Review Article

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Care in Normal Birth

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Abstract

Despite considerable debate and research over many years the concept of "normality" in labour and delivery is not standardized or universal. Recent decades have seen a rapid expansion in the development and use of a range of practices designed to start, augment, accelerate, regulate or monitor the physiological process of labour, with the aim of improving outcomes for mothers and babies, and sometimes of rationalizing work patterns in institutional birth. In developed countries where such activity has become generalized questions are increasingly raised as to the value or desirability of such high levels of intervention. In the mean time, developing countries are seeking to make safe, affordable delivery care accessible to all women. The uncritical adoption of a range of unhelpful, inappropriate and/or unnecessary interventions, all too frequently poorly evaluated, is a risk run by many who try to improve the maternity services

Keywords: Labour; Normal Birth; Care Giver.

Introduction

Even before conceiving women has many questions in her mind because she wants a healthy baby. After conceiving she starts hunting for right information. Many times even trained birth attendants also lack the right information; which may lead to complications. Being a health care professional we should be very careful to create a positive impact on the mind of people about health care delivery system. With this review article effort has been made to answer some common questions. It is very necessary to improve interpersonal behavior, as evidence from the review points to the importance women attach to being treated respectfully, irrespective of socio-cultural or economic context. Further research on maternal satisfaction is required on home deliveries and relative strength of various determinants in influencing maternal satisfaction.

Aim of the Care in Normal Birth, Tasks of the Caregiver

The aim of the care is to achieve a healthy mother and child with the least possible level of intervention that is compatible with safety. This approach implies that:

Assessing the Well-being of the Woman during Labour

Throughout labour and delivery the woman's physical and emotional well-being should be regularly assessed. This implies measuring of temperature, pulse and blood pressure, checking fluid intake and urine output, assessing pain and need of support. This monitoring should be

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maintained until the conclusion of the birthing process. The assessment of the woman's well-being also comprises attention to her privacy during labour, respecting her choice of companions and avoiding the presence of unnecessary persons in the labour room.

Routine Procedures

The preparation for birth on admission to a hospital or health centre often includes several "routine" procedures such as the measuring of temperature, pulse and blood pressure, and an enema, followed by shaving of all or some of the pubic hair.

Nutrition

Views on nutrition during childbirth differ widely across the world. In many developed countries, the fear of aspiration of gastric contents during general anaesthesia (Mendelson's syndrome) continues to justify the rule of no food and drink during labour. For most women in labour the withholding of food poses no problem, as they do not want to eat during labour anyway, although many desperately need to drink. In many developing countries traditional culturally-bound beliefs restrain the food and fluid intake of women in labour.

Place of Birth

So where then should a woman give birth? It is safe to say that a woman should give birth in a place she feels is safe, and at the most peripheral level at which appropriate care is feasible and safe (FIGO 1992). For a low-risk pregnant woman this can be at home, at a small maternity clinic or birth centre in town or perhaps at the maternity unit of a larger hospital.

However, it must be a place where all the attention and care are focused on her needs and safety, as close to home and her own culture as possible. If birth does take place at home or in a small peripheral birth centre, contingency plans for access to a properly-staffed referral centre should form part of the antenatal preparations.

Support in Childbirth

A woman in labour should be accompanied by the people she trusts and feels comfortable with; her partner, best friend, midwife or TBA. Generally these will be people she has become acquainted with during the course of her pregnancy. Professional birth attendants need to be familiar with both the supportive and the medical tasks they have and be able to perform both with competence and sensitivity. One of the supportive tasks of the caregiver is to give women as much information and explanation as they desire and need. Women's privacy in the birthing setting should be respected. A labouring woman needs her own room, where the number of attendants should be limited to the essential minimum.

Labour Pain

Almost all women experience pain during labour, but the responses of individual women to labour pain are widely different. According to clinical experience, abnormal labour, prolonged or complicated by dystocia, induced or accelerated by oxytocics, or terminated by instrumental delivery, seems to be more painful than "normal labour". Nevertheless, even completely normal labour is painful too.

Non-Pharmacological Methods of Pain Relief

An important task of the birth attendant is to help women cope with labour pain. This may be achieved by pharmacological pain relief, but more fundamental and more important is the non-pharmacological approach, starting during prenatal care by providing reassuring information to the pregnant woman and her partner, and if need be to her family. Empathetic support, before and during labour, from caregivers and companions, can reduce the need for pharmacological pain relief and thus improve the childbirth experience.

Monitoring the Fetus during Labour

Monitoring fetal well-being is part of essential care during labour. The occurrence of fetal distress, usually through hypoxia, can never be fully excluded, even though a labour may

meet the criteria for "normal" that is: it starts at term, after an uneventful pregnancy without factors indicating an increased risk of complications. The risk of fetal distress is somewhat higher during the second stage of labour and in the case of prolonged labour.

Cleanliness

Wherever labour and delivery are managed, cleanliness is a first and foremost requirement. There is no need for the form of sterility commonly used in an operating theatre, but nails must be short as well

as clean and hands must be carefully washed with soap and water. Attention should be paid to the personal hygiene of birthing women and birth attendants as well as to the cleanliness of the environment and all materials used during birth. In some countries masks and sterile gowns are used traditionally to protect labouring woman from infection. For that purpose they are useless (Crowther et al 1989). However, in regions with a high prevalence of HIV and hepatitis B and C virus protective clothing is useful to protect the caregiver from contact with contaminated blood and other materials (WHO 1995).

Immediate Care of the Newborn

Immediately after the birth the baby has to be dried with warm towels or cloths, while being placed on the mother's abdomen or in her arms. The baby's condition is assessed and the existence of a clear airway is ensured (if necessary) simultaneously. Maintaining the body temperature of the baby is important; newborn babies exposed to cold delivery rooms may experience marked drops in body temperature, and concurrent metabolic problems. A fall in infant temperature can be reduced by skin-to-skin contact between baby and mother.

The working group of department of reproductive health and research of WHO (*WHO/FRH/MSM/ 96.24),* classified its recommendations on practices related to normal birth into four categories:

- *Practices which are demonstrably useful and should be encouraged*
- *Practices which are clearly harmful or ineffective and should be eliminated*
- *Practices for which insufficient evidence exists to support a clear recommendation and which should be used with caution while further research clarifies the issue*
- *Practices which are frequently used inappropriately.*

Categorya A

Practices which are Demonstrably Useful and Should be Encouraged

1. A personal plan determining where and by whom birth will be attended, made with the woman during pregnancy and made known to her husband/partner and, if applicable, to the family.
2. Risk assessment of pregnancy during prenatal care, reevaluated at each contact with the health system and at the time of the first contact with the caregiver during labour, and throughout labour.
3. Monitoring the woman's physical and emotional well-being throughout labour and delivery, and at the conclusion of the birth process.
4. Offering oral fluids during labour and delivery.
5. Respecting women's informed choice of place of birth.
6. Providing care in labour and delivery at the most peripheral level where birth is feasible and safe and where the woman feels safe and confident.
7. Respecting the right of women to privacy in the birthing place.
8. Empathic support by caregivers during labour and birth.
9. Respecting women's choice of companions during labour and birth.
10. Giving women as much information and explanation as they desire.
11. Non-invasive, non-pharmacological methods of pain relief during labour, such as massage and relaxation techniques.
12. Fetal monitoring with intermittent auscultation.
13. Single use of disposable materials and appropriate decontamination of reusable materials throughout labour and delivery.
14. Use of gloves in vaginal examination, during delivery of the baby and in handling the placenta.
15. Freedom in position and movement throughout labour.
16. Encouragement of non-supine position in labour.
17. Careful monitoring of the progress of labour, for instance by the use of the WHO partograph.
18. Prophylactic oxytocin in the third stage of labour in women with a risk of postpartum haemorrhage, or endangered by even a small amount of blood loss
19. Sterility in the cutting of the cord.
20. Prevention of hypothermia of the baby.
21. Early skin-to-skin contact between mother and child and support of the initiation of breast-feeding within 1 hour postpartum in accordance with the WHO guidelines on breast-feeding.
22. Routine examination of the placenta and the membranes.

Category B

Practices which are Clearly Harmful or Ineffective and Should be Eliminated

1. Routine use of enema.
2. Routine use of pubic shaving.
3. Routine intravenous infusion in labour.
4. Routine prophylactic insertion of intravenous cannula.
5. Routine use of the supine position during labour.
6. Rectal examination.
7. Use of X-ray pelvimetry.
8. Administration of oxytocics at any time before delivery in such a way that their effect cannot be controlled.
9. Routine use of lithotomy position with or without stirrups during labour.
10. Sustained, directed bearing down efforts (Valsalva manoeuvre) during the second stage of labour.
11. Massaging and stretching the perineum during the second stage of labour.
12. Use of oral tablets of ergometrine in the third stage of labour to prevent or control haemorrhage.
13. Routine use of parenteral ergometrine in the third stage of labour.
14. Routine lavage of the uterus after delivery.
15. Routine revision (manual exploration) of the uterus after delivery.

Category C

Practices for which Insufficient Evidence Exists to Support a Clear Recommendation and which Should be Used with Caution while Further Research Clarifies the Issue.

1. Non-pharmacological methods of pain relief during labour, such as herbs, immersion in water and nerve stimulation.
2. Routine early amniotomy in the first stage of labour.
3. Fundal pressure during labour.
4. Manoeuvres related to protecting the perineum and the management of the fetal head at the moment of birth.
5. Active manipulation of the fetus at the moment of birth.
6. Routine oxytocin, controlled cord traction, or combination of the two during the third stage of labour.
7. Early clamping of the umbilical cord.
8. Nipple stimulation to increase uterine contractions during the third stage of Labour.

Category D

Practices which are Frequently Used Inappropriately

1. Restriction of food and fluids during labour.
2. Pain control by systemic agents.
3. Pain control by epidural analgesia.
4. Electronic fetal monitoring.
5. Wearing masks and sterile gowns during labour attendance.
6. Repeated or frequent vaginal examinations especially by more than one caregiver.
7. Oxytocin augmentation.
8. Routinely moving the labouring woman to a different room at the onset of the second stage.
9. Bladder catheterization.
10. Encouraging the woman to push when full dilatation or nearly full dilatation of the cervix has been diagnosed, before the woman feels the urge to bear down herself.
11. Rigid adherence to a stipulated duration of the second stage of labour, such as 1 hour, if maternal and fetal conditions are good and if there is progress of labour
12. Operative delivery.
13. Liberal or routine use of episiotomy.
14. Manual exploration of the uterus after delivery

Conclusion

Health care providers are expected to be accountable for the quality of their work to clients, institution, profession and to the society as a whole. It is very necessary to conduct researches on women expectation from health care agencies or about their experiences in maternity hospitals, in all over India and comparison should be done. So that better communication module can be prepared in view of improving maternity care.

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