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EXPERIENCES OF PUERPERAL WOMEN IN SKIN-TO-SKIN CONTACT WITH NEWBORNS IN THE FIRST POSTPARTUM HOUR

EXPERIÊNCIAS DE PUÉRPERAS NO CONTATO PELE A PELE COM RECÉM-NASCIDO NA PRIMEIRA HORA PÓS-PARTO

EXPERIENCIAS DE PUÉRPERAS EN CONTACTO PIEL CON RECIÉN NACIDO EN LA PRIMERA HORA POSTPARTO

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Objective: to describe experience of puerperal women on skin-to-skin contact with the newborn in the first hour after delivery. Method: qualitative research, carried out in the Joint Accommodation of the *Hospital Universitário da Universidade de São Paulo*, Brazil. 20 puerperal women were interviewed between July and December 2019. Content analysis was used, using the Atlas.ti 9 software. Results: three categories were unveiled: Surprising with the experience of skin-to-skin contact; Ambivalent feelings regarding skin-to-skin contact; and Reflecting on the actions of professionals regarding skin-to-skin contact. Final considerations: the experience was considered positive and different from previous experiences, despite insecurity and limited access to information since prenatal care. Skin-to-skin contact does not imply additional expenses, does not pose risks to the binomial, provides high quality care, contributing to the satisfaction of the woman and health benefits of the newborn.

Descriptors: Mother-Child Relations. Infant, Newborn. Postpartum Period. Humanizing Delivery. Obstetric Nursing.

Objetivo: descrever experiência de puérperas sobre o contato pele a pele com o recém-nascido na primeira hora após o parto. Método: pesquisa qualitativa, realizada no Alojamento Conjunto do Hospital Universitário da Universidade de São Paulo, Brasil. Foram entrevistadas 20 puérperas entre julho e dezembro de 2019. Utilizou-se a análise de conteúdo, com auxílio do software Atlas.ti 9. Resultados: foram desveladas três categorias: Surpreendendo-se com a experiência do contato pele a pele; Sentimentos ambivalentes em relação ao contato pele a pele; e Refletindo sobre ações dos profissionais quanto ao contato pele a pele. Considerações finais: a experiência foi considerada positiva e

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diferente de experiências anteriores, apesar da insegurança e do acesso limitado a informações desde o pré-natal. O contato pele a pele não implica em gastos adicionais, não oferece riscos para o binômio, proporciona alta qualidade no atendimento, contribuindo para a satisfação da mulher e benefícios à saúde do recém-nascido.

Descritores: Relações Mãe-Filho. Recém-Nascido. Período Pós-Parto. Parto Humanizado. Enfermagem Obstétrica.

Objetivo: describir la experiencia de las puérperas sobre el contacto piel con piel con el recién nacido en la primera hora después del parto. Método: investigación cualitativa, realizada en el Alojamiento Conjunto del Hospital Universitário da Universidade de São Paulo, Brasil. Fueron entrevistadas 20 puérperas entre julio y diciembre de 2019. Se utilizó el análisis de contenido, con ayuda del software Atlas.ti 9. Resultados: fueron desveladas tres categorías: Sorprendiéndose con la experiencia del contacto piel a piel; Sentimientos ambivalentes en relación al contacto piel a piel; y reflexionando sobre las acciones de los profesionales en cuanto al contacto piel con piel. Consideraciones finales: la experiencia se consideró positiva y diferente de experiencias anteriores, a pesar de la inseguridad y el acceso limitado a la información desde el prenatal. El contacto piel a piel no implica gastos adicionales, no ofrece riesgos para el binomio, proporciona alta calidad en la atención, contribuyendo para la satisfacción de la mujer y beneficios para la salud del recién nacido.

Descriptores: Relaciones Madre-Hijo. Recién Nacido. Periodo Posparto. Parto Humanizado. Enfermería Obstétrica.

Introduction

The birth of a child is one of the most transformative and unforgettable moments for a family. It is a moment of approximation and recognition between the mother and the baby, in which the bond and the affective bonds are established[1] or even more strengthened.

Skin-to-skin contact between the newborn (NB) and its mother is recommended by the World Health Organization (WHO) for full-term babies from the first minute of life, in order to facilitate the adaptation of the newborn in its transition to the extrauterine environment[2]. In Brazil, the Ministry of Health (MH) established in 2014 the Ordinance n. 371, in which it addresses the immediate and continuous skin contact after delivery as one of the guidelines for humanized care to the full-term newborn[3]. In this context, skin-to-skin contact immediately after delivery means placing the naked baby directly on the mother's chest or bare abdomen, in a vertical position and covered with preheated fields[4]. The scientific literature describes numerous benefits when performed with the correct technique[5], both for the baby[6] and for the mother[7].

For the newborn, skin-to-skin contact assists in stabilizing the heartbeat and respiratory rate, reduces crying, stress and energy loss, as well as keeps the baby warm by transmitting heat through the skin of his mother, besides favoring the early onset of breastfeeding and colonization with the maternal flora, instead of hospital heating[6]. Whereas, for mothers, skin-to-skin contact increases endogenous oxytocin levels, reducing the time of placental discharge and reducing postpartum bleeding[7].

Depending on the context in which skin-to-skin contact is performed, there are different maternal perceptions about this procedure. When health professionals do not evaluate maternal conditions that may hinder skin-to-skin contact between mother and child, such as perineal suture and maternal fatigue, as well as lack of information, this experience can be understood by the woman as "a mechanical act" or something obligatory[8]. On the other hand, women who are previously informed about skin-to-skin contact and its importance demonstrate satisfaction with this care in the immediate postpartum period, probably due to a strong sense of being heard and having confidence in the health team[1].

Maternal satisfaction about the assistance offered to him should be considered, since it means respecting and listening to the woman's opinion, in a process of sharing information and therapeutic decisions. Approaches with such

characteristics are present in the implementation of non-invasive care technologies in obstetric nursing. Such technologies are defined as all techniques, procedures and knowledge used by nursing staff during the care process, whose main characteristic is to be non-invasive[9], promoting demedicalization based on scientific evidence, considering labor, delivery and birth as physiological and non-pathological phenomena, but above all significant phenomena as human experiences.

According to the WHO, there is scientific evidence that several non-invasive care practices are strongly recommended during pregnancy, labor and delivery, as they promote better obstetric results, with a positive impact on perinatal outcomes[2] health of the population. Notwithstanding the demands for humanized care and adequacy of services, these changes are still not realities in several Brazilian care contexts, with the practice based on biomedical and interventional model and high rates of cesarean sections in the country[10].

This situation reinforces the importance of institutions that provide assistance to women and newborns restructure their services, mainly through training at the technical level, undergraduate and graduate, as well as the permanent education of its professionals in order to deconstruct the interventionist[10] and ritualistic model, which does not contemplate the individualization of care and the provision of better experiences to women. The WHO emphasizes that teaching and research should be prioritized, because it is through them that innovations and improvements in the experience of childbirth reported by women arise[2].

Therefore, in view of the recommendation of skin-to-skin contact and its benefits to mother and child health, its contribution to reducing neonatal mortality provided for in the Sustainable Development Goals - 2030 Agenda[11], as well as the urgency to include the perspective of the user of health services to better serve it, the following question arose: What are the experiences of puerperal women about skin-to-skin contact experienced after childbirth? Given the relevance of this theme for the improvement of health care for women and their child, the objective of this article is to describe the experience of puerperal women on skin-to-skin contact with the newborn in the first hour after delivery.

Method

This is a descriptive, qualitative research, carried out in the Joint Accommodation (JA) of the *Hospital Universitário* (HU) of the *Universidade de São Paulo* (USP), in the city of São Paulo, Brazil. The participants were pre-selected from the book used by the team of the Obstetric Center (OC) of HU-USP to register births in the hospital, in which there is a field designed to indicate whether the puerperal women made skin-to-skin contact with the newly born immediately after childbirth.

They were selected to participate in the study of puerperal women, on the second day postpartum, hospitalized in the premises of the Joint Housing of HU-USP, who received or not the spinal anesthesia during childbirth, between 18 and 35 years and who made skin-to-skin contact with the NB in the first hour after delivery without interruption. The choice for the second day postpartum to interview the puerperal women occurred because it is the day of hospitalization that tends to be more peaceful, according to the clinical experience of the authors of this study and the routine of the study site: on this day, the woman has already been able to rest and familiarize if with your baby. On the third day, they usually leave with the NB, which causes euphoria in the family and hurry to return home.

Among the women who had skin-to-skin contact in the postpartum period, post-cesarean delivery women, post-vaginal delivery women who had obstetric intercurrences, some cognitive or communication impairment or chemical dependency were excluded.

For data collection was used an instrument composed of two parts. The first one presented closed questions with characterization data (name, age, marital status, schooling, parity,

number of prenatal consultations in the current pregnancy and whether it was informed about skin-to-skin contact). The second part was a semi-structured interview script, with the trigger question: How was it for you to experience/ experience skin-to-skin contact with your baby after childbirth? The script also presented some topics that could be further explored if they were approached superficially by the participant. Thus, the interviewer sought to explore, to better understand the experience of each woman: feelings/sensations during skin-to-skin contact with the baby; expectations; information received before delivery and during skin-to-skin contact; duration of contact - whether deemed appropriate or not; knowledge about the benefits of skin-to-skin contact for mother and baby; behavior of the baby during contact.

In view of the ethical aspects and the strategy for conducting the interviews, the participants were initially clarified about the study objectives, reasons, risks and benefits, and invited to participate. Upon expression of interest, the Informed Consent Form (ICF) was presented, read and signed. The interview was recorded in audio, using mp4 player. To ensure privacy, the interview was conducted in a room reserved in the Joint Accommodation, where only the interviewer and the participant were. Anonymity was guaranteed by identifying the lines with the letter E followed by the cardinal number that identified the order of the interview.

Thus, participants were included and semi-structured interviews were conducted with puerperal women until theoretical saturation, in the morning and afternoon, according to the availability of the unit and the postpartum women, between July and December 2019.

Thematic content analysis was used to analyze the data[12]. For the application of this technique, the following steps were followed: pre-analysis, exploration of the material and treatment of the results, inference and interpretation[12]. For the organization of the material, the qualitative analysis software ATLAS.ti9 was used. Through the report issued via software, it was possible to construct three categories with 365 codes (registration units) and 15 related groups (meaning units): "Surprising with the experience of skin-to-skin contact", "Ambivalent feelings regarding skin-to-skin contact", and "Reflecting on the actions of professionals regarding skin-to-skin contact".

All ethical procedures for the study were respected, according to Resolutions n. 466/2012 and n. 510/2016, of the National Health Council. The project was evaluated and approved by the Research Ethics Committees under Opinions n. 3.301.505/2019 and n. 3.331.154/2019, Certificate of Presentation of Ethical Appreciation (CAEE): 06501519.3.0000.5392 and 06501519.3.3001.0076.

Results

Twenty puerperal women, aged between 18 and 35 years participated in the research. Most (12) reported living a stable union. Regarding schooling, 9 reported complete High School, followed by incomplete Higher Education (5), complete Elementary School (4), incomplete Elementary School (1), and complete Graduate (1). Regarding parity, 6 were primigravidae, 8 secundigravidae, 4 tergypsies and only 2 were in the fourth pregnancy or more. All underwent prenatal follow-up: 13 of the interviewees had 8 or more consultations; 3 reported 7 consultations; 2 between 4 and 6 consultations and 2 between 1 and 3 consultations. Although all the interviewees had prenatal care, only two received information about skin-to-skin contact in one of these visits.

Category 1: Surprising with the experience of skin-to-skin contact

The experience of skin-to-skin contact generated surprise for the puerperal women, sometimes generating ambiguous feelings, but being perceived positively and based on previous experiences, as we can observe below.

Considering a different experience from previous experiences

The reports were linked to the previous experiences of the postpartum women. "Previous

experiences", here, means having had another birth or having accompanied or heard about someone's experience of skin-to-skin contact with the newborn in the postpartum period.

They stated that the experience of skin-to-skin contact was surprising, as in previous experiences, they experienced rapid rapprochement with the baby and then referral to routine procedures. They reported the impossibility of touching the baby immediately after delivery and the delay in finding him again.

> *I was surprised, because my other daughter, as soon as she was born, they put it on top of me, but it was a matter of seconds, just so I could see her face* [...] *then they took her to the nursery and I just went to see her the other day*. (E2).

> *I was surprised because usually they give a kiss and only then bring it to us*. (E4).

> *This is my fourth son and he was the only one who came into skin-to-skin contact with me* [...] *So, making skin-to-skin contact was so cool and amazing! Feel her on top of me, moving, sleeping! Congratulations!* (E15).

The mothers narrated that, although some separation from the baby is expected to occur after birth, not having him around caused a feeling of insecurity, despair and fear. In addition, they considered this separation action as violent.

For these women who had previous births, it was possible to experience the stay with the baby in the lap for an hour on this occasion. This surprising experience for them also brings statements about the recognition of an improvement in care. However, receiving the baby in the arms generated estrangement for some. The interviewees said they imagined the service being done very mechanically in hospitals, especially in the public service network, and were surprised that it was not so. They felt distant from the possibility of this type of care, believing it to be possible only for famous women in private hospitals, as they usually see in social networks and the media.

> *Because in the past they took and took the baby, you did not even see the face and already took to another room, and this gave you a very great insecurity right?* (E5).

> *I thought that in the hospital things were a bit mechanical, and today it was very different, it was very good, much better*. (E13).

> *I've seen cases of acquaintances and photos of famous people who, after childbirth, took pictures with the baby in their lap. In this situation, I imagined: Wow! It should be very cool, the baby out of the belly and go straight to the lap*. (E19).

Positively qualifying the experience of skin-to-skin contact

The women described this experience with a cheerful and euphoric attitude. They described the experience as new, wonderful and fundamental. They emphasized that the experience generated memories for life and demonstrated difficulties in explaining with words what they felt at the time. Also, they considered that all mothers should have this opportunity. Care and zeal were adjectives used to refer to the team present during skin-to-skin contact.

> *It was a good experience that all pregnant women should pass*. (E11).

> *I felt a greater care, a zeal of the team with us! And also mine with the baby, because I was with him. So I felt care, zeal*. (E19).

The participants emphasized that skin-to-skin contact made a difference for them and was a milestone for the recognition of maternal identity, especially for those who had not planned pregnancy and did not feel like mothers until then. Taking the baby in the lap, immediately after childbirth, re-signified the feeling of being a mother.

> *So I think this moment* [skin-to-skin contact] *made all the difference for me* [laughs]. (E14).

> *I knew I was going to be a mother, that I was expecting a baby, I did all the preparation of trousseau, tea, photos* [...] *When she touched me, I said: she's mine!* [...] *In this contact, I got caught up. It was the time I said: I am a mother!* (E17).

When they reported their perceptions about the behavior of the baby at the time of skin-to-skin contact, they reported that they perceived him as calm in the lap and in visual contact with the mother.

> *Calm, quiet, even stopped crying!* (E7).

> *Calm! It seemed like he was already smelling the mother!* [laughs]. *The baby is safe with us*. (E8).

He was very calm, I even thought: Will he not cry? It seemed that nothing had happened. He was very calm, just looking at me. (E13).

The participants pointed to a moment of mutual recognition that favored the creation of a bond, even observed in the first days after childbirth. Recognition from the smell, warmth and sound of the heartbeat.

And I felt that with this contact, he became more attached to me. There's a time he doesn't want to suck, he just wants to be close to me. He wants to be well glued, I think it was through this contact in the first hours of his life. (E12).

I think it was also important for her to create this bond. Which she already had in her belly, but to feel the warmth of her mommy too! (E14).

Regardless of success in breastfeeding in the first hour, the puerperal women instinctively reported the baby's demand for the maternal breast. Even those who reported difficulties with the grip, positioning of the baby in the chest or sucking difficulties of the baby, did not disqualify the experience nor the importance of skin-to-skin contact in the first hour.

She sucked. It was even interesting, because she is so tiny, she had no training, but by the time they put her on my breast she already began to suck. (E17).

[...] *she went alone with her head, like a turtle [laughs] and sucked [her chest]! And she was calm.* (E9).

Category 2: Ambivalent feelings regarding skin-to-skin contact

The mothers reported positive feelings when experiencing skin-to-skin contact with their baby. They narrated the experience with positive feelings, as a reward after their efforts during labor and childbirth. As they saw and touched their son or daughter, they realized that pain and fatigue were replaced by relief and love. They also described the experience as amazing, surprising and special.

I felt a lot of happiness and fulfillment too. (E6).

I cried with happiness because I got it! It was a lot of struggle [childbirth], *and seeing her little one on top of me, was very gratifying!* (E20).

Because childbirth, because it is normal, it is well suffered, very difficult, so after everything you go through, the baby leave and I have already come straight, you see that it is very worthwhile! (E17).

However, they presented concerns related to the new experience. They reported apprehension for the baby's health and fear of knocking him down or doing something wrong. However, the concerns were quickly overcome.

Because it was a new experience, I was a little scared. I was just afraid to do something wrong and stuff, but then I was good [...]. (E1).

It is very small, I was afraid to fall, I can not explain, but still the moment is good! (E7).

Ah! I don't know! we get a little apprehensive, not knowing if everything is okay with the baby [...]. (E9)

Category 3: Reflecting on the actions of professionals regarding skin-to-skin contact

Although in the previous category there was a report of perception of skin-to-skin contact as zeal by the team, regarding the previous knowledge of the participants about skin-to-skin contact, women mentioned a lack of access to information. They reflected that they received little information during prenatal consultations about what would happen during childbirth and postpartum, as well as were not oriented on the benefits of skin-to-skin contact.

It was something unexpected for me, because where I did the prenatal I was not informed of any of this, I did not know how it was going to be. (E14).

No, I had never heard of it, at any time. (E2).

I think we do not talk much about the newborn in prenatal care, talk more about pregnancy. And not what will happen to the baby after childbirth. (E19).

The information they had came from searches on their own on web pages, via the internet, on television programs or on social networks. With this, they knew that skin-to-skin contact was a beneficial action, but considered that it would be something distant from the expected reality due to being users of the public health care system.

Ah, I had seen it on the television show. But I hadn't had the experience [of skin-to-skin contact]. (E16).

Already, I had heard [...] *Not* [remember] *specifically, but I know it's better.* (E11).

The limitation of previous guidelines on skin-to-skin contact contributed to the interviewees arriving in labor with little or no information about it, which then triggered surprise and insecurity. At the hospital, they were also not informed at the time of hospitalization, nor during the clinical phases of childbirth, that they would receive their baby in their arms after birth.

> *No, I didn't even know! I heard about it at the table!* (E9).

> *Only at the time of delivery even* [...] *Who put him on top of me.* (E3).

> *No. It was only when she was born! I didn't know* [that she would make skin-to-skin contact after childbirth]. (E2).

> *Because it was a new experience I was a little scared* [...] *I was just afraid to do something wrong and stuff, but then I got good.* (E1).

> *It is very small, I was afraid to fall, I can not explain, but still the moment is good!* (E7).

An important point mentioned by the interviewees was the duration of skin-to-skin contact: they considered it sufficient, essential and optimal. They completed by assessing that they did not notice time passing and that the maternal availability to live this moment with the baby can not be counted on the clock.

> *I found enough* [time] *for both of us.* (E10).

> *It was an essential time for us, who had just put out a little being like that there. So it's great, an hour was great.* (E18).

On the other hand, negative perceptions about this time of skin-to-skin contact were also reported, in which the woman did not feel heard by the health team. Even claiming not to want this contact due to fatigue, skin-to-skin contact was imposed by professionals.

> *I said I wanted to get some rest. But she* [someone on the team] *said I had to stay with him* [baby]. *Then they put him on my chest and he stayed with me.* (E12).

> *I think I could have spent half an hour with him. And then they could take it out to examine and do things.* (E9).

Discussion

Skin-to-skin contact between mother and baby has physiological, psychoemotional and clinical benefits for both[5-7]. The evidence is so robust that it continues to support skin-to-skin contact in the first hour of a baby's life, as shown in the 2018 World Health Organization Review[2].

Even with all the benefits of skin-to-skin contact, it was found in this study that this valuable technology is not yet a common practice and causes both surprise and estrangement on the part of women. These, for lack of information, lead to childbirth expectations based on their life experiences, which does not include this model of care. Mother-child separation after birth is still a standard practice in current obstetric care, and may present as limiting factors women undergoing cesarean section, without companions and assisted by the same professional who performed prenatal care and childbirth[13].

These aspects demonstrate that the omission of the rights of pregnant women, associated with the lack of information and the indiscriminate use of unnecessary interventions, reinforce the technocratic model, based on procedures and rigid routine, still being hegemonic and sometimes considered by women as something "normal" or ideal[1], as well as by professionals who perpetuate it.

In the technocratic model, the parturient woman is placed in the condition of an incapable patient, losing autonomy and decision power over labor, childbirth and birth. Authority and responsibility belong only to professionals. In this context, especially in hospitals, the standardization of care is extremely evident and the vast majority of routine procedures are devoid of sensitivity and emotional involvement[14-15].

Faced with this reality, the humanistic model reacts to the excesses of hospitalization and medicalization, in order to reformulate institutions and make them more relational, individualized and empathic[14]. The care model in Brazil is in a transition phase - the technocratic model is still predominant, but it has been confronted with the care model focused on humanization[16]. Good practices guide this change, reorganize the service, stimulate research, strengthen and sensitize the team in order to offer quality assistance. Skin-to-skin contact is a fundamental

part of this proposal for qualified and humanized assistance to the mother and child.

In this perspective, several public programs have been developed with principles based on the humanization of birth care and citizenship rights. Even so, difficulties are found for the effective implementation of these programs in health services, which run into administrative, social, economic and cultural issues, as well as consolidated practices that are often based on the convenience of health professionals and institutions[17].

In this context, non-invasive technologies of obstetric nursing care can contribute to the change in the scenarios of care for women, as they guarantee a respectful, healthy and safe way to give birth and be born. Promote a welcoming environment, establish a bond with the woman, offer guidance on the best evidence, so that she can empower, rescue and understand childbirth as a physiological process, may cause these technologies to stop causing estrangement[18].

The interviewees showed satisfaction with skin-to-skin contact, rejecting the way focused on the procedures. According to the theory of non-invasive care technologies, a fundamental element is the waiting for the right moment for the manipulation of the body, through shared and active decision[19]. In contrast, the testimonies showed that women were not prepared and included for the experience of skin-to-skin contact, from prenatal care to birth; which is presented both in the category that addresses positive perceptions about skin-to-skin contact and in the category that covers the limitations of professional performance.

The testimonies show that it is still urgent to interrupt the cycle of reproduction of mechanical care and change the usual routines, giving voice to women, listening to what they bring and understanding the signs they present. In order for women to be able to decide and plan their care together with the team, it is essential that they have access to information. It is up to professionals to be facilitators for the fulfillment of this right[20], since the speeches indicate that they considered that skin-to-skin contact would not be accessible to women served in public health services.

In the present study, postpartum women reported positive feelings and advantageously qualified skin-to-skin contact. However, as they did not have access to information before the experience, mistaken expectations, fears and insecurities emerged, which could have been mitigated by reception and professional information. The speeches of the interviewees brought that, throughout the skin contact the unexpected skin, they felt fear about the health of the baby and apprehension about the risk of overthrowing it, which denotes the relevance of being prepared for it. These data reinforce how the lack of guidance can be harmful in the meaning of an experience[20].

In addition to the benefits related to strengthening the bond between mother and child, maintaining the baby's body temperature and favoring breastfeeding, early skin-to-skin contact is a technology that does not generate additional costs for the institution. In addition to stimulating breastfeeding, it assists in sucking, in the period and frequency of breastfeeding[21], and consequently contributes to reducing neonatal mortality and improving maternal health[6,11]. In addition, it increases family satisfaction and enhances the quality of care provided. Thus, every effort is essential for the implementation of this action in the immediate postpartum period. Obstetric health professionals have an ethical responsibility to support this practice through education and implementation[22] since prenatal care.

It is noteworthy that the monitoring of women during prenatal care still follows the same technocratic philosophy that ignores the psychosocial needs of women, not addressing in opportune and individualized moments themes related to labor, childbirth, birth and puerperium. However, it is of paramount importance the access to quality information during the gestational period for a full experience of this process. In addition, the educational process will prepare the woman for understanding and choices regarding the care

she and her child will receive, including skin-to-skin contact[23].

During the prenatal period the woman lives a period of physical and emotional preparation that can favor greater willingness to contact new information. Therefore, it is the opportune moment for the development of educational practices with the woman and her partnership, regarding the good practices of childbirth care, and can be performed in groups of pregnant women, motivated by the exchange of knowledge and experiences[24].

Another professional attitude that contributes to the redefinition of care is qualified listening. Knowing how to listen is as important as knowing how to guide[14]. Professionals working in prenatal care, labor and delivery should actively listen and identify the woman's desires and needs[23]. It is noteworthy that even a beneficial action can become an imposition if the woman does not understand what is happening and can not participate in the decision process on such conduct, as evidenced in the results of this study.

The data show that some women did not consider the long duration of skin-to-skin contact adequate and were not heard or oriented about it, being the action imposed by the professional, without opportunity for dialogue. Here it is found that probably the professionals did not identify the opportunity to perform individualized assistance, seeking to understand the perception and needs of women and health education, to help her understand the relevance of the proposed duration for skin-to-skin contact. In addition, if even after understanding the proposal, the woman does not wish to maintain skin-to-skin contact, this should be respected.

Given this scenario, it is essential to offer individualized assistance and to value the psychosocial aspects of the parturients. This assistance, which focuses on relationships based on ethical principles, which preserve the privacy and autonomy of women, providing a positive experience of the first moments after birth. In this sense, women need to receive information about the benefits of skin-to-skin contact from prenatal care so that, at the time of birth, this practice makes sense for them[24].

The results of this study revealed that skin-to-skin contact was considered surprising for women, with reports addressing achievement, happiness and gratitude. Despite previous experiences not humanized and the precariousness of information prior to the experience, it was perceived as relevant for the puerperal women, by helping them to re-signify motherhood, strengthen bond with the newborn, besides perceiving such contact as something that provided well-being also to the newborn, which proved to be safe, comfortable and with fewer episodes of crying. Also, they described skin-to-skin contact as a positive reward after experiencing childbirth. These data show how much professional activity that promotes skin-to-skin contact in an intentional and qualified way can positively interfere with the experience of mother and child, which corroborates findings of other authors[25].

Thus, as already mentioned, it is worrying that they have reached the active phase of childbirth without knowledge about the beneficial actions of skin-to-skin contact. In this context, it is urgent to overcome the model of organized health care through rigid routines in services that care for pregnant women at usual risk, both in prenatal care and in the hospital environment. Thus, the permanent education of professionals can contribute to improve care, support the practice of skin-to-skin contact[14] and implement humanized and non-invasive technologies of Obstetric Nursing care. Therefore, professionals need to be sensitized, participate in continuous improvement activities, as well as be monitored and guided in the implementation of best practices, scientifically based.

As a limitation of the research, it is cited the difficulty to capture participants due to incompleteness or lack of information in the book of records on skin-to-skin contact. Often, it was recorded whether or not the skin-to-skin contact was performed, but without specifications about its duration. This lack of standardization of the records may also denote the lack of understanding of the team regarding

the relevance of this care that, with scientific proof, has such positive impacts on maternal and child health.

This study contributes so that health education strategies can be implemented with women, focusing on minimizing the lack of knowledge and the consequent insecurities identified in the reports of the mothers about skin-to-skin contact in the first hour after delivery.

Final Considerations

Based on the experience of postpartum women who experienced skin-to-skin contact with their newborns in the first hour after delivery, they were positively surprised and considered an important experience for the development of maternal identity and strengthening of bonds, as well as for the well-being of the baby. However, something negative in this experience was the fact that they were not previously informed by professionals about this care, which led some to have ambivalent feelings about the experience, ranging from positive feelings such as joy and gratitude, fear of bringing down his own son and fears about his health.

Nursing should act in the dissemination of the benefits of skin-to-skin contact, both for pregnant women and the general public, as well as professionals in the obstetric area, prenatal services, social media and permanent health education actions.

In addition, it is suggested that undergraduate health courses and continuing education activities for professionals should address the relevance of this care for the health of women and babies.

Collaborations

1 – conception and planning of the project: Carla Marins Silva and Gabriela Basílio do Amaral;

2 – analysis and interpretation of data: Carla Marins Silva, Gabriela Basílio do Amaral, Aurea Tamami Minagawa Toriyama, Elenice Valentim Carmona and Elaine Lutz Martins;

3 – writing and/or critical review: Carla Marins Silva, Gabriela Basílio do Amaral, Aurea Tamami Minagawa Toriyama, Elenice Valentim Carmona and Elaine Lutz Martins;

4 – approval of the final version: Carla Marins Silva, Gabriela Basílio do Amaral, Aurea Tamami Minagawa Toriyama, Elenice Valentim Carmona and Elaine Lutz Martins.

Conflicts of interest

There are no conflicts of interest.

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