti-qualitative approach, developed at the CEC/UEM. Study participants were all mothers of babies who entered the CEC after returning from a 180-day maternity leave, from February to December 2010, for a total of 20 mothers.

Data were collected in November and December of 2010, through the child's records at the CEC and interviews with the mothers. An instrument for data collection was used for the interviews, performed individually in a CEC room after scheduling with the mother. The instrument consisted of a questionnaire with closed- and open-ended questions about: the sociodemographic profile of the mother; maternal health during pregnancy and childbirth; and, the newborn and breastfeeding.

After collection, the data were entered into an Excel spreadsheet and then analyzed and presented in tables and graphs. The descriptive analysis was performed from the percentage distribu-

tion of the variables. For better comprehension of the consequences of the extension of maternity leave, it was decided to include the following open-ended question in the questionnaire: "how has the extension of maternity leave to six months influenced the length of your child's exclusive breastfeeding?" The participants were asked to write their answers on the questionnaire so that they could express themselves freely, after a few minutes of reflection.

The reports were submitted to thematic analysis, which consisted of discovering the thematic nuclei that composed a statement, whose presence or frequency was meaningful to the aim of the study. Operationally, thematic analysis comprises the steps of pre-analysis, material exploration and interpretation of the results, which were grouped into themes and categories.[14]

Ethical principles were abided by, in accordance with Resolution 196/96 of the National Health Council. The participants signed an informed consent and the project was approved by the Research Ethics Committee, number 271/2010.

RESULTS AND DISCUSSION

Considering that the process of BF is socially conditioned, as mentioned above, we proceeded to the sociodemographic characteristics of the subjects (Table 1).

Table 1 - Characteristics of study participants according to sociodemographic variables: Maringá – PR, 2010

Variables	n (20)	%
Maternal age (years)		
20 – 34	11	55,0
35 – 40	7	35,0
> 40	2	10,0
Education		
Incomplete higher education	1	5,0
Complete higher education	5	25,0
Post-graduation	14	70,0
Occupation		
Professor	9	45,0
Secondary education professional	7	35,0
Higher education professional	3	15,0
General assistant	1	5,0
Marital status		
Married	17	85,0
Stable union	2	10,0
Divorced	1	5,0
Number of children		
1	13	65,0
2 to 3	7	35,0

Regarding maternal age, 55% were in the range considered ideal for motherhood, that is, between 20 and 34 years (Table 1). A literature review evidenced that the children of older mothers are breastfed for a longer time compared to children of younger mothers.[4]

Regarding education, the fact of CEC being in a university certainly influenced the higher education of the subjects, since most (70%) had postgraduate education (Table 1). This situation was a positive factor, since a previous study showed an association between high maternal education and length of EBF, indicating that mothers with lower education tend to introduce food early.[15]

Considering the occupation, professors (45%) and secondary education professionals (21%) were predominant (Table 1). Regarding marital status, many had a partner: they were married (85%) or in stable unions (10%) (Table 1). The fact that mothers had stable unions and the support of other people, especially the partner, seemed to have a positive influence on the length of BF.[4]

Most (65%) had only one child, whereas 35% had two to three children (Table 1). The influence of parity on BF is widely discussed in the literature. Some studies suggest that primiparous women generally continue BF for a shorter period; for multiparous women, there seemed to be a correlation between how their previous children were breastfed and how the latter will be.[4]

Table 2 shows the obstetric and newborn variables. Most (95%) had prenatal follow-up in private health services (covenant or private ones). It is worth noting that UEM offers a health insurance plan for its employees.

During pregnancy, some women had specific factors that may pose risks for the health of the mother and/or fetus, above the population average. Such factors are grouped into four major groups, described as: unfavorable individual and sociodemographic conditions, reproductive history prior to the current pregnancy, obstetric diseases, and clinical complications in the current pregnancy.[16]

Considering that these factors can influence the process of BF due to restrictions and complications related to BF and impairment of maternal and child health, it was found that, among the women surveyed, most (70%) showed no gestational risk factor.

Among the six women (30%) with some kind of risk, three (50%) were classified as older mothers, two (33.3%) had placental changes, and one (16.7%) had a reduced birth interval. Despite the risk factors assessed in the study, they did not compromise EBF.

Regarding the type of delivery, 95% of children were born by caesarean section (Table 2). A study claims that there is a global trend towards increasing cesarean section, whose indices are well above those recommended by the WHO, which is 15%.[17] In Maringá, in 2009, 78.8% of births were from cesarean deliveries, which is a high rate of cesarean section in the city.[18]

Table 2 - Distribution of obstetric and newborn variables: Maringá – PR, 2010

Variables	n (20)	%
Prenatal consultations		
Private	19	65,0
Public	1	5,0
Number of prenatal consultations		
8 to 10	11	55,0
More than 10	9	45,0
Orientation about breastfeeding in prenatal consultations		
Yes	15	75,0
No	5	25,0
Type of delivery		
Caesarean section	19	95,0
Vaginal	1	5,0
Breastfeeding in the first hour		
Yes	7	35,0
No	13	65,0
Orientation about breastfeeding in the maternity hospital		
Yes	16	80,0
No	4	20,0
Early difficulties in lactation		
Yes	14	70,0
No	6	30,0
Gestational age (weeks)		
≥ 37	15	75,0
< 37	5	25,0
Birtweight (grams)		
≥ 2.500	17	85,0
< 2.500	3	15,0

Regarding the newborn, most were born at term (75%) and with adequate birthweight (85%) (Table 2). Most (90%) had an uneventful birth. Out of two children with problems at birth, one was related to low birthweight, and another to neonatal jaundice.

Most mothers (75%) received orientation on BF in prenatal consultations (Table 2), which approached the importance/advantages of breast milk (60%), the length of EBF (45%), positioning and correct latching on (45%), the most common problems in lactation (30%), duration of BF (25%), preparation of the breasts (20%), use of pacifiers (10%). Most of this information was provided by physicians (70%), by nurses (25%) and in 10% of the cases, by another professional. Many (70%) did not attend groups/lectures about BF in the prenatal period and sought other means to be informed, such as: internet (64.2%), conversation with relatives and friends (57.1%), magazines/books (50%), consulting the Human Milk Bank (14.2%) and television shows (14.2%).

Breastfeeding promotion in pregnancy has a proven positive impact on the prevalence of BF, especially among primiparous women.[1] Attention and orientation aimed at women about the course of BF are factors that promoted BF and prevention of complications related to BF. Thereby, these actions should be practiced from the prenatal period to the postpartum period, since it is an excellent opportunity to assist and motivate women to breastfeed.[19]

At the maternity hospital, 80% of mothers received information about BF (Table 2), which referred to the correct positioning and latching on (87.5%), the importance/advantages of breast milk (43.8%), the length of EBF (31.3%), the most common problems in lactation (18.8%), the use of pacifiers (18.8%), the length of BF (12.5%), breast care (12.5 %), and, to milk letdown (6.3%). This information was provided by the pediatrician in 50% of cases, in 50% by nurses, in 12.5% by obstetricians, and in 12.5% by the speech therapist.

The information, at this time, is of paramount importance, because now the mother is found in practice, making the learning easier. Moreover, no mother-baby should leave the maternity hospital without at least one observed feeding, because such assessment can indicate if the mother will need help and what kind of help.[20]

Only 35% of mothers had breastfed in the first hour following birth (Table 2), a lower percentage than that found in the Survey on Prevalence of BF II, which showed 63.5%.[2] This practice is recommended by WHO because it is a strategy for the promotion, protection and support of BF, in addition to corresponding to the fourth step of the Baby-Friendly Hospital Initiative.[21]

At the beginning of BF, 70% of mothers had some kind of difficulty (Table 2), mainly nipple fissure in 50% of cases, insufficient lactation in 35.7% and engorgement in 28.5% of cases. Out of these mothers, 85.7% received help during this process, 50% by physicians, 25% by nurses, 25% by the partner, 25% by Human Milk Banks, 16.6% by maternal grandmothers of the children, and 8.3% by nursing technicians.

Some problems faced by the mothers during BF, if not identified and treated early, can be important causes of interruption of BF. Health professionals have an important role in the prevention and management of these difficulties.[22,23] Most (85%) mothers visited the pediatrician routinely, being oriented about BF in 64.7% of cases. Orientations were about the importance of BF (72.7%), length of EBF (72.7%), length of BF (36.4%), correct positioning and latching on (36.4%), the most common problems in lactation (18.2%), use of creams (9.1%), interval between feedings (9.1%) and positioning of the baby after feeding (9.1%).

Most (80.0%) mothers introduced some kind of pacifier, and were oriented to do so by physicians (50.0%), by their own mothers (31.3%), by partners (18.8%), by the child's maternal grandmothers (12.5%), and by the mothers-in-law (6.3%). In 25% the introduction of these pacifiers occurred in the first week of life, 18.8% at 30 days of age, 31.3% at two months of life, 6.3% at three months of age, and in 18.8% at four months of age or older. In a

study conducted in Bauru-SP, it was found that pacifier use was a factor associated with higher chance of interruption of EBF.[24]

In addition to a 180-day maternity leave, mothers at the CEC often still had vacation or special leaves, thereby most (60%) children were older than six months when they started frequenting the service. Because of that, when they joined the CEC, 90% of children were given fruit, 85% juice, 65% baby food at lunch, 60% human milk, 45% baby food at dinner, 20% cow milk, 10% tea, 10% formula, 10% other foods, and 5% soy milk. In 85% of cases, dietary orientation was provided by pediatricians, in 15% by their own mothers, in 5% by the maternal grandmother, and in 5% by the nutritionist.

Only 10% of mothers did not exclusively breastfeed their children. Figure 1 presents the prevalence of EBF along the six months of the children's lives. It can be observed that EBF was high in the first 30 days of life (94.4%), decreased over the months, and significantly decreased after four months of life.

Out of the 13 mothers who exclusively breastfed for less than six months, 46.2% reported returning to work as a reason for discontinuation of EBF, 23.1% medical advice, 23.1% insufficient breast milk, 15.4% cracked nipples, 15.4% other causes, 7.7% pain, and 7.7% infected nipple.

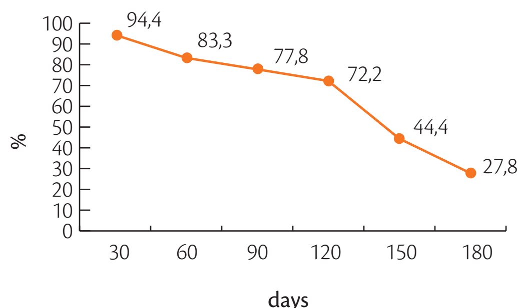

Figure 1 - Prevalence of EBF among women attending CEC at UEM, Maringá – PR, 2010.

When questioned about how the extension of maternity leave to six months influenced the length of EBF of their children, most mothers (65%) reported that it was very important for both mother and child, since they could breastfeed exclusively for longer, which would otherwise have been very difficult, as shown in the following reports:

The six-month leave was essential to exclusively breastfeed for five months and a half and then introduce other foods. When I returned to work, exclusive breastfeeding was difficult, and I started introducing other foods (E1).

The longer time spent with the baby enabled the offer of breast milk for longer, besides bonding with the child. If this law happened to still be four months, exclusive breastfeeding would probably be difficult, because expressing of milk would have to be done, which is more tiring for the mother (E10).

It certainly made it easier for me to exclusively breastfeed until six months (E11).

I always believed that breastfeeding should be exclusive to the 6th month, this measure helped strengthen the mother-child bonding and for sure the baby's health. For the working mother, it has been a great achievement (E17).

A study developed in Guarapuava-PR showed that maternal employment is an aggravating factor for discontinuation of EBF, being predominant for the minimum expectation of EBF length in children younger than six months old. The risk of discontinuation of EBF by mothers who had a job was 3.92 times higher compared to mothers who did not have a job.[25]

Some mothers reported that the extension did not influence the length of EBF and claimed that they had already introduced other foods at earlier ages, for several reasons:

For me there was no influence because I was ill [unable to breastfeed] (E4).

Unfortunately there was no influence because, as with my first daughter, I did not have enough milk, thus having to supplement his diet with soy milk. If it wasn't for this problem, exclusive breastfeeding would be very positive, considering that my daughter is allergic to cow's milk (E6).

In my case there was no influence because I had no milk [did not breastfeed] (E8).

It did not influence anything because I hardly breastfed, my nipple wasn't appropriate and my milk dried up after 2 months. But anyway the extension of maternity leave was important because I could spend more time with the baby, and I stimulated him a lot during this time, he acquired more independence, and when he entered the nursery he was already crawling! (E19)

Problems emerging from the process of BF may be subject to the lack of information and adequate support, resulting in the early introduction of complementary foods. That significantly influences EBF, decreasing its length, besides interfering with the absorption of important nutrients in breast milk, such as iron and zinc. The introduction of such food is also related to higher rates of chronic diseases in adulthood.[26]

Given this reality, when approaching the practice of BF, one should consider the sociocultural factors of the woman, tracing particular strategies that are consistent with the different needs and moments experienced by the mother-child.[27]

FINAL CONSIDERATIONS

This study has shown that the population presented favorable factors to breastfeeding, demonstrated by the fact that most mothers had appropriate maternity age, high education, had a partner, attended prenatal consultations, and, had their babies at term with appropriate weight. However, it is noteworthy that a quarter of mothers received no orientation on BF during the prenatal period, 20% of them did not receive such orientation at the maternity hospital, and 35.3% in the consultations. Moreover, 35% did not breastfeed in the first hour. The high percentage of cesarean section (95%) and use of pacifiers (80%) are noteworthy. Most (70.0%) mothers also had problems with early lactation, especially cracked nipples, insufficient breast milk and engorgement.

The results evidenced that the extension of maternity leave to six months has enabled maternal users of this CEC to exclusively breastfeed their children for a longer period, but still not for six months, as recommended by WHO, and the main reason for discontinuation of EBF mentioned was returning to work.

It was also noticed that the early introduction of complementary foods was still a common practice, begun before the mother's return to work, in order to introduce other types of foods to children, thus facilitating, in the belief of the mothers, the nutritional adaptation of the child when they joined the CEC.

In view of the difficulties mentioned by the participants and the emerging beliefs, the role of nursing is noteworthy, which is active in the pre- and post- natal periods, having the possibility to contribute positively through orientation, support and encouragement of the practice of EBF.

The limitation of this study is the restricted number of subjects investigated, considering the studied universe, not allowing the generalization of the results to the female population and other CECs.

In conclusion, this study emphasizes that efforts should be made by the health team of the CEC to orient working mothers, at all stages of pregnancy and childbirth, about the importance of EBF until six months of age, in addition to acting in BF management, so that when they return to work after a 180-day maternity leave, they are still breastfeeding their children.

REFERENCES

1. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Saúde da Criança: nutrição infantil. Aleitamento materno e alimentação complementar. Normas e manuais técnicos. Cadernos de Atenção Básica nº 23. [Child Health: child nutrition. Breastfeeding and complementary feeding. Standards and technical manuals. Primary Attention Collection n. 23] Brasília: MS; 2009. (Portuguese).
2. Marques ES, Cotta RMM, Botelho MIV, Franceschini SCC, Araújo RMA, Lopes LL. Rede social: desvendando a teia de relações interpessoais da nutriz. [Social network: revealing the nursing mother social affairs]. Physis. 2010; 20(1):261-8. (Portuguese).
3. Junges CF, Ressel LB, Budó MLD, Padoin SMM, Hoffmann IC, Sehnem GD. Percepções de puérperas quanto aos fatores que influenciam o aleitamento materno. [Perceptions of women in puerperium regarding factors that influence breast feeding]. Rev Gaúcha Enferm. 2010; 31(2):343-50. (Portuguese).
4. Faleiros FTV, Trezza EMC, Carandina L. Aleitamento materno: fatores de influência na sua decisão e duração. [Factors influencing breastfeeding decision and duration]. Rev Nutr. 2006; 19(5):623-30. (Portuguese).
5. Damião JJ. Influência da escolaridade e do trabalho maternos no aleitamento materno exclusivo. [Influence of mothers' schooling and work on the practice of exclusive breastfeeding]. Rev Bras Epidemiol. 2008; 11(3):442-52. (Portuguese).
6. Queluz MC, Pereira MJB, Santos CB, Leite AM, Ricco RG. Prevalência e determinantes do aleitamento materno exclusivo no município de Serrana, São Paulo, Brasil. [Prevalence of breastfeeding and associated factors in the municipality of Londrina (PR, Brazil)]. Rev Esc Enferm USP. 2012; 46(3):537-43. (Portuguese).
7. Souza SNDH, Migoto MT, Rossetto EG, Mello DF. Prevalência de aleitamento materno e fatores associados no município de Londrina-PR. [Prevalence and determinants of exclusive breastfeeding in the city of Serrana, São Paulo, Brazil]. Acta Paul Enferm. 2012; 25(1):29-35. (Portuguese).
8. Rivemales MC, Azevedo ACC, Bastos PL. Revisão sistemática da produção científica da enfermagem sobre o desmame precoce. [Systematic review of scientific productionin nursingon early weaning]. Rev Enferm UERJ. 2010; 18(1):132-7. (Portuguese).
9. Alves BA, Cursi J, Labegalini MPC, Higarashi IH, Bercini LO. Mães com aleitamento materno exclusivo em centro de educação infantil no local de trabalho. [Exclusive breastfeeding mothers making use of a day care center at the work place]. Rev Rene. 2009; 10(3):27-36. (Portuguese).
10. Oliveira DH. Do direito à saúde da criança por meio dos cuidados à mãe e a gestante segundo o estatuto da criança e do adolescente. [The law of child health through the mother to care and pregnant by statute of child and adolescent]. Rev Direito Público. 2010; 5(2):69-89. (Portuguese).
11. Brasil. Ministerio da Saude. Lei nº 11.770, de 9 de setembro de 2008. Cria o Programa Empresa Cidada, destinado a prorrogacao da licenca-maternidade mediante concessao de incentivo fiscal, e altera a Lei no 8.212, de 24 de julho de 1991. [Law 11.770, September 9, 2008. Creates the Citizen Company Program, destined to the extension of maternity leave through granting of tax incentives and changes Law 8212, July 24 1991]. Pub. L. no 11.770.
12. Paraná. Secretaria da Administração e Previdência Portal do Servidor. Licença à Gestante. [Maternity Leave]. 2009. [Cited 2012 Jan 04]. Available from: http://www.portaldoservidor.pr.gov.br/modules/conteudo/conteudo.php?conteudo=57. (Portuguese).
13. Brasileiro AA, Ambrosano GMB, Marba STM, Possobon RF. A amamentação entre filhos de mulheres trabalhadoras. [Breastfeeding among children of women workers]. Rev Saúde Pública. 2012, 46(4):642-8. (Portuguese).
14. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. [The knowledge challenge: qualitative research in health]. 11ª ed. São Paulo: Hucitec; 2008. (Portuguese).
15. Pereira RSV, Oliveira MIC, Andrade CLT, Brito AS. Fatores associados ao aleitamento materno exclusivo: o papel do cuidado na atenção básica. [Factors associated with exclusive breastfeeding: the role of primary health care]. Cad Saúde Pública. 2010; 26(12):123-35. (Portuguese).
16. Brasil. Ministério da Saúde. Secretaria de Políticas, Área Técnica da Saúde da Mulher. Gestação de alto risco. [High risk pregnancy]. Brasília: MS; 2000. (Portuguese).

17. Bonfate TM, Silveira GC, Sakae TM, Sommacal LF, Fedrizzi EM. Fatores associados à preferência pela operação cesariana entre puérperas de instituição pública e privada. [Factors related to the preference for c-section among puerperas from public and private medical clinics]. Arq Cat Med. 2009; 38(1):26-32. (Portuguese).

18. Brasil. Informações de Saúde. Estatísticas Vitais. 2009. [Health information: vital statistics]. [Cited 2011 Dec 20]. Available from: http://tabnet.datasus.gov.br/cgi/deftohtm.exe?sinasc/cnv/nvpr.def. (Portuguese).

19. Souza Filho MD, Gonçalves Neto PNT, Martins MCC. Avaliação dos problemas relacionados ao aleitamento materno a partir do olhar da enfermagem. [Evaluation of problems related to breastfeeding from the nursing perspective]. Cogitare Enferm. 2011; 16(1):70-5. (Portuguese).

20. Coca KP, Gamba MA, Silva RdeS, Abrão ACFV. A posição de amamentar determina o aparecimento do trauma mamilar? [Does breastfeeding position influence the onset of nipple trauma?]. Rev Esc Enferm USP. 2009; 43(2): 446-52. (Portuguese).

21. Unicef. Fundo das Nações Unidas para a Infância. Iniciativa Hospital Amigo da Criança. [Baby-friendly hospital Initiative]. 2008. [Cited 2011 Dec 28]. Available from: http://www.unicef.org/brazil/pt/activities_9994.htm (Portuguese).

22. Fonseca MO, Parreira BDM, Machado DC, Machado ARM. Aleitamento materno: conhecimento de mães admitidas no alojamento conjunto de um hospital universitário. [Breast feeding: knowledge of mothers admitted to the rooming-in of auniversity hospital]. Ciênc Cuid Saude. 2011; 10(1):141-9. (Portuguese).

23. Christoffel MM, Votto MG, Allevato CG, Ambrósio MDV, Araújo AS. Práticas de amamentação de puérperas na consulta de enfermagem neonatal em unidade básica de saúde. [Breastfeeding practices among postpartum women during nursing consultations in a primary health care Center]. REME – Rev Min Enferm. 2009; 13(2):202-8. (Portuguese).

24. Parizoto GM, Parada CMGL, Venâncio SI, Carvalhaes MABL. Tendência e determinantes do aleitamento materno exclusivo em crianças menores de 6 meses. [Trends and patterns of exclusive breastfeeding for under-6-month-old children]. J Pediatric (Rio J). 2009; 85(3):201-8. (Portuguese).

25. Brecailo MK, Corso ACT, Almeida CCB, Schmitz BdeAS. Fatores associados ao aleitamento materno exclusivo em Guarapuava, Paraná. [Factors associated with exclusive breastfeeding in Guarapuava, Paraná, Brazil]. Rev Nutr. 2010; 23(4):553-63. (Portuguese).

26. Dias MCAP, Freire LMS, Franceschini SdoCC. Recomendações para alimentação complementar de crianças menores de dois anos. [Recommendations for the complementary feeding of children under age two years]. Rev Nutr. 2010; 23(3):475-86. (Portuguese).

27. Lima AP, Javorski M. Amamentação interrompida: vivência de mulheres-mães. [Interrupted breast-feeding: the experience of women-mothers]. Rev Enferm UFPE on line. 2010; 4(1):230-8. (Portuguese).