

The roadmap of labour: a framework for teaching about normal labour

Penny Simkin, a leading American childbirth educator and author, describes her roadmap of labour, a teaching aid to guide parents through normal childbirth and variations on normal.

Introduction

Childbirth educators strive to provide timely, accurate, woman-centred information. We adapt our content and teaching methods to the time allowed, and the variety of learning styles, educational levels and cultural backgrounds of our students. We hope to build trust in the normal birth process, and instil the confidence and competence necessary for parents to meet the challenges of childbirth, and also to communicate effectively with their maternity caregivers. In this paper I describe a teaching aid, the roadmap of labour, and some ideas to help guide parents through normal childbirth, from early labour to active labour, transition, and the resting, descent and crowning-to-birth phases of the second stage. The discussion of each stage and phase includes what occurs, women's and partners' common emotional reactions, and advice on comfort measures and ways to work together to accomplish a safe and satisfying birth.

I do not describe how I teach about routine or indicated interventions, complications, pain medications, or surgical birth. Aside from space limitations, the real reason lies in my firm belief that when expectant parents appreciate the pure unaltered (and elegant!) physiological process of labour, they have more confidence that birth usually goes well, and they may feel reluctant to bypass it (with induction or caesarean) or alter it unnecessarily. Normal labour becomes the clear standard against which to assess the benefits and risks of specific interventions and the circumstances that increase or decrease

their desirability. If I combined the discussion of straightforward labour with complications and common procedures (along with their risks, benefits, and alternatives), parents would have a fragmented and confused perception of childbirth and an almost impossible burden of separating normal from abnormal, and elective from indicated procedures. All these topics must be covered, however, if parents are to participate in their care, whether labour is straightforward or not. Therefore I teach these topics in subsequent classes, using normal birth as the reference point. I also follow this approach in some other writings.^{1,2}

Initiation of labour, the six ways to progress and signs of labour

There are some key concepts that childbirth educators can use to raise parents' awareness and appreciation of events of late pregnancy and normal birth and how they can help the process flow smoothly. Parents need to understand these concepts well, so they can use the roadmap of labour to best advantage, and play a more confident and active role in labour.

For example, before introducing the roadmap, the teacher should inform parents about the hormonally-orchestrated processes in late pregnancy that prepare for birth, breastfeeding, and mutual mother-infant attachment. This is important because teachers face two common challenges: first, parents' impatience to end the pregnancy due to discomfort, fatigue and eagerness to hold their baby; and second, the possibility of a long, discouraging pre-labour phase.

These challenges make parents more accepting of induction or vulnerable to the belief that there is something wrong. Parents need to understand that labour normally begins only when all of the following occur:

- The fetus is ready to thrive outside the uterus (breathing, suckling, maintaining body temperature, and more).
- The placenta has reached the point where it can no longer sustain the pregnancy.
- The uterus is ready to contract, open and expel the baby.
- The mother is ready to nourish and nurture her baby.

If parents understand that fetal maturity is essential in initiating the chain of events leading to labour, they may be more patient with the discomforts of late pregnancy, and less willing or anxious to induce labour without a medical reason.

The six ways to progress to a vaginal birth

Progress before and during labour and birth occurs in many ways, not simply cervical dilation and descent, which is what most people focus on. Labour unfolds gradually and includes six steps, four of which begin weeks before labour and involve the cervix. The cervix moves forward, ripens, effaces and then dilates. When parents understand that a long pre- or early labour is accomplishing necessary progress – preparing the cervix to dilate – they are less likely to become anxious or discouraged that nothing seems to be happening. The two other steps involve the fetus: the fetal



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head repositions during labour by flexing, rotating, and moulding to fit into the pelvis; and lastly, the fetus descends and is born.

Three categories of signs of labour

By placing these in the context of the six ways to progress, parents may be better able to recognize the differences between pre-labour (often called 'false labour') and labour.

Possible signs of labour

These include: nesting urge; soft bowel movements; abdominal cramping; and backache that causes restlessness. These may or may not continue to the clearer signs of labour and may be associated with early cervical changes.

Pre-labour signs

The most important of these is the first one:

- Continuing 'nonprogressing' contractions (that is, over time, the pattern remains the same; they do not become longer, stronger or closer together)
- Possible leaking of fluid from the vagina
- Possible 'show' – bloody mucus discharge from the vagina

With these signs, the cervix is probably not dilating significantly, but is likely to be ripening and effacing (steps two and three of the six ways to progress).

Positive signs of labour

The most important of these is the first one:

- Continuing, progressing contractions, i.e. contractions that become longer, stronger, and closer together (or at least two of those signs). These progressing contractions cause cervical dilation (steps four and five of the six ways to progress), which is the clinical definition of labour.
- Spontaneous rupture of the membranes (SRM), especially with a gush of fluid. This happens before or at the onset of labour in about 8% of women at term.³ It most often happens late in labour. SRM is only a positive sign of labour in conjunction with continuing progressing contractions.

The roadmap of labour

I have created a visual guide to labour progress using the metaphor of a road map. It shows key labour landmarks, and appropriate activities and measures for comfort as labour progresses (see Figure 1).⁴ Parents can use it during labour as a reminder of where they are in the process and what to do. Teachers can use it as a tool for organised discussion of normal

labour progress, and as a backdrop for discussing labouring women's emotional reactions, and how partners or doulas may assist. Health professionals can use it to help parents identify where they are in labour, adjust their expectations and try appropriate comfort measures.

Normal labour pathway

The roadmap portrays three pathways. The main brick road represents normal labour and shows helpful actions, positions, and comforting techniques to use as labour progresses. The twists and turns in the brick road indicate that normal labour does not progress in a straight line; the large turns between three and five-to-six centimetres and between eight and 10 centimetres indicate large emotional adjustments for the labouring woman, and present an opportunity to discuss emotional support and comfort measures for the partner or doula to use. After 10 centimetres, the woman's renewed energy and confidence are represented by the second wind sign. Along with discussion of emotional support and comfort measures, the teacher can offer perspective and practical advice for partners and doulas, to use both when the woman is coping well and when she feels challenged or distressed.

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The roadmap provides a clear and effective way to teach about normal labour. It keeps the discussion focused purely on the physiological and psychological processes, without inserting discussions of pros and cons of interventions, complications, or usual policies and hospital practices that alter labour.

Once parents have a solid understanding of normal labour, the teacher can explain usual care practices and possible options for monitoring maternal and fetal wellbeing during labour. She can also discuss labour variations or complications and treatments with medical (including pain medications),

surgical or technological procedures. With this approach, parents are better equipped to discuss risks, benefits and alternatives, because they can distinguish situations and conditions that are more likely to benefit from the intervention from those in which the intervention is optional, unnecessary, or harmful.

Planned and spontaneous rituals

The normal labour road suggests measures to use for distraction, comfort, and progress. Distraction is desirable for as long as it helps. The Relax, Breathe, Focus sign reminds parents to use this pre-planned ritual for dealing with intensifying contractions when distraction is no longer possible. Parents need to rehearse these rituals in childbirth class (i.e. slow breathing, tension release, and constructive mental focus) and use them in early labour. They set the stage for the spontaneous rituals that emerge later in labour (as women enter active labour), when they realise they cannot control the contractions or continue their planned ritual, and give up their attempts to do so, though sometimes after a stressful struggle. Spontaneous rituals replace the planned ones. They are not planned in advance – they are almost instinctual – and almost always involve rhythmic activity through the contractions – breathing, moaning, swaying, stroking, rocking, or even letting rhythmic thoughts or phrases repeat like a mantra.

The three Rs

The spontaneous rituals usually involve the three Rs: relaxation (at least between contractions), rhythm, which is the most important, and ritual, the repetition of the same rhythmic activity for many contractions. In order to give herself over to spontaneous instinctual behaviour, the woman needs to feel emotionally safe, uninhibited, accepted unconditionally by partner and staff, and to be mobile in order to find comfort.

The motto 'Rhythm is everything' means that if a woman has rhythm during contractions, she is coping, even though she may vocalise and find it difficult. The rhythmic ritual keeps her from feeling totally overwhelmed. The goal is to keep her rhythm during contractions in the first stage. Once in second stage, however, rhythm is no longer the key. The woman becomes alert and her spirits are lifted. An involuntary urge to push usually takes over and guides her behaviour.

The role of the partner in labour

The partner helps throughout labour, comforting the mother with food and

Penny Simkin's Room



drink, distraction, massage and pressure, assistance with positioning, and constant companionship. Sometimes a doula also accompanies them, providing continuing guidance, perspective, encouragement, and expertise with hands-on comfort measures, positions, and other techniques gained from her training and experience.²

The role of an effective birth partner includes being in the woman's rhythm – focusing on her and matching the rhythm of her vocalisations, breathing or movements – by swaying, stroking, moving hand or head, murmuring softly in her same rhythm. Then, if she has difficulty keeping her rhythm, and tenses, cries out or struggles – as frequently occurs in active labour or transition – her partner helps her get her rhythm back, by asking her to focus her eyes on their face or hand and follow their rhythmic movements. This is the take-charge routine, and is only used if the woman has lost her rhythm, is fearful, or feels she cannot go on. Partners who know about this are less likely to feel helpless, useless or frightened. Simple directions, given firmly, confidently, and kindly ('look at me,' or 'look at my hand'), rhythmic hand or head movements, and 'rhythm talk' with each breath (murmuring, 'Keep your rhythm, stay with me, that's the way...') are immensely effective in helping the woman carry on through demanding contractions. During the second stage, rhythm is no longer important; now the partner encourages her bearing-down efforts and release of her pelvic floor, and also assists her with positions.

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The detour for back pain

A second pathway, a rocky, rough road, represents the more difficult 'back labour', which may be more painful, longer, or more complicated than the normal labour pathway. Fetal malposition is one possible cause. The measures shown for back labour are twofold: reduce the back pain and alter the effects of gravity and pelvic shape to encourage the fetus's movement into and through the pelvis. It helps a woman endure a prolonged or painful back labour if she and her partner use appropriate comfort



measures, and if they know that dilation may be delayed while the baby's head moulds or rotates to fit through, or that changing gravity and pelvic shape may give the extra room that the baby needs to move into an optimal position.

The epidural highway

This third pathway represents a dramatically different road – smooth, angular, man-made, more comfortable – but it comes with extensive precautions and numerous procedures, monitors, and medications, which are necessary to keep the epidural safe. The woman adopts a passive role while the staff manage labour progress, and monitors the mother's and fetus's wellbeing closely. The excellent pain relief and chance to sleep are the usual rewards. Discussion of how to work with an epidural in order to optimise the outcome is beyond the scope of the paper, but the basic principle is: treat the woman with an epidural as much as possible like a woman who does not have one! This essentially means, 'Keep her cool. Keep her moving. Keep her involved in the work of pushing her baby out. And don't assume that if she has no pain, she has no distress! Do not leave her alone.'

Conclusion

The roadmap of labour provides a useful framework for teachers to explain the psychological and physiological processes of labour, and a variety of activities for comfort and labour progress for women and their partners to use. By focusing on the normal unaltered process, parents learn to separate the norm from the numerous interventions that alter the process, sometimes for the better, sometimes for the worse. The intention is to give them confidence that they can handle normal labour and to participate meaningfully in decision-making when interventions are suggested.

About Penny Simkin

Penny Simkin is a US-based physical therapist who has specialised in childbirth education and labour support since 1968.

She estimates she has prepared over 11,000 women, couples and siblings for childbirth, and has assisted hundreds of women or couples through childbirth as a doula.

She has produced several birth-related films and is the author of many books and articles on birth for both parents and professionals.

Her books include *The Labor Progress Handbook* (2011), with Ruth Ancheta, *The Birth Partner* (2008), and *When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse of Childbearing Women* (2004), with Phyllis Klaus.

Penny and her husband have four adult children and eight grandchildren.

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