

Effectiveness of Skin- to Skin Contact on duration of third stage of labor in Baghdad Teaching Hospital: Comparative Study.

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الهدف : تحديد فاعلية تماس جلد لجلد / **المنهجية :** الدراسة الحالية استعملت تصميم شبه تجريبية في صالة الولادة في قسم النسائية في مستشفى بغداد التعليمي في مدينة بغداد. جمع العينة للمدة من (2) 2012 ولغاية (30) 2012. عينة غرض (80) ام وطفلها (40) منهن اعتبرن عينة الدراسة و(40) اخرى اعتبرن العينة الضابطة ويتلقين العناية الروتينية للمستشفى. استمارة استبانة كأداة لجمع البيانات لتحقيق غرض الدراسة حيث شملت الاستمارة على الخصائص الديموغرافية والتاريخ الصحي للأم وو انفصال المشيمة . كما أجريت دراسة استطلاعية لاختبار ثبات ومصادقية الاستمارة 10 ولغاية 30 2010. وتم تحليل البيانات من خلال استعمال أسلوب تحليل البيانات الإحصائية الوصفية (التوزيع التكراري والنسبة المئوية للقيم) وأسلوب تحليل البيانات الإحصائي الاستنتاجي (t). **النتائج :-** (27.5%) من عينة الدراسة كانت في مجموعة العمرية (21-25) سنة، بينما في المجموعة الضابطة (16-20) سنة ، فيما يتعلق بالمستوى التعليمي للأمهات (55%) (47.5%) على التوالي لعينة الدراسة والضابطة كانتا من خريجات الدراسة الابتدائية. فيما يتعلق بالمهنة كانت النسبة على التوالي (87.5%) (80%) (ربات بيوت. هناك فروق ذات دلالة احصائية بين مجموعة الدراسة والمجموعة الضابطة في تقييم المرحلة الثالثة للولادة في (اكتمال انفصال المشيمة ، تصلب الرحم فوراً بعد الولادة، موقع الرحم بين الصرة والعانة ، لا يوجد أي علامات خمول الرحم أو نزف بعد الولادة ، ويعطى مقلصات ا). **التوصيات :** اجراء برامج تعليمية وتدريبية لكل القابلات والمرضات العاملات في صالات الولادة وتوضيح فوائد تماس جلد لجلد للأم ووليدها.

Abstract:

Objectives: - To determine the effectiveness of the skin –to-skin contact on duration of 3rd stage of labor. **Methodology:** - A quasi-experimental design study conducted at the delivery room in maternity department at Baghdad teaching Hospital in Baghdad city. Data collection was started at 2nd January to end of March /2012. Purposive sample consisted of (80) mother and her neonate, (40) mother considered "skin –to-skin contact" group and other (40) considered " control group " and they receive the routine care of the hospital. An assessment tool was constructed for the purpose of the study , it was comprised of Socio-Demographic Data, Mother reproductive health history, assessment of placental separation time, Assessment of mothers third stage. Data were collected through the utilization of application, observation, assessment tool, and the interview techniques as a mean of data collection process. Pilot study was conducted on (10) Mothers on 2nd January to 10th January 2012. To make instrument valid, it was presented to a panel of (20) experts, the reliability of study, correlation coefficient of third stage of labor was (0.76). Data were analyzed through the application of descriptive statistical data analysis approach (i.e., frequency, percentage,) and inferential statistical data analysis approach (correlation coefficient, and chi- square & t test) **Results:** The study demonstrates that the highest percentage (27.5%) of study sample was in age group (21-25) years, while the control (16-20) years, concerning the educational level for mothers (55%) (47.5%) respectively for both study and control groups are primary school graduates. Concerning the occupation for mother: highest percentages for both study & control groups (87.5%) (80%) were housewives. There are significant differences between study and control group in third stage of labor assessment, in (complete placental separation, Uterus contract immediately after birth, uterus position between umbilici and pubic bone, absent of any abnormal signs of uterine atony or postpartum hemorrhage, & giving Methargen). **Recommendations:-**continuous educational and training program to all midwife work in delivery room on the implementation of skin-to skin contact for all mothers in delivery room, and clarify the benefits on mother and her neonate.

Keyword: Skin – to- Skin Contact, Physiological Responses, third stage of labor

INTRODUCTION

Third stage of labor spans is the time from the birth of the baby to the birth of the placenta. Third stage is a pivotal time for the health and wellbeing of mother and baby, and the beginning of their life-long relationship. In most modern obstetric settings, it is now standard practice to use drugs that cause the uterus to contract strongly to hasten the third stage, in an effort to prevent hemorrhage. This is called active management which includes early clamping of the cord, and pulling on the cord to deliver the baby's placenta quickly. In a spontaneous, unmediated, uncomplicated birth, it is reasonable to plan a physiological or natural third stage, without increasing the risk of hemorrhage. In natural third stage, the baby's cord usually not clamped or cut and the mother and baby stay in skin- to skin contact, in a warm, unstimulating birthing environment until after the placenta has been birthed. It is important that the midwife or doctor who has professional responsibility at the time of birth is competent in natural third stage, and does not interrupt the natural process without a good reason ⁽¹⁾.

Immediately after a baby has been born, the mother meets her baby for the first time and, if uninterrupted, will experience a natural and instinctive behavioral pattern that supports the establishment of confident mothering, early breastfeeding, and a secure bond or attachment between herself and her baby. This natural process includes a surge in the mother's love hormone, oxytocin, which also causes her uterus to contract, and assists in the birthing of the Placenta ⁽²⁾.

During the third stage of labor, strong uterine contractions continue at regular intervals, under the continuing influence of oxytocin. The uterine muscle fibers shorten, or retract, with each contraction, leading to a gradual decrease in the size of the uterus, which helps to "shear" the placenta away from its attachment site. Third stage is complete when the placenta is delivered. For the new mother, the third stage is a time of reaping the rewards of her labor. Mother Nature provides peak levels of oxytocin, the hormone of love, and endorphins, hormones of pleasure for both mother and baby. Skin to skin contact and the baby's first attempts to breastfeed further augment maternal oxytocin levels, strengthening the uterine contractions that will help the placenta to separate and the uterus to contract down. In this way, oxytocin acts to prevent hemorrhage, as well as to establish, in concert with the other hormones, the close bond that will ensure a mother's care and protection, and thus her baby's survival ⁽³⁾.

Western practices neither facilitate the production of a mother's own oxytocin, nor pay attention to reducing catecholamine levels, in the minutes after birth, both of which can be expected to physiologically improve the new mother's contractions and therefore reduce her blood loss. The routine practice of separating mother and baby deprives the mother of important opportunities to increase her natural oxytocin release ⁽¹⁾.

The objectives of the study:

1- To determine the skin –to-skin contact effectiveness on, maternal uterine involution, and 3rd stage duration.

2- To find out the relationship of mothers physiological responses concerning third stage duration between study & control groups.

METHODOLOGY:-

A quasi experimental design held at the delivery room in maternity department at Baghdad teaching Hospital in Baghdad city on non probability sample (purposive) of (80) mothers and their neonates, sample divided in to two groups (40) mother considered "skin – to-skin contact" group and other (40) considered " control group " and they receive the routine care of the hospital. The sample was selected according to the following criteria: Both study and control groups were healthy mothers , no cyanosis, regular heart beats, with no fatigue, chest pain, normal respiration, no difficulties in respiration when putting the neonate on mothers chest, and no respiratory distress. Regarding the neonates; all neonates for both study and control groups were healthy, with apgar scores (7-10), no cyanosis, regular heart beats, normal respiration. No distress syndrome, no wheezing or grunt during respiration, and clear air way passages. Regarding the delivery room temperature; (25C°) for both study and control groups.

A pilot study was conducted on (10) Mothers and their neonates to assess the effectiveness of skin – to skin contact on duration of third stage of labor in delivery room. The study was carried out for the period of 2nd January –10th January, 2012 at Baghdad Teaching Hospital. To make instrument valid, it was presented to a panel of (20) experts, the reliability of study, correlation coefficient of third stage of labor was (0.76). An assessment tool was constructed for the purpose of the study, it was comprised of Socio-Demographic Data, Mother reproductive health history, placental separation time, Assessment of mothers third stage of labor. Data were collected through the utilization of application, observation, assessment tool, and the interview techniques as a mean of data collection process. Data collection was initiated on 2nd January to end of March /2012. The investigator collected data during morning and evening shifts. Statistical analysis:- Data are analyzed through the use of SPSS (Statistical process for social sciences) Version 16 application statistical analysis system, the following statistical data analysis approach was use in order to analyze and assess the results of the study. Descriptive data analysis such analysis was employed through, frequency, Percentage, Mean of score, stander deviation. Inferential data analysis through Chi square, and t-test.

RESULTS

Table (1): Distribution of Socio-Demographic Characteristic for both Study & Control Groups.

Variables	Study group (n=40)		Control group (n=40)		χ^2	df	P-value	C. S
Age\ years	No.	%	No.	%				
16-20	8	20	11	<u>27.5</u>	2.355	4	.671	N S
21-25	11	<u>27.5</u>	10	25.0				
26-30	10	25.0	10	25.0				
31-35	6	15.0	4	10.0				
36-42	5	12.5	5	12.5				
$\bar{x} \pm SD$	27.025±6.342		26.075 ± 6.584					
Educational level for mother								
Not read & write	1	2.5	2	5	3.186	3	.364	N S
primary school graduates	22	<u>55.0</u>	19	<u>47.5</u>				
Intermediate &secondary	14	35.0	11	275				
Institute & college	3	7.5	8	20.0				
Educational level for father								
Not read & write	1	2.5	-	-	4.246	3	.236	N S
primary school graduates	20	<u>50.0</u>	24	<u>60.0</u>				
Intermediate & secondary school	5	12.5	8	20.0				
Institute & college	13	32.0	8	20.0				
Occupation for mother								

Housewives	35	<u>87.5</u>	32	<u>80.0</u>	.827	1	.363	N S
Government Employee	5	12.5	8	20.0				
Occupation for father								
Government Employee	15	37.5	9	22.5	2.143	1	.143	N S
Non Government (Free job)	25	<u>62.5</u>	31	<u>77.5</u>				

χ^2 = Chi- Square, df= Degree of Freedom, C.S.= Comparative Significant, NS= Non-Significant

Table (1) demonstrates that the highest percentage (27.5%) of study sample was in age group (21-25) years, while the control in age group (16-20) years, Concerning the educational level for mothers (55%)(47.5%) respectively for both study and control groups are primary school graduates. Concerning the educational level for father: The highest percentages (50%) (60%) respectively for both study and control groups are also primary school graduates. Concerning the occupation for mother: highest percentages for both study & control groups (87.5%) (80%) were housewives. Concerning the occupation for father: The highest percentages for both study & control groups (62.5%) (77.5%) were free jobs. There were no statistical significant differences between both study & control groups in socio-demographic characteristic.

Table (2): Distribution of mother reproductive health history for both Study & Control Groups.

Variables	Study group (n=40)		Control group (n=40)		χ^2	Df	P-value	C.S.
Gravida								
Once	4	10.0	7	17.5	3.461	3	0.629	N S
Twice	12	30.0	15	<u>37.5</u>				
Third	14	<u>35.0</u>	9	22.5				
Forth &more	10	25.0	9	22				
Para								
Once	6	15.0	8	20.0	1.544	3	0.819	N S
Twice	14	<u>35.0</u>	16	<u>40.0</u>				
Third	13	32.5	10	25.0				
Fourth & more	7	17.5	6	15.0				

Abortion								
No abortion	29	<u>72.5</u>	32	<u>80</u>	2.206	2	0.332	N S
One	9	22.5	8	20.0				
Two	2	5.0	0	0				
Number of dead births								
No	39	<u>97.5</u>	33	<u>82.5</u>	5.000	1	0.250	N S
One	1	2.5	7	17.5				
Order of neonate alive now								
One	6	15.0	13	<u>32.5</u>	3.55	1	0.470	N S
Two	14	<u>35.0</u>	12	30.0				
Three	13	32.5	9	22.5				
Four & more	7	17.5	6	15.0				
Sex of neonate now								
Female	20	50.0	24	<u>60.0</u>	0.808	1	0.369	N S
Male	20	50.0	16	40.0				
Body weight of neonate								
2.500-2.900	4	10.0	3	7.5	0.808	3	0.247	N S
3.00-3.400	17	<u>42.5</u>	10	25.0				
3.500-3.900	16	40.0	25	<u>62.5</u>				
4.00-4.500	3	7.5	2	5.0				
$\bar{x} \pm SD$	3.2700±.3329		3.490±.3447					

Table (2) shows that the highest percentages (35%) of study sample was in third gravida, while (37.5 %) in control was in second gravida, (35%) (40%) respectively for both study and control groups were in second para, (27.5%) (20%) respectively have one & two abortions, (2.5%) (17.5%) respectively have dead births , (35%) of the study sample their neonate order were the second, while in control (32.5 %) their neonate order were the first, (42.5%) of study sample have (3-3.400) kgm body weight of neonate, while in control (62.5%) have (3.500-3.900) kgm body weight of neonate.

Table (3): The assessment of first stage of labor for both study & control groups mothers

No.	Items	Answer	Study n=40		Control n=40		χ^2	df	P-value	C.S
			No.	%	No.	%				
1.	Assessment of mother during first stage									
1.1.	Giving oxytocin	Yes	12	30.0	37	<u>92.5</u>	6.646	1	0.01	S
		No	28	70.0	3	7.5				
1.2.	Take the permission to use skin to-skin contact	Yes	40	<u>100.0</u>	0	0	80.00	1	0.000	H S
		No	0	0	40	<u>100.0</u>				
1.3.	Emptying the bladder	Yes	38	<u>95.0</u>	37	<u>92.5</u>	0.241	1	0.623	N S
		No	2-	5	3	7.5				

Table (3) shows that there are significant differences between study and control group in assessment of mother first stage in giving oxytocin ($\chi^2=6.646, p=0.01$), Take the permission to use skin to-skin contact ($\chi^2=80.00, p=0.000$), no significant differences in emptying of bladder ($\chi^2=.241, p=0.623$).

Table (4): The assessment of second stage of labor for both study & control groups mothers

No.	Items	Answer	Study n=40		Control n=40		χ^2	df	P-value	C.S.
			No.	%	No.	%				
2	Assessment of mother during second stage									
2.1	Clean the abdomen & chest	Yes	40	<u>100.0</u>	4	10.0	65.455	1	0.000	H S
		No	0	0	36	<u>90.0</u>				
2.2	Episiotomy or maternal	Yes	24	<u>60.0</u>	24	<u>60.0</u>	3.200	1	0.074	N S

	injuries	No	16	40.0	16	40.0				
2.3	Cutting of umbilical cord	Yes	40	<u>100.0</u>	37	92.0	3.117	1	0.077	N S
		No	0	0	3	7.5				
2.4	Cover the neonate head & put on diaper	Yes	40	<u>100.0</u>	1	<u>2.5</u>	76.098	1	0.000	H S
		No	0	0	39	<u>97.5</u>				
2.5	Clothing the neonate all cloths	Yes	0	0	39	<u>97.5</u>	76.098	1	0.000	H S
		No	40	<u>100.0</u>	1	2.5				
2.6	Take the neonate to special room	Yes			39	<u>97.5</u>	76.098	1	0.000	H S
		No	40	100.0	1	2.5				

Table (4) shows that there are significant differences in assessment of mother during second stage in cleaning the abdomen & chest ($\chi^2=65.455$, $p=0.000$), no significant differences in episiotomy or maternal injuries ($\chi^2=3.200$, $p=0.074$), and cutting of umbilical cord ($\chi^2=3.117$, $p=0.077$). There are significant differences in covering the neonate head & put on diaper ($\chi^2=76.098$, $p=0.000$), clothing the neonate all cloths ($\chi^2=76.098$, $p=0.000$), and take the neonate to special room ($\chi^2=76.098$, $p=0.000$).

Table (5): Assessment of third stage of labor & mothers observation after delivery for both study & control groups mothers

No.	Items	Answer	Study n=40		Control n=40		χ^2	df	P-value	C.S.
			No.	%	No.	%				
3-	Assessment of mother during third stage									
3-1	Complete placental separation	Yes	40	<u>100.0</u>	39	<u>97.5</u>	76.098	1	0.000	H S
		No	0	0	1	2.5				
3-2	Uterus contract immediately after birth	Yes	40	<u>100.0</u>	32	<u>57.5</u>	21.587	1	0.000	H S
		No	0	0	17	42.5				

3-3	Uterus position between umbilical and pubic bone	Yes	40	<u>100.0</u>	31	<u>77.5</u>	10.141	1	0.001	S
		No	0	0	9	22.5				
3-4	Absent of any abnormal signs (uterine atony or postpartum hemorrhage)	Yes	40	<u>100.0</u>	10	25.0	11.429	1	0.001	S
		No	0	<u>0</u>	30	<u>75.0</u>				
3-5	giving methargen	Yes	0	0	23	<u>75.5</u>	32.281	1	0.000	H S
		No	40	<u>100.0</u>	17	42.5				

Table (5) shows, there are significant differences between study and control group in assessment of mother during third stage in Complete placental separation ($\chi^2=76.098$, $p=.000$), Uterus contract immediately after birth ($\chi^2=21.587$, $p=.000$), Uterus position between umbilical and pubic bone ($\chi^2=10.141$, $p=.001$), Absent of any abnormal signs (uterine atony or postpartum hemorrhage) ($\chi^2=11.429$, $p=.001$), giving Methargen ($\chi^2=32.281$, $p=.000$).

Table (6): Distribution of placental separation time for both Study & Control Groups

Variables	Study group (n=40)		Control group (n=40)		χ^2	df	P-value	C.S.
less than 5 minute	40	<u>100</u>	1	2.5	76.098	2	0.000	H S
5-9 minute	-	-	24	<u>60.0</u>				
10 - 15 minute	-	-	15	37.5				
$\bar{x} \pm SD$	1.880±.65758		8.0750 ±2.76783					

Table (6) shows there are significant differences between study and control group of placental separation time ($\chi^2=76.098$, $p=.000$). with mean and standard deviation (SD) in study group (1.880 $\pm$.65758) while (8.0750 $\pm$ 2.76783) in control group.

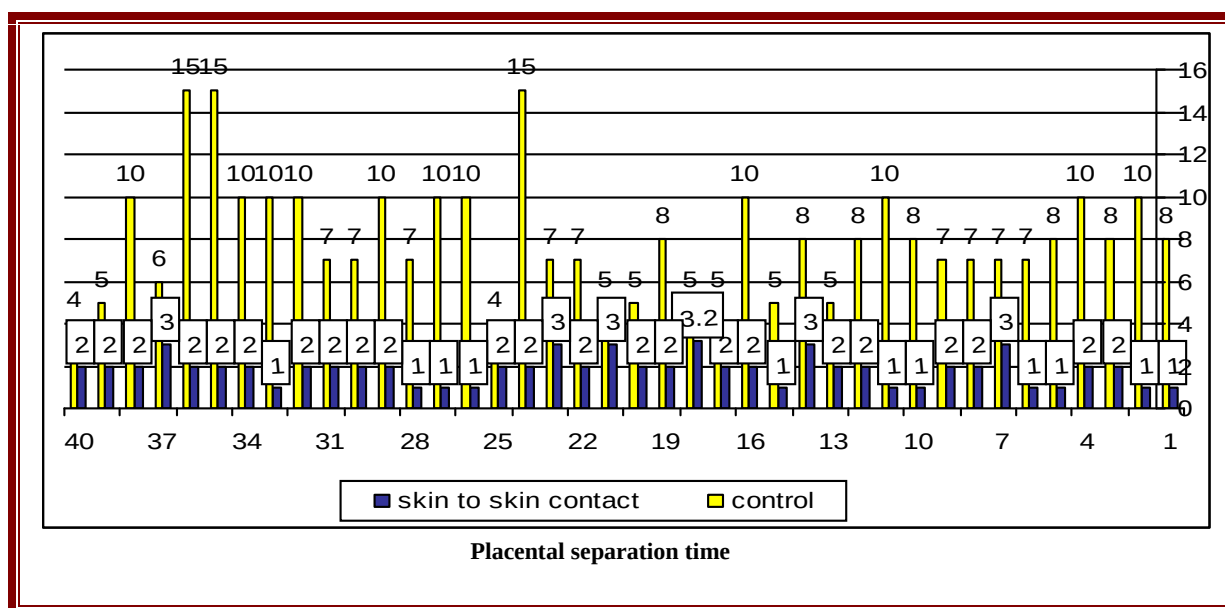


Figure (1) Bar charts for the distribution of placental separation time for both Study & Control Groups

DISCUSSION:

Many different demographic factors have been found to be predictors of initiation & maintenance of skin- to skin contact. These factors, however, differ across studies and among different populations. Socio-demographic factors are important determinants of skin to skin contact⁽⁴⁾. The present study reveals that the highest percentage (27.5%) of study sample was in age group(21-25) years , while the control in age group(16-20) years , and the mean with standard deviation (SD) of age for both groups were (27.025±6.342) (26.075 ± 6.584) respectively.

Ferber & Makhoul (2004) they present in their study the effect of Skin-to-Skin Contact shortly after birth on the Neurobehavioral responses of the term newborn. A randomized, controlled trial using a table of random numbers. After consent, the mothers were assigned to skin to skin contact shortly after delivery or a no-treatment standard care (control group). Skin to skin contact began at 15 to 20 minutes after delivery and Lasted for 1 hour. A Randomized, Controlled Trial the mean with standard deviation (SD) of age for both groups were (28.9±5.75) (27.56 ± 5.22) years. There were no significant differences ($p=0.45$) in any of the variables measured⁽⁵⁾, which is consistent with current study age groups.

Regarding the educational level for mothers (55%) (47.5%) respectively for both study and control groups are primary school graduates. Concerning the educational level for father: The highest percentages (50%) (60%) respectively for both study and control groups are also primary school graduates. Regarding the occupation for mother: highest percentages for both study and control groups (87.5%) (80%) respectively were housewives. There were no statistical significant differences between both study and control groups in socio-demographic characteristic.

Khadivzadeh & Karimi (2009) present in their study the effects of immediate and continues skin-to-skin contact in first two hours post-birth on breastfeeding initiation and the infant success in first breastfeeding, in Om-ol-banin hospital of Mashhad in 2007. In "routine care" group, after performing neonatal primary care breastfeeding was started. In "intervention" group, mother-infant skin to skin contact performed in the first two hours post-

birth. There were no significant differences in any of the variables measured, high school (42.6) in study sample, while in control sample Guidance school (42.2) $p=0.59$. Housewife in study group (97.90) in control group (97.80), $p=0.97$, there was no significant difference between two groups in parents' education, and parents' job ⁽⁶⁾.

This study was in contrast with present study, in educational level and in agreement with them in occupational status. All educational levels were enrolled in the study regardless of low or high educated, at the time of data collection most women were from low and moderate educated group who attended the hospital for delivery, the majority of them were housewives whether highly or low educated.

Regarding mother reproductive health history (table 2) the present study reveals that the highest percentages (35%) of study sample was in third gravida, while (37.5 %) in control was in second gravid, (35%) (40%) respectively for both study and control groups were in second para, (27.5%) (20 %) respectively have one and two abortions. (2.5%) (17.5%) respectively have dead births, (35%) of the study sample their neonate order were the second, while in control (32.5 %) their neonate order were the first. No significant differences were found between the parameters of mother history regarding gravid, parity, and abortion between both groups.

Ali et al (2009) presents in their study the efficacy of skin to skin contact as compared to conventional care for low birth weight babies, a randomized controlled trial was done on 114 neonates, delivered at Jawaharlal Nehru Medical College (JNMCH) Aligarh India (March 2006 to September 2007) by vaginal route and weighing ≤ 1800 grams at birth –58 neonates received skin to skin contact for 6-8 hours/ day in 4-6 sessions while 56 neonates in control group received conventional care (radiant warmers, cots in warm room). Efficacy was measured in terms of effect on growth, physiological parameters. there was no significant difference between two groups primipara in study group 21 (36.2%) in control group 16 (28.6%), ($p=NS$) multipara in study group 9 (16.1%) in control group 8 (13.8%) ($p=NS$), abortion in study group & control group ($p=NS$), also they found, that there was no significant difference between two groups in number of dead births, number of an alive births and order of neonate alive now⁽⁷⁾.

Regarding the assessment of first, second, and third stage of labor for mother, and placental separation time (table 3,4,5, & 6) the study presents that there are significant differences between study and control group in assessment of mother first stage in giving oxytocin ($\chi^2=6.646$, $p=0.01$), take the permission to use skin to-skin contact ($\chi^2=80.00$, $p=0.000$), no significant differences were found in emptying the bladder ($\chi^2=0.241$, $p=0.623$).

There are significant differences in assessment of mother during second stage in cleaning the abdomen and chest ($\chi^2=65.455$, $p=0.000$), no significant differences in episiotomy or maternal injuries ($\chi^2=3.200$, $p=0.074$), and cutting of umbilical cord ($\chi^2=3.117$, $p=0.077$). There are significant differences in covering the neonate head and put on diaper ($\chi^2=76.098$, $p=0.000$), clothing the neonate all cloths ($\chi^2=76.098$, $p=.000$), and take the neonate to special room ($\chi^2=76.098$, $p=0.000$).

Regarding assessment of mother during third stage there are high significant difference between study and control groups in complete placental separation ($\chi^2=76.098$, $p=0.000$), uterus contract immediately after birth ($\chi^2=21.587$, $p=0.000$), uterus position between umbilical and pubic bone ($\chi^2=10.141$, $p=0.001$), absent of any abnormal signs (uterine atony or postpartum hemorrhage) ($\chi^2=11.429$, $p=0.001$), and giving methargen ($\chi^2=32.281$, $p=0.000$) (table 3). There are significant differences between study and control group in placental separation time ($\chi^2=76.098$, $p=0.000$). With mean and standard deviation (SD) in study group

(1.880 ± 0.65758), while (8.0750 ± 2.76783) in control group (table 4 & fig.1). At the very time when we are starting to understand the importance of the third stage for the 'development of the capacity to love', we have to realize that this particular phase of labor has been dramatically disturbed by all cultural milieus via a great diversity of beliefs and rituals. During the third stage of labor, an appropriate maternal hormonal balance is more easily obtained, if in an atmosphere of privacy, the mother can feel the skin-to-skin contact, can try to establish eye-to-eye contact, and can smell the odor of her baby without any distractions ⁽⁸⁾.

Buckley (2010) found in her study that the practice of skin-to-skin contact, early suckling, or both during the first 2 hours after birth when compared with separation between the mothers and their infants positively affected maternal sensitivity, infant's self-regulation, and dyadic mutuality and reciprocity at 1 year after birth. Mother Nature provides peak levels of oxytocin, the hormone of love, and endorphins, hormones of pleasure for both mother and baby. Skin to skin contact and the baby's first attempts to breast feed further augment maternal oxytocin levels, strengthening the uterine contractions that will help the placenta to separate, and the uterus to contract down. In this way, oxytocin acts to prevent hemorrhage, as well as to establish, in concert with the other hormones, the close bond that will ensure a mother's care and protection, and thus her baby's survival ⁽⁹⁾.

CONCLUSIONS:

The study concluded that there are significant differences between study and control group in third stage of labor assessment, in complete placental separation, uterus contract immediately after birth, uterus position between umbilici and pubic bone, absent of any abnormal signs of uterine atony or postpartum hemorrhage. SSc mother have less complication than controls. Skin to skin contact mothers have less placental time versus to the control mothers, which have longer times.

RECOMMENDATIONS:

Continues education program to all midwife work in delivery room and department maternity engorged and explain to mother before birth about skin- to skin contact and clear benefits on mother and her neonate.

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