






Immediate contact between mother and newborn in the first hour of life: a cross-sectional study*

Contato imediato entre mãe e recém-nascido na primeira hora de vida: um estudo transversal

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ABSTRACT

Objective: to compare population and care characteristics of adherence to immediate contact between mother and newborn in the first hour of life in two public maternity hospitals at usual risk. **Methods:** cross-sectional study with 105 mothers after normal delivery and their respective newborns in the first hour of life in two maternity hospitals with Prepartum, Labor, and Puerperium units. We used an instrument with 36 questions based on the National Guidelines of Assistance to Normal Birth. Analysis was based on the chi-square test for homogeneity and Fisher's exact test to compare the assistance provided in maternity hospitals. **Results:** both maternity hospitals attended the usual risk binomials. Regarding the assistance provided, only the federal maternity promoted encouragement of immediate contact between mother and newborn in the first hour of life, besides favoring 7.1% (n=3) of the binomials with the golden hour in a correct and significant way (p=0.037). **Conclusion:** despite the similarity of the assistance profile, only one maternity hospital performed the golden hour, being necessary the insertion of good practices in maternity hospitals. **Contributions to practice:** direct observation of the assistance provided to binomial identified gaps in the format and durability of the immediate contact in maternity hospitals. **Descriptors:** Mother-Child Relations; Hospitals, Maternity; Infant, Newborn; Delivery of Health Care.

RESUMO

Objetivo: comparar as características populacionais e assistenciais de adesão ao contato imediato entre mãe e recém-nascido na primeira hora de vida em duas maternidades públicas de risco habitual. **Métodos:** trata-se de um estudo transversal, do qual participaram 105 mães que tiveram parto normal e seus respectivos recém-nascidos na primeira hora de vida em duas maternidades com unidades de Pré-parto, Parto e Puerpério. Para a pesquisa, utilizou-se um instrumento com 36 questões baseadas nas Diretrizes Nacionais de Assistência ao Parto Normal. A análise foi baseada no teste Qui-quadrado de homogeneidade e teste Exato de Fisher, para comparar a assistência prestada nas maternidades. **Resultados:** ambas as maternidades atenderam aos binômios de risco habitual. Quanto à assistência prestada, apenas a maternidade federal promoveu o incentivo ao contato imediato entre mãe e recém-nascido na primeira hora de vida, além de favorecer 7,1% (n=3) dos binômios com a hora dourada de forma correta e significativa (p=0,037). **Conclusão:** apesar da similaridade do perfil da assistência, apenas uma maternidade realizou a hora dourada, sendo necessária a inserção das boas práticas nas maternidades. **Contribuições para a prática:** por meio da observação direta da assistência prestada ao binômio, identificaram-se lacunas no formato e durabilidade do contato imediato nas maternidades. **Descritores:** Relações Mãe-Filho; Maternidades; Recém-Nascido; Atenção à Saúde.

Introduction

Immediate skin-to-skin contact between mother and newborn in the first hour of life, called the golden hour, is an internationally recommended practice by the World Health Organization and the United Nations Children's Fund⁽¹⁾. It aims to reduce the number of interventions and is a harm-free light technology according to scientific evidence in the axis of childbirth and birth⁽²⁾.

Among the benefits, skin-to-skin contact favors the promotion of breastfeeding, regulation of vital signs and metabolism, bonding with the mother, reduction of crying and stressful factors in childbirth/birth⁽²⁻³⁾. As a facilitator of skin-to-skin contact, it is possible to list the usual risk childbirth and the presence of professionals trained for good practices in the care setting⁽²⁾.

In Brazil, to improve assistance and innovate in relation to the care of obstetrics and neonatology, the existence of projects aimed at improving the practice began to exist, among them, the project for Improvement and Innovation in Care and Teaching in Obstetrics and Neonatology (Apice ON)⁽²⁾, existing since 2017 whose goal is focused on changing the assistance provided by health professionals in the childbirth room.

Despite the evidence portraying the benefit of the practice and governmental stimuli, the assistance to the mother and the newborn is characterized by the overload of hospital routines, reduced number of professionals in the assistance, and lack of knowledge of health professionals, parturient, and family about the practice and the importance of skin-to-skin contact⁽⁴⁻⁵⁾. In the same follow-up, the difficulty of maternity hospitals to record in the medical record the performance of the practice, its duration and the segment of care developed in the golden hour, not being possible to form an indicator of assistance⁽⁶⁾.

And, when compared to the assistance provided in maternity hospitals in different regions of Bra-

zil, the general context shows inequality in childbirth care, especially when the mothers are represented by poor women, besides experiencing pilgrimage in the search for assistance and obstetric violence during the interaction between parturient and professionals in childbirth care⁽⁷⁾.

It is evident in the findings the fragility of the assistance provided in the scenario of childbirth and birth in the expanded context, in addition, there is a need to understand whether the assistance provided differs, according to the profile of the population that seeks the service, with that associated with the practice of skin-to-skin contact. As an essential role in the assistance to the mother and the newborn, it is necessary to have a detailed knowledge of the work process provided to the binomial, to measure the quality of assistance provided to the institution⁽⁸⁾.

In the search for a positive experience for childbirth and birth, in a model of care centered on the needs of women in the act of giving birth and in the reduction of neonatal violence, investigations are needed that portray the adherence of maternity hospitals to the stimulus of immediate contact between mother and newborn in the golden hour as well as the assistance provided, and that can show if they differ according to the profile of the population that seeks the service.

Based on these considerations, the present study asks: What is the adherence to immediate contact between mother and newborn in the first hour of life in two public maternity hospitals? And, it aimed to compare the population and care characteristics of adherence to immediate contact between mother and newborn in the first hour of life in two public maternity hospitals at usual risk.

Methods

This is a cross-sectional study, supported by the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) tool. The collection occur-

red between May and July 2019 in two usual risk maternity hospitals, located in the State of Rio Grande do Norte, Brazil.

Both maternity hospitals were eligible for the study for having characteristics in common in the aspect of assistance to normal childbirth of usual risk, in addition to norms focused on assistance based on good obstetric practices, presence of the obstetric nurse in the childbirth setting, and physical structure for assistance in the format of Prepartum, childbirth, and Postpartum (PCP). Regarding the differences, the maternity hospitals are of different legal nature, being a state maternity hospital, located in the state capital, metropolitan region, while the second is considered a maternity school, part of the Apice ON project and located in the interior of the state, of federal legal nature.

The research considered as population the parturient in normal childbirth of usual risk. For the sample, there was a numerical survey of normal childbirths entered in the Hospital Information System of the Brazilian Unified Health System (SIH/SUS- in Portuguese) in the year 2020, corresponding to the maternity hospitals participating in the research. In all, both maternity hospitals, in the period corresponding to the research time of three months (May to July 2020), had an average of 154 childbirths in the state maternity hospital and 136 childbirths in the federal hospital, and from the non-probability sample, a total of 105 mothers who had normal childbirths with their respective children were assessed, 63 from the state maternity hospital and 42 from the federal hospital.

The study adopted as inclusion criteria: parturient with gestational age > 37 weeks, at usual risk and postpartum women who were in the first hour after a normal childbirth. Excluded were parturient at usual risk admitted for cesarean section and who, in the imminence of normal childbirth, had the need for cesarean section.

The collection occurred by convenience and through direct observation of the postpartum woman

in the normal postpartum period and the newborn in the first hour of life until the end of the golden hour by four researchers allocated weekly in the PCP units of the two maternity hospitals, who were leveled as to the use of the form based on training, in order to avoid measurement biases, and, in the follow-up, the use of the KAPPA test to confirm consistency and ability, with substantial agreement of 0.8 among observers.

To avoid potential confounding and modifying the results resulting from the observation, only the maternity hospital managers were aware of the research objective, and initially the team that provided direct assistance to the binomial was suspicious. Despite the initial fear of the team, the data show that, during the collection period, no changes were observed in the profile of assistance provided in the PCP units.

To compose the form, the guidelines included in the National Guidelines on Assistance to Normal Childbirth⁽²⁾ were used, totaling 36 questions with variables that favor/delay immediate contact between mother and newborn in the first hour of life. The Guidelines govern obstetric care in public maternity hospitals and aim to provide guidance to all involved in care, to encourage normal childbirth and birth without risk to the binomial.

The instrument was only applied after a pre-test was carried out in a usual risk maternity hospital and its adequacy to the proposed objectives of the study was confirmed. Thus, the instrument consisted of four sections: the first aimed at the socioeconomic and clinical characterization of the participants (parturient and newborns); the second referred to the characterization of the immediate contact in the maternities with variables focused on the time of contact (beginning and duration) and form of contact, in addition to the period for the newborn to return to the mother's lap; the third represents the intervening elements that influenced the beginning/continuity of the golden hour; and the fourth section refers to the professionals working at the end of the golden hour and beginning of late contact.

The data collection only began after the participants had been informed of the purpose, risks, and benefits of the research, in addition to the due signature of the Free and Informed Consent Form by the parturient or, when the participant was a minor, by her guardian,

The SPSS software was used to analyze and record the data obtained. Descriptive analysis with percentage frequency was adopted to characterize the socioeconomic and clinical profile of the participants. For the similarity of the maternity hospitals, the chi-square test of homogeneity was used, and the Fisher's exact test was used to compare the socioeconomic and clinical profile of the parturient, the characterization of the immediate contact in the maternity hospitals, the intervening elements that influenced the beginning/duration of the golden hour, and the professionals working at the end of the golden hour. Significant factors were considered those with 5% significance ($p < 0.05$).

The research followed Resolution 466/2012 of the National Health Council with approval from the Research Ethics Committee of the Federal University of Rio Grande do Norte under Opinion No. 3,187,286/2019 and Certificate of Submission for Ethical Consideration number 53254521,5,0000,5537.

Results

Table 1 shows that the socioeconomic characterization of the parturient was between 19 and 30 years old, self-reported to be brown, with high school education, with a partner, monthly income of one minimum wage, and that they came from the city where the maternity hospital was located. When comparing the distribution of the profile of the maternity hospitals, the homogeneity test was significant for origin ($p < 0.001$) and monthly income ($p = 0.017$), indicating differences among the maternity hospitals regarding origin and monthly income.

Table 1 – Socioeconomic characterization of the parturient (n=105). Natal and Santa Cruz, RN, Brazil, 2019

Variables	Maternities		p-value
	State n (%)	Federal n (%)	
Age (years)			
15 to 18	16(25.4)	7(16.7)	
19 to 30	38(60.3)	28(66.6)	0.568*
31 to 45	9(14.3)	7(16.7)	
Skin color			
White	19(30.2)	10(23.8)	
Black	3(4.7)	1(2.4)	0.605 [†]
Brown	41(65.1)	31(73.8)	
Education			
Illiterate	0(0.0)	1(2.4)	
Elementary school	23(36.5)	14(33.3)	0.400 [†]
High school	35(55.6)	26(61.9)	
Higher education	5(7.9)	1(2.4)	
Marital status			
Without partner	11(17.5)	6(14.3)	
With partner	52(82.5)	36(85.7)	0.665*
Monthly income (minimum wage)			
None	0(0.0)	3(7.1)	
Up to 1	48(76.2)	35(83.4)	0.017 [†]
From 2 to 3	15(23.8)	4(9.5)	
Origin			
Host city	61(96.8)	4(9.5)	
Adjacent city	2(3.2)	38(90.5)	<0.001*

*Chi-square test for comparison of homogeneity among maternity hospitals;

[†]Fisher's exact test

In the clinical characterization, 56 (53.3%) of the parturient women had six to nine prenatal visits, 71 (67.6%) had no complications during pregnancy, and 100 (95.2%) had no serological abnormalities. When comparing maternity hospitals, there was no significance between them ($p > 0.05$), indicating similarity of care profile in the homogeneity test.

Regarding the clinical characterization of newborns at birth, the Fisher's exact test showed that newborns had APGAR between 8-10 in the first minute and APGAR between 8-10 in the fifth minute of life. In relation to the aspect of weight in the interval of up to two hours after birth, the registration of weight was not observed, except for the federal maternity

hospital that performed the weighing of newborns in this time interval, and, in relation to the aspect of malformations identified at the time of birth, these were absent for both maternity hospitals. The homogeneity test was significant for weight ($p < 0.001$), indicating difference between the maternity hospitals.

Table 2 – Clinical characterization of newborns related to birth (n=105). Natal and Santa Cruz, RN, Brazil, 2019

Variables	Maternities		p-value [†]
	State n (%)	Federal n (%)	
APGAR Bulletin 1st minute			
0 to 3	0 (0.0)	3 (7.1)	0.180
4 to 6	7 (11.1)	3 (7.1)	
7	3 (4.8)	3 (7.1)	
8 to 10	53 (84.1)	33 (78.7)	
APGAR Bulletin 5th minute			
4 to 6	1 (1.6)	0 (0.0)	0.827
7	4 (6.3)	4 (9.5)	
8 to 10	58 (92.1)	38 (90.5)	
Weight (grams)			
No information	62 (98.4)	18 (42.8)	<0.001
500 to 2,500	0 (0.0)	1 (2.4)	
2,500 to 4,500	1 (1.6)	22 (52.4)	
> 4,500	0 (0.0)	1 (2.4)	
Malformation identified at birth			
Absent	50 (79.4)	39 (92.9)	0.118
Polydactyly (Supernumerary Digit)	1 (1.6)	0 (0.0)	
Not reported	12 (19.0)	3 (7.1)	

[†]Fisher's Exact Test

During the observation of the assistance provided by health professionals in the delivery scenario, it was identified that the state maternity hospital did not perform the weighing of the newborn in the first hour of life.

In reference to the characterization of the immediate contact in the investigated maternities, Table 3 shows that both maternities immediately initiated contact between mother and newborn, however, the form of immediate contact was in the skin-cloth contact format and lasted from one to five minutes. After

separation, the time for the newborn to return to contact was in the range of 31-60 minutes.

When comparing the maternity hospitals, the Chi-square test for homogeneity was significant only in the duration of immediate contact ($p = 0.037$). On the other hand, it is possible to observe in the same table that the federal maternity hospital, although it showed interference in the duration of immediate contact, presents better results in encouraging the golden hour between mother and newborn, which favored three (7.1%) newborns to have contact for 60 minutes in the skin-to-skin format.

Table 3 – Characterization of immediate skin-to-skin contact in maternity hospitals (n=105). Natal and Santa Cruz, RN, Brazil, 2019

Variables	Maternities		p-value*
	State n (%)	Federal n (%)	
Immediate contact start (minutes)			
Immediately	51 (81.0)	39 (92.8)	0.274
5 - 20	6 (9.5)	2 (4.8)	
>60	6 (9.5)	1 (2.4)	
Method of carrying out the immediate contact			
Not performed	6 (9.5)	1 (2.4)	0.302
Skin-to-skin contact	21(33.3)	18 (42.8)	
Skin-to-cloth contact	36 (57.2)	23 (54.8)	
Immediate contact duration (minutes)			
Immediate contact not performed	6 (9.5)	1 (2.4)	0.037
1 a 5	54 (85.7)	33 (78.6)	
6 a 59	3 (4.8)	5 (11.9)	
60	0 (0.0)	3 (7.1)	
Newborn Contact Turnaround Time (minutes)			
Up to 10	11 (17.5)	6 (14.3)	0.592
11 a 20	17 (27.0)	8 (19.0)	
21 a 30	5 (7.9)	6 (14.3)	
31 a 60	30 (47.6)	22 (52.4)	

*Chi-square test for comparison of homogeneity between maternity hospitals

Regarding the intervening elements in the golden hour, Table 4, through the Chi-square test for homogeneity, shows the absence of intervening elements for the beginning of the golden hour; however, the durability of the golden hour was interrupted for the execution of procedures on the newborn, and the variable is observed by more than 50% of the binomials

that received assistance in both maternity hospitals. When comparing the maternity hospitals, significant homogeneity is verified only for elements that intervened in the beginning of the golden hour ($p=0.017$), indicating difference between the maternity hospitals.

Table 4 – Intervening elements that influenced the initiation/continuation of the golden hour (n=105). Natal and Santa Cruz, RN, Brazil, 2019

Variables	Maternities		p-value*
	State n (%)	Federal n (%)	
Intervening elements at the beginning of the golden hour			
Absence of intervening elements	51(81.0)	39(92.8)	
Newborn complications	6(9.5)	1(2.4)	0.017
Procedures in the newborn	6(9.5)	0(0.0)	
Other factors (maternal refusal)	0(0.0)	2(4.8)	
Elements that intervened in the durability of the golden hour			
Other elements (structural elements)	2 (3.2)	0 (0.0)	
Maternal procedures	4 (6.3)	1 (2.4)	
No responsible factors	6 (9.5)	5 (11.9)	0.218
Newborn intercurrent	6 (9.5)	10 (23.8)	
Newborn procedures	45 (71.5)	26 (61.9)	

*Chi-square test for comparison of homogeneity between maternity hospitals

Regarding the professionals active in the termination of the golden hour, it was found that in both maternities the pediatrician intervened in the durability of the contact between mother and newborn, being responsible for the termination of the golden hour.

While the nursing team (obstetrician, generalist, and nursing technician nurses) was responsible for the initiation of late contact, followed by the absence of people who were favored by late contact, keeping the newborn in the crib warm during the golden hour as evidenced in Table 5. The test of homogeneity of distribution was not significant in the analyzed elements ($p>0.05$), indicating that the characteristics are similar in the two hospitals analyzed.

Table 5 – Professionals acting at the end of the golden hour and beginning of late contact in maternity hospitals (n=105). Natal and Santa Cruz, RN, Brazil, 2019

Variables	Maternities		p-value
	State n (%)	Federal n (%)	
Responsible for the end of the golden hour			
Nursing Team	1 (1.6)	2 (4.8)	
Companion Person/Father	2 (3.2)	0 (0.0)	
Obstetrician	2 (3.2)	2 (4.8)	0.698*
No professional	6 (9.5)	5 (11,8)	
Pediatrician	52 (82.5)	33 (78.6)	
Responsible for initiating late contact			
Postpartum woman	2 (3.2)	1 (2.4)	
Companion person	3 (4.8)	2 (4,8)	
Pediatrician	9 (14.3)	7 (16.6)	0.972†
Not observed	21 (33.3)	16 (38.1)	
Nursing team	28 (44.4)	16 (38.1)	

*Teste Chi-square test for comparison of homogeneity among maternity hospitals; †Fisher's exact test

Discussion

Regarding socioeconomic conditions, the results showed that the parturient admitted in the maternity hospitals differed in terms of monthly income and origin. This difference corresponds to the profile of the Health Region⁽⁹⁾, in which both maternity hospitals are inserted, that is, while the federal maternity hospital belongs to the Health Region that involves 21 cities and has a monthly income of 1.6 minimum wages, the state maternity hospital corresponds to the Region that includes five cities and has a monthly income of three minimum wages⁽¹⁰⁾, thus having a difference regarding monthly income and origin.

Despite the differences scored between the maternity hospitals, the obstetric conditions of the parturient are similar, being considered usual risk parturient and with an average of six to nine prenatal consultations. Regarding prenatal care, the stimulation of skin-to-skin contact between the binomials in the maternity hospitals becomes favorable when it exceeds four consultations⁽¹¹⁾. However, there are stu-

dies that show that there are still gaps in prenatal care and, therefore, in the education and production of knowledge of pregnant women⁽¹²⁾. It was found that, despite the average number of prenatal consultations being higher than recommended, the opportunity to experience skin-to-skin contact with the newborn in the first hour of life was related to maternity.

In contrast to that, despite the absence of intervening elements for the beginning of the immediate contact, it is verified that the state maternity hospital performs procedures on the newborn before the immediate contact, and both maternity hospitals, similarly, finish the practice to perform procedures on the newborn. Such practice is pointed out in investigations that show the performance of procedures without scientific recommendations during the golden hour and the incorrect performance of the practice in the skin-to-cloth format⁽¹³⁾.

In a group of 108 binomials, 42% of the newborns who underwent routine care in the maternity ward presented hypothermia, while only 2% of those who immediately experienced skin-to-skin contact had hypothermia⁽¹⁴⁾. On the other hand, a group involving 95 infants with a gestational age of 38 weeks and who experienced the practice at the golden hour had no negative impacts related to the practice, besides presenting stable physiological parameters and wakefulness⁽¹⁵⁾.

It is important to emphasize that the immediate skin-to-skin contact between mother and newborn in the first hour of life corresponds to the adaptation of the newborn to extrauterine life, that is, to the "new world" outside the womb⁽⁴⁾. Those who experienced the golden hour with their mother showed cardiovascular stability, maintenance of body temperature, higher blood glucose level, reduced crying, increased rate of first lactation, and long-term success in this process⁽¹⁶⁻¹⁷⁾, thus there is no need to separate mother and newborn if both have favorable clinical conditions.

Despite the numerous benefits of the practice, the early interruption of the golden hour with late return of the newborn to the mother's lap is still present,

as evidenced in this research. Thus, it is necessary to implement guidelines that encourage an assistance that prioritizes this practice in view of the need to perform procedures⁽²⁻³⁾. As for the professional aspect, the results show that there is homogeneity between the maternity hospitals both professional responsible for the end of the golden hour, represented by the pediatrician, and of the professional responsible for initiating late contact, represented by the nursing team, thus making the existence of paradigms in neonatal care questionable.

The insertion of the professional in the immediate assistance to the newborn in the first hour of life is essential; however, it is necessary to perform a clinical evaluation that disseminates and favors the immediate skin-to-skin contact as a beneficial practice for the binomial, postponing procedures that can be performed in newborns with clinical stability and APGAR > 8⁽¹⁸⁾ as evidenced in the study. It is believed that it is up to the team to overcome structural issues that dehumanize birth, and to value the national and international recommendations aimed at the positive experience of childbirth and birth⁽²⁾.

In both maternity hospitals, the obstetric nursing service is offered; however, the data showed a reduced participation of this professional in physiological childbirth and immediate assistance to the newborn due to the resistance of health services to the performance of the Obstetric Nursing and the persistence of the hospital-centric model. It is important to emphasize that, over the years, the presence of obstetric nursing⁽¹⁹⁾ and the monitoring of the pregnant woman's own support network⁽²⁰⁾ in childbirth and birth assistance favor the practice of immediate skin-to-skin contact.

Despite the benefits of the presence of the companion⁽²⁰⁾, it is verified, according to the results of the study, the performance in larger quantity of health professionals in the scenario of physiological birth. This is consistent with the hegemony of professionals in childbirth/birth care in maternity hospitals, and, when associated with the lack of knowledge of repro-

ductive rights, women are vulnerable to the routine of maternity hospitals and with their reduced autonomy in the parturition process, which favors the discontinuity of the golden hour^(5,17).

In the present study, it is noteworthy that only the maternity hospital integrating the Apice On project was the only one that enabled the golden hour in three newborns. In-service training based on realistic simulation and continuing education of health professionals generate significant changes in the assistance and implementation of evidence-based practices⁽²¹⁾, thus acting as an activity that can favor the skin-to-skin contact between mother and newborn in the realities of maternity hospitals.

Study limitations

In the study, limitations were identified related to the team acting in the assistance, which initially manifested attitudes of mistrust towards the researchers of the study. In view of this situation, all the observations were maintained with the same posture of the observers so as not to intervene in the assistance. As for the researchers, it was not possible to observe simultaneous births and to remain in the maternity ward on duty due to the reduced number of observers. Focusing on the binomial, the study also evidenced skin-to-skin contact performed incorrectly and in the reduced interval. And, in the follow-up, the involvement of the maternity hospital as a member of the Apice ON project, which requires the need for production of evidence to portray a new model of care that has been implemented in maternity hospitals schools.

Contributions to practice

As a relevant aspect, the study was pioneering in that it carried out, transversally, the direct observation of the assistance provided to the binomial in two public maternity hospitals of habitual risk, in an uninterrupted interval of one hour. Through direct observation of the assistance provided to the binomial, the

study identified gaps in the format of contact and the low percentage of newborns who experienced immediate skin-to-skin contact in its entirety, thus enabling the professionals to discuss the implementation of the practice of skin-to-skin contact between mother and newborn in maternity hospitals and the insertion of professionals in the scenario of childbirth that contributes to the practice.

Conclusion

The study, through direct observation of the assistance provided to the binomial, identified, occasionally, attempts to stimulate immediate contact, in the maternity hospitals, with the Prepartum, Childbirth, and Postpartum units. Furthermore, it was observed that, despite the difference between the maternity hospitals regarding the origin and monthly income of the mothers, the opportunity for contact was related to the maternity, and not to the profile of the mothers and newborns who were in the maternity. The findings reaffirmed that only one maternity complied with the golden hour according to ministerial recommendations. It is hoped that this research can prompt discussions and reviews on good practices performed in the maternity ward.

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Authors' contribution

Conception and design or analysis and interpretation of data; Agreement to be responsible for all aspects of the manuscript related to the accuracy or completeness of any part of the manuscript to be adequately investigated and resolved: Monteiro BR.

Writing of the manuscript; Agreement to be responsi-

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