STEP 1

MARILYN CURL

A mother-friendly hospital, birth center, or home birth service offers all birthing mothers unrestricted access to birth companions, labor support, and professional midwifery care.

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STEP 1A

POLICY TITLE: Unrestricted Access to Birth Companions

POLICY: To ensure that birth takes place among caring, supportive individuals who have been chosen by the laboring woman to share this life-changing event. Those selected may include father, partner, children, and other family members.

PURPOSE: Birth stress has been shown to be reduced when women are surrounded by trusted family and friends. Such supportive care is a basic necessity identified by experts in maternity services, such as the World Health Organization (WHO), the Society of Obstetricians and Gynecologists of Canada (SOGC), and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN).

- There is no evidence of medical harm found for unrestricted access by mothers to birth companions of her choice—fathers, partners, children, family members, or friends—at birth.
- Family support seems to be more important for siblings attending the birth than actually witnessing the birth itself. There are some recommendations for the inclusion of children at birth to ensure a positive experience for everyone involved.
- Mothers reported less satisfaction with birth support when the support provider was a nurse or a doctor compared with a partner or doula.
- The perception of support during labor is a key ingredient in a woman's ultimate satisfaction with her birth experience.
- A woman's perception of support during labor is more important than her experience of pain or her satisfaction with pain relief methods in her overall satisfaction.

PROCEDURE

1. Laboring women will have the sole right to determine how many family members, friends, and others will be present to provide supportive care during labor, birth, and the immediate period following birth.
2. Children who attend a birth should have:
   a. Preparation, such as talking about the birth, reading books, watching videos, and answers to any questions they may have.

   b. A caregiver assigned specifically to each child so each child can be given the opportunity to leave the room if he or she wishes.
   c. The freedom not to witness the birth.
3. Care shall be provided in an environment that supports physical comfort.
4. Throughout the birth process, birth companions shall be free to move from public areas (waiting rooms) into the birthing suite at the direction of the laboring woman.
5. In the event of an unexpected surgical delivery, the woman shall be able to choose at least one person to accompany her to the operating suite. The infant, if healthy and stable, shall remain with the mother at all times.
6. Since there is no evidence to support policies that restrict support during labor, the woman has the right and responsibility to select who will be present during labor and birth. This allows limiting, if desired, the number of staff members including nursing and medical students, who are present in an observational role.
7. Fathers will participate in roles personally comfortable to them and the birthing women.

STEP 1B

POLICY TITLE: Access to Continuous Emotional and Physical Support by a Skilled Woman

POLICY: Women giving birth should have unrestricted access to continuous emotional and physical support from a skilled woman; for example, a doula or labor-support professional.

PURPOSE: Skilled support (differentiated from support provided by family and friends) is the right of all laboring women and is supported by AWHONN (2011). The evidence is clear that:

- No evidence of harm has been identified when women have unrestricted access to continuous emotional and physical support from a trained caregiver.
- The perception of support during labor is more important in determining a woman's satisfaction with her birth experience than her experience of pain or her satisfaction with methods of pain relief.
- Compared with a similar population receiving comparable clinical care, continuous labor support reduces the likelihood of utilizing pain medication or analgesia in labor, increases the likelihood of spontaneous birth without assistive devices (e.g., forceps, vacuum extractors), increases satisfaction with the birth experience, and reduces the likelihood of severe postpartum pain.
- Women receiving continuous labor support are more likely to have spontaneous vaginal birth (Goer & Romano, 2012, p. 436).
- Compared with a similar population receiving comparable but intermittent support, continuous labor support results in fewer newborn admissions to a neonatal intensive care unit.
- Continuous one-to-one female labor support by providers who are not hospital staff and in environments more likely to provide physiologic care provides more beneficial effects.
- Intrapartum nurses provide minimal supportive care due to systemic and cultural factors (Goer & Romano, 2012, pp. 438–441), for example, high nurse-to-patient ratio.

- Fathers may not be able to provide adequate labor support (Goer & Romano, 2012, p. 444).
- Recognizing that studies have shown that similar positive outcomes can be achieved when other experienced women who are not medically trained provide supportive care, the birthing family shall be free to choose attendants at will.

PROCEDURE

1. The circle of support during birth may include both professional nurses and nonprofessional caregivers whose only purpose will be to meet the physical and emotional needs of the laboring mother. This includes but is not limited to assistance with ambulation, sitting on the birthing ball, positioning in labor for comfort, assistance in the shower or Jacuzzi, positioning for pushing during the second stage, and assistance with breastfeeding or infant comfort during the fourth stage.
2. Doulas should be considered a part of the mother's team of care reporting to and responding to other members of the team.
3. Preferably, doulas will not be members of the hospital staff.
4. Doulas will only perform continuous emotional and physical support. Doulas will not perform medical assessments or interventions even though they may know how to do these.
5. Doulas will involve the family and friends the mother has chosen to be with her in this support at their comfort level.
6. Providers attending birth (physicians, midwives, and nurses) should be offered training in nonpharmacologic care of women in labor.

STEP 1C

POLICY TITLE: Unrestricted Access to Midwifery Care in All Birth Settings

POLICY: To ensure that all women who have selected midwifery-based prenatal care have access to a midwife-attended birth regardless of the setting.

PURPOSE: In order to choose what best suits their needs, circumstances, and preferences, women must have access to all types of practitioners who are qualified to take sole responsibility for the care of childbearing women during the prenatal, intrapartum, and postpartum periods. While any individual practitioner may practice a model of care conforming with the philosophy of the Ten Steps of Mother-Friendly Care, research shows that such practitioners are more likely to be midwives.

A professional midwife is defined as a skilled attendant who has achieved official recognition as a midwife through licensure, registration, or certification. "Access to professional midwifery care" is defined as access to a professional midwife who is authorized to provide care independently throughout the childbearing period to women who are at low or moderate risk of complications. Professional midwives may attend births within hospitals, freestanding clinics or birthing centers, the family's home, or some combination of these locations.

According to the definition endorsed by the International Confederation of Midwives:

> The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventive measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical or other appropriate assistance and the carrying out of emergency measures. (International Confederation of Midwives, 2005; Goer & Romano, 2012, p. 451)

In comparison to physician care for similar populations, care by professional midwives is likely to result in the following maternal outcomes that support physiological birth:

- Women are likely to report longer and more frequent antepartum visits that resulted in increased education and counseling.

- There appeared to be a decreased incidence of antepartum and/or intrapartum hypertension that resulted in fewer antepartum admissions and fewer inductions of labor.
- Women reported increased access to food and drink in labor and limited use of intravenous fluids in labor.
- Midwives were more likely to encourage ambulation in labor and to use nonsupine positions for birth.
- Amniotomy was performed less frequently and there were fewer episodes of abnormal fetal heart rate in labor.
- Continuous electronic fetal monitoring, external and internal, was used less frequently.
- Women who preferred nonpharmacologic pain relief were more likely to achieve their goals and reported effective pain management in labor. They also had reduced need for analgesia including epidural anesthesia.
- Surgical intervention were less likely and women were as likely or more likely to experience spontaneous vaginal births with fewer or equivalent instrument-assisted births.
- Midwifery care in labor and birth reduces the likelihood of genital tract trauma (Goer & Romano, 2012, pp. 467–468).
- Midwives rely less on restrictive or invasive intrapartum procedures including:
  - Pharmacologic induction
  - Oxytocin augmentation
  - Any type of induction or augmentation
  - Amniotomy
  - Continuous electronic fetal monitoring
  - Prohibition of eating and drinking in labor
  - Routine intravenous fluids
  - Mobility in labor
  - Position for birth (Goer & Romano, 2012, pp. 471–472)
- With one exception, which may be explained by systemic factors, midwifery care results in equivalent or superior newborn outcomes compared with physician management (Goer & Romano, 2012, pp. 472–474).
- Midwife-led care produces equally good or better maternal and infant outcomes as physician-led or shared care, with lower procedure and medication rates (Goer & Romano, 2012, pp. 476–477).
- Both midwifery care and midwife-led models of care appear to be safe and beneficial for medically and sociodemographically moderate-risk and high-risk women and their infants (Goer & Romano, 2012, pp. 478–481).

PROCEDURE

1. Laboring women will choose who will support them in labor.
2. Laboring women will choose who will provide professional care during labor and birth.
3. Mother-friendly birth settings have policies in place that provide for full staff privileges for all licensed birth attendants including midwives.
4. In the event of a surgical birth, the midwife will attend in a supportive role and will remain with the family if desired through the initiation of breastfeeding.
5. Midwives will be integrated into the health system including hospital privileges, consultants, technology (e.g., resuscitation expertise, lab tests, medication), and collaborative relationships with physicians (Goer & Romano, 2012, pp. 474–475).
6. Midwives will be received warmly by the medical team when their clients are transferred to hospitals.
7. All low-risk women should have the option of booking midwifery-led care (Walsh, 2007, p. 28).
8. Free-standing birth centers should be established in metropolitan and rural areas (Walsh, 2007, p. 28).
9. Integrated birth centers should be established in all medium to large consultant units (Walsh, 2007, p. 28).
10. Labor-support staff need training in noninstitutional birth skills (Walsh, 2007, p. 28).

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