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Determinants of the Breastfeeding Pattern Among Working Women in São Paulo

Marina Ferreira Rea, MD, PhD, Sonia Isoyama Venâncio, MD, MPH, Luis Eduardo Batista, MS, and Ted Greiner, PhD

Abstract

The needs of breastfeeding women who work away from home differ from those of other women, particularly those who breastfeed exclusively. Sixty-nine factory workers were interviewed in São Paulo, both during pregnancy and when they returned to work. Median durations of exclusive (EBF), predominant (PBF), and any breastfeeding (BF) were found to be 10 days, 70 days, and 150 days, respectively. Despite having used the 4-month leave to which they were entitled, by 1 month, 86% of the respondents had given tea, 50% water, and 42% artificial baby milk. Only 2 women were still exclusively breastfeeding when they returned to work. Various personal characteristics were associated with longer duration of breastfeeding. Maternity ward routines were generally not supportive, but duration of PBF was longer where better support was received. Duration of EBF was longer among women with support for breastfeeding at work, and shorter for those working on weekends or doing shift work. Thus, women may have adjusted their feeding patterns based on whether or not they anticipated workplace support. Only weekend work and socioeconomic status were linked to shorter duration of breastfeeding. Stronger social and health care support for EBF may be needed before the full impact of workplace support can be usefully studied in Brazil. *J Hum Lact* 1999; 15:233–239.

Keywords: breastfeeding, working women, day care, Brazil, health care services, socioeconomic determinants

Introduction

A number of studies of breastfeeding show that early supplementation and cessation of breastfeeding continue to be common in Brazil.¹ A national survey conducted in 1996 indicated that although 93% of Brazilian women initiated breastfeeding, the median duration for any

breastfeeding (BF) was only 7 months and for exclusive breastfeeding (EBF) it was 1 month.

Compared with other Latin American countries,² the breastfeeding rate is low in Brazil, despite efforts to raise it by a variety of measures coordinated since 1980 by the Ministry of Health,³ including an improvement in maternity legislation. Various surveys show that gains were small and not sustained when pro-breastfeeding activities were discontinued.⁴

It is commonly believed that women's work outside the home is a major factor affecting breastfeeding patterns. In an extensive review of the literature, however, Van Esterik and Greiner⁵ suggested that formal employment outside the home usually has little effect on the initiation or duration of BF. Exceptions may include informal workers (eg, street sellers, house cleaners) with no maternity benefits, and situations in which there is virtually no legally mandated paid maternity leave even for formally employed workers, as in the USA. Van Esterik and Greiner left open the question of whether work might reduce the age of initiation of artificial feeding and did not address the potential impact of work on

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EBF. Rea and Cukier⁶ used in-depth interviews, giving respondents a chance to interact with the interviewer, empathize, and think about themselves as mothers and as working citizens. Their results suggested that paid work may have some impact on the duration of breastfeeding that does not show up in the kind of cross-sectional surveys that most investigators use.

It is now widely agreed that babies should be exclusively breastfed from birth until around 6 months of age.⁷ One controlled study suggested that there is no advantage in introducing solids before 6 months.^{8,9}

Such long periods of EBF may be difficult for women to achieve unless they receive greater support from employers, family, friends, indeed from social norms in general, as well as from health care professionals and lactation specialists when needed. For formally working women, we question the notion that the availability of maternity entitlements (employment guarantees, paid maternity leave, day-care centers and breastfeeding breaks) alone is sufficient to ensure that EBF can be practiced. For example, although nearly all mothers of young children work in Sweden, breastfeeding patterns over the past 50 years changed in ways that were unrelated to increased duration of maternity leave or increases in the pay received during these leaves.¹⁰ On the other hand, breastfeeding rates in Sweden have increased much more during the past 20 years than in the USA, where hardly any maternity entitlements have been legally mandated. Thus, it would seem likely that maternity entitlements, while not sufficient, may be necessary, at least for the achievement of long periods of EBF, among formally working mothers once other constraints are overcome.

Most women who work in Brazil do so informally, though many work in industrial production, especially in São Paulo. According to the 1970 census, Brazil's economically active population included only 20.7% of the country's women, but this rose to 40.4% in the 1990 census. Thus, more and more women are having to reconcile the roles of mother and worker. It has long been widely assumed that one reason for early supplementation in urban areas in Brazil is mother-infant separation when the mother returns to work outside the home, a situation worsened in large cities by long distances to the workplace and poor public transportation facilities.

The enactment of a new constitution for Brazil in 1988 led to improvements in maternity entitlements for formally employed women. Paid leave increased from 84 days to 120 days, paid paternity leave of 5 days was instituted, 2 paid breastfeeding breaks per 8-hour work-

ing period were offered, and the right to day-care centers was guaranteed (although the age of the child and the distance from the workplace have not yet been clarified).

The present study examines the breastfeeding patterns of women working under such a relatively beneficial system of maternity entitlements. It focuses on women formally employed fulltime in processing industries in the São Paulo metropolitan area, with legally guaranteed maternity entitlements, although access to day-care centers may not be rigorously implemented. The relationships between breastfeeding patterns and various types of workplace support, as well as other factors thought to affect breastfeeding rates, are examined.

Methods

Field Procedures

A list was made of the companies in the southern zone of the Municipality of São Paulo (SP) that were known to employ women. The companies were contacted by phone, the study was explained to them, and they were asked if they would be interested in participating. Most did not want to participate, some making statements such as, "If you belong to the health system, you are going to discover some irregularities such as unhealthy conditions for pregnant women" (which could lead to a heavy fine). Those companies that chose to participate were thus likely to be supportive of their women employees and not representative of all who employ women in São Paulo. Anonymity was guaranteed to both companies and individual respondents.

Out of the 81 companies contacted, 13 agreed to participate in the study, of which: 4 offered day-care facilities at the workplace; 3 offered day-care facilities outside the workplace; 1 offered facilities for collection and storage of breast milk; and 5 offered none of the above facilities. (Of these, 1 declared its intention to set up a breast milk collection facility.)

The companies were asked to prepare a list of pregnant employees. Interviews were conducted with all of the 76 employed women who were in the final 3 months of pregnancy and who provided their informed consent for participation in the study. The interview, with 10% of the questions being open, was designed to describe the women's social and demographic conditions and work skills, their families' financial and housing situation, health care provisions, and their past breastfeeding experience.

On returning to work following their maternity leave,

69 of the respondents were reinterviewed. Six of the others had been dismissed. (We do not know why, as contact with them was lost.) One woman declined the reinterview. This second interview was conducted with a semistructured questionnaire, asking about infant-feeding practices retrospectively from birth. Each liquid or food was asked about separately. The breastfeeding definitions used in this paper follow Labbok and Krasovec's recommendations.¹¹ Four female interviewers conducted the first interview, but only 1 of them remained to conduct the reinterview. They were selected among interested health workers of the health district, living in the same neighborhood as the factories. They were trained by one of the researchers (MFR) and the field supervisor. All questionnaires were reviewed in the field. Any problems were discussed and agreed upon with the principle investigator (MFR) in weekly meetings. The field supervisor repeated 10% of both first and second interviews to verify accuracy.

Analytical Procedures

By the time of the reinterview, nearly all women had given some solids and/or infant formula. Associations between EBF and PBF and other variables (socioeconomic status, relevant aspects of health care service delivery, various personal characteristics of the respondents, and labor conditions) could thus be analyzed using the Kruskal-Wallis test in EPIINFO 5.0.

For BF, we did not know the duration for about 40% of the sample who were still breastfeeding when the study ended. Therefore, the proportion breastfeeding at different ages and the median duration were estimated using the survival (life-table) technique with right censoring for BF. To examine determinants of BF, we used the Kaplan-Meier test, a nonparametric test that makes comparisons between 2 or more survival curves. After determining which variables were most significantly associated with breastfeeding, we used the Cox model of proportional risks for multivariate analysis, a stepwise procedure of forward selection.

In several cases, it was difficult to find one particular variable to operationalize a specific characteristic or phenomenon. In these cases, a group of variables was chosen, all of which hypothetically measured to some extent the characteristic in question, and these were added together to form a so-called linear summated composite index. This is based on the "Domain-Sampling Model" of index construction, which is outlined in Nunnally.¹² Variables were selected according to which yielded the largest reliability.

Coefficient, r_{kk} , based on the following equation:

$$r_{kk} = \frac{kr_{kk}}{1 + (k-1) r_{ij}}$$

where k is the number of variables in the index and r_{ij} is the average correlation of the variables. The value of r_{kk} can vary from 0 to 1 and the higher its value, the more reliable the index.

The following indices were created for use in the Cox model of proportional risks:

(1) Socioeconomic status (SES): salary, having a maid, having a car, blue-collar versus white-collar position in the factory, mother's years of schooling and father's years of schooling ($r_{kk} = .90$).

(2) Health services index (HS): mother touching the baby in the delivery room, professional orientation received at the maternity unit, type of orientation given, time of first feeding, whether breasts were examined at the maternity unit, and women's opinion as to whether or not the maternity unit facilitated breastfeeding ($r_{kk} = .73$).

(3) Personal characteristics index (PC): whether the woman was feeling prepared to breastfeed, how she experienced the first days after the childbirth, whether she expressed an intention to give other milk at the prenatal interview, the father's attitude toward breastfeeding, whether she experienced excessive stress before childbirth, whether she had positive expectations about breastfeeding, whether she had previous positive experiences with breastfeeding, how she perceived the baby's attitude toward breastfeeding, and whether she was under excessive stress after childbirth ($r_{kk} = .63$).

For all analyses, we adopted the 0.05 level of significance, but the small sample size increased the risk that some of our findings may be false negatives (ie, some truly significant associations appear not to be so because of low statistical power).

Results

Profiles of the Women

The respondents were 28 years old on average; 70% were white, 27% mulatto and 3% black; 95% were married, 57% had 1 child and 40% had 2. Sixty percent had completed elementary schooling, 32% high school, and 8% were college graduates; 10% were studying at the time of the study. Most were unskilled workers and their mean monthly wage was US\$452. They worked in the following industries: 24% food, 26% cosmetics, 11% pharmaceuticals, 35% metallurgy, and 4% garments. About 70% of the women worked on production lines and 30% in administration and general services. All de-

clared their intention to breastfeed their children after birth.

Feeding Patterns

Of the 69 women reinterviewed, 97% (all but 2) initiated breastfeeding. They returned to work an average of 4.5 months after giving birth. At this time, 55% were still breastfeeding, but 87% had introduced artificial milk. When the second interview was held, on average at 5.5 months after birth, 44% of the women were still breastfeeding, but only 2 (3%) were still practicing EBF.

Rates of EBF, PBF, and BF are plotted in Figure 1. EBF declined abruptly during the first 2 weeks after birth. The probability that a baby will be breastfed without receiving water, tea, or other foods for the first 2 weeks of life was estimated to be 38%, falling to 17% by the end of the second month. From Figure 1 it can be estimated that the median duration of EBF was around 10 days and that for PBF about 70 days. BF, defined as nursing at least once a day, was still practiced by 94% of the workers at 15 days, 60% at 4 months, and 40% at 6 months. The median duration was around 150 days. By the end of the first month of life, 86% of the babies had received tea, 50% water, and 42% artificial baby milk. None introduced semisolid food (soup or cereal pap) before 2 months of age, but 18% had done so by 3 months.

Determinants of Breastfeeding

Exclusive breastfeeding. The duration of EBF was found to be significantly associated with the following socioeconomic variables: occupation of the mother, presence of a maid in the household, and delivery in a pri-

vate room versus a public ward at the maternity hospital. In all cases, categories indicative of a higher standard of living corresponded with longer breastfeeding duration. The *p* values for these associations are given in Table 1. Women with more than 8 years of formal schooling tended to breastfeed exclusively 3 times longer than those who had less education, though this difference was only marginally statistically significant (average of 32 days vs. 11 days; *p*=0.06).

Associations between variables related to working conditions and breastfeeding are presented in Table 2. Among the 42% who had access to and utilized day care or facilities for breast milk extraction, the mean duration of EBF was 31 days, compared to 12 days for those who had access to neither. Doing shift work or being unable to change shifts (81% could do so) was associated with less EBF (a mean of 23 days compared to 8 days among those who worked fixed shifts).

Table 1. Duration (means $\pm$ standard deviation) of exclusive breastfeeding (EBF) and predominant breastfeeding (PBF) related to socioeconomic variables.

Variable	Categories	EBF	PBF
Mother's schooling	<8 yrs (n=41)	11 $\pm$ 16	44 $\pm$ 31
	>8 yrs (n=28)	32 $\pm$ 38	60 $\pm$ 38
Mothers' occupation	production line (n=50)	14 $\pm$ 20*	43 $\pm$ 20*
	service & admin (n=19)	37 $\pm$ 41	70 $\pm$ 36
Husbands' occupation	unskilled (n=45)	14 $\pm$ 19	43 $\pm$ 32*
	skilled (n=24)	31 $\pm$ 40	63 $\pm$ 37
Husbands' schooling	$\leq$ 8 yrs (n=44)	12 $\pm$ 16*	45 $\pm$ 31
	>8 yrs (n=25)	35 $\pm$ 40	61 $\pm$ 39
Housemaid available	no (n=61)	15 $\pm$ 16*	44 $\pm$ 42*
	yes (n=15)	44 $\pm$ 41	77 $\pm$ 80
Private room at maternity	no (n=46)	14 $\pm$ 20*	48 $\pm$ 31
	yes (n=12)	49 $\pm$ 45	68 $\pm$ 43

**p*<.05.

Table 2. Duration (mean $\pm$ standard deviation) of exclusive breastfeeding (EBF) and predominant breastfeeding (PBF) related to working conditions.

Variable	Categories	EBF	PBF
Room for breastfeeding or milk extraction at workplace	no (n=38)	12 $\pm$ 16*	43 $\pm$ 33
	yes (n=31)	31 $\pm$ 37	51 $\pm$ 36
Work on Saturdays	no (n=31)	27 $\pm$ 34*	58 $\pm$ 36
	yes (n=38)	12 $\pm$ 18	42 $\pm$ 32
Work on Sundays	no (n=64)	22 $\pm$ 30*	52 $\pm$ 35
	yes (n=5)	2 $\pm$ 2	31 $\pm$ 28
Shiftwork	no (n=55)	23 $\pm$ 31*	50 $\pm$ 36
	yes (n=14)	08 $\pm$ 15	50 $\pm$ 34

**p*<.05.

Formally employed women - Sao Paulo - 1994

Figure 1. Proportion of infants who received exclusive, predominant, and any breastfeeding.

Medical and hospital care were found to be relatively homogeneous, since the private care offered by company health-plan clinics was similar and uniformly indifferent to breastfeeding. All women in the sample had attended prenatal programs and given birth in private maternity facilities; however, there are some differences in health care services provided in these facilities. In particular, those who pay more can stay in private rooms.

None of the facilities offered rooming-in; none allowed breastfeeding in the delivery room or in the first hour after birth; the average timing of the first breastfeed was 14 hours; only 23% of the women received any kind of support at the first breastfeed; and all the babies received bottle feeds at the maternity clinics. Nevertheless, mother-baby contact in the delivery room, appropriate advice on the first feed, and earlier timing of the first feed proved to be marginally associated with longer durations of EBF (not statistically significant; see Table 3).

Among the women's personal characteristics, the following variables, presented in Table 4, were significant for EBF: not smoking during pregnancy and the women's perception that their babies were receptive to

the act of breastfeeding. Women who had breastfed a previous child exclusively breastfed for 27 days, but this was not statistically longer than for others.

Predominant breastfeeding. The duration of PBF was found to be significantly associated with the following socioeconomic variables: occupation of the mother, occupation of her spouse, and presence of a maid in the household. Working conditions were not associated with PBF.

Mother-baby contact in the delivery room, appropriate advice on the first feed, and earlier timing of the first feed proved to be associated with longer durations of PBF (Table 3). Personal characteristics that led to longer PBF included a smaller number of domestic chores, the mother feeling during pregnancy that she was prepared to breastfeed, and the perception that the baby was receptive to breastfeeding (Table 4). Previous experience with breastfeeding had no effect.

Any breastfeeding. The breastfeeding period was not complete for many mothers when the study ended and thus life-table methods had to be used to examine determinants. Using the Kaplan Meyer method, the variables showing statistically significant results were: work on Sundays ($p=0.009$); SES index ($p=0.05$); and duration of BF of previous child ($p=0.05$). The Cox model found only the socioeconomic index had a statistically significant relationship to the duration of breastfeeding. This meant that neither personal characteristics nor health care practices were associated with the duration of any breastfeeding.

Discussion

The rate of initiation of breastfeeding in this study (97%) was slightly higher than in the general population for São Paulo (92%).¹ Apparently, the duration of BF is increasing in Brazil. In 1986 it was 90 days,¹³ in 1989 it was 134 days, but by 1996 it had increased to about 210 days. The factors best explaining this trend may be improved education and standards of living.¹⁴ The median duration of BF in the present study, conducted in 1993–1994, was 150 days, presumably at or slightly below the national average and consistent with the duration found in small cities at that time.¹⁵ However, it is difficult to obtain an accurate mean value, even using survival techniques, when breastfeeding was still ongoing for such a large proportion of the sample (40%) when the study ended.

It is known that additional fluids are unnecessary, even in hot climates, during the first 4 to 6 months of breastfeeding.¹⁶ The duration of EBF, though longer

Table 3. Duration (mean $\pm$ standard deviation) of exclusive breastfeeding (EBF) and predominant breastfeeding (PBF) related to healthcare services.

Variable	Categories	EBF	PBF
First mother-baby contact in delivery room	no ($n=41$)	14 $\pm$ 21	42 $\pm$ 31*
	yes ($n=28$)	29 $\pm$ 36	63 $\pm$ 37
Appropriate advice and support on first feed	no ($n=48$)	19 $\pm$ 27	44 $\pm$ 33*
	yes ($n=14$)	25 $\pm$ 36	66 $\pm$ 36
Time of first feed	>12 hrs ($n=44$)	14 $\pm$ 19	41 $\pm$ 31*
	up to 12 hrs ($n=18$)	36 $\pm$ 42	69 $\pm$ 35

* $p<.05$.

Table 4. Duration (mean $\pm$ standard deviation) of exclusive breastfeeding (EBF) and predominant breastfeeding (PBF) related to mothers personal characteristics.

Variable	Categories	EBF	PBF
Smoking during pregnancy	no ($n=64$)	23 $\pm$ 30*	51 $\pm$ 36
	yes ($n=12$)	4 $\pm$ 4	48 $\pm$ 33
Small number of domestic chores	yes ($n=58$)	16 $\pm$ 18	45 $\pm$ 37*
	no ($n=11$)	13 $\pm$ 19	38 $\pm$ 30
Mother felt prepared to breastfeed during pregnancy	no ($n=9$)	10 $\pm$ 19	54 $\pm$ 34*
	yes ($n=60$)	22 $\pm$ 20	25 $\pm$ 30
Mother views baby as receptive to breastfeeding	no ($n=48$)	9 $\pm$ 13*	25 $\pm$ 31*
	yes ($n=21$)	31 $\pm$ 35	69 $\pm$ 35

* $p<.05$.

among mothers with more education, was still short. At a median of 10 days, it was seemingly much shorter than the national average of about 30 days in 1996.² However, our study took place 3 years earlier and there may have been an increase in EBF during this period, as it was being promoted various ways. In 1986, only 6% of mothers who were breastfeeding a baby less than 1 month old were exclusively breastfeeding.¹³

The early introduction of water and tea is widespread in Brazil, and pediatricians and other health workers have long been recommending both from the early months of life. At the time of this study, the maternity facilities used by these mothers were clearly not "baby friendly," offering no rooming-in and commonly introducing bottles. There were some differences however between the maternity facilities, and this influenced early feeding patterns. Although not statistically significant with respect to water and teas, earlier contact with the baby, earlier timing of the first breastfeed, and supportive advice were associated with delays in the introduction of other supplements (Table 3). In the authors' experience, the routines of most maternity hospitals in Brazil country were better than those observed in São Paulo, particularly by the time of the national survey in 1996.

Since only 2 women were still predominantly breastfeeding (and none were breastfeeding exclusively) when they returned to work, the associations we found between workplace variables and the duration of exclusive breastfeeding cannot be directly causal. Nor is reverse causality likely, that is, that more enlightened women choose more supportive workplaces. In a huge metropolis, women such as these, who are not highly skilled, are likely to seek almost any reasonable job and are more concerned about shorter travel times. However, it is possible that some women, knowing that their workplace was more supportive of breastfeeding, maintained more exclusive breastfeeding during their leave. In 1992–1993, Perez-Escamilla et al conducted a study in 3 countries, one of which was Brazil.¹⁷ The study site was Santos, a town near São Paulo, where a breastfeeding reference training center is well established. They also found that working women practiced little EBF, even though some had access to maternity leave.

In theory, BF could have been influenced by workplace variables, but multivariate analysis showed that only the SES index had a significant effect. Again, this may have been partly due to the fact that so many mothers still had not stopped breastfeeding at the end of the study, as well as the small sample size.

Only one company provided facilities for breast milk expression. Where women receive no guidance on how to express their milk from the health care services, then it must be given at the workplace. Working women need information on the availability and use of any facility available, be it a nursery at the workplace, breastfeeding breaks, or a place to express and store their milk. Petschek and Barber-Madden¹⁸ stress the role of occupational health nurse in evaluating women employees' needs, developing prenatal programs, and establishing a liaison with the various departments at the workplace.

Morse et al¹⁹ found that the factor contributing most to successful breastfeeding was the possibility of the mother having her baby accessible during the working day. Although many women in this study had access to day-care facilities fairly near the workplace, the distances involved still made it difficult to breastfeed during their brief rests and lunch breaks. This may be why breastfeeding duration was not associated with the availability of day care outside the workplace. Day-care center vouchers are provided to many workers, but often are sufficient only to pay a neighbor to care for the baby.

Many women exchange their breastfeeding breaks for permission to leave work an hour earlier or arrive an hour later. However, when the company offered bus service, some of the respondents said they preferred to wait for the company bus rather than trying to go home earlier. Some also stated that they would rather leave their babies at home than get them up early to take the bus or even to go to a day-care center.

Longer breastfeeding was associated with flexible working hours. Not working weekends may have allowed mothers to better maintain their breast milk supply. Changing shifts may have allowed them to adapt their working hours to the day-care center's hours. Van Esterik²⁰ reviews similar findings from several locations. Administrators and women with more education may have been more able to obtain flexible working hours. Kurinij²¹ also found that type of occupation was associated with duration of breastfeeding.

Our respondents often introduced other foods by bottle long before returning to work. A similar pattern has been described by Nessa and Rahman.²² Pediatricians in the company-provided health facilities, unaware of the breastfeeding-friendly facilities available at the workplaces, advised early introduction of bottle feeds to prepare the baby for the mother's return to work. Awareness of the importance of breastfeeding may lead

to consistent company policies regarding maternity entitlements and health care services. Pérez-Escamilla et al found that women in nearby Santos delivering in a maternity center with more breastfeeding-friendly policies practiced longer EBF.¹⁷

In summary, even with the relatively good working conditions these women enjoyed, they needed more than just labor benefits in order to breastfeed exclusively for 6 months and to sustain breastfeeding for longer periods. They needed improved information and support, both from society and from the health care services. Indeed, such support may need to be present before the impact of workplace support for breastfeeding can be meaningfully studied, at least when women receive some period of paid leave.

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Determinantes de patrones de lactancia en mujeres trabajadoras en São Paulo (Determinants of the Breastfeeding Pattern Among Working Women in Sao Paulo)

Resumen

Las necesidades durante la lactancia de las mujeres que trabajan fuera del hogar son diferentes a las de otras mujeres, particularmente las que practican la lactancia materna exclusiva. Se realizaron en este estudio entrevistas a 69 mujeres trabajadoras en una factoría en Sao Paulo, tanto durante el embarazo como al retornar al trabajo. La duración media de lactancia materna exclusiva (LME), lactancia predominante (LP), y lactancia parcial (Lp) fue de 10,70 y 150 días respectivamente. A pesar de que todas las madres hicieron uso de la licencia de maternidad disponible por cuatro meses, se encontró entre las respuestas que al mes, 86% habían dado té, 50% agua y 42% leche artificial (de fórmula) a sus bebés. Solo dos mujeres continuaban lactancia materna exclusiva al retornar al trabajo. Múltiples características personales se asociaron con una duración más prolongada de la lactancia. Las rutinas hospitalarias no apoyaban la lactancia, pero la duración de lactancia predominante era mas prolongada en las mujeres que recibieron apoyo en los establecimientos de salud. La duración de LME fue mayor entre las mujeres que recibieron apoyo en el lugar de trabajo, y más corta en las mujeres que trabajaban los fines de semana o por jornadas. Así que, las mujeres adaptaron los patrones de lactancia basados, de antemano, en si se contaba o no con apoyo en el lugar de trabajo. Una duración mas corta de la lactancia se relaciona solo a las trabajadoras de fines de semana y estado socioeconómico. Es necesario fortalecer el apoyo social y en los establecimientos de salud hacia una lactancia materna exclusiva antes de que se evalúen los estudios de impacto del apoyo a la lactancia en los lugares de trabajo en Brasil.