Perspective

The NCT publication for parent-centred midwifery

nct

Issue 6 • March 2010

Working with labour pain:
We review the evidence

Best Beginnings:
Helping mothers make a new start

Yoga in pregnancy and labour

Welcome to the March issue of *Perspective*, which has the theme of preparing for birth and beyond.

Virginia Campbell, the NCT Yoga for Pregnancy (YfP) co-ordinator, explains how yoga classes can help pregnant women relax, improve flexibility and develop strategies for labour. NCT YfP classes provide an opportunity for women to prepare physically and emotionally for labour and raise questions or concerns about pregnancy and birth. Nicky Leap, professor of midwifery at the University of Technology, Sydney, developed her master's thesis on working with pain in labour. Our collaborative overview of the evidence sets out the factors that maximise opportunities for women to cope during labour using support and their own resources, rather than resorting to drugs and invasive procedures.

We showcase the work of the Best Beginnings team of midwives in Greenwich, winners of the 2009 All Party Parliamentary Group on Maternity (APPGM) award for providing inclusive services for disadvantaged groups and communities. The NCT runs the awards for the APPGM and is delighted to support innovative services provided in Sure Start children's centres.

Sadly, pregnancy and the birth of a baby make women more at risk of domestic abuse. Antenatal teacher Stephanie Ward introduces the NCT's policy on physical and emotional abuse. The NCT backs the government's policy that women should be screened for domestic abuse during pregnancy as a means of promoting public health and safeguarding women and children.

Around three-quarters of women start breastfeeding, yet within the first six weeks nearly four in 10 stop. Research shows that most would like to continue for longer. Friendly encouragement from other mothers is an important contribution to the circumstances that make breastfeeding easier to sustain. The article on page 7 explains how the NCT's local peer support training package has been evaluated and is now being rolled out across the UK.

Mary Newburn

Perspective

Perspective is published by the NCT and sent out each quarter with the MIDIRS Midwifery Digest.

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News

Conservative plans for maternity care

The NCT calls for more clarity in Conservative plans for a 'rebirth of maternity care'

The NCT has welcomed Conservative Party plans, announced in November 2009, to improve NHS maternity care. The proposals, outlined in *The rebirth of NHS maternity care*, include the reform of maternity budgets and financing; an increase in the number of midwives; an emphasis on the involvement of fathers; and early support for parents, including home visits.

Belinda Phipps, chief executive of the NCT, gave cautious approval to the proposals, saying, 'We warmly welcome these intentions, which put women, their babies, and their partners at the centre of maternity care.' She expressed concern, however, about how the proposals could be implemented in a way that resulted in women seeing a real difference.

The NCT has called on the Conservatives to clarify their intentions, so that users of the service can fully understand how any potential changes will affect them. Maternity care funding, the NCT argues, must avoid a system where providers are encouraged to carry out interventions on women that may not be clinically necessary but attract financial advantages. The Conservatives propose a tariff based on an assessment of each woman's 'prospective risk'. The NCT believes this may result in higher levels of intervention. Instead, the tariff should be equal for all women, with extra funds available for providers in areas of greater social disadvantage.

The NCT is also disappointed that the importance of promoting and protecting normality in birth is not highlighted in the policy.

News

Albany contract terminated

King's College Hospital NHS Foundation Trust announced in December 2009 that it was terminating its contract with the Albany Midwifery Practice on safety grounds. The practice has provided an exemplar model of midwifery care with maximum continuity of care and high home birth rates. The King's College Hospital NHS Foundation Trust's decision to terminate the contract with the Albany may be a simple, expedient solution for the Trust, but it has repercussions, however, for the reputation of the model of care the Albany provided. Any damage to the reputation of the model will mean that other trusts will be less likely to adopt similar arrangements for women in their areas. In addition to national level work to ensure that any changes to the celebrated Albany model of care are done for the right reasons, the NCT has been supporting local families and local parents. You can visit www.nct.org.uk/choice for updates.

Relax, stretch and breathe

how yoga helps in pregnancy and labour

Virginia Campbell is the NCT Yoga for Pregnancy/Relax Stretch & Breathe co-ordinator, and has run an NCT yoga class for pregnant women for 17 years. She describes how yoga can relax women and prepare them for birth.

In the years that I have been running NCT yoga for pregnancy (YfP) classes I have witnessed at first hand the beneficial effect yoga has on pregnant women. Not only does it make women feel calmer and more relaxed, it improves their flexibility, helps them sleep, reduces some of the physical discomforts of pregnancy and increases the likelihood that they will have a normal birth.

What makes yoga different from other forms of exercise is that it takes a holistic approach, focusing on both body and mind. So as well as undertaking stretching exercises that improve flexibility and posture, women learn relaxation and breathing techniques that can help them think and feel differently, so that they can manage labour more effectively.

The classes

The classes are two hours long and combine a normal yoga class with an NCT antenatal class. We start with introductions, followed by an hour of focused breathing and gentle stretching postures designed specifically for pregnancy. Every class includes some practice contractions so women become confident in using their breath to work with the flow of their labour.

Research shows that people use different strategies for managing pain, so it's important to practise a wide variety of breathing strategies for labour so every woman can find one that suits her. Some strategies focus on the pain (so women will concentrate on what is happening inside – either on the baby, or on the uterus as a muscle, or actively breathing to relax the cervix), and some away from the pain (these women will often visualise something far removed from what is happening, so perhaps blowing a feather or imagining riding a wave or climbing a mountain). Many women find counting an effective method of managing the powerful feeling of contractions, so we practise different ways of doing this too. Imposing a strategy of the teacher's choice is counterproductive – if a woman benefits from focusing on the pain, practising contractions where she visualises a golden thread will be actively unhelpful: she may feel anxious and will cope worse than if she wasn't taught anything at all.

The exercise is followed by a long relaxation, which the women really enjoy. The final 20 minutes of the class can take a variety of formats – often someone who has previously attended the classes comes back with her baby to tell her story so the pregnant women hear lots of positive birth stories (most of the women who take the class have straightforward birth experiences). Nowadays pregnant women are exposed to many negative ideas and images of childbirth, so hearing lots of recent, and often joyful, birth stories goes some way to reducing any fear they might be feeling. Alternatively, we might discuss an issue, such as protecting the perineum, vaginal birth after caesarean, or introducing a new baby to his or her siblings. A strength of Yoga for Pregnancy (YfP) classes is that they include a mix of first- and second- or third-time mothers, so there are always more experienced mothers who can offer words of wisdom to the women just embarking on their parenting journey.

Helping with labour

Yoga can help women reduce typical pregnancy problems such as back and pelvic pain, and it can also help women cope more effectively with labour. I have now taught yoga to more than 1,000 pregnant women, and have found that 62% of mothers from my classes go on to have labours where the only pain relief used is Entonox. As many as 18% have planned home births and only 18% have epidurals, while the figures for England are 2.8% and 36.5%, respectively.[1,2] I don't know to what extent the results are affected by the particular women who choose to come to the YfP classes and how much the practice of yoga or coming to our particular classes makes a difference, but their labour experiences are very encouraging. As one mother from another YfP class said, '*I am sure it was the yoga classes and exercises I had done leading up to the birth that helped to ensure my baby was in the right position for an easier labour…I could breathe my way effectively through the contractions and knew that each one was bringing us a step closer to meeting our baby.*'

One reason for the low epidural rate may be that women can come to the classes for much longer than they would normally go to antenatal classes. One woman, Charlotte, who was on her third pregnancy, joined a YfP class (not mine) in her second trimester and stayed until she was 39 weeks pregnant. She found that the yoga helped her prepare for labour both physically and mentally: 'The gentle yoga really helped with the SPD symptoms I was experiencing. Most weeks I would go into the class in moderate to severe pain (on crutches on some occasions) and walk out pain-free, which would then last for the rest of the evening. The chance to learn and practise breathing techniques really helped me through a long labour with my baby. I also believe that the positive birth stories and visualisations had a very positive effect on my attitude towards the birth after one very traumatic birth in the past which came back to haunt me during my second son's birth.'

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What women say

'I found coming to yoga after surviving a really frantic busy and stressful week at work reminded me of the importance of looking after my body and not taking it, or my bump, for granted.'

'My hopes have been met brilliantly and I have gained so much more. It has given me a whole new perspective on childbirth. It has been the most useful thing I have done to prepare myself and help my pregnancy.'

'It has considerably increased my confidence in labour psychologically – I have increased faith in my body. I feel like I can have a natural birth and assert my needs to have natural methods.'

'The classes were one of the most enjoyable parts of my pregnancy.'

'This class was the main reason I had such a positive labour – thank you'

Best Beginnings

helping new mothers make a fresh start

The Queen Elizabeth Trust in Greenwich has won an award from the All Party Parliamentary Group (APPG) on Maternity for providing inclusive services for disadvantaged groups and communities. Vlora Hingley, a Best Beginnings team leader, tells Kim Thomas about the work that won them the award.

Greenwich Borough in London is an area with high levels of deprivation, which means that many pregnant women and new mothers face a particular set of problems that need to be addressed sensitively.

To help these women more effectively, the borough council introduced a Best Beginnings team: a group of six community midwives who would run antenatal and postnatal clinics in 12 children's centres in Sure Start areas. This meant they could meet vulnerable pregnant women and new mothers in a setting where the women felt comfortable, away from the traditional GPs' surgeries.

Whereas most midwife appointments typically last 10 minutes, the Best Beginnings team are able to spend much more time with their clients and talk through their problems.

Initially, vulnerable women were referred to the team by their GP or from agencies such as the police and social services, though now the service is more widely-known, some women come directly to the team as soon as they know they are pregnant. The clients include women experiencing domestic abuse, women with a history of postnatal depression, women who have learning difficulties, women who are already involved with social services, and refugees and asylum seekers (who have difficulties accessing care because of their immigration status). There is a lot of overlap between the groups, says Vlora Hingley, Best Beginnings team leader: 'Lots of women who suffer domestic violence have depression, as do lots of asylum seekers, so these are all linked together.'

Women using the service don't need to make an appointment – they just turn up at the children's centre. The team care for the women throughout their pregnancy and for a month after the birth. Part of the job is to help women in danger of having their babies taken away to prove they are able to care for their own children. For example, the midwives help women get out of abusive relationships, and offer advice on matters such as breastfeeding, healthy eating and giving up addictions. Whereas most midwife appointments typically last 10 minutes, the Best Beginnings team are able to spend much more time with their clients and talk through their problems. They work closely with other agencies to make sure the women are getting the help they need, so if a woman wants to stop smoking, the team will put her in touch with a Smoking Cessation group, and make sure that she turns up for her appointment. Sometimes, says Hingley, the team will be contacted by the police about domestic violence cases where the woman is pregnant: 'If we get a direct referral from the police, we visit the mother at home and make sure that if she's pregnant she gets one-to-one care. Obviously these women will have low confidence, so we introduce them to the community and to children's centres. The centres have a one-stop health shop, so they meet the health visitor, and they have lots of different groups where the women get to meet other mothers.' The team also puts the mother in touch with a domestic violence support group.

'Thanks to Best Beginnings Midwives, I've managed to look after my baby and my confidence has increased.'

Statistics are not yet available on the impact the team has made, but Hingley believes that the breastfeeding rates are higher, and the rates of caesarean sections lower, than would normally be the case for that group. Feedback from questionnaires and phone calls has been overwhelmingly positive, and includes comments such as, 'Thanks to Best Beginnings Midwives, I've managed to look after my baby and my confidence has increased.' Women with a history of postnatal depression (PND) say they have avoided depression this time round because they have been able to talk to the Best Beginnings team.

Hingley's favourite story is of a woman on her third pregnancy, whose two previous children had been removed from her. She had experienced domestic abuse, was a heavy alcohol user and suffered from depression. The Best Beginnings team helped her leave the violent relationship, give up alcohol and put her in touch with a mental health unit. The woman fully expected to have to give up her baby, but did so well with the team's support that when her child was a year old, social services removed her from their care. Now the mother is studying to become a lawyer, says Hingley: 'It's the best success story we've ever had. She sent me a text on International Midwives Day saying, "Because of midwives like you, mothers like me keep their babies."'

NCT Professional Resources

Supporting parents in labour and birth

Midirs Informed Choice cards - code 3258, £16.95

TENS machines - Hire starts from £22.95

Positions for labour and birth pad - code 3254, £4.50

'The Breathing'- teaching cards £39.50 or Book for £18.50

For more information and products that support parents in labour and birth, visit www.nctresources.co.uk or call 0845 8100 100

Action against physical and emotional abuse

NCT antenatal teacher and tutor Stephanie Ward, has worked with Sarah Fisher, NCT researcher leading on diversity, to develop an NCT policy briefing and new NCT internal policy and good practice guidance on identifying and responding to domestic abuse during pregnancy and the postnatal period. Here, Stephanie provides an update of what NCT is doing to address domestic abuse.

I have been involved with work on domestic abuse for 10 years. When I began, I knew very little about the subject and I found many of my views challenged. Misconceptions are rife – many professionals still believe that it's not something that happens in their client group. Yet the truth is that whether we live, work or volunteer in leafy Surrey (as I do), rural Scotland or an inner city, we will all meet or know women experiencing domestic abuse, although we are probably not aware of it.

One in four women experience domestic abuse during their lifetime, and on average two women are killed each week in England and Wales by a current or former partner.[1] Research shows that it is common for domestic abuse to begin or escalate during pregnancy and the postnatal period, and this can result in a number of serious, and sometimes fatal, physical and psychological consequences, for women and their babies, with older children also exposed to risk and long-term impacts.[2,3,4]

Encouraging good practice

As well as health professionals, NCT workers, including antenatal teachers, postnatal leaders and breastfeeding counsellors, have opportunities to identify women who may be experiencing abuse and offer them information about specialist support services. NCT has developed a detailed policy briefing on this issue, and an accompanying NCT internal policy and good practice guidance designed to inform NCT workers about good practice in identifying and responding to abuse.[5] As the majority of victims of domestic abuse are women, and because of the association between abuse and pregnancy, the policy briefing and guidance focus on abuse perpetrated against women, but the good practice principles also apply to male victims of abuse.

NCT policy on domestic abuse and the role of health professionals

NCT's policy briefing provides background information on domestic abuse that all individuals working with families during the perinatal period should be aware of. This includes the incidence and different forms of domestic abuse, the impacts on women and their children and signs and indicators of abuse.

Seeking to dispel common misconceptions, it makes it clear that women from all backgrounds, social classes and ethnic groups can be affected by domestic abuse, while raising awareness of the particular vulnerabilities or additional constraints faced by some women that can make it more difficult for them to access appropriate support or leave a violent relationship.

As a major public health concern, NCT believes that the health sector has an important role to play in addressing domestic abuse and recognises that health professionals are in an ideal position to identify and respond to domestic abuse. NCT supports routine enquiry about domestic abuse by midwives providing they have received appropriate training, including training on confidentiality and safeguarding and protection issues, and the necessary systems and structures are in place. These include systems for post-training support for midwives, development and dissemination of appropriate guidance and procedures, and development of multi-agency working and agreed referral systems from the maternity team to specialist providers of domestic abuse support services, social services, housing, and other necessary agencies.

The NCT is also keen for the health sector to do more to support women from ethnic minorities and women who do not speak English fluently to safely disclose domestic abuse. As well as health professionals being aware of the particular needs and sensitivities of some women from these groups, women should be given the opportunity to develop trusting relationships with a known carer and have access to appropriate interpreting services provided by female interpreters.

NCT guidance: helping to identify abuse

Looking back to when I was less informed than I am now, I can think of several instances where I've worked with mothers who may, in hindsight, have been experiencing abuse, such as where a partner appeared to be particularly controlling, or where there were other possible indicators of abuse. These indicators are outlined in the NCT guidance, which have been developed so that NCT workers are aware of these signs and act on them sensitively and responsibly, so as not to put the woman or her children at further risk.

Working with agencies

NCT workers are also encouraged to recognise the limitations of the help they can offer and have the responsibility to know where to refer women and encourage them to seek support, doing so safely and confidentially. The work of specialist support agencies such as Refuge (www.refuge.org.uk) and Women's Aid (www.womensaid.org.uk) is essential in offering women services to suit their situation such as housing, counselling and legal and economic information and support.

In addition to meeting our own specific responsibilities relating to domestic abuse, we can all help by raising awareness amongst colleagues and referring women to, or working alongside, the appropriate agencies.

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Breastfeeding

Creating a community of support

Mary Newburn, head of research and information, provides an update on NCT breastfeeding peer support.

Following the successful completion of the Department of Health-funded Breastfeeding Peer Support Project, the NCT is now rolling out packages of peer support training to the NHS and children's centres around the UK. Two different packages are being offered. One (package A) involves an NCT breastfeeding counsellor running the training within a local project managed by a local health professional. Another option (package B) includes management of peer supporters by the NCT.

Why peer support is important

Although about three-quarters of women start breastfeeding, nearly four in 10 stop within the first six weeks and almost all would have liked to carry on breastfeeding.[1] Young women from low-income areas are least likely to breastfeed. Embarrassment, lack of role models, fear of pain, misconceptions that their baby will not gain sufficient weight, as well as living in a predominantly bottle-feeding culture are some of the barriers to breastfeeding.[2,3] Peer support for breastfeeding, which the NCT defines as support offered by women who have breastfed themselves, can:

- make breastfeeding seem a realistic option
- normalise breastfeeding experiences
- reduce isolation
- enable women who breastfeeding to feel listened to and valued.[4]

Having contact with other mothers who have positive experiences of breastfeeding helps foster favourable attitudes and expectations,[5] yet without organised, informal groups that include breastfeeding support, young mothers may have no friends or family with positive breastfeeding experiences. Drop-ins that combine opportunities for support between mothers with the availability of a health professional and/or breastfeeding counsellor have been found to be particularly helpful.[6]

NCT peer support packages

Based on a tried and tested programme,[4] the NCT offers 16 hours of peer supporter training for mothers who have breastfed for at least three months, with six follow-up sessions for support and supervision. With package A, a health professional coordinator recruits the trainees and assists them in getting together with local mothers, on the postnatal ward, in community drop-ins, at a baby café or children's centre. In this model, the coordinator, under the umbrella of the NHS or local authority, is responsible for the peer support service provided. With package B, all management responsibility is retained by the NCT and trainees register with the NCT on qualification and are covered by NCT insurance. NCT support continues as long as the peer supporter maintains and develops their skills through support and re-registers annually.

Kate Williams, NCT parent services director, says, 'The NCT is renowned for its breastfeeding knowledge and expertise. We also have years of experience in creating community networks and working with NHS colleagues. Our packages of training and support are designed to assist busy NHS managers in meeting parents' needs and their breastfeeding targets.'

NCT peer support project

Based on the same principles as NCT breastfeeding counselling, the NCT peer supporter training involves:

- exploration of personal experiences
- effective listening-based communication
- breastfeeding knowledge
- understanding of the social aspects of breastfeeding
- the peer supporter role, including development of a non-judgemental, empathic approach, maintaining confidentiality and having clear boundaries.

The project evaluation found that the partnership model of NCT trainer and NHS/children's centre coordinator was successful. One trainer said:

'*(It was) brilliant - we worked really well together, and felt we were a team, learning a lot from one another. It felt like the whole project of training peer supporters and offering peer support at city-wide drop-ins was changing from dream to reality.*'[4]

Through the support of peers the mothers felt more confident about breastfeeding and less vulnerable to self-doubt and being undermined by other people. One of the mums who was interviewed said:

'*It was almost like talking to a friend...the peer supporter seemed genuinely interested in what you were going through. I felt listened to.*'

Finding out more

A document setting out the evidence for NCT breastfeeding services,[7] is available at www.nct.org.uk/evaluation. If you are interested in finding out more about peer support schemes, and what's happening in your area, please phone 020 8752 2338 or email professional@nct.org.uk

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Why Choose NCT?

- NCT has over 50 years of supporting breastfeeding.
- NCT offers excellence in training, peer support, breastfeeding counselling and evidence-based information.
- NCT peer supporter training is accredited by the National Open College Network.
- NCT offers peer supporters opportunities for further training, volunteering and paid work.
- NCT peer supporter training tools are available to help you design a programme suitable for your area's needs.
- NCT can offer bespoke packages including affordable project management for peer support services locally.

The Politics of Breastfeeding

When breasts are bad for business (*third edition*)

by Gabrielle Palmer

Published by: Pinter & Martin (2009)
ISBN: 978-1905177165
Price: £9.99

This book is exactly 'what it says on the tin'. It is frank, direct, compelling and honest. I found it a remarkable read.

Now in its third edition, the author doesn't hide the fact that she would rather not be reissuing this book. Her motive for doing so, however, is shocking: 'Twenty years ago when I was writing the first edition, more than 3000 babies were dying every day from infections triggered by the use of bottles, artificial milks and other risky products. This is still happening.'

Palmer covers the entire breastfeeding story, from biology to business, from wet nurses to WHO guidelines. She clarifies the mechanics and mysteries of how breastfeeding actually works in an uncomplicated way. The 'business' aspect of the book is profoundly shocking. The history behind the Nestlé boycott is explained in depth and the story behind the WHO International Code of Marketing of Breast-milk Substitutes unfurls in a captivating way.

The style of writing is fast, furious and to-the-point. The book is superbly written, well-researched and easy-to-read; I could put it down and pick it up again later with ease.

The book is essential reading for anyone connected to the world of babies or baby feeding. It could be important reading for some parents-to-be but Palmer's forthright style will not suit everyone: '...the continued denial of the risks of not breastfeeding and the value of breastfeeding supposedly to spare women's feelings is a patronising deception. The whine about "not making mothers feel guilty" is such a cop-out.'

Babies are big business. Among other things, this book seeks to open the reader's eyes to the exploitation and greed surrounding the industry. She has certainly opened mine.
Reviewed by Pip Armstrong

Improving breastfeeding rates with NCT Professional Resources

nct professional

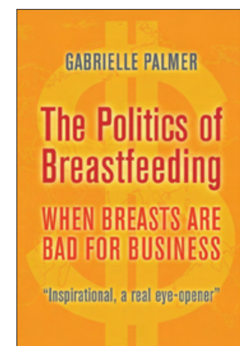
The Politics of Breastfeeding
Gabrielle Palmer (*2009 Revised and fully updated edition*) - code 2252, £8.99
A hard-hitting look at issues surrounding breastfeeding.

NCT Shop offers a range of Information Sheets for healthcare professionals to pass onto parents.
For the full range, please see www.nctresources.co.uk
What's in a nappy (x 50) code 3213 Pad, £4.50
Breastfeeding and your nipples (x 50) code 1708 Pad, £4.50
Breastfeeding step by step (x 50) code 3211 Pad, £4.50
Fathers and breastfeeding (x 50) code 1713 Pad, £4.50

Bestfeeding: How to Breastfeed Your Baby
Mary Renfrew/Chloe Fisher/Suzanne Arms - code 1862, £17.50
Ideal for first-time mothers. Fully illustrated and offering solutions to common and unusual problems.

Breastfeeding Matters
Maureen Minchin - code 1847, £13. 99
Breastfeeding Matters is a detailed, evidence-based look at the potential harm done by formula feeding, and the social, economic and other reasons why breastfeeding is under attack world-wide. Essential for breastfeeding counsellors and fascinating for anyone concerned with the issues.

Fit to Bust
Alison Blenkinsop - code 1861, £9.99
Fit to Bust is a breastfeeding book with a difference. Its aim is to entertain as well as inform, in songs, cartoons and stories from around the world.



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The effects of postnatal separation on mother-infant interaction

Miranda Dodwell, NCT researcher, looks at the findings of a paper on the effects of separation at birth on mother-infant interaction.

A recent Russian study[1] that would not be considered ethical in the UK provides startling evidence on the potential negative impact of early mother-baby separation. A randomised controlled experiment (or trial), was carried out involving 176 mother-infant pairs. The pairs were randomised as soon as the babies were born into four groups (see table 1), each with a different prescribed regime for physical contact, proximity and feeding. At one extreme, the mothers had skin-to-skin contact during the first two hours, cared for their baby in their room and breastfed on demand. At the other extreme, the mother and baby were separated during the first two hours and then the baby was kept in a separate room, with the baby being brought to the mother for scheduled breastfeeds. Overall this study had good randomisation and minimisation of bias. When the babies were one-year old, mother-baby interactions were observed.

There was significantly better mother-infant interaction at one year after birth for the pairs who were able to be together during the two hours after birth (groups I and II). There were measurable differences in interaction for mothers and babies who had been separated (groups III and IV), regardless of whether they had been reunited after two hours. Mothers who had been able to hold their baby in the first two hours were more sensitive toward them, and their babies more content at one year. Being reunited after separation during the first two hours (group IV) did not seem to compensate for the period of separation.

The study also reported that mothers who were in close contact with their clothed baby immediately after birth interacted better with their baby a year later if the baby had breastfed

> Taking a baby into special care for observation, particularly if the mother cannot stay in close proximity, is an intervention with unintended long-term psycho-social side effects.

during those two hours. It was suggested that suckling makes up for the lack of skin-to-skin contact. However this aspect of the study was based on observational data and is therefore less reliable. The effects ascribed to early suckling could actually be due to differences in characteristics of the mothers who achieved early suckling, rather than the effect of early feeding itself.

This demonstrates the importance of not disturbing the natural behaviour of mothers and babies in the hours immediately after birth, when institutional healthcare practices can have profound and long-lasting consequences.

> Pain-relieving hormones known as endorphins are released in the brain, encouraging a feeling of wellbeing and responsiveness to the baby.

It suggests, for example, that taking a baby into special care for observation, particularly if the mother cannot stay in close proximity, is an intervention with unintended long-term psycho-social side effects. It also supports other research findings which have indicated the importance of mothers and babies having undisturbed time together, and the value of skin-to-skin care and early breastfeeding.

Table 1: Mother-infant pairs

	First two hours	Subsequent hospital stay	Feeding
Group I	Skin to skin contact	In same room	Breastfed on demand
Group II	Clothed in mother's arms	In same room	Breastfed on demand
Group III	Separated	Separated	Scheduled breastfeeds
Group IV	Separated	In same room	Breastfed on demand (after first two hours)

Early contact

Other studies have shown that babies normally have high adrenaline levels after birth, so that they are energetic, alert, and ready to find the breast and start to feed soon after they are born.[2,3] In women, the oxytocin released during labour and birth stimulates 'mothering' feelings after birth; women look at their baby, generally want to hold them close and touch them. [4,5] This in turn releases more oxytocin, especially if babies are held skin-to-skin. Pain-relieving

hormones known as endorphins are released in the brain, encouraging a feeling of wellbeing and responsiveness to the baby. These hormones also increase the temperature of breast skin, which keeps the baby warm.[4] The presence of the baby increases the mother's attention, the initiation and maintenance of breastfeeding, and even improves her digestion, so that she uses food more efficiently.[5]

When the physiology of birth is undisturbed and close interaction is uninterrupted, the close presence and behaviour of both the mother and the baby has an immediate response in the other. Understanding the extent to which there is a symbiotic relationship between the mother and newborn baby helps to demonstrate why separation might have a significant long-term effect.

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Working with pain in labour: an overview of evidence

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This overview presents the case for developing a 'working with pain' approach to the care and support of women during labour. It sets out the rationale for this approach before comparing it with widely held beliefs and practices in the UK. Evidence to support a working with pain approach is presented.

'Working with pain' - beliefs and practices

The 'working with pain' approach to the care and support of women during labour was developed as part of a masters degree.[1] As a result of an extensive literature search on pain, drawing on multi-disciplinary discourses and undertaking interviews with midwives, it was found that attitudes to pain in labour could be separated into two paradigms, that of 'working with pain' and that of 'pain relief'.

The 'working with pain' paradigm includes the belief that there are long-term benefits to promoting normal birth in terms of women's experiences and lives, and that pain plays an important role in the physiology of this process.

At the beginning of labour, pain allows a woman to realise that she is about to give birth: to find a place of safety and gather people around her who will support her. As labour continues, the pain triggers a cascade of neurohormones that control the process; the pain changes and shows that labour is progressing as it should. The pain of labour marks the enormous change that is occurring in a woman's life – her transition to motherhood; the complex interplay of hormones and chemical changes helps her prepare to welcome her baby. Her joy at becoming a mother can be heightened by the contrast with the pain of labour, together with a sense of achievement and triumph at the completion of a huge and challenging task.

When labour is progressing normally – that is when contractions are normal and the baby is well positioned – it seems that, with support and encouragement, women are able to cope with the pain they experience.[1-4] This is due to the production of the body's natural pain-relieving opiates, endorphins.[5-7] Where midwives and birth supporters are using the working with pain approach, they try to create an environment which encourages the production of endorphins and to avoid creating the circumstances that inhibit their production. In contrast, if a woman experiencing normal labour is offered pharmacological pain relief, she will find it irresistible, as labour involves both pain and uncertainty, which can be emotionally demanding and exhausting. The use of pharmacological pain relief not only affects a woman's perception of labour, it increases the use of other medical interventions, reducing the chances of having a normal birth.[8]

In some circumstances, the pain can be described as 'abnormal pain' according to the working with pain approach, for example where the baby is poorly positioned or labour has been accelerated with drugs. Women experiencing abnormal pain are likely to have a genuine need for pharmacological pain relief. In contrast, the 'pain relief' paradigm is characterised by the belief that no women need suffer the pain of labour and it is a kindness to alleviate it by a variety of pharmacological methods of pain relief. Women are offered a 'pain relief menu' including the pros and cons of each method to enable them to make an 'informed choice'. Women may also receive the implied message that it is not possible to get through labour without resorting to pain relief. Many health professionals also promote the use of pain relief because they feel disturbed by the noise and behaviour of women labouring naturally.

Mainstream beliefs and practice

Historically, the childbirth culture might be viewed as being consistent with a 'working with pain' approach. Women were supported by other women when they gave birth. This began to change in the mid 19th century with the advent of obstetric anaesthesia and the notion of 'saving women from pain'.[9] The dominant cultural approach to labour in high income countries is now the 'pain relief paradigm' in which using some form of pharmacological pain relief in labour is the norm.[10] The pain relief approach is supported by NICE clinical guidelines for the NHS which state that women should be supported in making informed choices about pain relief.[11]

A recent survey of 26,000 women's experiences of maternity care in the NHS in England identified that 34.1% of women who experienced labour had an opiate injection and 29.4% had an epidural, with wide variations in the use of different methods of pain relief

Table 1. Methods used to relieve pain. Adapted from Healthcare Commission Survey: Women's experiences of maternity care in the NHS in England[12]
Response to: 'During your labour and birth, did you use any of the following to help relieve the pain?'
[n = 26,000 women who gave birth in February 2007 from 135 participating NHS trusts]

Methods of pain relief	Natural methods eg: breathing massage	Water or a birthing pool	TENS Machine	Gas and air	Pethidine injection or similar	Epidural or similar	I did not use any pain relief
Median rate for trusts	48.1%	10.7%	19.7%	80.7%	34.1%	29.4%	6.6%
Variation between trusts	31 - 61%	0 - 28%	2 - 47%	54 - 95%	5 - 66%	13 - 45%	0 - 21%

Taken from: http://www.birthchoiceuk.com/HealthCareCommissionSurvey/Q220.htm

across trusts.[12] Only a few did not use any pain relief in labour (6.6%), with varying rates between NHS trusts of 0% to 21% (Table 1).

In two linked studies, Green et al found evidence of growing use of pharmacological pain relief, particularly epidural use, in the period 1987-2000, yet the number of women who were fearful of labour pain increased significantly.[13,14] Their follow-up study showed an increase in women feeling 'frightened', 'powerless' and 'helpless' in labour.[14] They found that as well as an increasing proportion of women expecting to have an epidural in labour, there was an increase in the number of women who did not want an epidural but ended up with one.[14] This increase in fear over the last two decades is reported in several high income countries.[14-16] Recent national data for England show that in the period 1995-2006 overall epidural rates have risen little (27%-28%), and use of pethidine has dropped (42%-33%).[17] This change in the trend during the 1990s may reflect a growing awareness of the negative consequences of drug use in labour[18-20] and change in government policy towards more midwife-led care and greater information and choice for women.[21,22]

An English study of over 1000 women, published in 1993, found that doctors', and to a lesser extent midwives', approaches to easing pain tended to be restricted to pharmacological methods; professionals were more likely to agree with each other about the efficacy of different methods than with women.[23] Although attitudes and behaviour may have changed since then, in the 2007 study of women's experiences of NHS maternity care in England, only 10.7% of women reported that they had used water or a birthing pool and almost 15% reported that they were not encouraged at all to move around and choose the position that made them feel most comfortable.[12]

There is strong evidence that a woman's satisfaction with the experience of childbirth is positively affected by having midwife-led care,[24] greater continuity of caregiver,[24] continuous support during labour,[25] the quality of her relationship with her caregiver,[26] and the quality of support provided.[26] Despite this, many NHS trusts provide highly fragmented care, with 77.9% of women recently reporting they had not previously met any of the staff who looked after them during labour (NHS trust range, 56% - 91%).[12] Many women saw a succession of different midwives (see Table 2), and a quarter were left alone during labour or shortly after the birth at a time when it worried them to be alone,[12] replicating previous similar findings.[17]

Table 2. Number of midwives caring for individual women in labour. Adapted from Healthcare Commission Survey: Women's experiences of maternity care in the NHS in England[12]

Response to: Altogether, how many different midwives looked after you during your labour and the birth of your baby?

Number of midwives	One	Two	Three	Four	Five or more
All Trusts average [n = 153]	19.9%	37.3%	20.8%	10.1%	11.9%
Variations between Trusts	8 - 33%	27 - 48%	11 - 30%	4 - 19%	0 – 24%

Taken from: http://www.birthchoiceuk.com/HealthCareCommissionSurvey/Q232.htm

Table 3: Preferences for coping with pain during in labour

	1987		2000	
	Primips n=289	Multips n=443	Primips n=508	Multips n=682
Most pain free possible	6%	11%	21%	21%
Minimum drugs	71%	66%	65%	65%
Drug free	23%	23%	13%	14%
Total	100%	100%	100%	100%

Source: Green J, Baston H, Easton S et al 2003 Greater expectations? Inter-relationships between women's expectations and experiences of decision making, continuity, choice and control in labour, and psychological outcomes: summary report. Mother & Infant Research Unit, Leeds[14]

Working with pain – the evidence

What women want

There is evidence that the majority of women value giving birth with a minimum of drugs, provided that they feel they can cope. Although the proportion of women preferring to give birth 'drug free' or with a 'minimum of drugs to keep the pain manageable' fell during the period 1987-2000 (see Table 3), it was still the case that four in five women wanted either no drugs or a minimum of drugs. Approximately one in five women said their priority was for their labour to be as pain-free as possible.[14]

> The majority of women value giving birth with a minimum of drugs, provided that they feel they can cope.

Although there has been a shift in attitudes and the use of epidurals, particularly prior to 1995 in England, with more women relying on an epidural to help them cope with fear and pain, studies in a range of high income countries have demonstrated that effective forms of pain relief are usually not associated with greater satisfaction with the experience of birth for women who have uncomplicated labours[14,26,27] or with women's sense of psychological and physical wellbeing.[28,29] Indeed, studies have shown that women who use non-pharmacological methods of pain relief are more likely to be satisfied with their experience of labour and birth than those who used pethidine or epidurals.[14,23] Numerous observational studies show that when culturally diverse groups of women have been supported to cope with the pain of labour they have described childbirth as a difficult, yet empowering, experience, providing a sense of achievement.[30-34] However, for those women who positively 'desire or need' pharmacological pain relief, satisfaction is related to their expectations being met.[26]

Continuity of midwifery care

It is easier for women and for midwives to adopt a working with pain approach when women know the midwife caring for them during labour.[9,35] A systematic review showed that women receiving midwife-led care were nearly eight times more likely to be attended in labour

by a midwife they knew than those assigned to other models of care, were more likely to use no pain relief and to have a higher perception of control.[24] Continuity of caregiver throughout pregnancy, labour and birth reduces the amount of pain relief women have during labour, and increases their satisfaction with their maternity care, perhaps as a result of developing a trusting relationship.[36-39]

Emotional support

Support has a major impact on how women cope with pain in labour. A Cochrane review of continuous support for women in labour concluded that '(emotional) support, comfort measures, information and advocacy may enhance normal labour processes as well as women's feelings of control and competence, and thus reduce the need for obstetric intervention'.[25] In early labour, when the majority of women are at home without professional support, comfort and encouragement from family members, a friend or doula is important.[40] Without support women are more likely to go to hospital before labour is well established and to have epidural analgesia and other interventions.[41-44] Once admitted, a birth companion continues to play an important role, offering love, reassurance, praise and, sometimes, acting as an advocate.

Women have described how midwives supporting and guiding them through pain, on their own terms, enabled them to feel confident and positive about their capabilities and inner strengths.[31,32,45] Supportive interactions have more impact on women's experience than the level of pain per se.[26,30] Discussion about potential support activities is important to pregnant women[46] and a birth talk at 36 weeks provides an opportunity to explore the nature of labour pain with women and their birth companions.[47]

The physical environment and philosophy of care

Opportunities to adopt a working with pain approach can be affected by the environment in which a woman labours.[9] Privacy and protection from disturbance promote neuro-hormonal cascades of a woman's endogenous oxytocin and opioids, optimising the physiological process of labour and her ability to cope with pain.[48] She may go into an altered state of consciousness in which her mind lets go and involuntary processes takes over.[35, 48]

The philosophy of care provided in birth centres and at home is usually consistent with a 'social model of care' in which birth is seen as a normal physiological process and it is usual for women to labour without use of drugs for pain relief.[49-52] Those developing new birth centres focus on creating a social, 'homely' space.[53]
Observational studies indicate that women perceive home birth as less painful than hospital birth [23,54-56] and that women planning to giving birth at home or in a birth centre are less likely to use epidural analgesia.[11,54,57]
Increasing privacy and non-disturbance can be addressed in all birthing environments.[29,58,59]

Immersion in water during the first stage of labour significantly reduces women's perception of pain and use of epidural/spinal analgesia.

Natural and low-technology comfort aids

There are a number of low-tech comfort aids that can help women cope with labour. These include immersion in water and other self-administered methods of easing pain. Immersion in water during the first stage of labour significantly reduces women's perception of pain and use of epidural/spinal analgesia.[60] Women using upright positions are also less likely to have epidural analgesia.[11,61]
Despite varying effectiveness in relieving pain, Simkin's systematic review indicated that the majority of women felt positive about using acupuncture, massage, transcutaneous electrical nerve stimulation (TENS), hypnosis, relaxation and breathing, aromatherapy and the use of music.[62,63] A recent Cochrane review of complementary and alternative therapies reported that trials of acupuncture and self-hypnosis showed a decreased need for pain relief, including epidural analgesia, and greater satisfaction compared with controls. No differences were seen for women receiving aromatherapy, or audio analgesia.[64]

Preparing women and their partners for working with pain during labour

There are a number of challenges facing midwives and childbirth educators in preparing women and their partners for working with pain during labour, particularly those preparing to have their baby in a hospital labour ward.

A systematic review of women's expectations and experiences of labour showed that although some women hope for a drug-free labour they may still go into labour with the expectation that they will need some form of pain relief.[65] This suggests an underlying lack of confidence in their ability to cope with the pain of labour. During the labour itself, many women, including those who had hoped for a labour free of pharmacological pain relief, found that they had underestimated the pain that they experienced and that they needed pain relief.
The review concluded that inaccurate or unrealistic expectations about pain may mean women are not prepared appropriately for labour ('the expectation-experience gap').[65]

The same review described how many women wanted to remain in control during labour. For some women this meant participating in decision-making about the management of their labour and birth whereas for others it was about feeling in control of their emotions and behaviour in labour.[65,66] However, in labour their degree of reported control was less than hoped for.[65] As women's fears about pain in labour are often related to anxieties about losing control, addressing this antenatally is important if women are to feel confident and satisfied with their experience of childbirth.[34,67]
Parents can be helped to develop strategies for coping with pain based on their own repertoire for coping with pain and anxiety.[46] Women and practitioners also need to be well informed about factors that both facilitate and hinder straightforward labour and birth and the ability to adopt a working with pain approach.[46]

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Summary

The working with pain approach is based on the principle that pain is one aspect of the physiology of normal labour; to be respected, not to be feared. Many women want to avoid pharmacological pain relief and, where labour is progressing normally, factors including a trusting relationship with caregivers, continuous support, midwife-led care, preparation for labour, a home or birth centre setting, and use of a birth pool each help to make this a realistic expectation.

Key points

- According to the working with pain approach, given support and encour-

agement, women are able to cope with normal labour pain.

- Privacy, peacefulness, and absence of distractions promote the production of the body's natural pain relievers, endorphins.
- Epidural use is decreased where there is continuity of care and continuous support in labour from trusted caregivers and birth companions.
- Birth planned at home or in a birth centre is associated with reduced epidural use.
- Immersion in water, choosing comfortable positions and other self-help techniques help women to cope with pain in labour.
- Feeling emotionally supported and in control affects most women's satisfaction with labour more than the experience of pain itself.

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