Ann Ist Super Sanità 2021 | Vol. 57, No. 2: 161-166
DOI: 10.4415/ANN_21_02_08

Breastfeeding promotion and support: a quality improvement study

Daniela Menichini[1], Francesca Zambri[2], Laura Govoni[3], Alba Ricchi[3], Ramona Infante[3], Elisabetta Palmieri[3], Maria Cristina Galli[4], Maria Teresa Molinazzi[3], Marisa Patrizia Messina[5], Angela Putignano[4], Federico Banchelli[6], Sofia Colaceci[7], Isabella Neri[3] and Angela Giusti[2]

[1]*Dipartimento di Scienze Biomediche, Metaboliche e Neurali, Università degli Study di Modena e Reggio Emilia, Modena, Italy*
[2]*Centro Nazionale per la Prevenzione delle Malattie e la Promozione della Salute, Istituto Superiore di Sanità, Rome, Italy*
[3]*Dipartimento di Scienze Mediche e Chirurgiche, Università di Modena e Reggio Emilia, Modena, Italy*
[4]*Dipartimento Materno Infantile, Università degli Studi di Modena e Reggio Emilia, Modena, Italy*
[5]*Dipartimento di Scienze Ginecologiche e Ostetriche, Sapienza Università di Roma, Rome, Italy*
[6]*Dipartimento di Diagnostica, Medicina Clinica e Sanitaria, Unità di Statistica, Università degli Studi di Modena e Reggio Emilia, Modena, Italy*
[7]*Saint Camillus International University of Health and Medical Sciences (UniCamillus), Rome, Italy*

Abstract

Background. Breastfeeding success is determined by early skin to skin contact, early initiation of breastfeeding, rooming-in, baby-led breastfeeding, creation of a favorable environment, specific training of health professionals, and continuity of care.

Objective. To investigate the women's satisfaction regarding the care and support received in the first days after childbirth.

Material and Methods. A questionnaire of 24 items was administered to mothers before discharge, from May to September 2019 at the University Hospital of Modena.

Results. The predictive variables of exclusive breastfeeding were the delivery mode, age at birth and parity. The multivariate analysis showed that a high satisfaction score was associated with vaginal birth (OR=2.63, p=0.005), rooming-in during the hospitalization (OR=8.64, p<0.001), the skin to skin contact (OR=6.61, p=0.001) and the first latch-on within 1 hour after birth (OR=3.00, p=0.02).

Conclusions. Mothers' satisfaction is one of the important factors of positive experience during hospital stay and of better health outcomes.

Key words

- exclusive breastfeeding
- breastfeeding promotion
- breastfeeding support
- mother's satisfaction

INTRODUCTION

Breastfeeding is the physiological protraction of the relationship created between mother and child during pregnancy, and it is an investment for life [1]. Breastfeeding and breast milk are the biological norm, the expression of a sophisticated evolutionary mechanism that combined the need for neurobiological, microbial, psychological, affective and emotional imprinting and infant's nutritional needs [2]. Furthermore, it is always ready, at "zero kilometer" at the right temperature, highly digestible and protects the newborn from many diseases and infections that occur more frequently in formula fed babies [3, 4]. The Italian National Prevention Plan [5] and the international Agencies as World Health Organization (WHO) and UNICEF, states that "the breastfeeding promotion and support are a public health priority" [6]. According to the international [7] and national [8] indications, it is recommended to breastfeed exclusively during the first 6 months and continue breastfeeding for two years or more, while providing adequate and safe complementary foods. There is a consensus on the need for increasing the global prevalence of exclusive breastfeeding in the first 6 months of a child's life by 2025, with positive impact on the individuals, the health system and the society [9, 6].

In order to effectively start and continue breastfeeding, mothers need facilitating environments "to make healthy choices easy" [10], including active support from families, communities and healthcare services during pregnancy and after childbirth [7]. Since 1991, WHO and UNICEF launched the "Baby-Friendly Hospitals Initiative", providing the "ten steps to successful

Address for correspondence: Francesca Zambri, Centro Nazionale per la Prevenzione delle Malattie e la Promozione della Salute, Istituto Superiore di Sanità, Via Giano della Bella 34, 00162 Rome, Italy. E-mail: francesca.zambri@iss.it.

breastfeeding" as evidence-based strategy to support healthcare service in policy and procedures implementation. WHO has called upon all facilities providing maternity and newborn services worldwide to implement the "Ten Steps" [11].

Several studies highlighted the determinants of breastfeeding success, like early skin to skin contact [12, 13], early initiation of breastfeeding [14], rooming-in [15], baby-led breastfeeding [16], favourable environment [17], appropriate information at discharge [18] specific training of health professionals [19], continuity of care [20].

In order to guarantee the continuity of care, during mother and newborn's discharge, breastfeeding outpatient services are accessible and available in several Italian Regions. The Emilia-Romagna Region recognizes the importance of breastfeeding as a public health priority. Therefore, to protect and support breastfeeding practice, since 2005 a set of regional policies and programs have been provided to support the implementation at hospital and community healthcare level [21, 22]. According to the regional indications, a specific breastfeeding promotion and support outpatient service was introduced in 2011 at the University Hospital of Modena.

The study aims to investigate the women's satisfaction regarding the care and support received in the first days after childbirth at the University Hospital of Modena, in order to highlight aspects that can affect pre-discharge exclusive breastfeeding.

MATERIALS AND METHODS

From May to September 2019 an observational descriptive study was carried out at the Maternity Unit of the University Hospital of Modena, organized according to midwifery led-care model. We included all mothers during discharge, regardless the type of newborn feeding.

An *ad hoc* questionnaire was created by integrating two different tools: the first was the World Alliance for Breastfeeding Action (WABA) questionnaire, translated into Italian by the Italian Maternal Breastfeeding Movement (MAMI) [23]; the second was designed within the Emilia-Romagna breastfeeding promotion strategy [24] with the aim of improving the quality of healthcare practices.

The questionnaire consisted of 24 items; the first section was designed to collect socio-demographic data (age, nationality, level of education), obstetric anamnesis (attendance to antenatal classes, parity, mode of birth, gestational age, breastfeeding in the first 24-48 hours of life and neonatal feeding at discharge). The second section investigated the perceived quality as outcome of good practices implemented by healthcare personnel.

The study protocol has been approved by the Health Department of the University Hospital of Modena. The questionnaire was administered to pre-discharge mothers by the midwife dedicated to post-natal care. The exclusion criteria were the non comprehension of the Italian language, as the questionnaire was provided in Italian.

The aims of the statistical analysis were to estimate the association between the characteristics of mothers, the mode of delivery, hospitalization variables considering as outcomes 1) exclusive breastfeeding and 2) satisfaction score.

Categorical variables were described as absolute and percentage frequencies, quantitative variables as mean ± standard deviation (SD) and 95% confidence interval (95% CI).

A multivariable logistic regression model was performed to evaluate the likelihood of exclusive breastfeeding and the satisfaction score. For the satisfaction a 1-4 items scale was used, where 1 represented "highly inadequate" and 4 "highly adequate". For the multivariable logistic regression, the mean satisfaction score was dichotomized as high satisfaction (mean score ≥3) and low satisfaction (mean score <3) to evaluate the likelihood of high satisfaction expressed as Odds Ratio (OR) and 95% CI.

RESULTS

The questionnaire was administered to 176 women; all women accepted to be enrolled. Out of these, 165 (93.7%) answered to all the questions and were, therefore, included in the analysis.

The description of maternal characteristics, delivery and hospitalization are reported in *Table 1*.

Most of the women included in the study aged between 26-35 years. The 92.1% of women resulted to be of Italian nationality, with a high education level (50.3% had a master degree) and attended birthing classes for the 69.1% of the sample.

Seventy-four women had a spontaneous delivery (44.8%), while 75 had an induced and/or operative delivery receiving also epidural analgesia (45.5%). The caesarean section rate was 9.7% (16 women).

The vast majority of newborns weighted between 2.5-3.9 kg at birth (89.7%) and were delivered at term. Only 5 women delivered before 36 weeks of gestational age (3.0%) *(Table 1)*.

As far as the characteristics of hospital stay, in the University Hospital of Modena, the rooming-in is guaranteed for all mothers and babies unless there are medical conditions that do not allow it. Indeed, the 88.5% of newborns stayed with their mothers for all the hospitalization.

The use of breast-pumps was necessary in 59 women (35.8%), a similar percentage was also found for the use of the formula (35.8%) in addition to or in place of breast milk, where not available; while low percentages of use of nipple shields (7.3%) and glucose solution (1.2%) were found.

Exclusive breastfeeding during the hospital stay was 59.4% among the included women. The satisfaction of the quality of care received, calculated using a rage from 1 to 4, averaged from 3.24± 0.54, and the high satisfaction (expressed as mean score ≥3) was found in 129 women (78.2%).

The associations between maternal characteristics, delivery mode and the likelihood of exclusive breastfeeding are reported in *Table 2*. We found that mothers aged 18 and 25 compared to those aged over 35 years,

Table 1
Mother characteristics, birth mode and hospital stay

		n=165	%
Characteristics of mother at birth			
Age	18-25	26	15.8%
	26-35	94	57.0%
	>35	45	27.3%
Italian nationality	yes	152	92.1%
Master degree	yes	83	50.3%
Attended a birthing class	yes	114	69.1%
Previous births	yes	47	28.5%
Characteristics of childbirth			
Birth modality	spontaneous	74	44.8%
	induced/analgesia/ operative	75	45.5%
	caesarean	16	9.7%
Birth weight	<2.5 kg	9	5.5%
	2.5-3.9 kg	148	89.7%
	≥4.0 kg	8	4.8%
Gestational age	≤36 weeks	5	3.0%
	>36 weeks	160	97.0%
Characteristics of hospital stay			
Rooming-in	yes	146	88.5%
Breast-pump	yes	59	35.8%
Nipple shields	yes	12	7.3%
Formula	yes	59	35.8%
Glucose solution	yes	2	1.2%
Exclusive breastfeeding at discharge	yes	98	59.4%
Skin to skin	yes	149	90.3%
First latch-on after birth	none after more than 1 hour within 1 hour within 30 minutes	4 16 50 95	2.4% 9.7% 30.3% 57.6%
Mean satisfaction score	1-4	3.25 ± 0.54	
High satisfaction	≥3	129	78.2%

were more likely to breastfeed exclusively (OR=5.87, p<0.001). Furthermore, mothers who had already given birth were more likely to breastfeed exclusively (OR=4.23, p=0.005). Likewise, women delivering vaginally, when compared to those undergoing to operative or caesarean delivery were more likely to have an exclusive breastfeeding (OR=1.22, p=0.03). To worth noting that exclusive breastfeeding resulted strongly associated with the rooming-in, the skin to skin practice and a first latch-on within 1 hour after birth, as well as having received a practical support by midwives to breastfeed during the hospital stay.

The associations between maternal characteristics, delivery mode, hospital stay and satisfaction score are reported in *Table 3*.

Table 2
Association between maternal and childbirth characteristics and the likelihood of exclusive breastfeeding

		OR	95% CI	p-value
Maternal age	18-25 *vs* >35	5.87	2.43-14.16	**<0.001**
Master degree	yes *vs* no	0.66	0.37-1.20	0.18
Attended a birthing class	yes *vs* no	1.33	0.51-3.45	0.55
Previous births	yes *vs* no	4.23	1.56-11.51	**0.005**
Vaginal birth	yes vs no	1.22	1.0-2.1	**0.03**
Gestational age at birth	≥37 *vs* <37	1.12	0.87-1.43	0.34
Birth weight 2.5-3.9 kg	yes *vs* no	2.51	0.89-7.02	0.08
Rooming-in	yes *vs* no	13.67	3.76-20.62	**0.002**
Skin to skin	yes *vs* no	15.8	3.7-30.5	**0.009**
First latch-on within 1 hour	yes *vs* no	3.93	1.42-10.83	**0.008**
Received practical support by midwives	yes *vs* no	21.76	6.81-35.63	**p<0.001**

Table 3
Association between maternal and childbirth characteristics and a high satisfaction score

		OR	95% CI	p-value
Maternal age	18-25 *vs* >35	1.02	0.92-1.17	0.35
Master degree	yes *vs* no	0.87	0.53-1.42	0.59
Attended a birthing class	yes *vs* no	2.28	1.08-4.77	**0.03**
Previous births	yes *vs* no	0.72	0.21-2.36	0.58
Vaginal birth	yes *vs* no	2.63	1.02-7.02	**0.05**
Gestational age at birth	≥ 37 *vs* < 37	1.43	0.96-2.13	0.07
Rooming-in	yes *vs* no	8.64	3.92-20.63	**p<0.001**
Skin to skin	yes *vs* no	6.61	2.22-19.63	**0.001**
First latch-on within 1 hour	yes *vs* no	3.00	1.14-7.90	**0.02**
Breast-pump	yes *vs* no	0.14	0.06-0.31	**p<0.001**
Formula	yes vs no	0.10	0.04-0.23	**p<0.001**
Glucose solution	yes *vs* no	0.31	0.01-5.14	0.41

The multivariable analysis showed that women who attended birthing classes are more likely to have a high satisfaction score (OR=2.28, p=0.03), likewise, women who had a vaginal birth (OR=2.63, p=0.005) instead of an operative or caesarean delivery. Moreover, rooming-in during the hospitalization (OR=8.64, p <0.001), the skin to skin contact (OR=6.61, p = 0.001) and the first latch-on within 1 hour after birth (OR=3.00, p=0.02) were associated with a high satisfaction. Conversely,

mothers who were asked to consider using breast pumps (OR=0.14, p<0.001), and the integration with infant formula (OR=0.09, p<0.001), were less likely to have high satisfaction.

DISCUSSION

Our study explored the mother's perception of cares during hospital stay, showing overall a high satisfaction rate, in the first days after childbirth. Satisfaction is a multi-dimensional concept affected by several factors such as personal features, values and expectations [25]. Patient satisfaction during childbirth is one of the main outcomes frequently used for measuring the quality of care in health institutions affecting mother's satisfaction [26, 27]. In our results, this aspect is positively associated with the attendance of antenatal classes, vaginal birth, rooming-in, skin to skin contact and the first latch-on within 1 hour after birth. Most of these findings are in line with a study, which investigated maternal satisfaction regarding care during delivery [28]. The attendance to antenatal classes represents the first step for a positive birth experience and, moreover, improves women's awareness and empowerment [29]. A study which evaluated the effects of the antenatal classes on mothers' and babies' health and women's satisfaction, found that women attending courses were more satisfied with the experience of childbirth and had better health outcomes [30].

Another aspect emerged in our study is that women who had vaginal birth are more likely to be satisfied. These findings are consistent with other studies [31-34]. In this context, the father plays a key role in the delivery-room and, therefore, it is necessary also to consider the fathers' birth satisfaction and their role as a future parent and not only as the mother's partner [35, 36]. Bélanger-Lévesque *et al*. showed that mothers consider themselves more prepared and more supported during childbirth than fathers, and these ones were less satisfied with quality of care provision, their baby's health and the mother's health [37].

Our women seemed to be more satisfied with rooming-in during hospitalization. This result is in line with another Italian study on mother's views about rooming-in, showing that women were satisfied with rooming-in offered by the hospital, despite several difficulties with baby's management [38]. For this purpose, a continuous support and help from health professionals is important to create a positive rooming-in experience for postpartum mothers. Likewise, skin to skin contact reached the same results. In fact, it was positively associated with a high satisfaction score as also found in other studies [39, 40]. Research suggests that this aspect is also confirmed after caesarean section [41] and the association between skin to skin and birth satisfaction is especially strong for women who had operative births [42]. The high maternal satisfaction following skin to skin contact underlines the importance of increasing this practice, in addition to all others the health benefits [43, 44]. This approach is included in the framework of "Zero Separation" according to which keeping mother-baby together from birth, protects physiological and neurophysiological processes for both, and guarantees successful breastfeeding [45].

We found that women who were advised to use a breast pump or those who used the integration with infant formula were less satisfied. We may speculate that the use of mechanical support, as breast pump, make the mother feel inadequate, reducing her confidence in her body and ability to breastfeed. This is supported by research on breastfeeding self-efficacy perception, which is strongly associated to maternal breastfeeding satisfaction [46]. As for formula feeding, several qualitative and quantitative studies reported negative emotions experienced by mothers using breast milk substitutes [47-49]. As secondary outcome, our results reported a high prevalence of exclusive breastfeeding of the women included in the study and its association with best practices and receiving a practical support by midwives.

As confirmed by our study, decision makers and clinicians should invest in breastfeeding promotion and support programs, including good practices during pregnancy and childbirth, in order to improve maternal satisfaction, as provided by the Emilia Romagna Region policies [20]. It is known that the absence of support for breastfeeding in the workplace, the advertising of formula, and lack of knowledge of the women, partners, family members, healthcare providers and policy makers contribute to low rate of exclusive breastfeeding [6]. Thus, our organizational model [22], documented in literature [50] and based on "dedicated" personnel to support breastfeeding [51], was effective in promoting mothers' satisfaction and breastfeeding rates.

Among the limitations of this study, we acknowledge the reduced number of questionnaires, which is related to the fact that the 40% of women who give birth at the university hospital are foreigners, with a level of linguistic competence not compliant with the research. This certainly has an impact on the generalizability of our results. In order to offer an overview of the foreign population, we suggest a broader study using a questionnaire translated into multiple languages and with support of cultural mediators, in order to break down language barriers.

CONCLUSIONS

Mothers' satisfaction is one of the most important factors for a positive experience during hospital stay and for better health outcomes. Improving quality of care is fundamental to achieve Universal Health Coverage by 2030 [52]. Our results are in line with Academy of Breastfeeding Medicine protocol [53], which recommends, among other things, the skin to skin contact, rooming-in, support to breastfeeding, the non-use of formula feed, physiological labour and birth, and the non-use of artificial nipples. Furthermore, our organizational model ensured maternal satisfaction and good practices. To increase the number of mothers who received a satisfactory delivery provision of care, contributes to enhance the use of the services, especially for hard-to-reach women. It is, therefore, advisable to invest in pre-service and in-service training of dedicated personnel and guarantee one-to-one organizational models of care.

Acknowledgments

Authors would like to thank all women who gave their availability and participated to the survey, as reported in the present study.

Author contribution statement

All Authors participated in the interpretation of the study results and approved the final manuscript as submitted and they agree to be accountable for all aspects of the work.

Conflict of interest statement

Authors have no conflicts of interest. Authors have no financial relationships relevant to this article. This research received no grant from any funding agency in the public and private sectors for the research, authorship, and/or publication of this article.

Received on 24 March 2021.
Accepted on 22 April 2021.

REFERENCES

1. Ministero della Salute. Allattare al seno. Un investimento per la vita. Ministero della Salute; 2019. Available from: www.salute.gov.it/.
2. Giusti A. Allattamento: salute, prevenzione e biosostenibilità. Epidemiol Prev. 2015;39(5-6):386-91.
3. Diouf JS, Ngom PI, Badiane A, Cisse B, Ndoye C, Diop-Ba K, Diagne F. Influence of the mode of nutritive and non-nutritive sucking on the dimensions of primary dental arches. Int Orthod. 2010;8(4):372-85. doi: 10.1016/j.ortho.2010.10.001
4. Di Mario S, Gagliotti C, Donatini A, Battaglia S, Buttazzi R, Balduzzi S, Borsari S, Basevi V, Barbieri L, Regional breastfeeding monitoring group. Formula feeding increases the risk of antibiotic prescriptions in children up to 2 years: results from a cohort study. Eur J Pediatr. 2019;178(12):1867-74. doi: 10.1007/s00431-019-03462-0
5. Ministero della Salute. Piano Nazionale della Prevenzione 2020-2025. Ministero della Salute; 2020. Available from: www.salute.gov.it.
6. World Health Organization, UNICEF. Global nutrition targets 2025: breastfeeding policy brief (WHO/NMH/NHD/14.7). Geneva: World Health Organization; 2014.
7. World Health Organization. Guideline: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services. Geneva: World Health Organization; 2017.
8. Italia. Decreto del Presidente del Consiglio dei Ministri 12 gennaio 2017. Definizione e aggiornamento dei livelli essenziali di assistenza, di cui all'articolo 1, comma 7, del decreto legislativo 30 dicembre 1992, n. 502. (17A02015). Gazzetta Ufficiale Serie Generale n. 65 del 18-03-2017 (Suppl. Ordinario n. 15).
9. World Health Organization and the United Nations Children's Fund. Global breastfeeding scorecard 2018: Enabling women to breastfeed through better policies and programmes. WHO/UNICEF; 2018.
10. World Health Organization. Gaining health: the European strategy for the prevention and control of noncommunicable diseases. Copenhagen: WHO Regional Office for Europe; 2006.
11. World Health Organization and the United Nations Children's Fund. Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services: implementing the revised Baby-friendly Hospital Initiative 2018. Geneva: WHO/UNICEF; 2018.
12. Cinquetti M, Colombari AM, Battisti E, Marchetti P, Piacentini G. The influence of type of delivery, skin-to-skin contact and maternal nationality on breastfeeding rates at hospital discharge in a baby-friendly hospital in Italy. Pediatr Med Chir. 2019;41(1). doi: 10.4081/pmc.2019.207
13. Dueñas-Espín I, León Cáceres Á, Álava A, Ayala J, Figueroa K, Loor V, Loor W, Menéndez M, Menéndez D, Moreira E, Segovia R, Vinces J. Breastfeeding education, early skin-to-skin contact and other strong determinants of exclusive breastfeeding in an urban population: a prospective study. BMJ Open. 2021;11(3):e041625. doi: 10.1136/bmjopen-2020-041625
14. World Health Organization and the United Nations Children's Fund. Capture the moment - Early initiation of breastfeeding: the best start for every newborn. WHO/UNICEF; 2018.
15. Jaafar SH, Ho JJ, Lee KS. Rooming-in for new mother and infant versus separate care for increasing the duration of breastfeeding. Cochrane Database Syst Rev. 2016;(8):CD006641. doi: 10.1002/14651858.CD006641.pub3
16. Fallon A, Van der Putten D, Dring C, Moylett EH, Fealy G, Devane D. Baby-led compared with scheduled (or mixed) breastfeeding for successful breastfeeding. Cochrane Database Syst Rev. 2016;9(9):CD009067. doi: 10.1002/14651858.CD009067.pub3
17. World Health Organization and the United Nations Children's Fund. Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative. Geneva: World Health Organization; 2018.
18. Colaceci S, Chapin EM, Zambri F, Reali L, Cedrone L, Del Brocco A, Masi M, Mohamed A, Dellafiore F, Nichinonni S, Giusti A. Verba volant, scripta manent: breastfeeding information and health messages provided to parents in the neonatal discharge summary in the Lazio Region, Italy. Ann Ist Super Sanità. 2020;56(2):142-9. doi: 10.4415/ANN_20_02_03
19. Balogun OO, Dagvadorj A, Yourkavitch J, da Silva Lopes K, Suto M, Takemoto Y, Mori R, Rayco-Solon P, Ota E. Health facility staff training for improving breastfeeding outcome: A systematic review for step 2 of the baby-friendly hospital initiative. Breastfeed Med. 2017;12(9):537-46. doi: 10.1089/bfm.2017.0040
20. Ministero della Salute. Tavolo tecnico operativo interdisciplinare per la promozione dell'allattamento al seno (TAS). Ministero della Salute; 2019. Available from: www.salute.gov.it.
21. Dallacasa P, Baronciani D. Allattamento al seno. Strumenti per facilitare il cambiamento delle pratiche assistenziale. Bologna: Regione Emilia-Romagna; 2005. Available from: www.saperidoc.it/flex/cm/pages/ServeBLOB.php/L/IT/IDPagina/455.
22. Italia. Deliberazione di Giunta Regionale n. 533 del 21 aprile 2008: Direttiva alle Aziende Sanitarie in merito al programma percorso nascita. Regione Emilia-Romagna; 2008.
23. Movimento Allattamento Materno Italiano. Questionario

MAMI sull'assistenza ospedaliera. Available from: https://d2qoapb3mdmmc9.cloudfront.net/mami-quest05.pdf.
24. Servizio Sanitario Regionale Emilia-Romagna. Centro di Documentazione sulla Salute Perinatale e Riproduttiva. Allattamento. Un programma per studi locali. Questionario analisi quantitativa. Available from: www.saperidoc.it/flex/cm/pages/ServeBLOB.php/L/IT/IDPagina/395.
25. Waldenström U, Rudman A, Hildingsson I. Intrapartum and postpartum care in Sweden: women's opinions and risk factors for not being satisfied. Acta Obstet Gynecol Scand. 2006;85(5):551-60. doi: 10.1080/00016340500345378
26. Goodman P, Mackey MC, Tavakoli AS. Factors related to childbirth satisfaction. J Adv Nurs. 2004;46(2):212-9. doi: 10.1111/j.1365-2648.2003.02981.x
27. Anderson G, Zega M, D'Agostino F, Rega ML, Colaceci S, Damiani G, Alvaro R, Cocchieri A. Meta-synthesis of the needs of women cared for by midwives during childbirth in hospitals. J Obstet Gynecol Neonatal Nurs. 2021;50(1):6-19. doi: 10.1016/j.jogn.2020.10.005
28. Colaceci S, Corsi E, Berardi F, Coscarella P, Mariotti M, Ramacciati N. Soddisfazione materna ed evento nascita: una web-based survey. Prof Inferm. 2020;73(3):181-7. doi: 10.7429/pi.2020.733181
29. Prata N, Tavrow P, Upadhyay U. Women's empowerment related to pregnancy and childbirth: introduction to special issue. BMC Pregnancy Childbirth. 2017;17(Suppl. 2):352. doi: 10.1186/s12884-017-1490-6
30. Spinelli A, Baglio G, Donati S, Grandolfo ME, Osborn J. Do antenatal classes benefit the mother and her baby? J Matern Fetal Neonatal Med. 2003;13(2):94-101. doi: 10.1080/jmf.13.2.94.101
31. Falk M, Nelson M, Blomberg M. The impact of obstetric interventions and complications on women's satisfaction with childbirth a population based cohort study including 16,000 women. BMC Pregnancy Childbirth. 2019;19(1):494. doi: 10.1186/s12884-019-2633-8
32. Floris L, Irion O, Courvoisier D. Influence of obstetrical events on satisfaction and anxiety during childbirth: a prospective longitudinal study. Psychol Health Med. 2017;22(8):969-77. doi: 10.1080/13548506.2016.1258480
33. Guittier MJ, Cedraschi C, Jamei N, Boulvain M, Guillemin F. Impact of mode of delivery on the birth experience in first-time mothers: a qualitative study. BMC Pregnancy Childbirth. 2014;14:254. doi: 10.1186/1471-2393-14-254
34. Rijnders M, Baston H, Schönbeck Y, van der Pal K, Prins M, Green J, Buitendijk S. Perinatal factors related to negative or positive recall of birth experience in women 3 years postpartum in the Netherlands. Birth. 2008;35(2):107-16. doi: 10.1111/j.1523-536X.2008.00223.x
35. Vehviläinen-Julkunen K, Liukkonen A. Fathers' experiences of childbirth. Midwifery. 1998;14(1):10-7. doi: 10.1016/s0266-6138(98)90109-7
36. Chalmers B, Meyer D. What men say about pregnancy, birth and parenthood. J Psychosom Obstet Gynaecol. 1996;17(1):47-52. doi: 10.3109/01674829609025663
37. Bélanger-Lévesque MN, Pasquier M, Roy-Matton N, Blouin S, Pasquier JC. Maternal and paternal satisfaction in the delivery room: a cross-sectional comparative study. BMJ Open. 2014;4(2):e004013. doi: 10.1136/bmjopen-2013-004013
38. Cuttini M, Del Santo M, Kaldor K, Pavan C, Rizzian C, Tonchella C. Rooming-in, breastfeeding and mothers' satisfaction in an Italian nursery. J Reprod Infant Psychol. 1995;13(1):41-6. doi: doi.org/10.1080/02646839508403230
39. Brubaker LH, Paul IM, Repke JT, Kjerulff KH. Early maternal-newborn contact and positive birth experience. Birth. 2019;46(1):42-50. doi: 10.1111/birt.12378
40. Ghanbari-Homayi S, Fardiazar Z, Mohammad-Alizadeh-Charandabi S, Meedya S, Asghari Jafarabadi M, Mohammadi E, Mirghafourvand M. Skin-to-skin contact, early initiation of breastfeeding and childbirth experience in first time mothers: a cross sectional study. J Neonatal Nurs. 2020;26(2):115-9. doi: doi.org/10.1016/j.jnn.2019.08.003
41. 41 Jabraeili M, Seyedrasouli A, Kheiri Z, Sadeghi-Bazrgani H, Jannatdoost A. Impact of skin-to-skin care on satisfaction and experience of cesarean mothers: A randomized, double-blinded clinical trial. Ann Trop Med PH. 2017;10(6):1756. doi: 10.4103/ATMPH.ATMPH_642_17
42. 42 Kahalon R, Preis H, Benyamini Y. Who benefits most from skin-to-skin mother-infant contact after birth? Survey findings on skin-to-skin and birth satisfaction by mode of birth. Midwifery. 2021;92:102862. doi: 10.1016/j.midw.2020.102862
43. Safari K, Saeed AA, Hasan SS, Moghaddam-Banaem L. The effect of mother and newborn early skin-to-skin contact on initiation of breastfeeding, newborn temperature and duration of third stage of labor. Int Breastfeed J. 2018;13:32. doi: 10.1186/s13006-018-0174-9
44. Moore ER, Bergman N, Anderson GC, Medley N. Early skin-to-skin contact for mothers and their healthy newborn infants. Cochrane Database Syst Rev. 2016;11(11):CD003519. doi: 10.1002/14651858.CD003519.pub4
45. Bergman NJ. The neuroscience of birth and the case for Zero Separation. Curationis. 2014;37(2):e1-e4. doi: 10.4102/curationis.v37i2.1440. PMID: 25685896
46. Awaliyah SN, Rachmawati IN, Rahmah H. Breastfeeding self-efficacy as a dominant factor affecting maternal breastfeeding satisfaction. BMC Nurs. 2019;18(Suppl. 1):30. doi: 10.1186/s12912-019-0359-6
47. Fallon V, Komninou S, Bennett KM, Halford JCG, Harrold JA. The emotional and practical experiences of formula-feeding mothers. Matern Child Nutr. 2017;13(4):e12392. doi: 10.1111/mcn.12392
48. Bailey C, Pain RH, Aarvold JE. A 'give it a go' breastfeeding culture and early cessation among low-income mothers. Midwifery. 2004;20(3):240-50. doi: 10.1016/j.midw.2003.12.003
49. Cloherty M, Alexander J, Holloway I. Supplementing breast-fed babies in the UK to protect their mothers from tiredness or distress. Midwifery. 2004;20(2):194-204. doi: 10.1016/j.midw.2003.09.002
50. Ricchi A, Rossi F, Borgognoni P, Bassi MC, Artioli G, Foa C, Neri I. The midwifery-led care model: a continuity of care model in the birth path. Acta Biomed. 2019;90(6-S):41-52. doi: 10.23750/abm.v90i6-S.8621
51. Bettinelli ME, Chapin EM, Cattaneo A. Establishing the Baby-Friendly Community Initiative in Italy: development, strategy, and implementation. J Hum Lact. 2012;28(3):297-303. doi: 10.1177/0890334412447994
52. World Health Organization: Standards for improving quality of maternal and newborn care in health facilities. WHO; 2016. Available from: www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/.
53. Hernández-Aguilar MT, Bartick M, Schreck P, Harrel C. Academy of Breastfeeding Medicine. ABM Clinical Protocol #7: Model maternity policy supportive of breastfeeding. Breastfeed Med. 2018;13(9):559-74. doi: 10.1089/bfm.2018.29110.mha