

## **STANDARD OPERATING PROCEDURE FOR IMPLEMENTATION OF SKIN-TO-SKIN**

1. The care that a mother experiences during labour and birth can affect initiation of breastfeeding and her ability to care for her baby.
2. Skin-to-skin is practiced in medically stable infants and mothers.
3. Skin-to-skin contact should start immediately or as soon as possible in the first five minutes after delivery.
4. The infant must be delivered onto the mother's abdomen before cord clamping and remain there as long as the mother is happy as per the 2015 Maternity Guidelines.
5. This is an opportunity to initiate breastfeeding.
6. During Antenatal Care Classes or before delivery discuss with the mother her wishes regarding skin-to-skin.
7. Explain the benefits of skin-to-skin during health education referring to the following benefits thereof:
  - a. Regulates infant temperature, heart rate and respiration.
  - b. Assists with metabolic and glucose stabilisation in the infant.
  - c. Enables colonization of the infant's gut with the mother's normal body bacteria.
  - d. The release of oxytocin promotes contraction of the uterus and stimulates the breast to release colostrum.
  - e. Allows infant to find the breast and self-attach which is more likely to result in effective suckling (rooting reflex).
  - f. Reduces infant crying and therefore stress for both mother and infant.
  - g. Mother more likely to want to breastfeed straight away.
  - h. Calms mother and infant so promotes bonding.
8. Skin-to-skin contact should be carried out by observing the following principles:
9. In a normal situation delivery of infant can be straight onto the abdomen. Therefore skin-to-skin can be done immediately.
10. Dry the infant's head and body while on the mother's abdomen.
11. Allow the infant freedom of movement so that he can crawl up to chest of mother unhindered (breast crawl).
12. Should an infant be too drowsy to seek the breast himself, place him between the mother breasts and place a towel or blanket over the infant.
13. Ensure both mother/ carer and infant are comfortable and secure.
14. The care can continue with other immediate delivery care duties while being aware of the safety of mother and infant.
15. Infant observations and care can be conducted while infant remains skin-to-skin on the mother's chest or abdomen.
16. Ensure unhurried, uninterrupted skin-to-skin contact for at least one hour, but ideally for longer and throughout the stay in postnatal ward.

### **How to advise a mother to provide skin-to-skin care for her infant:**

17. Encourage the mother to lean back in bed at an angle of 30-40 degrees as this supports infant's breathing.
18. Place the naked infant gently on the mother's naked chest facing her, with infant's legs curled up in the Foetal position which is more comfortable for the baby
19. Gently turn infant's head sideways, putting the infant's hands near his/ her face for self-soothing.
20. Encourage the mother to hold her hands underneath and behind her infant.
21. Cover the mother and the infant.
22. The mother's body will automatically warm up the infant.

23. Reassure her that she may feel warm to but this will only ensure her infant is warm enough. If it is cold in the room, you may want to put a cap on the infant's head.

### Special Circumstances

24. In special circumstances such as a caesarean section, skin-to-skin can commence in the operating theatre or the recovery room if both the mother and the baby is medically stable.

25. Place the infant skin-to-skin on the mother's chest following the skin-to-skin procedure described above.

26. Mother and infant should leave the theatre together in skin-to-skin position.

27. The infant should be securely tied onto the mother's chest with his/her neck extended.

28. If the mother is too ill, the infant can be placed on the father's or birth companion's chest as soon as possible after delivery of the infant.

29. Challenges in implementation of skin-to-skin can be addressed as per the table below:

<b>Potential Barriers to skin to skin</b>	<b>Potential Changes in Practice</b>
Health care providers are concerned that infant will not maintain temperature and is at risk of hypothermia.	<ol style="list-style-type: none"> <li>1. Dry the baby and place baby naked on the mother's chest.</li> <li>2. Put a dry cloth or blanket over both the baby and the mother.</li> <li>3. If the room is cold, also cover the baby's head to reduce heat loss.</li> <li>4. Infants in skin-to-skin contact have better temperature regulation</li> </ol>
Routine physical examination and weighing of the infant.	<ol style="list-style-type: none"> <li>1. Most examinations can be done with the baby on the mother's chest where baby is likely to be lying quietly.</li> <li>2. Routine care such as weighing can usually be done later unless required for medical reasons</li> <li>3. If weighing is urgently require, it can be done in the birthing room at bedside and not in a separate room. Return the baby to the mother as soon as possible to continue skin-to-skin.</li> <li>4. Continue skin-to-skin without dressing or wrapping the baby.</li> <li>5. A nappy may be placed on the baby.</li> </ol>
Mother requires lithotomy for procedure such as suturing.	<ol style="list-style-type: none"> <li>1. The infant can remain on the mother's chest if an episiotomy requires suturing as long as it is positioned safely.</li> <li>2. Skin-to-skin can be an effective distraction for the mother.</li> </ol>
Health care provider wants to bathe infant.	<ol style="list-style-type: none"> <li>1. Delaying the first bath allows for the vernix to soak into the baby's skin, lubricating and protecting it.</li> <li>2. It reduces risk of heat loss.</li> <li>3. A first bath is only required if baby is soiled with meconium/blood/offensive liquor or as a demonstration bath for first time mother.</li> <li>4. It should only be performed during the day and the infant's temperature must be above 36.5°C before bathing</li> <li>5. Baby must be wiped dry after birth to avoid hypothermia.</li> <li>6. It is encouraged that skin-to-skin continue after the bath.</li> </ol>
Unavailability of KMC wraps	<ol style="list-style-type: none"> <li>1. Encourage pregnant women to make their own or bring their own wrap and cap when coming to deliver their baby.</li> <li>2. Alternatively if not available, the facility can use sheets and towels to secure babies to mothers' chests.</li> </ol>
Delivery room is busy and mother and infant need to be transferred to post-natal ward.	<ol style="list-style-type: none"> <li>1. If the delivery room is busy, the mother and baby should be transferred to the ward in skin-to-skin contact.</li> <li>2. Contact should continue on the ward.</li> </ol>

Potential Barriers to skin to skin	Potential Changes in Practice
No health care provider available to stay with mother and infant.	<ol style="list-style-type: none"> <li>1. Staff are not required to observe skin-to-skin contact for the full period, ensure mother is safe and well.</li> <li>2. Mothers will appreciate this time to get to know their infant in privacy.</li> <li>3. The birthing companion or family member can stay with the mother and baby.</li> </ol>
Infant appears drowsy, is not alert.	<ol style="list-style-type: none"> <li>1. If a baby is sleepy due to maternal medications it is even more important that the infant has skin-to-skin contact as he/she needs extra support to bond and feed.</li> </ol>
Mother is exhausted after delivery.	<ol style="list-style-type: none"> <li>1. A mother is rarely so tired that she does not want to hold her baby.</li> <li>2. Contact with her baby can help the mother to relax.</li> <li>3. After the first breastfeed baby and mother often sleep very well due to the release of Oxytocin.</li> <li>4. Review labour practices such as withholding fluid and foods, and practices that may increase the length of labour, which can leave the mother lacking energy.</li> </ol>
Mother does not want to hold her infant.	<ol style="list-style-type: none"> <li>1. If a mother is unwilling to hold her baby it may be an indication that she might be nervous about holding her baby and just needs support and reassurance.</li> <li>2. Continued resistance to bonding could be an indication that she is at risk of depression, mother/infant bonding may be compromised.</li> <li>3. Encouraging skin-to-skin contact enhances bonding and is important as it may reduce the risk of harm to the baby.</li> </ol>
Twin delivery.	<ol style="list-style-type: none"> <li>1. Twin that is delivered first can have skin-to-skin contact with mother until the mother starts to labour for the second birth.</li> <li>2. Alternatively first twin can have skin-to-skin contact done by birthing companion for warmth and contact while the second twin is born.</li> <li>3. The mother can alternate skin-to-skin contact with the twins when she is ready, or hold both babies at the same time.</li> </ol>
Staff knowledge and attitudes	<ol style="list-style-type: none"> <li>1. Training and upskill of staff in skin to skin will improve attitudes. A positive or negative attitude will strongly influence outcomes. Having a good, can-do attitude will influence fellow staff members as well as clients.</li> </ol>
Caesarean section	<ol style="list-style-type: none"> <li>1. There is often a concern either for mother or infant's health which can delay skin-to-skin care after surgery.</li> <li>2. Recovery room staff need to be educated regarding the benefits of breastfeeding and their role in supporting skin-to-skin care and how to do it, and, if possible, practice this in recovery room.</li> <li>3. It has been shown that post-caesarean pain can be decreased when doing skin-to-skin (1).</li> <li>4. If not be feasible, skin-to-skin should be practised as soon as possible in the postnatal ward. Keep in mind that a mother will need additional support and that skin-to-skin can also be done by the birth companion.</li> </ol>