Promoting normal birth the easy way

Mary Sidebotham presents her normal birth guide for midwives

SUMMARY There is a growing concern internationally about the continued rise in birth intervention. Caesarean section rates continue to rise within the international arena. Women are losing confidence in the birth process being natural and safe and often exhibit moderate to high levels of fear during pregnancy. Simultaneously midwives are in danger of losing their role as the guardians of normal birth. This paper presents an easy to follow, evidence based framework that midwives can use at a personal or organisational level to promote normal birth and support women to move back to feeling excited anticipation about birth.

Keywords Normal birth, midwife, framework, easy guide

Author Mary Sidebotham, Senior Lecturer and Programme Director of the Bachelor of Midwifery Programme at Griffith University, Australia

Introduction
Internationally the impact of medicalisation on birth can be witnessed by rising intervention rates. If we are to believe the media, it is women who are driving the rise in operative births. Others would argue that fear is the real instigator of the internationally observed rising caesarean section (CS) rates (Fenwick et al 2009). Women appear to have lost faith in their body’s ability to birth their babies. We hear women say that they will try to have a normal birth, but give a long list of fears all compounding their lack of self belief in their ability to give birth naturally and safely. In order to combat this epidemic, midwives need to re-establish their position as the guardians of normal birth and take positive action to reverse the trend. The easy guide to promoting normal birth (North West Local Supervising Authority (NWLSA) 2008) was developed to provide birthing facilities, organisations and individuals with a framework to promote normal birth.

The easy guide provides an evidence based framework which when applied at a personal or organisational level will contribute to the development of a culture where normal birth can happen.

Explaining the model

Environment
The birth environment has the potential to impact on birth outcome (Walsh and Ebrary 2007). Where midwives are aware of this they can...
undertake simple activities that will significantly reduce the risk of birth intervention.

These include encouraging healthy women with normal pregnancies to decide on place of birth during the course of the pregnancy or in labour, rather than at booking. This will enable women to keep all options open. Healthy women should be supported to birth at home or within a free standing birth centre where possible.

To feel safe and uninhibited the woman must have her right to privacy respected. She should have the companions of her choice with her. ‘Medical’ equipment in the birthing room should be kept to a minimum and only used when required. The birthing room should contain equipment designed to promote mobility and active position change. There should also be comfort aids and wherever possible women should be encouraged to use water in labour. In hospitals the bed often assumes a dominant position in the room. This often encourages women to spend much of their time on the bed – often facing a door feeling exposed and vulnerable. Wherever possible the bed should be moved to the side or outside the room altogether to create a birthing space that invites mobility. This simple initiative can create the beginning of a major culture change. The ambience in the birthing room should be calm and inviting; and there should be every effort made to help the woman control the ambience wherever she chooses to give birth. The woman should have access to food and drink to prevent dysfunction due to dehydration or hunger.

**Empowerment**

The two factors that are most likely to reduce a woman’s chances of achieving a natural birth are lack of knowledge and fear. It is easy to observe the preventable ‘cascade of intervention’ that can result from this scenario, with women immobilised by the insertion of an early epidural, resulting in labour often being accelerated due to lack of progress. This scenario is witnessed by midwives regularly where women are ill informed and fearful. The fear is compounded by constant exposure to different staff when women are not receiving care within a continuity of midwifery care scheme. All too often the woman in the latent phase of labour ends up with an unnecessary artificial rupture of membranes (ARM) followed by unnecessary augmentation and, potentially, an unnecessary caesarean section (CS). Empowered women would ask why before agreeing to any intervention and if they were knowledgeable they would understand the process of labour. Similarly if midwives were empowered they would seek to create and work within models that offered continuity of care. They would advocate for women, feeling safe to challenge unnecessary intervention by citing and promoting the use of current evidence.

Empowerment of women and their partners reduces fear and intervention, increases control and strength and promotes normal birth (Lindgren and Erlandsson 2010). This can be achieved through education and exposure.

**Education**

We should encourage women to attend childbirth preparation sessions with their partners or other supporters where the focus is on normal childbirth and on practical ways to support the physiology of birth. Similar sessions should be included in mandatory education sessions similar to those dealing with obstetric emergencies for all personnel supporting birthing women.

Midwives have a role in challenging society’s impression of birth and should contribute where possible to the education curricula to begin to change societal views on birth. Midwives can also use their knowledge to challenge poor media portrayal of birth and are proud to promote their art within all sectors of society.

As a profession, midwifery should value the development and nurturing of basic midwifery skills, which are in danger of being lost as our roles and scope of practice are increasingly extended into ‘high technology’ skills. Doctors should be educated alongside midwives to create a shared community of practice to ensure they have a complete understanding of the physiology of normal birth to form a sound knowledge base before trying to solve the complex problems experienced by some women in pregnancy and childbirth.

**Exposure**

Women often receive their first impressions of what birth is like from listening to their mothers and friends. Many of the mothers of today’s mothers gave birth in the 1970s and 1980s when medicalisation and intervention began their stranglehold on the birthing process. Their friends are likely to have experienced operative and often traumatic births. Women’s expectations are therefore likely to be of pain and an inability to cope. They expect to be strapped to a monitor in a clinical environment where mobility is not possible. Increasingly, they expect an assisted or operative birth. Additionally the media reinforces women’s perceptions of childbirth as dramatic and dangerous, secure only within a hospital environment.

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- The birthing room should contain equipment designed to promote mobility and active position change.
- There should also be comfort aids and wherever possible women should be encouraged to use water in labour.
- In hospitals the bed often assumes a dominant position in the room.
- This often encourages women to spend much of their time on the bed – often facing a door feeling exposed and vulnerable.
- Wherever possible the bed should be moved to the side or outside the room altogether to create a birthing space that invites mobility.
- The simple initiative can create the beginning of a major culture change.
- The ambience in the birthing room should be calm and inviting; and there should be every effort made to help the woman control the ambience wherever she chooses to give birth.
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We must use the evidence to ensure that we never stand still, but constantly question, not just what we do, but the effect of what others do, on women and childbirth.

Supported by technology. High profile celebrities in the public eye further reinforce these impressions by opting to have CSs – the ‘too posh to push’ syndrome.

As midwives, we should take every opportunity to question this portrayal and seek ways to redress the balance. Exposure to normal birth can be achieved through enabling midwives to promote and experience as wide a range of birthing environments as possible. In order to achieve this an interdisciplinary culture of respect and trust should be fostered. Shared goals should be developed and then lead policy and practice. In organisations where this collaborative cluster approach to promoting normal birth is taken, non interventionist birth will increase.

Conclusion
If more midwives practise in a woman centred environment where women’s choices are respected and birth is protected, a different cascade is possible. If every midwife decides to use this framework to guide practice development at a personal and institutional level, rates of normal birth will increase.

EvidenCe
The evidence to support all of these initiatives is available and growing all the time. For example a recent Cochrane review confirms that cardiocotography (CTG) on admission increases the risk of CS and should not be used routinely for low risk women (Devane et al 2012).

Midwifery must contribute to the evidence base and be prepared to collaborate with other disciplines in public health, sociology, psychology, physiotherapy, mental health and others.

Homeopathic Remedies and Creams for Pregnancy, Childbirth and the newborn

The Helios Homeopathic Childbirth kit contains 18 safe and gentle homeopathic remedies specifically for use during pregnancy, labour and postnatal symptoms. Each kit is accompanied by an information booklet giving an introduction to homeopathy, an A-Z of complaints that can be treated and a materia medica section detailing the main uses of each remedy. Our natural plant based creams are formulated to ease varicose veins, piles and stretch marks and soothe nappy rash, cradle cap and other minor skin complaints and first aid situations.

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Web: www.helios.co.uk

References