Midwifery 62 (2018) 230–239

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/locate/midw

Midwifery one-to-one support in labour: More than a ratio

Georgina A. Sosa, PhD MSc, BA (Hons), RM, RGN[a,*], Kenda E. Crozier, PhD, MSc, BSc, RN, RM, (Professor of Midwifery)[b], Andrea Stockl, PhD, MA, MSc, (Lecturer in Medical Sociology)[c]

[a] Faculty of Medicine and Health Sciences, University of East Anglia, Norwich Research Park, NR4 7TJ England, United Kingdom
[b] Faculty of Medicine and Health Sciences, University of East Anglia, Norwich Research Park, NR4 7TJ, England, United Kingdom
[c] Faculty of Medicine and Health Sciences, University of East Anglia, NR4 7TJ, England, United Kingdom

ARTICLE INFO

Keywords:
One-to-one
1:1
Midwifery
Labour support
Continuous support
Ethnographic

ABSTRACT

Objective: To explore midwifery one-to-one support in labour in a real world context of midwife-led birth environments.
Design: Ethnographic study. Data was collected from 30 observations inside and outside the birth environments in three different birth settings. Semi-structured interviews were completed following the births with 29 low-risk women and 30 midwives with at least one year labour support experience to gain their perspectives. Twenty-seven maternity records were also analysed.
Setting: An alongside midwife-led unit, freestanding midwife-led unit and women's homes in England.
Findings: Six components of care were identified that required balance inside midwife-led birth environments: (1) presence, (2) midwife-woman relationships, (3) coping strategies, (4) labour progress, (5) birthing partners and (6) midwifery support. Midwives used their knowledge, experience and intuitive skills to synchronise their care for the six components to work in balance. Balancing of the six components have been translated into continuums representing the labour care and requirements.
Conclusion and implications for practice: Midwifery one-to-one support in labour is more than a ratio when translated into clinical practice. When the balance of the six components were tuned into the needs of women, women were satisfied with their labour and birth experience, even when it did not go to plan. A one midwife to one woman ratio should be available for all women in labour.

Introduction

Increased clarity on the meaning of midwifery one-to-one support in labour is vital as it is associated with improved birth outcomes (Bohren et al., 2017), but it is unclear why and how better birth outcomes occur. Midwifery one-to-one support is a complex concept to translate into clinical practice. There are disparities in the literature regarding the level of presence, who should perform it, when and where it should happen, and what type of model of care should be applied (Sosa et al., 2012). Although research studies include ratio, presence, exclusive focus, continuous support, equal midwife-woman relationship as attributes of midwifery one-to-one support in labour, the connections between these attributes are not understood.

In the global literature midwifery one-to-one support in labour is most commonly described as a ratio of one midwife to one woman:

> '*One-to-one care … means that each midwife cares for one woman in labour*' (Gu et al., 2011: 245).

In the United Kingdom (U.K.), there has been no research specifically looking at one-to-one support in labour. However, the midwifery professional bodies (RCOG et al., 2007; RCM, 2010), government policies (Department of Health, 2004) and the guideline group representing NICE (2015) describe midwifery one-to-one support in labour as a ratio of one midwife to one woman in labour. The clearest practice standard available to date for U.K. maternity care providers regarding midwifery one-to-one support in labour stated that:

> *'Maternity services develop the capacity for every woman to have a designated midwife to provide care for them when in established labour for 100% of the time'* (Department of Health, 2004: 28).

This definition has been used to audit midwifery one-to-one support in labour within NHS Trusts (Sosa, 2017). A survey by the Comptroller and Auditor General (2013) reported that only 78% of maternity units were achieving midwifery one-to-one support in labour. Surveys (National Federation of Women's Institutes and National Child birth Trust, 2013; Care Quality Commission, 2015) show that women have

* Corresponding author.
E-mail addresses: georgina.sosa@uea.ac.uk (G.A. Sosa), k.crozier@uea.ac.uk (K.E. Crozier), a.stockl@uea.ac.uk (A. Stockl).
Social media: (G.A. Sosa), (K.E. Crozier)

https://doi.org/10.1016/j.midw.2018.04.016
Received 6 September 2017; Received in revised form 30 March 2018; Accepted 14 April 2018

been left alone during labour or shortly after giving birth. It is unclear if the results are associated with staffing levels or working practises.

Ball and Washbrook (2003, 2010) have designed workforce analysis tools (Birthrate, Birthrate plus, Birthrate Plus Acuity) to calculate the number of midwives required in an NHS organisation to meet the midwifery one-to-one standard in labour that reflects clinical need. There is no evidence however, that current staffing levels provided by these workforce analysis tools have enabled NHS Trusts in the UK to achieve midwifery one-to-one support to all women in labour (NICE, 2014).

The consistent stipulation for a ratio of one midwife to one woman, however, is to ensure that a midwife can exclusively focus their attention on one woman in labour and have no external obligations. Randomised trials in the meta-analysis by Bohren et al. (2017) indicated that midwives and student midwives have additional duties and are constrained by institutional policies and routine practices. Hodnett et al. (2013) has previously argued that such constraints affect the ability of midwives and student midwives to exclusively focus on providing labour support to women. The studies included in the meta-analysis by Hodnett et al. (2013) and Bohren et al. (2017) however, were completed in hospital environments. A knowledge gap existed concerning how midwifery one-to-one support in labour translated into practice within midwife–led environments. The aim of this study was to explore midwifery one-to-one support in labour in a real world context of midwife-led birth environments.

Methods

Design

An ethnographic approach was used to learn about the culture of midwife-led birth environments where midwifery one-to-one support in labour was achieved. Direct observations were used to identify and understand the activities inside and outside the birth environments. Inside the birth environment the researcher observed labour and birth until one hour postpartum. This was unless the researcher was asked to leave, or once over eight hours of observations had been completed. Outside the birth environment observations were performed inside the staff room. In relation to home births, observations were limited outside the birth environment as there were no areas such as a staff room to observe activities. While observing, the researcher attempted to blend into the background to achieve a balance so that normal activities were not disrupted (Bonner and Tolhurst, 2002). Fieldnotes and drawings were completed using a touchscreen tablet while observing the activities, interactions and events inside and outside the birth environments.

Setting

The study settings included three midwife-led birth environments: Alongside midwife-led unit (AMU), freestanding midwife-led unit (FMU) and women's homes in England. Ten observations were completed within the birth environment at each of the three study sites (165 hours). 616 hours of observations were also completed outside the birth environments.

Sample

Purposive sampling was utilised to determine the geographical sites, midwives and women to target specific characteristics. Using 'Dr Foster' website (2007: accessed 12/02/11) hospitals and midwife-led units were identified that provided midwifery one-to-one support in labour. Midwives had to have at least one year experience providing labour support, band 6 or over and not under supervised practice. Women participants had to be low-risk, under midwife–led care, over eighteen years old and able to speak English.

Data collection

The fieldwork for the three study sites was completed over 39 weeks between October 2011 and December 2012. Midwives introduced the research within antenatal clinics providing invitation letter, participant information leaflet, and consent forms. Women were asked to bring consent forms with them when they presented in labour. The consent of midwives was considered in the absence of the researcher and discussed with their peer midwives. When consent was provided by a woman and midwife the researcher was contacted to observe the labour. Following a labour observation the midwife approached the woman prior to discharge and checked if consent was provided for a postnatal formal interview. Women who consented were interviewed two weeks postpartum. The interviews included those partners of women who were keen to contribute.

Rigour

Reflexivity was an integral part of the study as *'every ethnographic description is a translation'* (Spradley, 1979:22). Ethnography is not a straightforward process of observing and documenting. The researcher is required to directly participate to some degree in the social action in a setting and this work in the field requires the continuous reflection on the action of the social world under observation. In this study the assumptions that come with a background in midwifery meant that, while in the field, there needed to be an internal interplay considering whether observations were being made in the role of researcher or being accepted as face value based on midwifery knowledge. This insider/outsider consideration (Allen, 2004) was discussed as part of the process of analysis between the researcher and supervisors, checking and rechecking assumptions. The process of reflexivity was part of data gathering field note memos and formed part of the consideration of analysis. Reflexivity allowed the researcher to capture and document their cultural assumptions, values and emotions within a reflective diary and all the fieldnotes collected. Atkinson (2015) points out that ethnographic data collection and analysis is complex and needs to do justice to the complexity of social worlds which it attempts to capture. The reflexivity is a genuine attempt to ensure that justice is done to the complexity of data collected within the complex social world that involves women, midwives and other actors within the birth settings observed.

Reflexivity is an important element of ensuring the rigour of the ethnographic approach. Alongside this, the data trail as illustrated by the use of quotes and extracts from field notes and the analysis of the policies and guidelines that underpinned midwifery one-to-one support in labour all contribute to the thick description of the ethnography. This audit trail, the prolonged engagement in the fieldwork and the scrutiny of peer review of the analysis process by supervisors underwrites the validity of the qualitative method (Sarantakos, 2013).

Using three study sites also provided an opportunity to make a comparative analysis of three types of midwife-led care birth environments. Multiple study sites increase the transferability of findings. Transferability implies that the findings from this study can be transferred to a similar context, situation and participants (Yin, 2016). The atmosphere created and the activities performed by midwives inside the birth environments were found to be very similar within all three study sites.

Data analysis

Interviews were audio recorded and transcribed by the researcher, with data organised and categorised using the software program NVivo 10. All data was anonymised and pseudonyms are used to present the report. Thematic analysis enabled the different data sources and different study sites to be compared. The guidance from Braun and Clarke (2006) included familiarising the researcher with the data, generating initial codes, searching for themes; and reviewing, refining and naming themes until data saturation. The theoretical stance evolved from