REUFSM
REVISTA DE ENFERMAGEM DA UFSM

UFSM
Rev. Enferm. UFSM - REUFSM
Santa Maria, RS, v. 10, e93, p. 1-19, 2020
DOI: 10.5902/2179769242729
ISSN 2179-7692

Original Article Submission: 03/04/2020 Approval: 06/16/2020 Publication: 12/11/2020

Understanding of nursing about skin-to-skin contact between mother/baby in the delivery room

Compreensão da enfermagem sobre o contato pele a pele entre mãe/bebê na sala de parto

Comprensión de la enfermería sobre el contacto piel con piel entre la madre/bebé en la sala de parto

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Abstract: Objective: to describe the understanding of the nursing team in the delivery room about skin-to-skin contact between mother and baby in the first hour of life. **Method:** descriptive, qualitative study with nursing professionals in the delivery room. Data were collected from August to November 2018, through semi-structured interviews and analyzed by the thematic content analysis method. **Results:** three thematic categories were extracted: Knowledge of the nursing team about skin-to-skin contact in the first hour of life; Benefits and importance of skin-to-skin contact in the immediate postpartum period in the professionals' view; Practices performed in the immediate postpartum in the delivery room. **Conclusion:** nursing professionals have knowledge about skin-to-skin contact, even if some weaknesses, and see the importance of this knowledge for this stimulus to be widely actualized in the care of the mother and newborn.
Descriptors: Nursing, team; Infant, newborn; Perinatal care; Mother-child relations

Resumo: Objetivo: descrever a compreensão da equipe de enfermagem da sala de parto sobre o contato pele a pele entre a mãe e bebê na primeira hora de vida. **Método**: estudo descritivo, qualitativo, com profissionais de enfermagem da sala de parto. Os dados foram coletados de agosto a novembro de 2018, por meio de entrevista semiestruturada e analisados pelo método de análise de conteúdo temática. **Resultados:** foram extraídas três categorias temáticas: Conhecimento da equipe de enfermagem sobre o contato pele a pele na primeira hora de vida; Benefícios e importância do contato pele a pele no pós-parto imediato na visão dos profissionais; Práticas realizadas no pós-parto imediato na sala de parto. **Conclusão:** os profissionais de enfermagem possuem o conhecimento sobre o contato pele a pele, mesmo que apresentando algumas fragilidades, e ver-se a importância deste conhecimento para o que esse estímulo seja amplamente efetivado nos cuidados à mãe e ao recém-nascido.

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Descritores: Equipe de enfermagem; Recém-nascido; Assistência perinatal; Relações mãe-filho

Resumen: Objetive: describir la comprensión del equipo de enfermería en la sala de partos sobre el contacto piel con piel entre la madre y el bebé en la primera hora de la vida. **Método:** estudio descriptivo y cualitativo con profesionales de enfermería en la sala de partos. Los datos fueron recogidos de agosto a noviembre de 2018, a través de entrevistas semiestructuradas y analizados por el método de análisis de contenido temático. **Resultados:** se extrajeron tres categorías temáticas: Conocimiento del equipo de enfermería sobre el contacto piel con piel en la primera hora de la vida; Beneficios e importancia del contacto piel con piel en el período posparto inmediato de acuerdo con los profesionales; Prácticas realizadas en el posparto inmediato en la sala de partos. **Conclusión:** los profesionales de enfermería tienen conocimientos sobre el contacto piel con piel, incluso si presentan algunas debilidades, y ven la importancia de este conocimiento para el cual este estímulo se ve ampliamente realizado en el cuidado de la madre y el recién nacido.
Descriptores: Grupo de enfermería; Recién nacido; Atención perinatal; Relaciones madre-hijo

Introduction

Childbirth and childbirth care have undergone several transformations over time. In humanity, the routine separation of the mother/baby binomial in the immediate postpartum period is considered a practice of the 20th century. However, this differs within the historical evolution itself, in which neonatal survival depended on immediate and continuous maternal contact with the newborn (NB).[1]

Although early skin-to-skin contact is considered an appropriate evolutionary practice, separating newborns from their mother soon after birth has become a common behavior in many industrialized societies due to hospitalization of childbirth and adherence to routine practices, hindering a better mother-baby bond.[1] Skin-to-skin contact in the first hour of life of healthy newborns is immediate and continuous contact, in which this NB is placed on the abdomen or thorax of the mother according to her will, face down and covered with a dry and heated cloth,[2] and this contact is recommended by the Brazilian Society of Pediatrics (SBP)[3] when the NB is born in good conditions of vitality.

The Ministry of Health (MH) also encourages the establishment of this practice, enabling the humanization of maternal and childcare, together with the determinations of the Prenatal

and Birth Humanization Program (PHPN) and the *Rede Cegonha*, which argue that women and babies should receive good care practices. Thus, it is possible to guarantee the permanence of the NB at the mother's side during the entire length of hospitalization, from the first moments of life, with skin-to-skin contact and support for breastfeeding, if possible, still within the first hour of life.[4]

The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), aiming to increase the rates and benefits of Breastfeeding, conceived, in 1990, the Child-Friendly Hospital Initiative (CFHI[2]), being implemented in Brazil in 1992. This includes hospitals that must follow established minimum global criteria, which are embodied in the "ten steps to successful Breastfeeding". Among these is the fourth step, which consists of "putting the baby in skin-to-skin contact with the mother immediately after delivery, for at least an hour and encouraging them to recognize when their babies are ready to be breastfed.[5-6]

In this context, the role played by the nursing team is paramount, because these professionals provide care in the delivery room twenty-four hours a day, and are facilitators of the bond between mother and baby in the transition between the intra- and extrauterine worlds. In addition, the proposal of humanization in delivery and birth care recommends that these professionals encourage this approach in the immediate postpartum period, in skin-to-skin contact,[7] placing the NB on their chest, performing the late clamping of the umbilical cord, encouraging breastfeeding and providing guidance to mothers. [8]

In view of the above, it is important to discuss the implementation of skin-to-skin contact between the mother-baby binomial in the first hour of life, the knowledge and role of the nursing team, active in the parturition process, about the accomplishment of this practice. Thus, understanding this experience is important because it favors humanized and embracing care according to the needs presented in this care context.

Thus, this study presents as a research question: What is the understanding of the nursing team in the delivery room about skin-to-skin contact between the mother/baby binomial in the first hour of life? Its objective was to describe the understanding of the nursing team in the delivery room about the skin-to-skin contact between the mother and baby in the first hour of life.

Method

Descriptive research with a qualitative approach, which allowed researchers to work with the meanings, feelings, motives, attitudes and perceptions of the interviewees.[9] The same occurred in a public hospital of reference in the area of maternal-child care, being located in the northeastern backwoods and serves as support for the 55 cities that make up the Pernambuco/Bahia network. Since August 1995, it has the title of Child-Friendly Hospital.

The study scenario was the Delivery Room of the institution, which has the support of a multidisciplinary team composed of obstetricians and pediatricians, nurses, nursing technicians, psychologists, social workers, among others. The nursing team consists of 19 nurses and 20 nursing technicians. The participants were 13 professionals of the nursing team, eight nurses and five nursing technicians, who met the following selection criteria: being nursing professionals and/or nursing technicians in the delivery room; who were not on vacation or on any kind of leave during the period of data collection.

The number of participants was defined by the theoretical data saturation, in which the collection process is terminated when the information obtained does not bring new elements that deepen or support the desired theorization in view of the objectives of the study.[9]

Data were collected from August to November 2018, with the application of semi-structured interviews, initially composed of sociodemographic data and the following guiding questions: Talk about the care provided in the immediate postpartum period to the NB in the

delivery room; Describe the good practices that should be performed during immediate postpartum with the NB; Describe the understanding about early skin-to-skin contact between mother and baby; Talk about the importance/benefit for mother and baby of skin-to-skin contact in the first hour of life; Report contraindications to perform early skin-to-skin contact of mother and baby; Cite the existing difficulties that prevent the performance of skin-to-skin contact between mother and baby, even when indicated.

The interviews were conducted using a portable recorder, after authorization of the participant, at a place and time previously established according to their availability, after rigorous training of the researchers, in order to enable the progress of the process and not allow the loss of important information for the completion of the research. This stage of data collection lasted an average of 20 minutes per interview. To preserve the anonymity of the participants, identifier codes were assigned according to the sequence in which they were interviewed (I1, I2, I3... I13).

All participants were informed about the objectives, methodology, risks and benefits of the study. The interviews were initiated after reading and signing the Informed Consent Form, soon after they were transcribed and reviewed after exhaustive listening to the recordings. The data were analyzed through thematic content analysis, which was processed from three distinct stages: pre-analysis, in which the empirical material was organized and involved the full transcription of the audio-recorded material, performed after each interview. From the transcription of the material, an exhaustive reading of the material was performed, seeking to organize it according to similarities of the statements and other relevant aspects brought by the interviewees, according to the general theme of this research, constituting as a pre-analysis of the corpus.[9]

The second stage, constituted by the exploration of the material, comprised the categorization of the speeches, which served to advance the thematic analysis of the material.

The meanings about the view of the nursing team and the skin-to-skin contact between the mother/baby binomial in the first hour of life were prioritized, according to the proposed objectives. The third and last stage was the treatment of the results with data interpretation, which aimed to treat the investigated material through codification, classification and interpretation, resulting in the categories of analysis.[9]

This study follows all aspects of researches in accordance with Resolution n. 466/12 of the National Health Council, having been approved by the Human Research Ethics Committee at the Institute of Integral Medicine Professor Fernando Figueira on July 11, 2018, under opinion number 2.766.197 and CAAE 90824718.5.0000.5201.

Results and discussion

The research participants were all female, eight nurses and five nursing technicians. Of the nurses interviewed, six were specialists in obstetrics; one was studying obstetric nursing specialization and was a specialist in urgency and emergency; and one had no specialization. Regarding age, six were between 24 and 28 years old; six were between 30 and 35 years old, and one of them was 57 years old.

Regarding the time of profession, three of them were working in nursing between one and two years; six worked from three to five years; three from six to 10 years, and one had 20 years of professional experience. Regarding the time of service in the delivery room, three had been working for less than one year in the sector; five, from one to two years; and five, from three to five years. Regarding participation in training and/or qualifications that addressed the theme of the research, ten stated that they participated in some moment in a training that addressed skin-to-skin contact in the mother and child binomial; and three did not participate in any approach of the subject, however, one of them stated having already received guidance in this regard in the delivery room itself.

After thorough reading of the reports found and the search for meaning cores, three thematic categories were extracted, which will be addressed below:

Knowledge of the nursing team about skin-to-skin contact in the first hour of life

The immediate and continuous skin-to-skin contact performed between the mother and the baby in the first hour of the immediate postpartum period aims to improve the adaptation period of the NB and the mother in the transition from the intra to the extrauterine space.[2,10] In this perspective, the participants showed an adequate understanding about this technique:

> *In the immediate postpartum, if everything is fine, the newborn stays with the mother for at least one hour, so that he can normalize* [...]. (I3)
>
> [...] *skin-to-skin contact means putting the baby on the mother right after the delivery, with direct contact.* (I6)
>
> [...] *right after leaving the uterus, goes straight to the mother, skin to skin, the baby naked on the mother, between her breasts.* (I11)

These statements corroborate the findings evidenced in researches of similar approach, conducted with professionals of the nursing team, in which the researchers concluded that the team showed a good scientific knowledge about humanization practices performed in the delivery room, including skin-to-skin contact in the first hour of life.[7-8]

When asked about the indication of skin-to-skin contact, the participants brought several considerations regarding indications and contraindications, for example, the Apgar score, the presence of meconium and prematurity.

> *If the baby is not born with a good vitality, prematurity and a low Apgar, there is the immediate care.* (I5)
>
> *We do it with low-risk babies* [...]*. The NB with meconium, heart rate below 120* [...] *we usually stimulate and immediately clamp the cord and provide the proper care.* (I6)

> *It is indicated for full-term babies, who are born with a good vitality. And we cannot do it when the baby is premature and requires more specific care.* (I8)

The contraindications guided by the Ministry of Health and SBP have undergone updates and comprise the presentation of the NB with gestational age different from the term; the absence of the onset of regular respiratory movements of the NB and/or those in which the muscle tone is flaccid, and in these cases, they should be conducted to the resuscitation table and the team should follow the flowchart of the SBP Resuscitation Program.[2-3]

In 2016, the new SBP resuscitation guideline, considering the NB ≥34 weeks, born in the delivery room, brought updates that reflect the indication and contraindication of early skin-to-skin contact between mother and child, rectifying ordinance n. 371/2014, which contraindicates the performance of early skin-to-skin contact in the presence of meconial fluid.[3] This change was reaffirmed by the Ministry of Health through the new national guidelines for normal delivery care in 2017.[11]

Considering the Apgar bulletin as a way to evaluate the indication of skin-to-skin contact indicated by some participants, it is noteworthy that this bulletin corresponds to a clinical evaluation of the NB, which evaluates five aspects of the newborn: muscle tone, heart rate, respiratory effort, reflex irritability and skin color. For each of these items, a score of 0, 1 or 2 is assigned, which, adding up the score of each item, obtains a minimum of 0 and a maximum of 10 points. Thus, the Apgar bulletin is not used to indicate procedures in neonatal resuscitation or vitality of the NB. However, its application allows evaluating some data from the assessment of vitality, such as breathing and muscle tone.[3,12]

Moreover, it is emphasized that, in order to institute this contact successfully, the mother and baby need to be alert from the neurological point of view, interacting naturally. Thus, it is essential that skin-to-skin contact occur early, soon after birth, since, in a few hours after delivery, the neonates remain drowsy.[10]

In addition to the observations mentioned in relation to the NB, one of the interviewed professionals cited the rapid HIV-reactive test as a contraindication related to the mother.

> *Putting to nurse um the first hour of life, if the rapid tests are not reactive, of the HIV, done in the triage.* (I9)

The participant's report is consistent with what is recommended by the Clinical Protocol and Therapeutic Guidelines for the Management of HIV Infection in Children and Adolescents. Skin-to-skin contact should not be indicated in the first hour of life due to the management of newborns exposed to HIV, indicating the execution of specific care after birth in order to ensure the prevention of vertical transmission of the virus, being the NB placed next to the mother as soon as possible after care.[13]

Benefits and importance of skin-to-skin contact in the immediate postpartum period in the professionals' view

According to the participants, skin-to-skin contact between the mother-child binomial provides several benefits, such as bonding and physiological adaptation of the NB, besides being important in the transition from the period of delivery and birth, for both the NB and the mother.

> *It increases the feeling, the affective bond* [...]*. For the baby, it decreases the heart rate, a way to calm him down* [...]*. It also stimulates the breastfeeding* [...]*.* (I3)
>
> *I guess, for the mother, when she gets in touch with the baby, her anxiety ends. For the baby, we have the warming, bond-strengthening issue.* (I4)
>
> *For the baby, there is the warming, also stabilizing his breath.* (I7)

The participants' view of the benefits was coherent and corroborates the data described in the literature, regarding the enormous range of short- and long-term benefits for both, in addition to the organization of the behavioral state of the NB.[1,14]

Another study conducted with members of the multidisciplinary team in the delivery room corroborated the findings of this research in relation to the benefits evidenced by the participants, highlighting that there are numerous immediate benefits of this technique for the puerperal woman and newborn, such as establishing the bond, regulating the body temperature of the NB, physiological adaptation of the NB and stimulating breastfeeding.[15]

According to the WHO and UNICEF,[16] early skin-to-skin contact is capable of: calming the mother and NB, assisting in baby's blood, heartbeat and breathing stabilization; reducing the crying and stress of the NB with less energy loss; keeping the child warm by the mother's heat transmission; assisting in metabolic adaptation and stabilization of the newborn's blood glucose; allowing colonization of the baby's intestine with normal bacteria from the mother's intestine, as long as she is the first person to hold the NB; facilitating the narrowing of affective bonds between the mother and child binomial, helping to stimulate breastfeeding, with a probability of resulting in effective nursing.[14,16-17]

Also when asked about the importance of skin-to-skin contact, it can be observed that most participants make a direct correlation between its execution only as a way to promote breastfeeding in isolation to the other procedures:

> *It is the contact for the breastfeeding occur in the baby's first hour of life.* (I3)
>
> *At the moment the baby is born, he is already placed on the mother* [...] *the issue of promoting the breastfeeding.* (I4)
>
> *As soon as he touches the mother's skin,* [...] *to nurse, latch on.* (I12)

Moreover, a meta-analysis study showed that early skin-to-skin contact between mother and child has a very positive effect on breastfeeding in the adequacy of the blood glucose level of NBs in the first hours of life, besides helping in the cardiorespiratory stability of the same.[18] However, it is worth mentioning that the performance of this contact is a procedure of proven

short- and long-term benefits, for mothers and children, and not only related to breastfeeding.[1,18]

Some statements unveiled the relationship between skin-to-skin contact and the physiological and hormonal changes that happen to the mother when breastfeeding the NB, besides helping in the prevention of possible complications, corroborating the findings of another study, which also evidenced the advantages arising from breastfeeding for the mothers' own health.[19]

> *It is important to avoid the maternal hemorrhage* [...] *prevent anemia* [...]. (I1)
>
> *For the mother, it will help produce more milk,* [...] *it will help produce more hormones* [oxytocin] *which will even help reduce the bleeding.* (I7)
>
> *For the mother, when the baby starts to nurse, the uterus starts to involute, which will avoid the maternal hemorrhage* [...]. (I13)

The skin-to-skin contact between mother and baby in the first hour of life is one of the strategies used by the Ministry of Health that aims to promote, protect and support breastfeeding and is based on the ability of newborns to interact with their mothers, right after birth.[2,6] Besides being related to the increase in the duration of breastfeeding and exclusive breastfeeding.[20]

According to a controlled and non-randomized study, conducted in a delivery room with 100 women to evaluate the effects of immediate skin-to-skin contact, this practice increases uterine contraction immediately after birth, decreasing uterine atony and excessive blood loss. In addition to significantly decreasing the duration of the third stage of labor.[21]

One of the interviewees also reported a relationship in the prevention of infections when skin-to-skin contact is performed in the first hour of life.

> *For the baby, the contact with the mother warms and tranquilizes him. It also protects against infections.* (I10)

The literature addresses that one of the benefits of performing skin-to-skin contact is protection against infections, since it facilitates the colonization of the newborn's skin by the bacterial flora of the maternal skin, prior to contact with hospital bacteria, helping to prevent infections, in addition to stimulating breastfeeding, which has antimicrobial, anti-inflammatory and immunoregulatory functions. All this helps in the transfer of passive immunity in the postnatal period.[16,22]

Practices performed in the immediate postpartum in the delivery room

When asked about what immediate care is offered to newborns in the delivery room, participants included skin-to-skin contact as one of the first to be performed after birth. However, some of them only mentioned this technique when asked about good practices:

> *As soon as the baby is born, we put him on the mother, one hour later, the pediatrician gets him, auscultates, weights, measures, and does the Credé procedure.* (I2)

> *In the immediate postpartum, the NB is weighted, receives vitamin K, the Credé, the medications. As good practices, if the is well, with no complication, he is placed on the mother and the clamping is done* [...]. (I3)

> *As soon as the NB is born, we warm the baby, place him on the mother and leave him there for one hour. The cord clamping is done, and then the baby is taken to the warmed cradle, where he will receive the care.* (I8)

These findings are recurrent in several realities, in which, first, skin-to-skin contact is provided, followed by immediate care, such as the hygiene of the NB. It is necessary to know what the Policy for Prenatal and Birth Humanization recommends regarding the immediate care with the NB after birth.[4]

When the NB is born with good vitality, the child should be covered with a warm cloth or towel to keep him/her warm, while maintaining skin-to-skin contact. Then, the clamping of the umbilical cord is performed within one to five minutes, or physiologically when the pulse ceases. After at least one hour of skin-to-skin contact, other procedures are performed, such as prophylaxis of neonatal ophthalmia (Credé procedure). It is also recommended that all newborns receive vitamin K for the prophylaxis of hemorrhagic disease. Record cephalic circumference, body temperature and weight after the first hour of life, among others.[2-3,11,15]

At birth, the NB goes through a phase called alert inactivity, with an average duration of forty minutes, in which it is recommended to reduce routine procedures in low-risk NB. At this phase, mother-child contact should be provided, because it is a period of alertness that favors the recognition of the parties, with the exploitation of the mother's body by the baby.[10]

On the other hand, many professionals listed some obstacles to the facilitation of skin-to-skin contact, bringing the great demand of the sector and the bad will of some pediatricians as the main barriers for its implementation.

> *The pediatricians want to take them soon, fast, to provide the care, sometimes they do not even let it happen.* (I1)
>
> *It is difficult because of the number of simultaneous deliveries.* [...] *They remain for only 10, 15 minutes, and then they are taken for the first care.* (I8)
>
> *Some pediatricians want to accelerate the process and take the NB, tell them to clamp, we clamp the cord, and they take him* [...] *but a few of them follow the fourth step.* (I9)
>
> *The demand, the number of patients* [...] *so, we take the child, do the procedures and then return him to the mother* [...]. (I13)

Professionals working in the delivery and birth scenarios are essential to stimulate early contact between mother and baby, and can act as facilitators of these processes.[7,23] However, studies[10,15,24] show the existence of non-conformities in the performance of professionals regarding the promotion of early contact in the delivery room. Sometimes, the professionals of

the multidisciplinary team provoke the separation of the mother/baby binomial due to institutional barriers such as the high demand of the hospital routine, corroborated by the results found in this study.

Authors emphasize that the search for agility in hospital routines, the dynamism of the work shift and the high productivity often end up leading professionals to provide fragmented and mechanistic care, distancing them from the precepts established by the CFHI and the MH.[10,15,24] In this sense, other authors affirm that these justifications should not be an impediment to the implementation of humanized care to the NB in the delivery room, since skin-to-skin contact is an easy-to-perform and low-cost technique, and has numerous benefits.[18]

In this context, other professionals reported that there are no difficulties in performing skin-to-skin contact between mother-baby, and that it is not performed in the routine of the service only if there is no clinical indication, attributing to the training performed in the institution as responsible for the maintenance of the correct actions in the sector.

> *We have no more difficulties here in the sector. A job was done with some pediatricians and now the team is well cohesive in this issue.* (I3)
>
> *Here in the delivery room, if the babies can stay with the mothers, the pediatricians let it happen with no problem at all.* (I7)

The implementation of the humanization model in childbirth requires the sensitization and constant qualification of workers in Obstetric Centers, and training is necessary to implement the practice of skin-to-skin contact.[7] Thus, it is emphasized that the team knows and believes this care, however, training is necessary for its implementation, since the mechanization of care and longer time in the service causes many professionals to trivialize the care provided, often requiring continuous education processes to update knowledge and rethink the way of offering their routine care.[25]

In the meantime, the limitations found in the development of this research involved the fact that data collection took place only in the maternal and child reference maternity of the

region, being important to expand the research to other local obstetric centers, in order to know the extent of this practice in places with less structure. Thus, new studies should be developed in this perspective in other places of delivery care, also encompassing other professional categories, such as medicine, who assist women in this care context.

Conclusion

This study showed that the nursing team has the knowledge about the skin-to-skin contact between the mother and baby binomial in the first hour of life of the NB. However, some professionals showed fragility in the knowledge about the indications and contraindications of this technique, with some of them directly correlating skin-to-skin contact only with breastfeeding. It was also evidenced the relative knowledge about the benefits of performing contact for the NB and the mother, since most professionals mentioned more the bond and the benefits related to breastfeeding and the minority cited the physiological benefits for the NB.

Related to the practices performed in the immediate postpartum period, most of the participants included skin-to-skin contact as immediate care, but only when asked about the performance of good practices. Other interviewees cited the great demand for deliveries and non-adherence by some professionals as barriers to its actualization. On the other hand, they mentioned that qualifications helped improve the actions of most of the medical team, stimulating the performance of skin-to-skin contact when indicated.

In this context, the results found are relevant, since the nursing team plays a fundamental role in childbirth and in the performance of the care provided to the mother and the NB. Thus, the adequate knowledge of the team is essential for the stimulation and execution of new practices established in the institutions.

In view of the discussion brought about in this research, it is reiterated the importance of producing new studies in this same theme, aiming to stimulate the execution of this practice and increase the benefits in the short and long term. In addition to the need to enhance, with professionals, the theme addressed in this study.

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Chief Scientific Editor: Cristiane Cardoso de Paula
Associate Editor: Aline Cammarano Ribeiro

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How to cite this article

Souza HLR, Fernandes FECV, Pereira RCLF, Melo RA. Understanding of nursing about skin-to-skin contact between mother/baby in the delivery room. Rev. Enferm. UFSM. 2020 [Cited: Year Month Day]; vol.10 e93: 1-19. DOI: https://doi.org/10.5902/2179769242729