



The Royal College of
Midwives

Evidence Based Guidelines *for* *Midwifery-Led Care in Labour*

Supporting Women
in Labour



Practice Points

Studies have suggested four dimensions to the support that women want in labour: emotional support; informational support; physical support and advocacy (Hodnett et al. 2011; MIDIRS 2008; NICE 2007).

All women should receive one to one midwifery support in established labour (DH 2007; NICE 2007; RCOG 2007).

A woman in established labour should not be left on her own except for short periods or at the woman's request (NICE 2007).

Evidence indicates that continuous support during labour has a number of measurable positive impacts on key birth outcomes when compared to intermittent support (Hodnett 2011; Scott et al. 1999; Zhang et al. 1996).

Continuous support is associated with less use of pharmacological analgesia, fewer operative births and fewer reports of dissatisfaction with birth (Hodnett 2011).

Support from the midwife may include helping the woman in her wish to avoid pharmacological pain relief or helping her choose among pharmacological and non-pharmacological methods of pain relief (Enkin et al. 2000).

The quality of the support may outweigh many other aspects of the birth experience when women describe their satisfaction with their birth, including the number of medical interventions, pain relief and the type of birth (Larkin and Begley 2009; Hauck et al. 2007; Commission for Healthcare Audit and Inspection 2007; Bowers 2002; Waldenstrom et al. 1996).

Poor support and communication during labour and birth is associated with a higher rate of postnatal mental health problems including postnatal depression and post traumatic stress disorder (Lemola et al. 2007; Creedy et al. 2000; Czarnocka and Slade 2000).

Midwives should support women in use of coping strategies (breathing, relaxation and positions) in labour as use is associated with benefits in terms of pain and women's emotional experiences of labour (Spiby et al. 2003; Spiby et al. 1999).

Midwives should keep up to date with non-pharmacological methods of pain relief. These include water, positions and movement, massage, coping strategies and alternative therapies (Simkin and Bolding 2004; Mander 1998).

Supporting Women in Labour

Women in labour have need for companionship, empathy and help (DH 2004; DH 1993; Simkin 1992). Descriptive studies of women's childbirth experience have suggested four dimensions to the support that women want in labour: emotional support, informational support, physical support and advocacy (MIDIRS 2008). Good skills in active listening are essential to supportive midwifery practice.

All current national intrapartum practice guidance and maternity policies state that one to one midwifery care should be provided to all women in established labour (Scottish Government 2011; DH 2007; RCOG 2007; NICE 2007; DH 2004).

Women experience a wide range of pain in labour, and have an equally wide range of responses to it (Mander 1998). A woman's reactions to labour pain may be influenced by the circumstances of her labour, including the environment and the support she receives (Enkin et al. 2000). Support from the midwife may include helping the woman in her wish to avoid pharmacological pain relief or helping her choose among pharmacological and non-pharmacological methods of pain relief (Enkin et al. 2000). Midwives should keep up to date with non-pharmacological methods of pain relief. These include water, positions and movement, massage, coping strategies and alternative therapies (Simkin and Bolding 2004; Mander 1998).

Provision of support during labour and childbirth is recognised internationally and nationally as a core role of the midwife (Midwifery 2020 2010; NMC 2004, ICM 2005; WHO 1996).

Evidence indicates that continuous support during labour has a number of measurable positive impacts on key birth outcomes when compared to intermittent support (Hodnett 2011; Scott et al. 1999; Zhang et al. 1996). The Cochrane review of continuous versus intermittent intrapartum support carried out a meta-analysis of twenty one randomised controlled trials carried out since 1980 involving over 15,000 women (Hodnett 2011). The impact of continuous support includes a significant reduction in the number of caesarean sections and operative deliveries, an increase in the number of normal births, a reduction in the use of analgesia and a reduction in the length of labour. It should be noted that none of the randomised controlled trials included in the review were carried out in the UK. The majority of the studies were carried out in highly medicalised systems in which normal care was provided by obstetric nurses rather than midwives, where one to one care was not generally provided and where women were not generally supported by their partners during labour. In the majority of studies continuous support was provided by 'doulas' or lay birth supporters rather than by maternity care professionals. No randomised controlled trials have yet been carried out in the UK comparing the different outcomes obtained when continuous support is provided by midwives, lay supporters or 'doulas'.

Research from the US suggests that the support offered to a woman by the nurse or midwife caring for a woman during labour may have a greater impact than many other variables on the rate of operative deliveries, including maternal age, gestational age, infant weight, antenatal classes and attending physician (Radin 1993). A large body of research with women identifies that the nature of the support given to them during labour and childbirth is the 'essential structure' of a positive birth experience (Larking and Begley 2009; Hauck et al. 2007; Bowers 2002). For women 'the experience of childbirth and the experience of care are considered as a whole' (Waldenstrom 1996).

The quality of the support may outweigh many other aspects of the birth experience when women describe their satisfaction with their birth, including the number of medical interventions, pain relief and the type of birth (Larkin and Begley 2009; Commission for Healthcare Audit and Inspection 2007; Hauck et al. 2007; Bowers 2002; Waldenstrom 1996). Hodnett, in a systematic review of 137 studies exploring women's experiences of birth found four key factors that were so important in women's evaluation of their birth experience that they outweighed 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). These four factors were personal expectations, amount of support from caregivers, the quality of the caregiver-patient relationship and the involvement of the woman in decision-making. This led Hodnett to conclude that "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 behaviours of the caregivers" (Hodnett 2002).

Women's birth experiences have widespread and long-term implications for women and their families. Studies have found women have detailed life-long memories of their births (Simkin, 1991). Poor experiences have been found to contribute significantly to perinatal mental health problems including post-traumatic stress disorder and postnatal depression, undermine the development of a positive mother-baby attachment (Lemola et al. 2007; Creedy et al. 2000; Czarnocka and Slade 2000) and influence women's decisions about future childbearing. Increasingly, women's views of their birth and their memories are being recognised as an important outcome of childbirth (Lavender and Kingdon 2006; Beech and Phipps 2004; NCT 2002).

A consensus exists in the literature from theoretical, qualitative, empirical and observational research that intrapartum support consists of four key categories:

1. Emotional support, includes presence, demonstrating an effective caring attitude, positive and calming verbal expressions and non-verbal expressions, distraction, use of humour.
2. Physical support and comfort measures, including environmental control, encouragement of different positions and mobilisation, touch, massage, application of hot and cold packs, hygiene, hydrotherapy, promotion of urinary elimination and nourishment.
3. Information and advice, includes listening to women's views, instruction on breathing and relaxation, information about routines, procedures and progress.
4. Advocacy, includes protecting the client, assisting the client to make informed choices, being the client's voice when required and conflict resolution.

Four systematic reviews of research into women's views and satisfaction with care and support in labour have been published (Larkin and Begley 2009; Bowers 2002; Hodnett 2002; Hodnett 2002).

Research suggests that intrapartum support by professionals may not always be prioritised by maternity care professionals and that other technical aspects of care such as surveillance of the fetal heart, monitoring of maternal vital signs, management of epidural anaesthesia and intravenous augmentation may take precedence or distract from offering support (Barnett 2008; Gale et al. 2001; Gagnon and Waghorn 1996; McNiven et al. 1992).

Attendance at antenatal classes is associated with less use of pharmacological pain relief during labour (Hetherington 1990) and in increasing women's knowledge (Hillier and Slade 1989). Use of different coping strategies during labour varies significantly between strategies, even within a group who have attended the majority of an antenatal education programme. Women expect support from midwives in relation to coping strategies, and midwives should find out from women about their preparation in the use of these methods from birth and care planning (Spiby et al. 1999). The use of coping strategies in labour is associated with definite benefits in terms of women's experience of pain and emotional distress (Spiby et al. 2003). Coping strategies are easily disrupted by changing environment and after procedures such as monitoring or examinations; midwives need to be aware of this in order to help women re-connect with their coping strategies (Spiby et al. 2003). Niven (1994) suggests that midwives may not always give value to psychological coping strategies: they can give the impression of being somewhat hostile to the use of "NCT type" techniques.

Evidence also suggests that while the majority of women are happy with the midwifery support they receive during labour in the UK, some systems of maternity care in the UK may not always provide women with adequate levels of professional support in labour (Commission for Healthcare Audit and Inspection 2007).

Further research is needed into a number of aspects of intrapartum support including the way in which intrapartum support is provided by midwives in the UK; how the quality of intrapartum support may be improved; the impact of support provided by different care providers in the UK and the impact of different approaches to midwifery support on outcomes.

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The guidelines have been developed under the auspices of the RCM Guideline Advisory Group with final approval by the Director of Learning Research and Practice Development, Professional Midwifery Lead.

The guideline review process will commence in 2016 unless evidence requires earlier review.

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Appendix A

Sources

The following electronic databases were searched: The Cochrane Database of Systematic Reviews, MEDLINE, Embase and MIDIRS. As this document is an update of research previously carried out, the publication time period was restricted to 2008 to March 2011. The search was undertaken by Mary Dharmachandran, Project Librarian (RCM Collection), The Royal College of Obstetricians and Gynaecologists.

Search Terms

Separate search strategies were developed for each section of the review. Initial search terms for each discrete area were identified by the authors. For each search, a combination of MeSH and keyword (free text) terms was used.

Journals hand-searched by the authors were as follows:

- Birth
- British Journal of Midwifery
- Midwifery
- Practising Midwife
- Evidence-based Midwifery