Intrapartum support: what do women want?

A literature review

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Introduction

Women have life-long memories of their children’s births (Beech and Phipps, 2004; Simkin, 1991). Women’s views and memories of their child’s birth are increasingly recognised as being supportive during labour, alongside physical wellbeing (Beech and Phipps, 2004; NCT, 2002; Lavender et al, 1999; Lavender and Walkinshaw, 1998).

This paper reports a literature review to explore women’s views about what contributes to a positive birth experience and what behaviours they value most highly from the professional caring for them during labour.

A consensus exists in the academic literature that labour support consists of three sub-categories of emotional, physical and informational support (Hodnett, 2002; Miltner, 2002; Sauls, 2002; Bryantan et al, 1994). Emotional support is defined as expressions of love, admiration, liking, reassurance and respect, spending time with the client and making them feel cared for. Tangible or physical support includes direct assistance and informational support includes advice, information and feedback (Lazarus, 1991; Kahn, 1979). One of the key qualities of a birth supporter is the advocacy and partner support have been added in some studies to reflect research that women’s feelings about the support received. Most of the trials did not seek to identify what aspects of the continuous support were of particular importance to the participants, Hodnett and Osborn’s 1989 RCT comparing continuous care with usual care by an obstetric nurse (n=54) and asked women about the care received in a postnatal questionnaire. The study found that women in the intervention group reported significantly higher ratings of physical, emotional, informational and advocacy support: the average number of support actions by the trained birth supporter was 15.1, while the average in the control group was 8.6 (Hodnett and Osborn, 1989). Fewer than one-third of control subjects reported receiving any physical comfort measures from the nurse. However, the study’s authors concede that the postnatal questionnaire employed was a ‘crude measure’, as it did not look at perceived helpfulness or the relative importance of each type of support.

Another study analysed in the Cochrane review undertook direct interviews with a small sub-group of 16 women involved in the larger randomised trial (Campero et al, 1998). This identified that women in the intervention arm of the trial experienced a sense of comfort and valued the information and reassurance that those providing continuous support were able to provide.

Evidence-based midwifery

Intrapartum support has been extensively studied over the last 50 years. This has included substantial exploration of the role of intrapartum support in women’s assessment of their childbirth experiences and women’s definitions of support. The review of research found that support was a central factor in women’s responses to childbirth. Studies with women found a consistent list of priorities over time and across geographical and cultural boundaries.

Conclusion

High-quality continuous support is key in promoting normal birth and reducing medical interventions. It also improves women’s perceptions of the birth experience, promotes a positive adaptation to motherhood and reduces the risk of post-traumatic stress disorder and other perinatal mental health problems. A large body of evidence enables the definition of the key concepts and behaviours considered by women to be central to the provision of high-quality intrapartum support.

Key words: Intrapartum support, support, labour, midwife support, evidence-based midwifery

Literature search method

The review of the literature relating to support during childbirth was undertaken in July 2009 using CINAHL electronic library database to ensure completeness. The search terms ‘Support + childbirth’ or ‘labo’ were employed, limiting results to articles available in English and published since 1980. A total of 86 articles were selected for detailed review. Secondary searches were undertaken for key cited articles and related search terms identified in the initial review. This theme review included ‘women’s experience + childbirth’, ‘supportive experience + childbirth’, ‘fathers + childbirth’, ‘fathers + childbirth’, ‘professional support + childbirth’, ‘participants + childbirth’, ‘care + childbirth’, ‘care + childbirth’, ‘mothers + childbirth’, ‘satisfaction + childbirth’, ‘post-traumatic stress disorder + childbirth’ and ‘satisfaction + childbirth’, ‘post-traumatic stress disorder + childbirth’, ‘information + childbirth’, ‘satisfaction + childbirth’, ‘post-traumatic stress disorder + childbirth’, ‘information + childbirth’, ‘satisfaction + childbirth’, ‘post-traumatic stress disorder + childbirth’, ‘information + childbirth’, ‘satisfaction + childbirth’, ‘post-traumatic stress disorder + childbirth’. The search was cross-referenced with a search using the NHS Scotland electronic library database to ensure completeness. The search terms ‘Support + childbirth or labo’ were employed, limiting results to articles available in English and published since 1980. A total of 86 articles were selected for detailed review. Secondary searches were undertaken for key cited articles and related search terms identified in the initial review. This theme review included ‘women’s experience + childbirth’, ‘supportive experience + childbirth’, ‘fathers + childbirth’, ‘fathers + childbirth’, ‘professional support + childbirth’, ‘professional support + childbirth’, ‘companion + childbirth’, ‘companions + childbirth’, ‘maternity + support’, ‘social support + theory’, and led to the critical review of a further 60 papers. Papers and position statements from UK governments, national and international maternity care professional bodies and lay childbirth organisations over the last 10 years were reviewed. The literature search was repeated in September 2011 to include material from mid-2009 to 2011, which led to the review of 52 further papers.

When analysing the evidence for what women experience as being supportive during labour, the hierarchy of evidence (NHS Centre for Reviews and Dissemination, 1996) provided a helpful framework. The review first explored findings from meta-analyses of randomised controlled trials (RCTs), then individual randomised studies, then meta-analyses of non-randomised studies and, finally, reviewed individual non-randomised studies. This assisted in the evaluation of the strength and generalisability of findings, as well as enabling the review to move from the more general to the specific.

Meta-analysis of RCTs

One Cochrane library systematic review of specific relevance to this review was identified. The review analysed RCTs comparing the impact of continuous and intermittent support. It identified that women receiving continuous intrapartum support were significantly less likely to report dissatisfaction with the birth experience than women receiving intermittent support (Hodnett et al, 2011). Data on women’s overall satisfaction with the birth experience were collected in 11 trials, with 11,133 participants in total. Reported negative ratings or negative health about their childbirth experience were significantly lower among women who received continuous support (RR 0.69, 95%; CI 0.59 to 0.78).

Only two of the RCTs included in the review collected any further data on the relationship of women’s feelings about the support received. Most of the trials did not seek to identify what aspects of the continuous support were of particular importance to the participants, Hodnett and Osborn’s 1989 RCT comparing continuous care with usual care by an obstetric nurse (n=54) and asked women about the care received in a postnatal questionnaire. The study found that women in the intervention group reported significantly higher ratings of physical, emotional, informational and advocacy support: the average number of support actions by the trained birth supporter was 15.1, while the average in the control group was 8.6 (Hodnett and Osborn, 1989). Fewer than one-third of control subjects reported receiving any physical comfort measures from the nurse. However, the study’s authors concede that the postnatal questionnaire employed was a ‘crude measure’, as it did not look at perceived helpfulness or the relative importance of each type of support.

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Individual RCT

The next stage in the review identified any individual RCTs that were not part of the Cochrane review that explored women’s feelings about labour support. One individual RCT relevant to the review was identified. The primary aim of this RCT was to compare labour management and outcomes between the intervention arm, where a partogram action line was used, with routine care where no action line was used. Patients’ views of their labour were gathered using an open-ended question in a postnatal questionnaire (Lavender et al, 1999). The questionnaire asked the 412 respondents to identify the elements that were most important to them about their labour experience. The study found that the elements of labour care most frequently identified by the participants were professional support, information giving, decision-making, medical interventions, a sense of control and pain relief (Lavender et al, 1999).

Though meta-analysis and RCTs are viewed as the highest methodological standards, the following synthesis of the studies, including descriptive RCTs and systematic reviews of intrapartum interventions. The findings of each of these three key types of research were synthesised separately and then summarised qualitatively. A total of 29 studies of satisfaction with intrapartum care were reviewed, ranging from small qualitative studies (n=16) to large population-based surveys (n=2000), including more than 14,000 women in nine countries. Of the included qualitative interviews were undertaken in the UK. Hodnett described two of the larger population-based surveys undertaken in the UK (Green et al, 1998; Green and Coupland, 1990) as among the most rigorous.

The review identified that professional caregiver support is complementary, but distinct from the support provided by a partner: ‘Although the support of people who love her undoubtedly is of great benefit to the woman, it is no substitute for the nurse’s support’ (Hodnett, 1996: 258).

Following the synthesis of the studies, Hodnett concluded that supportive care was the most helpful nursing measure. Strong predictors of dissatisfaction with the birth experience were support and advocacy. These include emotional support, obstetric interventions and caregivers that were perceived as unhelpful. Four key factors were so important in women’s evaluation of their birth experience that they were found to outweigh the effects of all other variables (age, ethnicity, socio-economic status, birth environment, medical interventions, attendance at antenatal education, pain perception, continuity of care and mobility) (Hodnett, 2002). It is likely that the provision of support from caregivers, the quality of the caregiver–patient relationship and the involvement of the woman in decision-making, leading the author to conclude: ‘The influences of pain, pain relief and intrapartum medical interventions on subsequent satisfaction are neither as obvious, as direct nor as powerful as the influences of the attitude and behaviour of caregivers’ (Hodnett, 2002).

A further significant systematic review was undertaken by NICE. The 2007 NICE guideline on intrapartum care of low risk women included a review of studies relating to intrapartum communication and psychosocial outcomes.
for women (NICE, 2007). NICE employed a ‘hierarchy of evidence’ approach to evaluating evidence from 1+ (high-quality meta-analyses and systematic reviews of RCTs with little methodological variation) to 3 (expert opinion). The highest level of evidence relating to the topic of communication and psychosocial outcomes reported in the intrapartum guidance was 2+ (high-quality case control or cohort studies).

The BANSILQ approach to assessing women’s views during childbirth. Of the 185 participants were providing pain medication, were more likely to have relief from pain, to have a safe outcome, to have a sense of security, to communicate effectively with and perception of their childbirth experience and pain (Larkin and Begley, 2009).

A review identified the importance of factors that support women’s feelings about their birth experience (Bowers, 2002). This review included the importance of the caregiver being friendly, open and gentle, communicating a warm positive regard and being able to convey a sense of security and tranquility (Bowers, 2002).

The review highlighted that women’s perception of care is a key element of their overall experience of childbirth: ‘Women who perceived their nurses as negative or uncaring were more likely to believe that their childbirth experience was 2+ (high-quality case control or cohort studies).’

A comprehensive approach was taken by Bowers in a systematic review and synthesis of 17 qualitative studies of women’s perceptions of professional support in labour including 533 women. The study responses were analysed by Bowers through categorisation into four theoretical domains: emotional support, informational, contextual and advocacy. This review identified that the continuous presence of a midwife or nurse, physical comfort measures, advocacy and emotional support were strongly associated with birth (Bowers, 2002).

A recurrent theme was the importance of the caregiver being friendly, open and gentle, communicating a warm positive regard and being able to convey a sense of security and tranquility (Bowers, 2002).

The BANSILQ approach to assessing women’s views during childbirth. On average, 11% of women wanted the nurse in the room most or much of the time. The type of nursing care was most strongly associated with satisfaction. Presence of the nurse was the most helpful nursing measure, the majority of women wanted the nurse in the room most or much of the time. The presence of other supporters, such as the partner or mother, did not alter the woman’s need for the presence of the nurse and Begley in 2009. This review sampled 62 papers from 180 papers identified as being relevant, including 30 qualitative and 30 quantitative studies. The study was undertaken in the UK (n=22), North America (n=13), Sweden (n=8) and Australia (n=7). The most commonly identified themes in the sample of papers were control, support, the relationship with the caregiver and pain (Larkin and Begley, 2009).

Two large studies concluded emotional support to have an important impact on women’s feelings about childbirth by including a number of subsequent studies. The questionnaire, devised by the author and based on the research available at the time, provided women with a list of nursing behaviours which they rated on a 5-point Likert scale, with the highest rating attributed to feeling treated as an individual. The questionnaire asked women about the importance of positive support behaviours to women in labour and some insight into the key elements of that support. In order to develop a more detailed definition of ‘emotional support’, the questionnaire identified the priorities for care defined by women, and the impact of the care on women’s feelings about the birth.

Findings of individual studies – identifying priorities Since the 1950s, research has identified the key role that professional support plays in women’s overall satisfaction with and perception of their childbirth experience and has sought to identify what behaviours women find most (and least) supportive. A total of 44 papers were reviewed that focused on identifying women’s priorities for care during childbirth. Of the 185 participants were providing pain medication, were more likely to have relief from pain, to have a safe outcome, to have a sense of security, to communicate effectively with

An influential study in the development of knowledge of women’s priorities for care was that by Kintz in the US in 1987, which developed the ‘nursing support in labour questionnaire’ (Larkin and Begley, 2009). This questionnaire had formed the basis for a number of subsequent studies. The questionnaire, devised by the author and based on the research available at the time, provided women with a list of nursing behaviours which they rated on a 5-point Likert scale, with the highest rating attributed to feeling treated as an individual.

The behaviours chosen least frequently were: providing pain medication, explaining hospital routines, encouraging my partner, communicating with my surroundings, including me in decisions and distracting me by talking (Bryanton et al, 1994).

Bryanton et al concluded ‘emotional support during labour was more important than technical support’ (Bryanton et al, 1994: 643).

The BANSILQ has been used in a number of subsequent studies with women from a range of cultural and ethnic backgrounds. Mbye et al (2011) used the BANSILQ in a qualitative study with 825 women in Sweden, identified the importance of feeling in control, reassurance, answer questions, helping me with breathing and keeping me as comfortable as possible, support, keeping me calm, provided a sense of security, spent time in the room, instructed me in breathing and made me physically comfortable.

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Women were less satisfied when the staff caring for them in labour were considered to be less helpful and when they were left alone (Green et al., 2003).

The importance of a sense of control to women during their childbirth experience has been found in repeated surveys, both small qualitative and larger population-based study surveys (Wilde-Larsson et al., 2011; Namey and Lyerly, 2010; Larkin and Begley, 2009; Green et al., 2003).

The relationship between satisfaction with intrapartum support and postnatal mental health is important. In order to fully understand the role of support in women’s experience of childbirth and what women want from that support, it is helpful to look at the evidence exploring the impact of support on women’s wellbeing postnatally. A total of inadequate support during labour can have serious consequences for women’s psychological health. It was felt to be evident that exploring the elements of care that women identified as having an ongoing impact, contributed further to the development of understanding of what women want (and don’t want) from their intrapartum care.

The literature reviewed identified that generally women are very satisfied with their childbirth experience and the care received (Records and Wilson, 2011; Wilde-Larsson et al., 2011; Care Quality Commission, 2010; Green et al., 2003; Ortega et al., 1999).

Waldenstrom’s Swedish study of 1111 women identified 50.3% of women had a very positive overall experience with childbirth, with satisfaction scores being linked to the development of acute or chronic trauma symptoms. The level of obstetric intervention experienced during childbirth and information through antenatal questionnaires, including demographic details, antenatal risk factors, relationship status and state and trait anxiety scores (Creedy et al., 2000; The authors concluded: Antenatal variables (partner support, antenatal risk factors and birth environment) measured antenatally did not contribute to the development of acute or chronic trauma symptoms (Creedy et al., 2000: 104).

The impact of women’s childbirth expectations on their perceptions of their birth experience has been examined in a number of studies (Records and Wilson, 2011; Kuo et al., 2010; Bryant and Gagnon, 2007, 2003; Green et al., 1998).

Green’s study found that women with higher expectations of the birth had higher levels of satisfaction (Green et al., 1998), a finding which is echoed by Bryant et al’s considerable body of work. They identified a large correlation between the perinatal experience of the mother and her postnatal wellbeing (Berg M, Lundqvist I. 1996: Women’s experiences of the encounter with the midwife during childbirth. Midwife 12(1): 11-15).


Several high-quality studies explored birth experiences and the importance of post-traumatic stress symptoms (Steenven et al., 2011a, 2011b, Stramrood et al., 2011, Yang et al., 2011; Olde et al., 2003; Creedy et al., 2000).

An Australian study including 499 women gathered information through antenatal questionnaires, including demographic details, antenatal risk factors, relationship status and state and trait anxiety scores (Creedy et al., 2000; The authors concluded: Antenatal variables (partner support, antenatal risk factors and birth environment) measured antenatally did not contribute to the development of acute or chronic trauma symptoms (Creedy et al., 2000: 104).

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