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Skin-to-skin contact in the newborn's first hour of life from the maternal perspective

Contato pele a pele na primeira hora de vida do recém-nascido sob o olhar materno

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ABSTRACT

This paper aimed to identify the experience of (mother-child) skin-to-skin contact in the first hour of the newborn's life through the mothers' accounts. This descriptive, qualitative, and prospective study was conducted through open, semi-structured interviews with postpartum women admitted to a high-risk maternity hospital linked to the Unified Health System in Espírito Santo. Three thematic categories were elaborated: experiencing the first feelings when meeting and breastfeeding the baby, time influence on skin-to-skin contact, and conduct of health professionals in skin-to-skin contact. The mothers had positive feelings about the experience of skin-to-skin contact and highlighted the importance of the presence of health professionals. The study becomes relevant for a reflection by and attitude of professionals regarding the care provided to the mother-baby dyad and the qualification of skin-to-skin contact in a humanized way.

Keywords: Breastfeeding. Kangaroo method. Childbirth. Newborn. Mother-child relationships.

RESUMO

Identificar, por meio de relatos das puérperas, a experiência do contato pele a pele (mãe-filho) na primeira hora de vida do recém-nascido. Estudo descritivo, prospectivo de abordagem qualitativa, realizado por meio de entrevista aberta, semiestruturada, com puérperas internadas em uma maternidade referência em alto risco, vinculada ao Sistema Único de Saúde, do Espírito Santo. Foram elaboradas três categorias temáticas: vivenciando os primeiros sentimentos ao conhecer e amamentar o bebê; influência do tempo sobre o contato pele a pele; e, condutas dos profissionais de saúde no contato pele a pele. As puérperas apresentaram sentimentos positivos em relação à experiência do contato pele a pele e destacaram a importância da presença dos profissionais de saúde. O estudo torna-se relevante para reflexão e postura dos profissionais em relação aos cuidados prestados ao binômio mãe-bebê e à qualificação da prática do contato pele a pele de forma humanizada.

Palavras-chave: Aleitamento Materno. Método canguru. Parto. Recém-nascido. Relações Mãe-filho.

INTRODUCTION

The search for best practices for humanizing birth in Brazil and globally has enabled new perspectives on offering evidence-based care, with skin-to-skin contact (SSC) recommended for newborns with good vitality. This procedure resulted from Rey and Martinez idea in 1978 at the Bogotá Maternity and Childhood Institute[1]. The first hour of a newborn's life is called the "golden hour", a critical transition period to extrauterine life. Given this, the healthcare team should identify possible risks or changes and engage in evidence-based practices during skin-to-skin contact between mother and child, offering the least interventionist care possible[2].

SSC is a cheap and safe technique that promotes long-term benefits by enabling early contact between mother and child after the baby is born. National and international guidelines and recommendations regarding good obstetric practices consistent with humanized childbirth and the postpartum period[2] are followed during the "golden hour". Therefore, SSC is recommended as a hospital routine, making it viable for most puerperae, even in developing countries, as it is a low-cost strategy[3,4].

The WHO/UNICEF Baby-Friendly Hospital Initiative (BFHI) established the "Ten Steps to Successful Breastfeeding", where the fourth step is "Help mothers initiate breastfeeding within an hour of birth"[5]. Therefore, strengthening skin-to-skin contact in the first half hour of life after birth is essential, as it reinforces the bond between mother and child and reduces neonatal mortality rates[6].

SSC regulates the newborn's body temperature with less energy loss, assists with breathing, heart rate, and crying, and predisposes bonding and maternal care in the first hour of life, in a vital adaptation and recognition period for the mother and baby. It should be continuous, prolonged, and established in every healthy mother-child dyad[7]. It is recommended to place the baby bare, face down, on the mother's bare chest or abdomen and cover both with a heated blanket, regardless of whether the birth is natural or by cesarean section[8]. When meeting their child for the first time, women's bodies activate prolactin to support breastfeeding and release oxytocin, which acts on uterine contractility, preventing hemorrhage and anemia in the postpartum period. It also curbs adrenaline, reduces postpartum anxiety, and calms the puerperae[2].

In this context, the multidisciplinary team should provide prior guidance on practicing this technique for pregnant women. Prenatal care is the most appropriate time to start a conversation about skin-to-skin contact in the first half hour of life and the importance of exclusive breastfeeding and a support network[6]. Professionals must provide clarifications and stress the practice's relevance effectively[9].

The presence of Obstetric Nursing and its team promotes safety, reception, and effective care at all times during parturition, providing greater autonomy to women and assuring their rights[10]. Therefore, this study aims to identify the experience of (mother-child) skin-to-skin contact in the first hour of the newborn's life through postpartum women reports.

METHODOLOGY

This descriptive, qualitative, and prospective study was conducted through open semi-structured interviews with puerperae with full-term babies linked to a large public hospital, a high-risk reference for pregnant women.

Qualitative research is exploratory and subjective by nature, allowing respondents to express themselves spontaneously about a topic, object, or concept. It is essential in structuring social relationships, both in their advent and significant human transformations and constructions[11]. Furthermore, the qualitative

approach allows the creation of new approaches, concepts, and categories during the investigation.

Thus, this type of research provides a model of in-depth understanding of connections between elements to understand the manifestation of the study object. The number of respondents is generally small; information is usually collected through a roadmap. After collection, the information is analyzed and recorded in a report, underscoring the most relevant opinions, comments, and phrases that emerged, reducing texts to meaningful words and expressions[12].

The puerperae admitted to the maternity ward were invited to participate in the research voluntarily, signing the Informed Consent Form, and the anonymity of both newborns and families was preserved.

We included primiparous/multiparous women with vaginal or cesarean deliveries, who had skin-to-skin contact with the newborn in the first hour of life during the current birth, and who were over 18. We excluded women who failed to perform skin-to-skin contact, as provided in the birth document attached to the newborn's medical record.

We highlight that the Research Ethics Committee of the Cassiano Antônio Moraes University Hospital approved the research under N° 8791289. First, a pilot interview was conducted in a private location to validate the instrument. Then, after necessary adjustments, the interviews were recorded and transcribed in full by the researchers, guaranteeing each respondent's privacy.

The sample size was guided by the saturation criterion, defined as "the suspended inclusion of new participants when the researcher assesses that the data retrieved start to show some redundancy or repetition and are not relevant to persist in data collection"[13].

The analysis of a qualitative study requires the researcher to listen very carefully to what the respondent said, without drawing or imposing hasty conclusions or attributing value judgments and taking their beliefs and principles as a basis, thus keeping greater reliability to what the respondent wanted to convey. Scholars recommend using artifacts such as photographs, videos, interview recordings, and notes in thematic content analysis. Furthermore, we adopted the work "The Challenge of Knowledge: Qualitative Research in Health" (our free translation from Portuguese) as a basis for data analysis, following techniques and steps (pre-analysis, exploration of the material or coding and processing the results obtained/interpretation and categorization) recommended by Maria Cecília Minayo[12].

In Thematic Content Analysis, words or expressions that give rise to theoretical or empirical categories responsible for specifying the theme[11] are defined after data classification and aggregation. Hence, the analyst proposes inferences and makes interpretations, interrelating them with the theoretical framework initially designed or opening other clues around new theoretical and interpretative dimensions, suggested by reading the material[12].

Thus, based on the responses of postpartum women to the questions that guided the production of this study: "Did you receive prenatal care? If yes, where and how many appointments?"; "Did you receive any guidance about skin-to-skin contact during prenatal care? From which professional?"; "What do you believe skin-to-skin contact? is"; "How long did your skin-to-skin contact with the newborn last?"; "Do you know the benefits of skin-to-skin contact? If so, what are they?"; "Did you breastfeed your child during skin-to-skin contact?"; "How did you feel at the moment of contact?"; and "Regarding skin-to-skin contact, do you have any suggestions regarding how the team assisted you?". Four thematic units emerged, including "relationship", "baby and mother", "unique moment", and "breastfeeding". These gave rise to the categories: "Experiencing the first feelings when meeting and breastfeeding the baby"; "Time influence on skin-to-skin contact"; and "Healthcare professional

conduct in skin-to-skin contact", which will be presented below.

RESULTS AND DISCUSSION

For confidentiality reasons, participants will be named with the acronym "M" for mother and the number according to the order of the interviews (M01, M02, M03...). Thirteen postpartum women aged 18 to 43 participated in the study (the pilot interview was excluded). Nine had vaginal births and four had cesarean sections. Two participants studied until elementary school, nine until High School, and two until Higher Education.

The number of prenatal care appointments largely ranged from four to seventeen. The Ministry of Health[8] recommends a minimum of six appointments, and only two participants did not follow this recommendation. Guidance on the course of pregnancy and the postpartum period is essential in prenatal care appointments, including skin-to-skin contact. However, we could not observe this in the postpartum women's reports, as they showed a complete lack of knowledge about the SSC technique. Only two received guidance from the medical team about what it was about and its benefits.

As it is a reference hospital for high-risk pregnant women, the Cassiano Antônio de Moraes University Hospital (HUCAM) provides two types of prenatal care: high-risk, in the outpatient clinic[2] of the hospital itself, and that of the Municipality of Vitória (ES). Therefore, even postpartum women who had their prenatal care at the hospital also did not have information about the SSC.

Regarding the golden hour, breastfeeding is an essential protective factor for the newborn. However, seven participants reported not having breastfed due to some difficulties that hampered this moment, such as secretion or amniotic fluid in the airways and the baby's drowsiness[8]. These puerperae reported impaired SSC time, lasting 10-15 minutes instead of 30 minutes or more, as the Ministry of Health recommended. Three thematic categories were built from the analysis of the information obtained, and they are discussed below.

EXPERIENCING THE FIRST FEELINGS WHEN MEETING AND BREASTFEEDING THE BABY

In this category, the puerperae interviewed talked about their experiences and feelings during the SSC with their babies. As seen in the following account:

(M05) "(...) I didn't have this contact with my first child, so it was hard for me to adapt to him, so much so that he didn't even breastfeed. Not my girl. I pick her up, and she becomes increasingly calmer; she stops crying when she hears my voice."

According to the Ministry of Health[8], several benefits are expected when performing SSC, such as stabilizing the baby's vital parameters; keeping the newborn's body temperature; strengthening the bond between mother and newborn; and favoring the adaptation of extrauterine life. SSC also increases the amount of breast milk. Monteiro's study[2] points out that when meeting her child for the first time, women's body activate prolactin to support breastfeeding and release oxytocin, which acts on uterine contractility, preventing hemorrhage and anemia in the postpartum period. Furthermore, it curbs adrenaline, reducing postpartum anxiety, which calms postpartum women. Therefore, breastfeeding is essential in the first hours of life. As a result, SSC jointly with early breastfeeding contributes to the newborn's good sucking and stimulates the production of hormones crucial for generating and producing milk in the mother's body.

According to the WHO[5], skin-to-skin contact is the fourth step of the "Ten Steps to

Successful Breastfeeding". Therefore, early contact, including touching the nipples, can have significant effects on maternal behavior in general and on the mother-child bond. This contact can be valuable and should be encouraged for mothers who do not intend to breastfeed and those who do. To this end, breastfeeding should be encouraged from birth to ensure the newborn's spontaneity regarding his willingness to breastfeed, which usually occurs within an hour of birth but can vary and take place at any time within the first two hours.

When asked what skin-to-skin contact would be like in the first hour of life, the postpartum women responded:

(M02) "In this case, would it be the baby with me? I can't tell."

(M03) "Is it touching each other? Is it that? The baby, I don't know."

(M04) "I think it's us with the baby, right?"

(M05) "I don't know how to explain it. It's the mother in contact with the baby, breastfeeding, things like that?"

The accounts above denote critical weaknesses regarding postpartum women's knowledge of SSC. These vulnerabilities are directly linked to the need for more previous information on the topic, causing uncertainty in answering the question. The health team should pass this knowledge on as guidance during prenatal care since pregnant women must understand the SSC concerning the benefits and the ideal way to perform it.

The results confirm the study by Jung et al. in a private hospital in the Vale dos Sinos region, Rio Grande do Sul, in which only two participants reported receiving information about SSC during prenatal care[14]. The Ministry of Health[10] points out that health professionals, including nurses, are fundamental to the success of skin-to-skin contact as they must guide pregnant women, even during primary care appointments. Thus, weaknesses regarding health education behaviors and SSC guidance can be identified.

In the following account, the parturient compares the current birth to the experience of a previous delivery in which the SSC was not performed:

(M05) "(...) Yes, very important. I really liked it. My first child wasn't like that. I really liked this one, so much so that she sits calmly on my lap".

Gains can be clearly seen concerning breastfeeding and establishing a mother-child bond in the face of effective SSC. Corroborating the above, skin-to-skin contact favors the onset of breastfeeding in the first hour of life[15]. Therefore, it is necessary to offer qualified support to mothers during the first breastfeeding and, when necessary, in subsequent sessions to ensure that the newborn has adequate suction and breastfeeds effectively. Support should be offered appropriately and encouragingly, and be sensitive to the mother's desire for privacy. It is also crucial to ensure the mother and baby stay in joint accommodation in maternity wards[16].

Thus, for implementing an effective SSC, it is necessary to train the multidisciplinary team that works with puerperae and newborns to sensitize them regarding this care practice, as inadequate hospital routines and techniques can end up interfering with the efficacy of the moment[10].

TIME INFLUENCE ON THE SKIN-TO-SKIN CONTACT

In this category, the pregnant women interviewed talked about the time they had skin-to-skin contact with their babies:

(M01) "It was quick because she had discharge. It was speedy. I believe that for a maximum of two minutes. She didn't cry; she was vital, but she was as if she were regurgitating".

(M04) "It was about 5 minutes".

(M07) "We stayed together for 1 hour, then they went to pick her up for triage".

(M10) "The doctor left him for about 40 minutes, cleaned him, and then put him skin to skin."

(M11) "About 10 minutes".

The statements reveal that many accounts indicate that the skin-to-skin contact time did not follow the Ministry of Health's proposal. Comparing this data with Jung's et al.[14] study, we identified that accounts are congruent as the participants also reported a short SSC time.

According to data from Fiocruz[17], the most important thing is respecting the first skin-to-skin contact for an hour or more. From the first hour onwards, the professional can quickly pick babies up, do the routines, and put them back on their mother's lap. Notably, practices far from the comprehensiveness proposed in the 1988 Federal Constitution are performed at the hospital, as the focus is only on the sector's routine so that everything is done and resolved quickly, thus resulting in inefficient and often non-existent SSC and early breastfeeding.

Adhering to the fourth step of the BFHI is still a challenge throughout the national territory. Furthermore, high cesarean section rates hamper this good practice[18]. Although cesarean birth can be considered an obstacle to achieving contact, good practices must be adopted in both delivery types[19]. An article by Silva LLA et al.[20] points out that recent studies on this topic reveal that no patient undergoing a cesarean section had the opportunity to perform the fourth step of the ten recommended by the Baby-Friendly Hospital Initiative. This step involves placing babies in skin-to-skin contact with their mothers immediately after birth for at least one hour, encouraging them to recognize when their babies are ready to be breastfed as recommended.

(M13) "That's what they did to him. They took him out, cleaned him a little, and brought him to me. They left him on me for an hour until the cesarean section was over".

The account shows that it is possible to perform SSC even in the face of difficulties in the Surgical Center environment, such as strong lights, cold space, noise, and traffic of many professionals who may need to make the environment more comfortable. Fiocruz[17] affirms that there are other obstacles besides the ambiance of the delivery room being unfavorable for SSC, such as training the team working in the obstetric center on this evidence and good birth practices, support from the team so that the companion can help with skin-to-skin contact, and changing flows and routines so that skin-to-skin contact is a constant in surgical deliveries.

HEALTH PROFESSIONALS' CONDUCT IN SKIN-TO-SKIN CONTACT

Professional conduct from the perspective of postpartum women will be discussed in this category. Delayed clamping of the umbilical cord, immediate skin-to-skin contact, and the initiation of exclusive breastfeeding are three simple practices that provide instant benefit to the newborn and have a long-term impact on nutrition and the health of the mother and baby and possibly affect the child's development well beyond the neonatal and postpartum periods[16].

Therefore, health professionals should pay attention to the needs of these practices and their implications. As a result, professionals' conduct must transcend technique. Professionals should guarantee postpartum women's primary role, confidence, and safety throughout the process, as noted in the following statement:

(M07) "Your (nursing) participation was excellent. The girls (nurses) were very nice. It helped me a lot. I had a trauma with my number 5 (fifth child) because this is number 6, so I didn't know if I could do it or not. They helped me a lot. The nurse gave me confidence that I was capable again, right? I had a (childbirth) block."

Given the above, one understands how important it is for the team to ensure that all measures to facilitate the SSC are taken[14]. This mother's report also highlights that professional support provided during childbirth was essential to achieve what is currently recommended since she delivered her child without complications and performed skin-to-skin contact.

Therefore, the account proves how meaningful the participation of the health team is in encouraging the parturient and facilitating her autonomy and leading role throughout the pre-, trans, and postpartum process. Because it is a unique moment in the life of both the woman and her family network and brings meanings where women often find themselves in a situation of vulnerability, insecurity, fear, and anxiety, it should not be treated superficially and disrespectfully but rather a humanized way and focusing the primary role of the moment on the parturient and her baby[21].

Thus, health professionals must encourage and support postpartum women, always paying attention to the dyad to make this contact as pleasurable and effective as possible. In this setting, health professionals play an essential role as supporting actors[22].

The following account points out that it is necessary to respect women's autonomy and decisions during SSC since, when identifying something different in her baby, the puerperae preferred that the health team take the newborn to be evaluated, and her decision-making was respected.

(M01) "I was very nervous at the time because I saw that she hadn't cried. I saw her regurgitating, [...] something was wrong, I preferred that they take her".

The SSC is when the bond created and established during pregnancy strengthens. It is a period that facilitates the establishment of a mother-child bond. Given this report, we see that the mother knew how to get to know her baby, identify her needs, and understand that she was not well during skin-to-skin contact.

The bond developed during pregnancy, and the SSC was essential for this identification. The mother who interacts with her child from the first hours of life takes ownership of the maternal role, understanding her child's needs and offering the necessary care to the baby. Therefore, healthy bonding reflects the child's development and the construction of adequate motherhood[23].

A factor that corroborates this mother-child recognition is hormones. The study by Russo and Nucci[24] reports that the hormone oxytocin, released by the woman's body during childbirth and breastfeeding, is responsible for the intense and emotional bond naturally established between the mother and baby during postpartum and breastfeeding, agreeing with the M01 account above, in which the mother identified her daughter's needs due to the bond established.

The following report clearly shows the postpartum woman's joy in feeling like she was the leading player of her birth before the team that assisted her at the time:

(M09) "Wow, it's essential! Essential because from the moment he came out, I only heard: 'Look how he has calmed down; he cried very little'. So, it was not a traumatizing experience for him since he left my belly, you know. So much so that he even opens his eyes. Wow! I thought it was sensational; it was enjoyable."

In this way, routine care and unnecessary manipulations of the baby can wait, as they are less important than the baby's stay with his/her mother in skin-to-skin contact immediately after birth[25]. Abdala and Cunha[15] say that the newborn should not be separated from his/her mother at birth except for significant clinical reasons. Therefore, the birth site should be a receptive, silent environment with an ideal temperature to avoid making this process disruptive and inefficient[9].

However, as the study was limited to a single institution, it is interesting to analyze other settings to contribute to and better evaluate SSC's effectiveness at the national level. Finally, another limitation of the study is incomplete data in the medical records, which prevents us from identifying the postpartum women eligible to be included in the research. Some documents should have recorded whether or not the SSC occurred and its length.

CONCLUSION

We identified that the study achieved its objective by constructing and discussing the thematic categories, which showed the experience of feelings, the influence of SSC time, and the overview of health professionals' behaviors for the best postpartum women experience.

However, we observed difficulties in performing the SSC recommended by the literature employed, mainly regarding the team's interventionist and concerned attitude in following the routines determined by the hospital, often forgetting the relevance of that moment for the benefit of mother-baby's health. The accounts revealed that postpartum women had positive feelings regarding childbirth, SSC, and postpartum care, expressing contentment and gratitude to the team.

Besides in-hospital care, at birth and postpartum, we observed that comprehensive prenatal care was deficient regarding previous guidance on skin-to-skin contact, early breastfeeding, and their benefits. Given this, many postpartum women were insecure, fearful, and anxious about what this moment would be like, as guidance was provided by the Obstetric Center team at birth. However, through guidance and encouragement from the team, placing trust, and allowing maternal autonomy and leadership, SSC, and breastfeeding in the first minutes of the newborn's life were gentle and exciting moments, especially for multiparous mothers who did not have this experience in previous births.

Given maternal feelings concerning SSC and the weaknesses identified in this research, the training of professionals to raise awareness on practical techniques and conduct enriching and well-oriented prenatal care is relevant and fundamental for a better experience of this moment.

Thus, the study becomes relevant for professionals reflection and stance, predicting that the results will contribute to better obstetric practices toward fully humanized and comprehensive care centered on the biopsychosocial needs of the actual leading figures of the birth scene.

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26. Na lista de referências ao final do artigo devem ser numeradas consecutivamente, conforme a ordem que forem mencionadas pela primeira vez no texto de acordo com o Estilo Vancouver, espaçamento simples e alinhados a esquerda.