The partogram can be used as a means of monitoring and imposing routine interventions on those women whose labour does not conform with pre-set time limits on measurable progress, with the objective of preventing prolonged labour as a result of ‘inefficient uterine action’. The partogram currently in widespread use in the UK is based on studies carried out in other countries and several have included women who were not in established labour. Alternatively, it can be used as a tool for recording observations of clinical significance with the objective of reducing lengthy notetaking, thus enabling midwives to use their time more effectively. However, the proportion of labours requiring augmentation was reduced by 54% but their observation that the improvements were ‘most marked in normal women’ suggested that the previous rate was unnecessarily high. Therefore the partogram was correcting a poor standard of care, rather than making childbirth safer per se.

The majority of trials of partograph have taken place in hospital settings where most maternal deaths occur among women admitted with severe complications who have been unattended for many hours of labour. No trial to date has demonstrated that the partogram reduces maternal mortality. In a culture where mortality is low, physical and psychological well-being and morbidity may be more appropriate markers of effective care.

Summary and key points

- There is an urgent need to evaluate the use of the partogram and its effect on women's experience of childbirth, both in its conventional use within a medicalised model of care and when adapted for use within a midwifery model of care which specifically aims to safeguard and promote normal births.
- The partogram currently in widespread use in the UK is based on studies carried out in other countries and several have included women who were not in established labour.
- The partogram can be used as a means of monitoring and imposing routine interventions on those women whose labour does not conform with pre-set time limits on measurable progress, with the objective of preventing prolonged labour as a result of ‘inefficient uterine action’. The partogram currently in widespread use in the UK is based on studies carried out in other countries and several have included women who were not in established labour. Alternatively, it can be used as a tool for recording observations of clinical significance with the objective of reducing lengthy notetaking, thus enabling midwives to use their time more effectively.

Evaluation

Surprisingly, the partogram was only rigorously evaluated more than twenty years after its introduction, when an adaptation of the one formulated by Philpott and Castle was developed by The World Health Organisation. To test whether the use of the WHO partogram improved labour management and reduces maternal and fetal morbidity and mortality, a prospective study of 35,484 women was carried out. The study involved four pairs of tertiary level hospitals in South East Asia. During the intervention period it was suggested that the previous rate was unnecessarily high. Therefore the partogram was correcting a poor standard of care, rather than making childbirth safer per se.

The WHO claimed that the use of the partogram reduces the caesarean section rate; however, this finding did not reach statistical significance. The authors reported that the proportion of labours requiring augmentation was reduced by 54% but their observation that the improvements were ‘most marked in normal women’ suggested that the previous rate was unnecessarily high. Therefore the partogram was correcting a poor standard of care, rather than making childbirth safer per se.

The majority of trials of partograph have taken place in hospital settings where most maternal deaths occur among women admitted with severe complications who have been unattended for many hours of labour. No trial to date has demonstrated that the partogram reduces maternal mortality. In a culture where mortality is low, physical and psychological well-being and morbidity may be more appropriate markers of effective care.

Midwifery care

There is some evidence to suggest that although midwives find the partogram to have practical and educational benefits, the partogram’s status within some obstetric units is such that it is associated for many midwives with restrictions in their clinical practice, reduced autonomy, and limited flexibility to treat each woman as an individual. Recently, however, the partogram has been incorporated into a new protocol for clinical care designed by midwives in Wales to protect and promote normal births, the All Wales Clinical Pathway for Normal Labour. The rationale for advocating the tool in the context of the normal labour pathway has been to reduce the time midwives spend on note-taking, while enabling them to keep detailed and accurate records, so as to free them up to provide emotional support to labouring women. As in any context, the partogram allows clinically significant observations to be recorded clearly; however, the emphasis within the Clinical Pathway for Normal Labour is on an individual holistic approach rather than as a means of imposing strict time constraints on what is ‘normal progress’. Rather than expecting dilation to occur at a rate of 1cm an hour once labour is established, the Pathway suggests that in the absence of other indicators for intervention, progress at the rate of 0.5cm per hour is within normal limits. Standards of normalcy and no particular action is required, apart from continuous support for the labouring woman. Observation of the ‘alert line’ is not now being carried out in Wales; however, there is no evidence at present to show how outcomes are affected by the Pathway or use of the partogram.
The Health Development Agency (England) have published a review of the evidence of interventions to promote the initiation of breastfeeding. This is particularly relevant to the target to increase the proportion of women starting to breastfeed by 6% over the next three years in England but it will also be useful and pertinent to the targets in other parts of the UK. Evidence shows that breastfeeding makes an important contribution to meeting the target to reduce infant mortality as a core element in reducing health inequalities.

The briefing presents the current evidence from selected good quality systematic reviews and meta-analyses published since 1996. There is evidence that training health professionals or written material alone were not effective in improving breastfeeding rates. Peer support and multiple interventions including media campaigns, in combination with health education programmes, training of health professionals and/or changes in government and hospital policies were more successful. Do look at the full report for the details.

You can obtain these and other summaries of the evidence from the Health Development Agency, PO Box 90, Wetherby, Yorkshire, LS23 7EX. Tel: 0870 121 4194, or see: www.hda.nhs.uk/evidence

References:
2. Priorities and Planning Framework of the NHS Plan. www.doh.gov.uk/planning2003-2006/appb.htm#8 (See also research summary on Baby Friendly hospital practices, on page 20 of Research Roundup in this edition of New Digest.)

There have been several recent publications which provide evidence based information about postnatal health and care. The NCT booklets, Early Days and Happy and Healthy after Childbirth are particularly suitable for new parents, as is the new MIDIRS Informed Choice leaflet number 15 for women, Caring for yourself and feeling well after you have had your baby. These are all evidence based, although the references are not included in the leaflets.

The MIDIRS leaflet points out that ‘care after childbirth has been a neglected area for research and there is still a need for more studies about womens’ physical and psychological health after childbirth’. The companion MIDIRS leaflet for professionals, Health and care after childbirth is likely to be useful for NCT reps and specialist workers as it provides an accessible, referenced summary of current research evidence. Anyone needing a quick reminder of the reference for the ineffectiveness of salt in bathwater, or the emerging evidence for the use of a cool gel pad for perineal trauma will find it here. Although the recurrence of phrases such as ‘results inconclusive’, ‘no significant difference’ and ‘little evidence’ bear out the comment about the need for more studies, this leaflet is well worth reading and provides a useful introduction to general issues of postnatal care.

A more substantial publication for those NCT workers who have a special interest in postnatal care and support was published last year - Postnatal care: evidence and guidelines for management by Bick, MacArthur and Knowles. This book includes details of the IMPaCT trial (Implementing Midwifery-led Postnatal Care Trial), which tested a particular package of midwife-led postnatal care, a comprehensive overview of postnatal health needs, and the evidence-based guidelines developed for midwives as part of the trial. The treatment arm of the IMPaCT trial involved midwives delivering a new model of care using a...
brought together the statistics to answer the questions which parents ask about the likelihood of particular problems arising, and lead into discussion on risk factors and recommended management following diagnosis.

There are interesting comparisons using major studies of postnatal experience in other countries, including Australia\textsuperscript{11}, France and Italy\textsuperscript{12}, and Scotland\textsuperscript{13}. Some of the statistics are fascinating: 12 months after the birth, 17\% of Italian women report constipation, compared with 26\% of French women, although Italians were more likely to suffer backache (65\% compared with 47\% of French women).

The book is also an invaluable resource for NCT Reps lobbying to improve postnatal care locally, identifying significant research papers on each topic and providing a critique of the studies’ shortcomings or lack of research in the area.

If the book has a shortcoming, it is its focus on a biomedical perspective of postnatal morbidity. There is little discussion about normal physiological and social and emotional adjustment after childbirth. In contrast, the final page of the MIDIRS leaflet highlights the need for better information on what constitutes postpartum normality, ending, promisingly, that ‘an approach that embraces the philosophy of the Changing Childbirth report, by encouraging the woman to be within the circle of health rather than outside it, is key to the provision of a model of pro-active care that will meet the needs of women and their babies as individuals’\textsuperscript{14}.

(See also research summary on postnatal mental health on page 24 of Research Roundup in this edition of New Digest.)

References:

3 Caring for yourself and feeling well after you have had your baby. London, MIDIRS. MIDIRS Informed Choice for Women. No 15. 2002.

The full version of the Current Awareness Bulletin (on which Research Roundup is based) is available on-line from: http://groups.yahoo.com/group/nct_research AND http://groups.yahoo.com/group/nct_reps

Please read abstracts critically in the context of your wider knowledge and experience. To read the publication in full if it is relevant to your work. You may be able to obtain these through your local library or your nearest NCT tutor may be able to help. The NCT library may be able to supply photocopies (within the terms of current copyright regulations) but this will be subject to staff availability and there may therefore be a delay in our ability to supply. Where photocopies are provided we would appreciate a donation towards the costs of providing the Library and Information Service (LIS).

The LIS will try to prioritise support for NCT tutors, registered reps and specialist workers. Photocopies can be obtained from other, larger libraries: MIDIRS (0800 581 009) or the Royal College of Midwives library (020 7291 9200/9221). There are charges for these services.

\section*{Child}

\subsection*{Low Birth Weight}


Background: Kangaroo mother care (KMC), defined as skin-to-skin contact between a mother and her newborn, frequent and exclusive or nearly exclusive breastfeeding, and early discharge from hospital, has been proposed as an alternative to conventional neonatal care for low birthweight (LBW) infants. Objectives: To determine whether there is evidence to support the use of KMC in LBW infants as an alternative to conventional care after the initial period of stabilisation with conventional care. Search strategy: We used the standard search strategy of the Neonatal Review Group of the Cochrane Collaboration. MEDLINE, EMBASE, LILACS, POPLINE and CINAHL databases (to December 2002), and the Cochrane Controlled Trials Register (The Cochrane Library), were searched using the key words terms ‘kangaroo mother care’ or ‘kangaroo care’ as well as synonyms. The search was limited to English language articles, although KMC literature in other languages was included. Data extraction and data analysis: Data extraction was done independently by two reviewers. Statistical analysis was conducted using the standard Cochrane Collaboration methods.

Main results: Three studies involving 1362 infants, were included. All the trials were conducted in developing countries. The studies were of moderate to poor methodological quality. The most common shortcomings were in the areas of blinding procedures for those who collected the outcomes measures, handling of dropouts, and completeness of follow-up. The great majority of results consist of results of a single trial. KMC was associated with the following reduced risks: nosocomial infection at 41 weeks’ corrected gestational age (relative risk 0.49, 95\% confidence interval 0.25 to 0.93), severe illness (relative risk 0.30, 95\% confidence interval 0.14 to 0.67), lower respiratory tract disease at 6 months follow-up (relative risk 0.37, 95\% confidence interval 0.15 to 0.89), not exclusively breastfeeding at discharge (relative risk 0.41, 95\% confidence interval 0.22 to 0.75).

KMC infants had gained more weight per day by discharge (weighted mean difference 3.6 g/day, 95\% confidence interval 0.8 to 6.4). Scores on mother’s sense of competence according to infant stay in hospital and admission to NICU were better in KMC than in control group (weighted mean differences -0.18, 95\% confidence interval -0.35 to -0.01). Psychomotor development at 12 months’ corrected age was similar in the two groups. There was a trend for a difference of 0.18, 95\% confidence interval -0.16 to 0.68), and maternal dissatisfaction with method of care (relative risk 0.41, 95\% confidence interval 0.22 to 0.75). The standard Cochrane Collaboration methods.

Available from: http://www.cesdi.org.uk/publications/P2727/mainreport.pdf Ref ID: 2277