



**Position Paper No 1a**  
**THE USE OF WATER IN LABOUR AND BIRTH**

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Immersion in water during labour was popularised as a formal method of analgesia by Odent in the 1970s (Beake 1999), and became widespread after the Winterton Report recommended that all maternity services provide women with the option to labour or deliver in water (House of Commons Health Committee, 1992). As with all aspects of midwifery care, the use of water during labour and birth requires evaluation of associated benefits and risks, yet there are no large, collaborative, randomised controlled trials to date (Nikodem, 2000). This paper clarifies the RCM's position and recommendations to its members. It should be used in conjunction with local policies and guidelines.

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### **Introduction**

It has been estimated that 50 per cent of maternity units now provide facilities for labour or birth in water, and that between 15% and 60% of the women attending those units choose to use these facilities. The number of births occurring in water is much lower, however; between April 1994 and March 1996, a survey identified only 0.6% of births in England and Wales occurring in water, 9% of which were home births (Tookey and Gilbert, 1999). These averages conceal wide variation, with some units passively or actively discouraging women from using water, while one birth centre reports up to 80% of women using water during labour, with up to 79% giving birth within the pool (Beech, 2000).

There is not enough evidence to evaluate the use of immersion in water during labour (Nikodem, 2000), but both potential benefits and adverse effects have been described in the literature. Beneficial effects include maternal relaxation, less painful contractions, shorter labours, less need for augmentation, less need for pharmacological analgesics, more intact perineae, and fewer episiotomies (Schorn et al, 1993; Garland and Jones, 2000). Among the adverse effects discussed are unrealistic labour expectations, restricted mobility, infection, and the potential problem of the neonate inhaling water (Alderdice et al, 1995; McCandlish and Renfrew, 1993). The systematic review produced by the Cochrane Library highlights that 'although no significant adverse effects have been reported, the possibility of adverse outcome for the neonate should not be ignored' (Nikodem, 2000).

There is clearly a need for more research, and midwives should give high priority to developing midwifery knowledge in this area. In the meantime, the available evidence does not justify discouraging women from choosing this increasingly popular option. Women experiencing normal pregnancy, who choose to labour or deliver in water, should be given every opportunity and assistance to do so.

## **RCM recommendations**

1. All maternity units should develop policies and guidelines, underpinned by the available evidence, on the use of water in labour and birth. These should be developed in consultation with midwives, supervisors, and local user representatives.
2. Managers and supervisors should ensure that midwives acquire and sustain the competence, skills and confidence necessary to assist women who choose to labour or deliver in water (UKCC, 1992a; UKCC, 1992b; UKCC, 1998a).
3. Midwives should ensure they are competent to provide support to women who choose to use water, and should keep themselves updated on the research evidence in this area.
4. Midwives should audit and evaluate their practice, and the outcomes of labour and birth in water, in order to contribute to midwifery knowledge and the development of best practice.
5. All midwives should ensure their record keeping of labour and births in water is accurate and adheres to UKCC standards (UKCC, 1998b).

## **Policies and guidelines for the use of water**

Every maternity unit should have, or should develop, policies and guidelines on the use of water in labour and birth. These should be underpinned by the best available evidence, and should be developed in consultation with supervisors and user representatives. They should cover the following areas:

### *1. Professional expertise*

The assistance of women to labour and deliver in water should be considered a core midwifery competence. However, some will have lacked experience in this area, and therefore appropriate education, training and supervision will be necessary. Continuing professional development in this area should be seen as a service requirement.

### *2. Information for choice*

- All women should be offered information on the option of using water in labour and birth. There are no grounds for seeing this option as particularly suitable for, and acceptable to, certain groups of women on the basis of non-clinical criteria.
- All women who express an interest in the use of water should be given full verbal and written information, including where appropriate a copy of the unit's policy. This should include any expectations of the woman (for example, on the supply of equipment), and what steps will be taken in the event of an emergency.

### *3. Criteria for use of water*

Criteria for use of water may include:

- Women's informed choice
- Normal term pregnancy at 37+ weeks
- Singleton fetus with cephalic presentation
- No systemic sedation
- Spontaneous rupture of membranes < 24 hours

Other non-clinical criteria – such as the availability of staff or equipment – may reasonably be deployed; however, as with all other areas of maternal choice, their obstruction of women’s informed decision-making should be actively kept to a minimum.

#### 4. *Equipment*

- Local policies should specify essential and desirable equipment for the use of water, and make clear who is responsible for supplying it.
- All unit equipment should conform to British Safety Standards, and be checked by the Health and Safety Officer (RCM, 1998).

#### 5. *Health and safety*

- Local infection control policies should cover the use of water in labour and birth, and midwives should ensure they implement universal precautions (RCM, 1998).
- Specialist health and safety advice should be sought to develop policies on pool cleaning.
- Health and safety advice on moving and handling should be adhered to at all times (RCM, 1999).

#### 6. *Additional professional issues*

- **Temperature:** All midwives should understand the physiological basis of maternal and fetal hyperthermia, local guidelines should specify target temperatures for the water during delivery and birth (Steer and Deans, 1995; Garland and Jones, 2000). Maternal, core water and room temperatures should all be checked regularly.
- **Analgesia:** Local guidelines for the use of additional pain relief should be developed in consultation with an anaesthetist, and discussed with all women prior to labour. These should cover all forms of pain relief, including complementary therapies.
- **Birth:** Local guidelines should be developed to guide midwives on best practice during delivery. These should be underpinned by the best available evidence (Nikodem, 2000).
- **Emergencies:** Local guidelines should detail what steps are expected in an emergency situation. All midwives, and all women using water for labour or birth, should know and understand these steps.

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### **Further reading**

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