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# BEHAVIOR PROFILE: SKIN-TO-SKIN

**HEALTH GOAL**

Improve maternal and child health

**BEHAVIOR**

The proportion of live births for which skin-to-skin contact between the mother and baby was initiated within 10 minutes of delivery.

## BEHAVIOR ANALYSIS

### BEHAVIOR AND STEPS

What steps are needed to practice this behavior?

**Behavior**

Mother or caregiver maintains skin-to-skin contact (SCC) immediately after birth and during first hour

**Steps**

1. Provider (including community health worker) supports family to learn about and prepare for skin-to-skin contact at birth during antenatal care (ANC)
2. Provider keeps mother and baby together at all times from birth to discharge
3. Provider ensures appropriate environment and supplies for skin-to-skin contact (e.g., bolsters, blankets, pillows)
4. Family accepts SSC by mother and other caregivers
5. Mother requests newborn to be placed on chest and breast immediately (within first hour) after birth
6. Provider supports mother, father, or other family member to continue SSC for at least 1 hour after birth

### FACTORS

What factors may prevent or support practice of this behavior?

**STRUCTURAL**

**Service Provider Competencies**: Essential newborn care (ENC) protocols are not always followed: practices often still include immediate washing and wrapping of baby instead of putting baby to chest immediately

**Service Provider Competencies**: Many facilities lack supplies, such as bolsters for propping baby up or beds that can be positioned correctly and safely for a mother to care for newborn

**Service Provider Competencies**: Management and Provider Capacity and Commitment: Managers and providers are not always aware of importance of immediate SSC

**Service Provider Competencies**: Management and Provider Capacity and Commitment: Many providers do not consider SSC required protocol, and they prioritize other concerns

**Service Provider Competencies**: Management and Provider Capacity and Commitment: Usually, few providers are on duty at night, which limits their time to support SSC

**Service Provider Competencies**: Management and Provider Capacity and Commitment: Providers often are not trained or equipped to orient families during ANC and after birth

**Service Experience**: Some facilities still separate newborns from mothers after birth, especially those who are small or sick

**Service Experience**: Many facilities lack privacy screens, recovery rooms, or other amenities to allow for SSC

**Service Experience**: Often family members are not allowed in recovery area or post-natal ward to assist mother with SSC as needed

### SUPPORTING ACTORS AND ACTIONS

Who must support the practice of this behavior, and what actions must they take?

**INSTITUTIONAL**

**Logistics Personnel**: Ensure necessary supplies are on hand via medical supply or locally available avenues (e.g. bolsters, blankets, privacy screens)

**Facility Managers** : Include SSC in protocols, supervision checklists, and feedback

**HOUSEHOLD**

**Family Members**: Support and facilitate SSC immediately after birth for all newborns, including remaining with the mother to help physically support her if required.

**Male Partners**: Agree prior to birth to support SSC; support at birth and thereafter

## STRATEGY

### POSSIBLE PROGRAM STRATEGIES

What strategies will best focus our efforts based on this analysis?

*Strategy requires Communication Support*

**ENABLING ENVIRONMENT**

**Institutional Capacity Building**: For all facilities, craft protocols that include SSC considerations at birth, during facility stay, and in discharge care

**Institutional Capacity Building**: Disseminate protocols with SSC to each facility manager; post in facilities

**Institutional Capacity Building**: Include options for father/male partner and other family members to support SSC after childbirth, including at night, in the case of a cesarean section or other need

**SYSTEMS, PRODUCTS AND SERVICES**

**Supply Chain**: Include key supplies in the logistics program or identify locally available sources for pillows, bolsters, and blankets

**Quality Improvement**: Use a Knowledge-to-Action training approach, including simulation and post-training support and follow-up, to train providers on skills; elicit and resolve important feedback on learning and capacity

**Quality Improvement**: Create support mechanisms for provider peer groups to discuss new protocols and practices and to hold each other accountable

**Quality Improvement**: Facilitate reviews of ENC, including SSC, to identify and address gaps

**Quality Improvement**: Incorporate SSC in community health worker activities, including ANC education and promotion

**DEMAND AND USE**

**Advocacy**: Recognize high-performing providers (across all priority behaviors or care provision) through local and subnational media

**Communication**: Use targeted media to highlight experiences of providers who support families to practice SSC

**Communication**: Develop easy-to-use job aids to support counseling on SSC at birth, within one hour after birth, and during the first 48 hours

**Service Experience**: Management and Provider Capacity and Commitment: Providers fear newborns might fall if SSC is practiced unsupervised and if mother is unsupported by bolsters or pillows

**Service Experience**: Management and Provider Capacity and Commitment: In more complicated births, including those requiring a cesarean section, mothers and babies are often separated, inhibiting skin-to-skin

**SOCIAL**

**Family and Community Support**: Families and home/traditional birth attendants are often unaware of the benefits of SSC

**Norms**: Male norms do not encourage fathers' involvement in supporting partner to provide SSC (or providing it themselves when the mother cannot) and do not promote that providers speak with male partner/father about providing support

**Collective Engagement**: Organize community dialogues and home visits before birth to discuss skin-to-skin contact as part of the childbirth experience and to prepare with father/male partner and other family members