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Midwives' perceptions of skin-to-skin contact between the mother and baby after birth in selected rural primary healthcare facilities in Schoonoord, Limpopo province, South Africa

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Abstract

The implementation of skin-to-skin contact between the mother and baby immediately after birth is associated with the successful initiation of exclusive breastfeeding. Midwives have the responsibility to promote and support breastfeeding and ensure that the mother and baby are in a satisfactory condition. The purpose of the study was to explore and describe the perceptions of midwives regarding the implementation of skin-to-skin contact between the mother and baby after birth in selected primary health care facilities in Schoonoord, Makhuduthamaga Sub-district of the Limpopo province, South Africa. This study employed a qualitative, exploratory and descriptive approach to understand the perceptions of midwives with regards to implementation of skin-to-skin contact between the mother and baby after birth. Face-to-face individual interviews were used to collect data and Tesch's method of data analysis was applied to analyse data. Three themes emanated from the study, namely: awareness about skin-to-skin benefits, facilitating factors for successful implementation of skin-to-skin and perceived barriers to the practice of skin-to-skin during birth. This study recommends that on-going education and unit-based in-service training for mother-baby friendly practices should be established and strengthened. Furthermore, a model of support for mother-friendly care amongst midwives in primary healthcare facilities should be developed.

Keywords: Midwife, mother, baby, perceptions, skin-to-skin.

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Introduction

Skin-to-skin contact refers to the holding of a baby's naked body to the bare chest of the mother as it assists facilitates the adjustment of a new-born to being outside the womb (Moore, Anderson, Bergman & Dowswell, 2012; Olsson, Eriksson & Anderzén-Carlsson, 2017). Ideally, this should take place immediately after the birth within thirty minutes (Alenchery, Thoppil, Britto, de Onis, Fernandez & Rao, 2018) and as frequently as possible during the first few

days of life. The World Health Organisation (WHO) (2011) recommends that babies and their mothers should remain skin-to-skin for an hour after birth and continue after discharge. Midwives have the responsibility to make sure that the condition of the baby after delivery is satisfactory and are responsible for the early initiation of breastfeeding as they are the first primary caregivers during birth period. Evidence-based practice has shown numerous advantages of mother-baby skin-to-skin contact such as its impact on breastfeeding initiation, reduction of formula supplementation, facilitation of bonding and maintenance of the baby's temperature while reducing stress to the mother (WHO, 2010; Stevens, Schmied, Burns & Dahlen, 2014). In South Africa, the 'Mother-Baby Friendly Initiative' (MBFI) package recommends uninterrupted immediate skin-to-skin contact after birth for at least an hour if the mother is alert (Department of Health (DoH), 2014). This is to ensure that the baby bonds with the mother and gets the first latch of breastfeeding within the first hour after delivery.

Midwives play a pivotal role in ensuring that there are no complications (Dahlberg, Persen, Skogås, Selboe, Torvik & Aune, 2016) and facilitating early initiation of breastfeeding through the implementation of skin-to-skin as the first step (Moore, Bergman, Anderson & Medley, 2016). In South Africa, about 64.5% of deliveries (46% in urban areas and 54% in rural regions) are conducted by midwives (Pattinson, 2014; Pattinson, 2015) and these primary caregivers are expected to implement mother-baby skin-to-skin contact during birth period. Despite the reported benefits of immediate skin-to-skin contact between the mother and baby, the implementation of skin-to-skin contact has not been adopted as a universal postnatal care method as millions of babies die annually due to hypothermia and delayed initiation of breastfeeding (Righard, 2008; Khan, Vesel, Bahl & Martines, 2015). According to Nahidi, Tavafian, Heidarzadeh and Hajizadeh (2013), midwives should encourage mothers to initiate skin-to-skin contact with the infant soon after birth to facilitate early initiation of breastfeeding. A study conducted in Iran reported that most midwives refused to implement and encourage skin-to-skin despite the calls made by their health ministry (Nahidi, Tavafian, Heidarzadeh, Hajizadeh & Montazeri, 2014) and the recommendation made by the United Nations Children's Fund (UNICEF) (2012). The successful implementation of skin-to-skin contact during birth is associated with high rates of breastfeeding (Brimdyr, Cadwell, Widström, Svensson, Neumann, Hart, Harrington & Phillips, 2015; Callaghan-Koru, Estifanos, Sheferaw, Graft-Johnson, Rosado, Patton-Molitors, Worku, Rawlins & Baqui, 2016; Miller, 2017).

Breastfeeding is regarded as the best feeding option for all babies. For example, the WHO (2010) recommends, 'that mothers initiate breastfeeding within an hour after birth and continued for six months without giving any solid food or drinks.' According to WHO (2012) report, South Africa is at eight percent for exclusive breastfeeding. Several reasons for low breastfeeding rates include lack

of skin-to-skin implementation, separation of babies from their mothers, lack of understanding of the critical benefits of breastfeeding, mixed feeding practices and fears of HIV transmission (WHO, 2012; Mgolozeli & Shilubane, 2015. A study conducted by Siziba, Jerling, Hanekom and Wentzel-Viljoen (2015) found that 90% of mothers initiated breastfeeding within an hour after giving birth and that skin-to-skin contact with their babies took place soon after birth. According to Landwehr (2015), midwives are the primary source of information for breastfeeding and should motivate mothers to perform skin-to-skin immediately after birth to enhance mother-infant bonding. OlaOlorun and Lawoyin (2006) posit that a high level of breastfeeding knowledge is associated with more consistent and positive professional practices.

Midwives working in rural primary healthcare facilities face many challenges such as staff shortages, lack of resources and are overworked due to the large populations that they serve (Spencer, du Preez & Minnie, 2018). There are many studies that have been conducted on positive birth practices throughout the world. There is dearth of research focusing on midwives perceptions of skin-to-skin contact between the mother and baby after birth in rural primary healthcare facilities. Many policies distributed to primary health facilities by the Health Ministry are informative but implementers (midwives) are not engaged during the development process and their voices are not heard. Research that explores and describes the perceptions of midwives about the implementation of skin-to-skin contact between the mother and baby after birth is imperative in order to inform the development of strategies to support midwives on positive birth practices. Such research may also help in prevention of infant mortality related to hypothermia and low breastfeeding uptake. Therefore the main purpose of this study was to explore and describe the perceptions of midwives regarding skin-to-skin contact between the mother and baby after birth in selected rural primary healthcare facilities at Schoonoord in the Limpopo Province of South Africa.

Methodology

Research design

A qualitative, explorative and descriptive-approach was used to investigate the perceptions of midwives regarding skin-to-skin contact between the mother and baby in rural primary health care facilities in the Limpopo Province. This approach enabled the researcher to gain insight into the perception of midwives regarding the implementation of skin-to-skin contact between the mother and the baby after birth.

Sample and sampling procedure

The sample comprised all midwives in primary healthcare facilities of Schoonoord at Makhuduthamaga sub-district. All five non-accredited centres were purposively selected. A convenience sampling method was used to select

12 midwives who participated in the study. The inclusion criteria consisted of the following: registration as a midwife who has worked in the current facility for a minimum period of six months.

Data collection

The collection of data took place in a series of face-to-face individual interviews. The interviews were conducted in Sepedi (an indigenous South African language widely spoken in Limpopo province) and tape recorded. Immediately after data collection, a language expert who was Sepedi speaking translated the transcripts into English language. Field notes were taken and observations made (Brink, 2012). The following question was asked: 'What are your perceptions about skin-to-skin contact between the mother and the baby immediately after birth?'

Data analysis

This study employed the eight steps suggested by Tesch to analyse the data (Creswell, 2014). The interviews were transcribed verbatim. The transcripts were read several times while ideas and key concepts were identified and written down in the margins of the transcripts. Member checking was done with all the participants and all the transcripts were checked and compared to the audio by the second and third authors who are experts in qualitative research. The analysis of data resulted in the emergence of three themes and sub-themes. A literature control was presented after data collection and analysis as it formed a basis for comparing the findings of the study (Creswell, 2014).

Trustworthiness

Trustworthiness was maintained throughout this study by using Guba's model (Babbie, 2013; De Vos, Strydom, Fouche & Delport, 2011). The meetings were extended as necessary to ensure credibility and to enable the interviewer spend more time with the participants to establish rapport and trust. Triangulation was used involving a one-on-one interview, which was conducted while making field notes on the non-verbal aspects of the dialogue. Transferability, or how far the results can be generalised to other contexts, was established by a complete description of the study methodology and an accompanying literature control was undertaken to maintain clarity.

Ethical considerations

Ethical approval was obtained from the University of Venda Ethics Committee (Ref. no: SHS/15/PDC/34/0502). Permission to conduct the study was granted by the Limpopo Department of Health, Sekhukhune Primary Health Care (PHC) Directorate as well as Schoonoord Local Managers and Management of Health Facilities. Verbal informed consent was obtained from all the midwives who participated in the study. Interviews were conducted in private rooms within the clinics to ensure privacy and confidentiality. The researcher explained to the midwives that their information would be confidential and that they were not

forced to answer the questions if they believed these violated their right to confidentiality. Participants were also informed that field notes would be made and a voice recorder used during interviews to capture the proceedings of the discussions. They were assigned codes to protect their identities and to ensure confidentiality and anonymity.

Results and Discussion

Participants' demographic data

The ages of the participants, who were all females, varied from 30 to 58 years. Eight midwives had Diplomas and four were holders of Bachelor's degrees. Only three out of 12 midwives indicated that they were trained on the 20-hour lactation management course but they all had10 years of experience in midwifery practice on average. All the themes and sub-themes that emerged from the interviews are provided in Table 1.

Table 1: Summary of themes and sub-themes

Themes	**Sub-themes**
1. Awareness about skin-to-skin benefits	1.1. Prevention of hypothermia 1.2. Promotion of bonding between the mother and the baby 1.3. A good start for successful breastfeeding
2. Facilitators to successful implementation of skin-to-skin contact	2.1. Positive staff attitude 2.2. Continuous health education and in-service training 2.3. Team work spirit
3. Perceived barriers to successful implementation of skin-to-skin contact during birth	3.1. Lack of knowledge about skin-to-skin contact 3.2. Delaying of routine work 3.3. Lack of motivation from management

Theme 1: Awareness of skin-to-skin benefits

The awareness of skin-to-skin benefits have been highlighted by midwives as the main driving force towards continuous implementation of skin-to-skin contact after birth. Most midwives were completely aware of the benefits of skin-to-skin contact and understood its association with early initiation of breastfeeding. Three sub-themes that emerged during the analysis of this theme included the prevention of hypothermia, promotion of bonding between the mother and baby and a good start to successful breastfeeding.

Sub-theme 1.1: *Prevention of hypothermia*
Midwives reported that skin-to-skin contact between the mother and baby helps to keep the baby warm and thus prevent hypothermia. For example, one participant said: *"The only reason why I do skin-to-skin when I deliver a woman is that I know that it keeps the baby warm and since we don't have heaters and incubators, it remains the only way to prevent hypothermia."*

The findings concur with the that of the study conducted by Phillips (2013) who revealed that skin-to-skin contact provides physiological stability that includes stabilising the new-born's breathing, maintaining normal blood sugar levels, keeping the infant warm and minimising crying. Furthermore, a study conducted by Vilinsky-Redmond and Sheridan (2014) found that babies who had skin-to-skin contact were not at risk for hypothermia compared to a control group without skin-to-skin contact. By using skin-to-skin contact, babies can remain warm as they utilise their mother's body heat, which is a safe and cost-effective way of keeping babies warm in the hospital and after discharge (Vilinsky-Redmond & Sheridan, 2014).

Sub-theme 1.2: *Promotion of bonding*
Some participants indicated that they practice skin-to-skin contact because it promotes bonding between the mother and baby. They further highlighted that this helps the mothers to love their babies and provide caring throughout their lifespan. For instance, some participants commented: *"Skin-to-skin contact promotes bonding between the baby and the mother. The baby tends to know the mother better and the mother also learns to love the baby." "The baby develops the love of the mother and learns the smell of his mother. On the other side, the mother also gains attachment with her baby. I strongly believe that without skin-to-skin the mother cannot really bond with her infant."*

Sub-theme 1.3: *A good start for breastfeeding*
Midwives articulated that skin-to-skin contact between the mother and her infant immediately after birth lasting an hour helps the baby in latching and early initiation of breastfeeding. They also indicated that skin-to-skin contact stimulates oxytocin secretion assisting in relaxation and uterine contractions. Participant 2 supported this view when she stated that: *"Skin-to-skin stimulates the release of oxytocin which helps the let-down reflex and the release of breast milk. The baby gets used to the mother's smell and will root to the mother's nipple."*

In Participant 4's opinion:
"Babies that are not placed in their mothers' chests immediately after birth usually do not latch well from their mother's breasts because they are not used to the smell. Heeey, I remember one mother that refused to put her baby into her

chest after delivery, the baby could not suck from the breast and she was crying."

A systematic review undertaken by Renfrew, Craig, Dyson, McCormick, Rice, King, Misso, Stenhouse and Williams (2009) indicated that there was evidence that skin-to-skin contact lasting an hour increases the breastfeeding time by four weeks following discharge. Mahmood, Jamal and Khan (2011) also found a significantly higher breastfeeding rate at intervals of one and four months for mothers who were in a skin-to-skin contact group.

Theme 2: Facilitators to successful implementation of skin-to-skin contact

Midwives reported that there are many factors that could facilitate the successful implementation of skin-to-skin contact such as positive staff attitudes, continuous health education and in-service training, and teamwork amongst healthcare professionals.

Sub-theme 2.1*: Positive staff attitude*
Participants stated that skin-to-skin is not difficult to achieve especially when midwives have positive attitudes towards it. They reported that challenges about skin-to-skin implementation are influenced by the attitudes of midwives as primary care givers during child birth. Participant 12 indicated as follows: *"If we can all have positive attitudes about skin-to-skin, I think all babies would be put skin-to-skin with their mothers. It's just a matter of each individual's attitude and of course, if a midwife is negative about it, then she will not see any need to do it."*

Sub-theme 2.2: *Continuous health education and in-service training*
Participants indicated that one of the facilitators to the successful implementation of skin-to-skin contact is continuous health education and in-service training within the facilities. They indicated that health education should be provided to all pregnant mothers and their families about what skin-to-skin entails as well as its benefits. They further highlighted a need for continuous in-service training amongst health care professionals about skin-to-skin implementation. Some of the participants stated: *"The only way to win this case about skin-to-skin is to teach patients about when and how skin-to-skin is done, explain the benefits so that they can remind us when we forget to put their babies in their chest after birth.""We attend workshops about breastfeeding and other issues but I think it is very important that after every workshop, we come back as staff members and hold in-service trainings for each other so that we all do the same thing."*

***Sub-theme 2.3**: Teamwork*
Participants indicated a need for a spirit of teamwork in order to achieve a common goal. They suggested that the best way to gain consistency and continuous implementation of skin-to-skin contact in their facility would be through collaborative teamwork where all could speak in one voice. For example, Participant 6 suggested as follows: *"We need to work as a team and agree on one thing. If we can make mother-infant skin-to-skin contact a uniform procedure in our practice as a group, then all the babies would be breastfed successfully and there will be no baby that will die in our facilities due to hypothermia and delayed breastfeeding."*

This view agrees with the findings of Norris-Grant and Jaggers (2014) in which they demonstrated that skin-to-skin contact was increased because of the collaborative efforts of those involved in the care of mothers and new-borns. This is consistent with the WHO's (2012) recommendation that there should be ongoing in-service training for all healthcare professionals to effectively implement all the steps for successful breastfeeding.

Theme 3: Barriers to effective implementation of skin-to-skin contact during birth

The participants reported several factors that hamper the implementation of mother-infant skin-to-skin contact in their facilities. They argued that as much as they would love to adhere to the recommendations of UNICEF (2011) for mother-baby friendly care, there are still limitations such as inadequate knowledge, negative attitudes, working with non-cooperative mothers and lack of motivation.

***Sub-theme 3.1:** Lack of knowledge about skin-to-skin contact*
Participants reported that one of the barriers to implementing skin-to-skin contact successfully between the mother and baby is the poor knowledge amongst health care professionals. They hinted that it is not easy for people to do things if they don't have the basic information and knowledge. Participant 10 stated: *"I always argue with my colleagues because they do not know the exact duration of skin-to-skin and one blunder is committed when they cover the baby and put her back to the mother's abdomen. You will correct them every day and they will just say they did not know."*

A study by Zwedberg, Blomquist and Sigerstad (2015) found that skin-to-skin contact was important and they experienced many obstacles, such as inadequate knowledge of participants (parents and other professionals) about the advantages.

Sub-theme 3.2: *Skin-to-skin contact delays routine work*
Participants reported that skin-to-skin contact between the mother and baby delays routine work in their facilities. They indicated that their clinics are very busy and they are under-staffed. Participant 2 commented: *"Our clinics have shortage of staff, so waiting for skin-to-skin for the whole hour will delay our daily routine. The baby needs to be weighed and given immunisations at the same time."*

This view resonates with that reported by Nahidi et al. (2014) who found that some groups of midwives were very negative about skin-to-skin contact as they needed to keep up with the routines in wards and discharge of mothers to their homes. They further argued that there were not enough beds to cater for all the women and they believed all those that had delivered should be discharged (Nahidi et al., 2014).

Sub-theme 3.3: *No motivation from managers*
Participants asserted that one of the reasons that they did not take skin-to-skin contact seriously and never implemented it was the lack of motivation from their management. They related that their managers never showed appreciation for their work, so they felt no need to waste their time on skin-to-skin contact between mothers and babies. In her response, Participant 11 indicated: *"Our management does not motivate us, so we get discouraged to implement skin-to-skin contact. No one congratulates you and the performance management system does not even look at those things."*

Oshvandi, Zamanzade, Ahmadi, Fathi-Azar, Anthony and Harris (2008) have also reported a similar finding in which majority of nurses who participated in their study demonstrated poor performance and had no job satisfaction due to lack of motivation from senior management. Their participants complained about working long hours without compensation (Oshvandi et al., 2008).

Limitations of the study

The study focused on midwives in rural primary healthcare facilities of one local area. The circumstances of these midwives may be different from those in urban areas. Therefore, the present findings cannot be generalised to other parts of Limpopo province that were not covered in this study.

Recommendations

Based on the findings of this study, it is recommened thatthere should be on-going education and facility-based in-service training on MBFI implementation. All midwives should receive formal training on 20-hour lactation management. A network of support for midwives needs to be established to promote better

birth practices with special emphasis on MBFI strategy implementation. A model of support for mother-friendly care amongst midwives in primary healthcare facilities should be developed, implemented and evaluated. This study further recommends the need for research studies to investigate the experiences and perceptions of women regarding skin-to-skin contact and early initiation of breastfeeding with special emphasis on the rural South African context.

Conclusion

This study explored the perceptions of midwives concerning skin-to-skin contact between the mother and baby in non-accredited rural primary healthcare facilities at Schoonoord area of Makhuduthamaga sub-district in Limpopo province. The participants in this study indicated poor knowledge, negative attitudes and lack of motivation as barriers to successful implementation of skin-to-skin contact. This has a negative impact on the quality of patient care, as well as on the image of midwives and their eagerness to adhere to evidence-based practices.

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