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Rangel da Silva, Leila; Izidro de Souza Elles, Maria Emanuele; Domingues Bernardes Silva, Maíra; Meneses dos Santos, Inês Maria; Ventura de Souza, Kleyde; Manhães de Carvalho, Sheini

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Leila Rangel da Silva
http://www.objnursing.uff.br/
rangel.leila@gmail.com
Department of Maternal-Child Nursing, Nursing School Alfredo Pinto, Universidade Federal do Rio de Janeiro State.

SOCIAL FACTORS THAT INFLUENCE BREASTFEEDING OF PREMATURE NEWBORNS: DESCRIPTIVE STUDY

Leila Rangel da Silva[1], Maria Emanuele Izidro de Souza Elles[2], Maíra Domingues Bernardes Silva[3], Inês Maria Meneses dos Santos[4], Kleyde Ventura de Souza[5], Sheini Manhães de Carvalho[6]

1,4 Federal University of the State of Rio de Janeiro; 2 Federal Hospital of the State Servers; 3 Central Hospital of the Military Police of Rio de Janeiro; 5 Federal University of Minas Gerais;6 Brazilian Association of University Education.

ABSTRACT
Objective: describe the social dimensions that enhance and/or interfere with breastfeeding. Method: Descriptive study with qualitative approach, with the participation of 30 mothers and performed in the outpatient segment of newborns discharged from the Neonatal Intensive Care Unit of a Municipal Maternity of Rio de Janeiro. Data were collected from a semi-structured questionnaire in the period from July to August 2008, after approval of the CEP SMS/RJ, Protocol 89/08, with 30 mothers and it was analyzed according to the Theory of Cultural Care of Madeleine Leininger. **Results:** were identified four categories: technological influences in nursing, family and social support in breastfeeding; influences of culture and previous family experiences in lactation and the biological aspects and breastfeeding. **Conclusion:** The factors are intertwined and are influential among themselves within the social structure of women in the breastfeeding process.
Keywords: Transcultural Nursing, Premature; Breastfeeding.

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INTRODUCTION

This study has as an object the social dimensions that affect and/or enhance the breastfeeding experience of mothers of premature neonates (PN) discharged from a Neonatal Intensive Care Unit (NICU).

The World Health Organization (WHO) recognizes the benefits and advantages of breastfeeding, therefore, it recommends exclusive breastfeeding for the first six months of a child's life and continuing after the introduction of appropriate complementary foods up to two years or more[1].

In Brazil, breastfeeding has been a priority for government actions over the past 30 years. In response, there is a favorable feeding of indicators, such as the increase in median duration of this practice in the country[2]. Yet the country needs to advance much to meet the WHO recommendation with regard to exclusive breastfeeding until six months of life. Data from a national survey in 2008 found that only 9.3% of infants breastfeed exclusively at the age of 180 days[3].

Broader and more complex factors have been influencing the practice of breastfeeding in our country, such as: socio-economic status, education level, age and maternal employment, urbanization, labor conditions, encouragement of the husband/partner and family and the desire of women to breastfeed. It is worth noting that all of them, understood as factors of social structure, have been related to the reasons that lead to early weaning[4]. Because breastfeeding is a process that involves cultural, social and political factors of multiple and large dimensions, many health professionals, especially nurses, need to be better prepared for dealing with it[4], including appropriate clinical management and the use of techniques of communication skills.

For the nurse and anthropologist Madeleine Leininger, human care is universal and it is experienced differently across cultures[5] and, in his Theory of Cultural Care (TCC), about Diversity and Universality, she advocates the need for such knowledge for the development of nursing care practice of quality and humanistic[6].

Taking into account that society and culture are overlapping in women's lives and that values, beliefs and lifestyles are closely related to the process of breastfeeding, to grasp it, it is required to relate socio-economic structures and cultural experience of women, as well as the family, community and society, in addition to the health condition of mother and child.

In this perspective, we sought to describe the reality experienced by mothers who decide to breastfeed, trying to minimize the socio-cultural factors and barriers that hinder the practice of breastfeeding, in order to provide the longest possible time of feeding their children, newborns discharged from critical units, as in the case of premature infants.

For that we outlined as an objective of the study: to describe the social dimensions that enhance and/or interfere with the process of breastfeeding of mothers of preterm infants discharged from the NICU.

With regard to care and nursing research, the study offers support for the care with cultural focus, while also contributing to the expansion of knowledge on the subject. It is noteworthy that this research confirms the studies developed by the Center for Research, Studies and Experimentation in the Health of Women and Children (NuPEEMC) of the Nursing School Alfredo Pinto (EEAP) of the Federal University of Rio de Janeiro State (UNIRIO).

METHODOLOGY

Descriptive study with qualitative approach, approved by the Ethics Committee (CEP) of the Municipal Health Secretariat of Rio de Janeiro (RJ-SMS), protocol number 89/08, June 23, 2008, considering what provides the Resolution No. 196/96[7]. The participants, after receiving all the information pertinent to the study, signed the consent form. To remain anonymous, they were coded with names of stars and constellations.

The study field was a Municipal Maternity, located in the northern area of Rio de Janeiro, which has a NICU and outpatient for *follow-up* of the NICU. This was the first institution in the municipality, to receive the title of Baby-Friendly Hospital. All preterm infants in this study were discharged from the NICU with scheduled appointment at the outpatient for *follow-up* of newborns at risk of maternity – or *follow-up*, using this English expression[8].

The participants were 30 mothers who met the following inclusion criteria: mothers of preterm newborns discharged from the NICU, with more than seven days hospitalization, who breastfed or milked human milk during hospitalization of their children, with a record of attendance to appointments for follow-up, and who agreed to participate in the research. Note that the number of mothers, witnesses, was determined after obtaining the saturation point[6].

For the production of data, we used a questionnaire that focused on the socio-economic, demographic and cultural identification and characterization of the subjects, and finally on the breastfeeding process. It was used, primarily, a pilot questionnaire, and seven mothers were interviewed before the definition of the standard questionnaire. It was also used a semi-structured interview recorded on magnetic tape (K7). In this script there were open questions that favored the analysis of the social dimensions that enhance and/or interfere with breastfeeding. Therefore the strategy was adopted to accomplish the purpose of the study.

We studied the social, economic, demographic (age, education, occupation, family income, race, marital status) and cultural characteristics and those related to the breastfeeding process (type of feeding, initiation and/or establishment of breastfeeding or early weaning; lactation period). Data were recorded and analyzed based on thematic analysis[9].

The information was organized and arranged in individual files. After sorting the statements, the statements were grouped according to similarities and thus were set together with some others. Then, the data collected went through a process of reduction, which allowed grouping the lines in themes by their similarity. Therefore subtopics were constituted and finally there was the definition of broader themes that encompassed smaller themes[9].

To identify the social and cultural dimensions, we used as a theoretical basis, the first level of the Sunrise Model, one of the instruments used in Leininger's Theory of Cultural Care[6]. This tool examines seven factors of the dimensions of social structure: technological, religious and philosophical, of fellowships and social, cultural and lifestyles, political and legal, economic and educational.

RESULTS

Profile of the study subjects

The construction of the social profile reflects more than just the environment that surrounds the child and mother, but also a set of needs, which give us support for a cultural look[5]. In this study, the subjects' profile facilitated the understanding of social and cultural aspects of the study group.

Thus, with respect to age, of the 30 respondents, we found that 13 were aged between 21 and 30 years. Regarding marital status, 10 reported consensual union, but there was also a significant number

of civil and religious marriages, with six women. The mothers, in their majority (21), do not work away from home and are housewives.

Regarding education, the majority (19) has complete secondary school or almost complete And most of them (28) reported family income between 1 and 5 minimum wages. And when it comes to religion, 16 said they were Catholic. With regard to skin color, 11 declare themselves white, 12 brown and 7 black.

Regarding the number of children, 16 had only one child. With respect to the type of delivery, 19 said they had cesarean section and the remainder reported normal delivery. In relation to gestational age, 15 were in the range of 31 to 33 weeks, 9 were between 34 and 36 weeks and 6 between 28 and 30 weeks.

the survey was conducted in a favorable environment for breastfeeding, for it is a hospital with the title of "Baby Friendly". However, despite the benefits and advantages for women, their babies and families concerning the promotion, protection and support to breastfeeding, it was found in the study group factors of the dimensions of social and cultural structures that directly and/or indirectly were influencers in the breastfeeding process.

It is known that the process of breastfeeding has its specificities and some necessary conditions in order to happen. It is necessary first of all, to understand the possibilities of each woman for the act of breastfeeding; the competence of those who will support her and guide her to overcome her limitations is also essential. The greatest example of this last requirement is to have sensitivity and empathy to share her pain and insecurity. We highlight the importance of integrated actions, that is, that does not separate the biological aspects of social, cultural and historical ones, taking into account the breastfeeding not only as a biologically determined act, but also social culturally conditioned[6].

It was possible then to identify and describe more sharply factors that are technological, of companionship, social, cultural and lifestyle, adding at the first level of the Sunrise Model, biological factors.

During the study it was found, also, the support and information provided to these mothers on the importance of exclusive breastfeeding for their babies and the problems of premature infants - that can be addressed in order to reduce the statistics of early weaning. The factors, as shown by Leininger in his theory, are intertwined and, therefore, are together influencing factors[6].

In this study, we identified three of the seven factors: technological, companionship and social, cultural and lifestyles. We added to them one more factor in addition to the proposed by Madeleine Leininger that was the biological factor, totaling four factors, according to Table 1:

Table 1 - Factors that enhance or interfere in the process of breastfeeding

Factors	**Defining Characteristics**
Technological factors	Use of nasogastric tube, duration of ICU stay and IU and use of artificial respirator (Inter 5, CPAP) prolonged.
Companionship and social factors	Support and information from health professionals, NGOs, Bank of milk. Family support (mother, partner, friends, mothers and grandparents).
Cultural factors and lifestyle	The culture of exclusive breastfeeding of the unit and family culture lived in various stages of life of the woman as a daughter, sister, wife and mother.
Biological factors	Maternal complications (premature rupture of membranes, preeclampsia, urinary tract infection), plane and hypogalactia nipples. Prematurity of the newborn.

Source: Research data

After analysis, we coded four analytic categories: 1) technological influences on breastfeeding, 2) The family and social support in breastfeeding, 3) Influences of culture and previous family experiences in the lactation and 4) Biological aspects and breastfeeding.

DISCUSSION

Technological influences on breastfeeding

The subjects of this study demonstrate in their speech that they have experienced, closely, the use of technology as the maintenance of lives of their children, given the long length of stay in the Neonatal Intensive Care Unit. The use of catheters and drains, according to the testimony, compromised the process of breastfeeding and continuity of lactation.

> *[...] I couldn't breastfeed while my son was hospitalized because he was in ICU and could only take the milk, after a few days, but only through the syringe because he couldn't be taken out of the incubator [. ..] I neither could take him out , because he had a chest tube and we could not move him all the time and besides, he was also doped, so it wasn't possible, it could only be done through the probe in the ICU. Later he was taken to the IU and when I left I could finally breastfeed him. (Ursa Major)*

Is important to highlight, as of these reports, the possibility of contribution of nurses in the gradual transformation of the model of the current health care, which prevails in most services, replacing the technological paradigm for humanistic one[10]. In this sense, the path to be taken, particularly by Nursing/Nurse is the (re)invention of attitudes and practices that consider the joint knowing-practice, in order to overcome the biological field[11].

The fellowship factor, that is, the support from family was present, and could be represented in the following quote:

> *[...] I didn't have a nipple, then I tried to take it with the pump. My mother taught me the massage to stimulate the nipple, but it failed. Well! I just tried, but I had no nipple and the baby was in the ICU for too much time and the milk has dried up. (Southern Cross)*

Thus, the companionship and social factors can be potentiated while empowering women in the process of breastfeeding, even in spite of the difficulties, as in this case, represented by the separation between mother and child.

The family and social support in breastfeeding

By the mothers' reports, it is clear that the support, both familiar and institutional, by health professionals, is of paramount importance for the success of breastfeeding. Care, both from the family

and the nurse, offers information about what to do and how to care for a premature newborn, how to feed him, ask questions about the capacity to nurture their children and ease their insecurities.

Given these considerations, the family cannot be seen merely as the one that must fulfill specific actions by health professionals. By recognizing the role of the family - taking responsibility for the health of its members - the health professional should consider the doubts, opinions and actions of the family nucleus in proposing their actions in health. It is known that the benefits of social support are most noticeable when they are offered by family and friends than with people outside the family nucleus[12].

The family is the unit of care to its members. This involves knowing how each family cares, and identify their strengths, their difficulties and their efforts to share responsibility[12]. The link between family and work is an important ally in the solidification of a new care model[11].

> *[...] I was very scared. Oh, I would come to the doctor, he explained it to me and then I could get the hang of it. It was really easy, but just after nine months, and my colleague was guiding and explaining it to me ... How to breastfeed not lying and put him sideways ... The other experiences with my first daughter. My mother in law and my husband would tell me it was cool to give her health and then I gave it, she was breastfed until 3 ½ years. (Antares)*
>
> *[...] What I know I learned from my mother and my breastfeeding friends, massaging the breast and to donate to the milk bank and I had no difficulty. (Columbia)*

It is noteworthy that, according to the profile of these women, it was found that 21 mothers were housewives, unemployed with no fixed income and half of them breastfed. However, among the other nine mothers (who worked) the majority of them (seven) breastfed their children. Based on this information, we perceived that, with the guidance of health professionals or support groups, the encouragement and presence of family members (partner, mother, mother in law, friends) positively influenced the process, as well as the desire of women to breastfeed, of course.

When we consider the relationship between mother's occupation and the act of breastfeeding, the data collected are in line with a study that used the scale on the breastfeeding self-efficacy. The work in question also concluded that there was any association between the activity performed by the mother and low time of exclusive breastfeeding[13].

In this process of knowledge of the family, the professional must have a vision of the relationship that the family holds with neighbors and relatives. The social support network, maintained by the family, it is evidenced, especially when families are going through a difficult time with their members or when

they are experiencing a situation of risk. The family care is enriched by the social relations formed by relatives, friends and neighbors. For families in crisis, and even in everyday family life, close and significant people develop an important role providing help in various situations.

Influences of culture and family experiences previous to breastfeeding

Previous experiences of the mother, grandfather, friends and those acquired in the maternity ward "child friendly", as from the interaction with health professionals, formed the so-called influences of cultural values. The research found its importance in the process of breastfeeding, as well as their modes of social and family lives.

All these cultural values potentiated in women the ability to provide the newborns with a good development of breastfeeding. This, however, has not always happened exclusively in the first six months, because of the difficulties and barriers that they have faced for being mothers of preterm infants. The failure of the majority was due to personal reasons and the conflict derived, in a way, from the desire to breastfeed, and in another way, from immaturity of the preterm infants, as well as with the complications they lived with since birth.

Madeleine Leininger has defined culture as values, beliefs, norms and lifestyles of a particular culture, learned, shared and transmitted, that guide thinking, decisions and actions, in a standardized way and often across generations[6], The statements reproduced here illustrate the theoretical categories supported by the author:

> *[...] I learned most things here at the hospital. He was the one who was hospitalized, but I would not leave here [...] in my family, out there with the children, there were days no one was willing to breastfeed either. I was the one that wanted to stay there up to six months only breastfeeding anyway, then they just wanted to give me food, but no one ever wanted me to breastfeed. When I went home, they just wanted me to force him to take soup, then I said: no, I'll keep him for 6 months only taking the breast. (Ursa Major)*

The discourse in their interviews also demonstrates that is to in the environment they live - where they share some information about breastfeeding - that women formulate their own ideas and values:

> *[...] I had cracks in the three, then put a banana peel, which my mother told me to and an ointment that the gynecologist recommended me, then that was it.(Antares)*

> *[...] My friend and my grandfather told me [...] do not let him burp on the breast or else the milk dries up. (Antari Alpha)*

Biological aspects and breastfeeding

Several aspects highlighted in the range of data collected were relevant to the research. We highlight, among them, maternal complications (ruptured membranes. preeclampsia, urinary tract infection), plane nipples and hypogalactia and prematurity of the newborn. All were analyzed as biological factors that interfered in the breastfeeding experience.

Therefore these biological factors cannot be detached from social and cultural dimensions. It should be taken into account, in this case, the fragility in the first hours of life of preterm infants, the permanence of long days of admission to neonatal care units for a long time and deficient suction due to immaturity. It is also worth noting that the bond of breastfeeding soon after birth is not established, most often because, initially, the PN receives power with the aid of probes and remains in incubator for many days.

Therefore, lactation is crucial in the early hours for these PNs, not only to enhance the sucking reflex, but for the nutritional and psychological support that breastfeeding provides both the baby and the postpartum woman in conditions of doing it.

It was also observed in the data collected, that the reasons for many days of hospitalization were for low birth weight (8) and respiratory failure (9), I mean, the lungs were still incomplete. Thus the length of hospitalization and use of technological resources required, in addition to prematurity, interfere and impair the healthy process of breastfeeding of these mothers and their newborns.

In addition to maternal complications and limitations of prematurity, explained in the reports, another important aspect within the neonatal care units, is the feeding of preterm infants in these units. This procedure requires great care due to gastric limitation of the PN when he is able to be fed. The mother's own milk is the most suitable because it contains in the initial four weeks, a high concentration of nitrogen, proteins with immunological function, lipids, fatty acids, vitamins A, D and E, calcium and energy when compared to the milk from mothers of term neonates. The newborn remains on alert for very short periods, but is capable of feeding at the breast, since the procedure is conducted with help and appropriate support.

> *[...] I didn't have nipples for him to pull, then he could not suck. Every day I would put to suck it, but even so he failed. My mother breastfed three children and was successful, because none was premature. (Veja)*

> *[...] He had difficulty at the suction [...] I tried to breastfeed, but he would not suck, nor could he drink it from the cup. (Polar)*

As to the gestational age, we perceived the interference of the biological factor of prematurity in the process of initiation of breastfeeding. In the period from 28 to 30 weeks of gestation, none of the women could breastfeed. The mothers claimed to have flat nipples, due to the long time of the preterm infants in the NICU, and they also mentioned insufficient lactation and sucking difficulties. Between 31 and 33 weeks of gestation, only one third of the universe surveyed managed to breastfeed. In the range of 34 to 36 weeks, all of them breastfed, and it is worth noting that at this gestational age, their children did not remain more than 20 days in the NICU and did not present serious problems of respiratory failure and suction.

In light of the data collected and presented, this study confirms a survey about the process of breastfeeding with mothers of hospitalized preterm infants[14]. The literature already existing on the subject, considers the different dimensions in nursing, and indicates that the path to be traced, by the services/health professionals, is that of (re)innovation of attitudes and practices, based on social context and the possibilities and individual limitations of mothers, as well as the clinical condition of the newborn.

FINAL CONSIDERATIONS AND IMPLICATIONS FOR NURSING

When identifying the dimensions of social and cultural structure as a set of factors that constitute the social structure of the women surveyed, we sought to understand the importance of the need to look at the mother-child with a more comprehensive and complex view. Thus, it is not only about studying and defining the reasons for success or failure of breastfeeding experience, their possibilities and limits. Therefore, our focus was to identify the main and relevant factors - through the testimony of the mothers of the preterm infants discharged from NICU - that interfere with the healthy process of breastfeeding.

We conclude that the social structure of these women has imposed some factors that affect breastfeeding experience, including the prolonged hospitalization of newborns undergoing invasive procedures and treatments necessary due to their prematurity. Another e We conclude that the social

structure of these women has imposed some factors that affect breastfeeding experience, including the prolonged hospitalization of newborns undergoing invasive procedures and treatments necessary due to their prematurity. Another evidence found was the set of biological dimension factors, both related to prematurity, and those related to maternal complications - which removed the preterm infants from the initiation of breastfeeding.

On the other hand, we found potential factors of breastfeeding in the same social context that involves, in part, the cultural values presented by the interviewees. They are, companionship and social interaction of these women, by their mothers, mothers in law, partner, health professionals and support groups (nurses, physicians, breastfeeding friends, milk bank, speech therapists and psychologists). As the experiences and information given by the mothers, friends and professionals from the hospital to mothers of preterm infants are also of paramount importance for encouraging the act of breastfeeding, according to testimonies. According to the interviewees, the support received gives them the confidence necessary to care for and feed their children when they saw them so frail and small.

This study examined not only the reason for the failure of the process of breastfeeding of these preterm infants discharged from NICU, but also the experiences of their mothers. It is worth noting that some social and cultural dimensions, whether religious, philosophical, political, legal, economic and educational, were not evidenced in this study. But as they are admittedly influenced by the standard of care and the lifestyle of people, and possibly of these women, these variables must be studied in further researches.

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