



ALMA MATER STUDIORUM
UNIVERSITÀ DI BOLOGNA

DOTTORATO DI RICERCA IN
SCIENZE MEDICHE GENERALI E SCIENZE DEI SERVIZI

Ciclo 38

Settore Concorsuale: 06/H1 - GINECOLOGIA E OSTETRICIA

Settore Scientifico Disciplinare: MED/40 - GINECOLOGIA E OSTETRICIA

ADVANCEMENT AND INTEGRATION OF MIDWIFERY COMPETENCIES IN
SUPPORTING PHYSIOLOGICAL BIRTH AND PROMOTING THE HUMANISATION
OF THE CHILDBIRTH EXPERIENCE

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Esame finale anno 2026

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TITOLO TESI

Advancement and integration of midwifery competencies in supporting physiological birth and promoting the humanisation of the childbirth experience.

Valorizzazione e implementazione delle competenze ostetriche nel mantenere la fisiologia e l'umanizzazione del percorso nascita.

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A tutte le donne che mi hanno mostrato la strada
e a quelle per cui sarò da esempio

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Introduction

Each year, an estimated 140 million births take place worldwide, and the vast majority involve women who enter labour without identifiable risk factors for complications for themselves or their babies (WHO, 2018). This global reality underscores a fundamental premise of contemporary maternity care: for most women, childbirth is a physiological process that unfolds safely when appropriately supported. In this context, the World Health Organization has positioned a *positive childbirth experience* as a primary outcome for all pregnant women, shifting the focus from a narrow clinical definition of safety toward a broader understanding of wellbeing, autonomy, and satisfaction (WHO, 2018).

Increasingly, scholars and international bodies argue that childbirth must be understood not only as a health event but also as a profound moment of empowerment, identity formation, and decision-making, with long-lasting effects on women, babies, and families. The experience of labour and birth shapes psychological adjustment, early parenting, and perceptions of bodily capability, and it can influence future reproductive choices and engagement with health services (Maimburg & Downe, 2021; White, 2022). As such, supporting physiological birth is not merely a clinical task but a public health priority with social, emotional, and relational implications (Downe, 2026; Papoutsis & Antonakou, 2023).

However, across Europe—and particularly in Italy—patterns of care often diverge from this vision. Euro-Peristat data consistently show that Italy has among the highest rates of obstetric interventions in the region, including caesarean sections, inductions, and early-term births, even among women with a physiological pregnancy (EUROPERISTAT 2015_2018, 2018). These indicators reflect a maternity system in which medicalization is deeply embedded. Spina's sociological analysis reinforces this picture, describing Italy as a context where pregnancy and childbirth remain “rather medicalized” compared to other European countries, shaped by historical, cultural, and organizational factors that privilege specialist-led, technology-driven care (Spina, 2023). She highlights significant regional variation and a persistent reliance on interventions that may not always align with international recommendations promoting physiological labour and woman-centred care. Together, these findings raise important questions about equity, quality, and the extent to which Italian maternity services support women's autonomy and the pursuit of positive birth experiences.

Midwives occupy a central role in achieving these goals. Evidence consistently shows that midwifery care contributes to improved maternal and neonatal outcomes, reduced intervention rates, and enhanced satisfaction with the birth experience (WHO, 2024). Yet, despite the long-standing recognition of midwives' importance, there remains limited conceptual clarity about what midwifery care actually entails, particularly regarding its core practice of *watchful attendance*—a form of continuous, attentive presence that supports physiological processes while safeguarding against emerging risks (de Jonge et al., 2021). Recent concept analyses highlight the evolving and multifaceted nature of midwifery care, emphasizing woman-centredness, relationality, and respect for autonomy, but also revealing significant gaps in how these concepts are operationalized in practice and research (Barbieri et al., 2025; Brady et al., 2024).

At the same time, debates about what constitutes “normal birth” and how it should be supported have intensified. Some authors argue that prevailing definitions are outdated or insufficiently aligned with women's lived experiences, while others call for renewed attention to physiological labour within modern maternity systems (Ely et al., 2020; Hernández-Martínez et al., 2025). These discussions converge on a shared concern: without a clear understanding of the principles and practices that underpin high-quality midwifery care, efforts to promote positive birth experiences risk becoming fragmented or ineffective.

This thesis emerges from these intersecting challenges. It is structured around two complementary projects: first, providing a comprehensive review of the literature on what constitutes midwifery care in support of physiological birth (chapter 1 and 2); and second, conducting a quantitative, descriptive, observational study designed to quantify and describe the daily midwifery care provided in clinical practice (chapter 4). More specifically, the thesis aims to describe the components of midwifery care during the first and third stages of labour by conducting a systematic review to address the first research question and a scoping review to explore the second. This because a recent paper already described midwifery care during the second stage of care (Healy et al., 2020). Building on these findings, and in collaboration with the AUSL della Romagna, an observational descriptive quantitative study was undertaken to measure daily midwifery care. This empirical phase was made possible through the translation and cultural validation of the *Physiological Practice Observing Tool* for the Italian context, enabling the systematic assessment of midwifery practices within local maternity services (chapter 3). Together, these methodological strands aim to generate a more coherent and evidence-based understanding of midwifery care and to inform policies and guidelines that genuinely reflect the needs and preferences of childbearing women.

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Chapter 1 How do midwives keep the first stage of labour normal? A systematic literature review.

This paper is under review in the Birth journal

Abstract

Background: Preserving the physiological process of labour is a cornerstone of midwifery care. However, rising medicalisation—even among women experiencing uncomplicated pregnancies—threatens this process and the midwife’s role in protecting and promoting normal birth. Understanding how midwives uphold physiological labour during its first stage is vital for sustaining woman-centred, evidence-informed midwifery practice.

Aim: To synthesise evidence on how midwives support physiological labour during the first stage of birth.

Methods: A systematic review was conducted in accordance with PRISMA guidelines (PROSPERO: CRD42023424741). Five databases (CINAHL, PsycINFO, PubMed, LILACS, Scopus) were searched from January 2000 to June 2023. Qualitative and mixed-method studies describing midwifery care aimed at preserving physiological birth during the first stage of labour were included. Data were analysed using thematic synthesis; quality was appraised using the CASP checklist.

Results: Seventeen qualitative studies from ten countries were included (n = 228 midwives). Seven key themes were identified: (1) Trust in the birth process, (2) The woman–midwife relationship, (3) Creating and protecting the birthing environment, (4) Presence and patience, (5) A broad understanding of normality, (6) Preparing women and managing expectations, and (7) Collegial support and shared midwifery philosophy. These findings highlight that midwives safeguard normal birth through relational presence, clinical sensitivity, and a strong philosophical commitment to women’s innate birthing capacities.

Conclusion: Midwives maintain physiological labour through a holistic, woman-centred approach grounded in midwifery values. Their actions are relational, context-sensitive, and deeply embedded in trust—in both the birthing process and the woman. These findings support the need for education, policy, and organisational frameworks that enable midwives to promote physiological labour in all settings.

Keywords:

Midwifery care; physiological birth; labour support; first stage of labour; woman-centred care; systematic review

Background

Most of the 140 million births that take place worldwide each year involve women without risk factors for complications for themselves or their babies at the beginning and throughout labour (WHO, 2018). However, the use of a variety of labour techniques to start, speed up, end, regulate, or monitor the physiological process of labour has increased significantly during the past 20 years in an effort to improve outcomes for mothers and infants. The woman's capacity to give birth is generally weakened by the growing medicalization of the delivery process (Downe et al., 2020). Since 1996, the World Health Organisation has been advocating for the elimination of needless interventions, in an effort to support normal, physiologic deliveries (World Health Organization, 1997). Later on, the World Health Organization introduced the “positive birth experience” as a primary outcome for all pregnant women (WHO, 2018). Through this definition the World Health Organization wants to highlight that the birth process is not only a health issue but also a moment of empowerment and decision-making with strong and long lasting effects for women, babies and families.

The concept of normal physiologic birth is complex and its definition is ambiguous (Shorey & Ng, 2023). As medical standards change over time, there has been much discussion about the subjectivity of the term "normal," which refers to spontaneous, physiological births that do not require medical interventions (Shorey & Ng, 2023; White, 2022). Having a physiologic birth is highly beneficial for women and infants as it results in less postpartum pain, higher self-esteem, faster recovery and can enhance mother-infant bonding (Khooshide et al., 2015).

Normalcy, which promotes delivery as a sequence of physiological processes that are healthy and best carried out by women's natural capacities, is the foundation of midwifery philosophy and practice. Since the publication of the Lancet series on Midwifery, it is clear how midwifery care is associated with more efficient use of resources and improved outcomes (Renfrew et al., 2014). As such, midwives play a fundamental role in helping women accomplish physiologic birth. However, little is known of how midwives facilitate the physiological birth process and the variety of physical and emotional actions the midwife performs when ‘being with’ a woman during labour. According to Kennedy et al. (2016) finding and emphasising the components of care that optimise -and those that interfere with- the biological/physiological processes during childbirth is a research priority. Interestingly, in 2020 a systematic review on how midwives facilitate women to give birth during the second stage of labour was published (Healy et al., 2020). The article’s conclusions are important in describing what constitutes midwifery care

during the second stage of labour. However, more understanding of midwives' care during the whole childbirth process is essential, given the advantages of a normal physiologic delivery and the vital role that midwives play as advocates for physiologic birth. Therefore, the aim of this systematic review was to investigate how midwives facilitate women to give birth during physiological first stage of labour.

Methods

2.1 Study design

This systematic review was conducted according to Page et al.'s (2021) Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) guidelines. The protocol was published in PROSPERO on 9th March 2023 (reference CRD 42023424741)

2.2 Review question(s)

This systematic review aims to investigate how midwives assist women in giving birth during the physiological first stage of labour.

2.3 Search strategy and selection criteria

The search strategy was developed by the authors and a librarian at the University of XXX.

A comprehensive search of five electronic databases (CINAHL, PsycInfo, Pubmed, Lilacs, and Scopus) from their inception to June 2023 was used to find studies, and a manual search of bibliographies from pertinent papers was also conducted. The PEO (Population; Exposure; Outcomes/themes) framework was utilized to facilitate the establishment of the inclusion and exclusion criteria as well as the search terms (See Table 1). The search strategy can be retrieved as Supplement 1

The inclusion criteria covered all birth settings and included both qualitative and quantitative studies that described midwifery care throughout the first stage of labour. Studies were included if described any kind of midwifery care aimed to achieve or keep birth physiological. Those studies describing the efficacy of midwifery intervention during labour were excluded. For those articles describing the whole birth process, only available data for first stage have been taken into account. Studies including midwifery students, traditional birth attendants, mothers or other healthcare professionals (e.g physicians and obstetricians), were excluded from the review.

2.4 Study/sources of evidence selection

The first author ran the database searches, with potentially relevant articles downloaded into Rayyan (a web-based tool that supports collaborative systematic reviews - <https://www.rayyan.ai/>). After duplication remove, two authors (ET and SF) carried out title and abstract screening to weed out unrelated studies. Any disagreements were settled by talking with a third author (AN) until an

agreement was achieved. After that, two authors (ET and SF) completed the entire text screening; once more, a third author (AN) was brought in to help with perspective and conflict resolution. Fig. 2 provides the PRISMA flow chart of the literature search process. The initial database searches were undertaken in March 2023. Alerts were set up with the databases to assure notification of recent publications related to the search terms, which contributed with 1 article.

2.5 Data extraction and quality assessment

Two authors (ET, SF) extracted data, independently, from full-text papers using a data extraction tool template. The data extracted included publication details such as authors, country, year of publication, aim of the study, design, data collection methods, birth setting, participants and key findings. For a chart of the listed studies, see Table 2.

The Critical Appraisal Skills Programme (CASP) checklist for qualitative research was used to evaluate the quality of each study. (Critical Appraisal Skills Programme, 2023) Two reviewers (ET and SF), independently, used the CASP tool by responding yes or no to ten questions that evaluate various aspects of the research. Studies have historically not needed to be ranked in order to use this method. No studies were removed after quality appraisal.

2.3 | Data synthesis

Although a meta-synthesis was originally intended, the included studies exhibited considerable heterogeneity in terms of study populations, contexts, methodologies, and research aims, making a meaningful synthesis unfeasible. Therefore a thematic synthesis approach was chosen (Thomas & Harden, 2008). Thematic analysis is a systematic method for analyzing and synthesizing qualitative research findings by identifying, organizing, and interpreting patterns of meaning (themes) across multiple studies. Based on the research by Thomas and Harden (2008), this approach involves three key stages: line-by-line coding of text to capture key concepts, developing descriptive themes that group similar codes together, and generating analytical themes that go beyond the original studies to create new interpretive insights. This methodological approach is particularly valuable within this review, because it allows researchers to systematically combine findings from multiple qualitative studies while maintaining transparency in how conclusions are drawn, ultimately helping to bridge the gap between individual research findings and practical applications in fields like education and healthcare.

Fig. 2. Provides a thematic map illustrating an example of the thematic analysis process

Results

The search identified 11,626 articles; after the removal of duplicates, 7864 records remained. Title and abstract screening resulted in 159 records identified for full text review. A further 143 records were removed at this point as they did not meet inclusion criteria. Due to notifications of new publications pertaining to the search terms, one extra article was added to the original 16 items, leaving 17 articles for the final review.

3.1 | Characteristics of studies and participants

Studies were conducted across 10 countries, with the majority carried out in Norway (Aune et al., 2017, 2018; Blix, 2011; Remvik-Larsen et al., 2023) ($n = 4$) the USA (J. A. P. Davis, 2010; Kennedy, 2004; Kennedy & Shannon, 2004)) ($n = 3$), and Australia (Kruger & McCann, 2018; Reed et al., 2016)($n=2$), between 2004 and 2023. Sample sizes ranged from 7 to 37 yielding data from a total of 228 midwives. Most of the studies included midwives working in multiple setting, , including hospitals, midwifery units, and at home. See Table 2 for study characteristics.

3.2 Key Themes Seven main issues emerged from the studies of midwifery care during first stage of labour: ***The vicious cycle of being confident, The woman-midwife relationship, Protect the bubble: clinical practice points, Devoting time, Range of normality, Thinking ahead: Understanding and Managing Expectations, Neighbourliness among midwives.***

1 The vicious cycle of being confident

This theme is described in almost all the included studies (Aune et al., 2017, 2018; Butler, 2017; J. A. P. Davis, 2010; M. Hunter et al., 2018; Kennedy et al., 2010; Kennedy & Shannon, 2004; Reed et al., 2016; Remvik-Larsen et al., 2023; Stone, 2012; Vague, 2004). The studies offer two distinct nuances about “being confident”. On one hand, the midwife must be truly and internally confident in the childbirth process, and in the woman’s innate ability to give birth and to face labour and childbirth. On the other hand, the midwife must also trust her own competences in caring/supporting the labouring woman and in the birth process itself (Butler, 2017). In fact, the more confident the midwife is in the process, the more likely labour is to progress normally (Davis, 2010). According to Reed (2016), midwives reflect the mother's inner wisdom back to her, and doing that they reiterate the idea that she can handle things on her own by listening and trusting her bodies. Kennedy (2004) emphasized that giving birth is a life event grounded in inner strength and prior knowledge, resources that can sometimes be obscured by life experiences . The study of Stone (2012) is the only one included, presenting also the baby as a human being with competencies, working for being born. Moreover, giving a baby an identity helps the mother overcome pain and exhaustion.

Midwives that truly believe in the normal process express this attitude to the labouring woman and act in a way that allow the process to take place (M. Hunter et al., 2018). Their words and thought patterns reflect their level of confidence. Conversely, a risk-focused or deficit-based approach can indicate a lack of trust in the birth process.. For example, expressions such as “poor contractions” or “slow progress” can undermine a woman’s confidence in her body (Aune, 2017). Studies highlighted the importance of supporting women’s confidence in their ability to give birth, which facilitates the physiological process. Based on data, this can be achieved by not being directive nor leaping in, or taking over the woman.(Vogue, 2004).In addition, the midwives' therapeutic lens and philosophical values are key aspect for a normal labour (Davis, 2010), although these values may at times be challenged by differing perspectives, such as those of obstetricians (Thompson, 2016).

2 The woman-midwife relationship

The woman-midwife relationship is pivotal in keeping birth normal (Aune et al., 2018; Blix, 2011; Butler, 2017; J. A. P. Davis, 2010; Kennedy et al., 2010; Kennedy & Shannon, 2004; Kruger & McCann, 2018; Remvik-Larsen et al., 2023; Thompson et al., 2016; Vague, 2004). Although this is mainly a professional relationship, there may occasionally be a personal, partnership, or friendly relationship as well (J. A. P. Davis, 2010; Kennedy, 2004)). Stronger and more effective relationships are often those that develop over time (Aune et al., 2018; Butler, 2017; Kruger & McCann, 2018; Remvik-Larsen et al., 2023). In fact, meeting a midwife that the woman was previously familiar with was important in encouraging a normal birth since it made the circumstances seem predictable and secure (Aune et al., 2018; Remvik-Larsen et al., 2023). The woman–midwife relationship is fundamentally empowering. Midwives intentionally use each interaction to strengthen a woman’s belief in her capacity to give birth (Kennedy, 2004a). To achieve this the midwife makes the woman aware of her ability to give birth and helps the woman discover or reflect on her strengths for facing labour and childbirth. Kennedy describes this relationship as “Midwives consciously work to dispel fear and replace it with knowledge and power” (Kennedy, 2004 p 557). This empowering relationship respects and reinforces woman’s freedom and intuition (Aune, 2017).

Kennedy and Shannon (2004) emphasized the use of probing questions to help women work through certain life issues during labour time. This requires ability to listen, spirit of inquiry and ability to gently probe, but is also incredibly helpful because it helps women recognize internal distraction and react to them (Reed et al., 2016).Two studies (Kennedy & Shannon, 2004; Thompson et al., 2016) introduce the concept that the woman-midwife relationship has long and short term

outcomes both for the woman and the midwife. The empowering relationship helps both the woman and the midwife grow and learn one another.

The purpose of the professional relationship is to recognise the unique qualities of every single woman, providing individualized maternity care that meets the women's needs (Aune et al., 2018; Kruger & McCann, 2018). This kind of care requires the use of a woman centred approach of care (Kruger & McCann, 2018), working to support woman's need and expectations.

3 Protect the bubble: clinical practice points

The labouring woman was characterized as "being in a bubble" (Andrén et al., 2021) during labour. That image means that, although it's a delicate process, giving birth is an incredible and strong process and midwives are the guardians of this. They have to protect the woman and the process from all the external signals that can mine a woman's ability to give birth, and that can "break the bubble" (Andrén et al., 2021; Aune et al., 2018; Butler, 2017). Midwives can protect the bubble through many strategies.

The first action taken by midwives is to establish a serene, secure, and tranquil environment. Creating a low-tech, homelike environment even in hospital settings is vital (Butler, 2017; Remvik-Larsen et al., 2023). This includes protecting the woman's physical and social space, ensuring privacy, and assisting in managing external expectations and pressures. It is essential to maintain a quiet atmosphere, minimizing disturbances, and developing strategies to recognize and mitigate potential distractions. Kennedy(2004) also highlights midwives' strategies for reducing reliance on beds during labour, suggesting that beds be kept at their highest position, allowing midwives to spread their charts on them (Kennedy, 2004, p. 265). Midwives must be mindful of various disturbances that could affect a woman in labour; even the presence of a midwife can become a source of distraction. As Blix (2011) notes, midwives should remain conscious of their spatial occupation, avoid dominating the room, and refrain from arriving too early in the labour process. According to Davis (2010), providing women with physical freedom and fostering an atmosphere that instils confidence in their abilities is imperative. Midwives work to eliminate any cues or situations that could lead a woman to think at risks or difficulties.

Midwives also work to modify the environment in order to encourage a woman to trust her gut and follow her instincts or help freedom of movement . In fact, while in labour, a woman can express all of her skills and qualities and come up with creative solutions to deal with the challenges that labour will bring. Furthermore, midwives need to view labour as a holistic experience, understanding that contractions may not occur frequently, which could indicate a slower progression of labour, yet still

recognizing the natural rhythm of the process. To foster a successful childbirth experience, it is essential to enhance, protect, and strengthen both the woman's physical and mental functions. Midwives recommend that women rest, eat, and hydrate, as well as prepare mentally for what to expect, emphasizing that childbirth is as much a mental challenge as a physical one (Remvik-Larsen et al., 2023). Women are encouraged to remain at home for as long as possible, with midwives visiting them to provide assessment, reassurance, and support. Midwives should manage and protect early labour, to be in a good position to go into active labour (Butler, 2017). Midwives must allow women sufficient time and space to engage in their desired birthing practices, which in turn promotes the normality of the birth process. Butler (2017) underscores the significance of effectively managing early labour.

Balancing the "rites of passage" with the "rites of protection" (Reed, 2016) is another critical aspect of a midwife's role. This involves cultivating a private environment that minimizes interruptions and distractions, limiting verbal interactions, and maintaining a calm and dimly lit room with a minimal number of people present (Reed, 2016). Assessments of progress and well-being can be conducted discreetly, primarily through observation and listening to the woman. According to Kennedy (2004a), midwives function both as advocates and conductors during childbirth. Advocacy entails supporting the wishes of the woman regarding her birthing experience, while conduct refers to the belief that midwives facilitate the woman's natural birthing process.

4 Devoting time

The importance of time in the context of childbirth cannot be overstated. It is essential to provide women with the space they need to navigate their own journeys, allowing them to find their own paths without undue interference. This concept is encapsulated in Vague's (2004) assertion that time should be regarded as a friend, facilitating a genuine opportunity for listening and fostering patience—an essential component in promoting normal birth.

Viewing time as a supportive ally rather than an adversary can greatly enhance the birthing experience. Helping women manage time by breaking it into smaller, manageable segments makes the process less daunting. Simply being present with her—minimizing conversation and action—can significantly impact her comfort and emotional state. The act of being present is highlighted as a critical element of a normal birth, as it allows for individualized guidance and support (Aune, 2018; Kennedy, 2004).

Establishing a trusting relationship from the early stages of pregnancy is vital for effective communication and informed decision-making. By dedicating sufficient time to be with the woman,

caregivers can provide information in an accessible manner, thereby facilitating tailored care that respects individual choices (Aune, 2018). This investment in time is not merely about presence; it also allows for an accurate assessment of the woman's position within the birthing process, enabling adjustments to care that focus on her specific needs.

Devoting time also means exercising patience. It is essential to allow women the opportunity to discover their own solutions without prematurely intervening. By reassuring them of your presence and support, you foster an environment conducive to their empowerment (Vague, 2009). The thoughtful allocation of time, characterized by patience and presence, is fundamental in promoting positive birth experiences. By prioritizing these aspects, caregivers can significantly enhance the support women receive during one of the most pivotal moments of their lives.

5 Range of normality

Midwives embrace a broad understanding of normality, recognizing that each woman experiences childbirth in a unique way, shaped by her personal history, cultural background and available resources. The concept of normalcy is not monolithic; rather, it varies widely between women. What may be appropriate or typical for one woman might not be for another (Kennedy, 2010; Aune, 2017; Davis, 2010; Kennedy, 2004). A restrictive definition of normalcy may lead to the classification of numerous labour experiences as abnormal.

Midwives provide both descriptions and reassurances regarding a vast array of processes, employing both medical terminology and the language associated with the birthing experience (Stone, 2012). They gather information about the normalcy of labour not only through clinical indicators but also by interpreting subtle cues from the woman, such as her vocalizations, breathing patterns, movements, and verbal expressions, as well as relying on intuitive insights. Midwives are skilled at reassuring women about a diverse spectrum of feelings and signs, incorporating them into the framework of normality within the birthing process.

Definitions of normal birth can differ based on context and are often influenced by the midwife's own perceptions and experiences. According to Davis (2010), midwives possess a wide array of criteria for determining the normalcy of labour, which extends beyond conventional parameters to include observational data and other indicators such as movements and sounds. The research conducted by Kennedy (2004) highlighted that midwives seek both physiological and non-physiological explanations for prolonged labour, emphasizing the importance of considering the woman's complete history rather than solely focusing on contraction patterns or foetal positioning.

Kennedy (2010) also introduces a novel perspective regarding the role of evidence in practice, suggesting that evidence and recommendations should not be applied rigidly but rather tailored to the individual circumstances. This is largely due to midwives' comprehensive understanding of normalcy and their use of a diverse range of strategies to assess labour, pregnancy, and the well-being of the woman.

The discussions presented by Davis (2010), Stone (2012), and Butler (2017) further explore the definition of a normal birth from the midwives' perspective, advocating for an approach that considers different aspects of birth, birthing women, and interventions. The concept of normalcy encompasses a spectrum of definitions; some emphasize gentle interventions, while others prioritize the well-being of the mother and baby or support the woman's ability to give birth independently. The midwife's own definition of normal birth informs the various approaches that can be employed.

6 Thinking ahead: Understanding and Managing Expectations

It is essential to prepare women and their families for the labour process, including the potential for unexpected developments (Butler, 2017; Kennedy et al., 2010; Remvik-Larsen et al., 2023; Vague, 2004). This includes discussing the possibility of a transfer from a midwifery unit (MU) to a hospital setting. In such situations, midwives strive to acclimate the woman to the new environment, fostering a sense of calm and reinforcing her confidence to navigate any challenges that may arise. Preparing in advance can facilitate the establishment of realistic expectations, empowering couples to handle various scenarios effectively (Butler, 2017).

Butler (2017) emphasizes the complexities involved in providing balanced information to women, enabling them to make informed choices while advocating for natural birth. Certain interventions, such as membrane rupture, may be presented as beneficial options. Therefore, it is crucial to convey information authentically and honestly, avoiding any communication that could cause fear or coercion.

During prenatal meetings, the woman and her partner, alongside the midwife, can engage in discussions about potential disturbances during labour and strategies to mitigate them. Additionally, they can explore the woman's needs and the supportive role of fathers or partners (Blix, 2011).

7 Neighbourliness among midwives

Maintaining a shared philosophy and perspective on normal labour is essential for standardizing practices across teams. This consistency ensures that all team members engage in similar practices and manage labour unified way. It also allows midwives to carry out necessary tasks—such as

rearranging furniture or concealing a resuscitator—without the need for extensive explanations. Furthermore, it is crucial to have experienced midwives available to mentor novice midwives, helping them develop confidence in the concept of normalcy.

Some authors (Kennedy, 2004; Remvik-Larsen et al., 2023)) provides valuable insights into the dissemination of a low-technology philosophy in environments that have not traditionally embraced it. They emphasizes the significance of philosophical consistency and inclusivity among midwives. It is essential to have senior midwives in consultant roles, facilitating multidisciplinary discussions that support the practice of normal birth. Hiring staff who advocate for normal birth, fostering supportive and trusting relationships among clinicians, engaging in discussions on management strategies, and conducting follow-ups on challenging labor cases are all vital components (Kennedy, 2010; Thompson, 2016).

Discussion

Midwives play a pivotal role in safeguarding the physiological course of childbirth. This systematic review highlights the complex interplay of midwifery philosophy, clinical expertise, and relational dynamics that collectively contribute to keeping the first stage of labour normal. The results reveal a multifaceted process in which midwives' philosophical beliefs, practical skills, and interpersonal relationships work in synergy to support physiological birth.

A central finding is the foundational role of midwifery philosophy in preserving physiological birth. While these insights are not entirely new, they underscore the enduring relevance of a philosophy rooted in trust in the natural process of birth. This philosophical stance, when combined with skilled clinical practice, can create optimal conditions for labour to unfold without unnecessary intervention. Such an integrated approach holds valuable implications for both midwifery education and practice (L. P. Hunter, 2009; Prosser et al., 2018; Shorey & Ng, 2023),

Confidence and belief in normal birth emerge as essential midwifery attributes. The review indicates that when midwives trust the birthing process and women's innate capacity to give birth, this belief fosters a positive feedback loop that enhances physiological outcomes. This professional confidence is not only internal but also communicated externally—shaping the birthing environment and influencing women's own confidence in their ability to labour. Prior studies have highlighted the centrality of midwives' belief systems in facilitating normal birth (D. L. Davis & Walker, 2010; Leap, 2010; Shorey & Ng, 2023)

Equally vital is the quality of the relationship between the midwife and the birthing woman. This relationship extends beyond professional rapport to include emotional support, presence, and

empowerment. Continuity of care, in particular, strengthens these relational bonds, fostering trust and emotional safety—both of which are conducive to physiological labour ((Sandall et al., 2016)). Midwives use various strategies to promote women’s agency, such as asking reflective questions, addressing psychological blocks, and individualising care based on each woman’s needs and context (Kennedy et al., 2016; Leinweber et al., 2023; Prosser et al., 2018)

A particularly evocative finding is the metaphor of “protecting the bubble,” which captures how midwives curate the birth environment to maintain privacy, calm, and focus. This involves careful management of space, sound, lighting, and interpersonal dynamics to reduce stress and disruption. Protecting the birth space includes minimizing clinical interruptions and applying interventions judiciously and respectfully. This practice aligns with previous ethnographic research describing the midwife’s role in “holding the space” for birth (Davis-Floyd, 2001; Newnham et al., 2017; Shorey & Ng, 2023).

Taken together, these findings reinforce the importance of cultivating a strong philosophical and relational foundation in midwifery education. In addition to developing clinical competence, midwives must also be supported in nurturing their belief in normal birth and their ability to work with rather than over the labouring body. Mentorship, reflective practice, and experiential learning may be particularly effective in this regard, helping to build confidence and professional identity among novice midwives ((Bradfield et al., 2019; Leinweber et al., 2023)

Implications also extend to organisational and policy levels. Practice guidelines and institutional norms should support midwives in creating environments conducive to physiological labour, promoting relational continuity, and avoiding routine interventions that may disrupt the normal process. These system-level changes are essential to aligning practice with evidence and protecting the integrity of normal birth (Renfrew et al., 2014; Prosser et al., 2018). Further research is needed to better understand how midwifery philosophy is operationalised in practice and how it translates into measurable outcomes. Mixed-method studies combining observational and quantitative data could help elucidate the mechanisms by which midwives influence physiological labour and inform future education, policy, and service design.

A key strength of this review lies in its systematic approach to synthesising qualitative evidence on how midwives support the normal progression of the first stage of labour. The review provides an in-depth understanding of midwifery practices grounded in relational care, environmental awareness, and a strong belief in physiological processes. By integrating findings across multiple studies, including recent qualitative research (Leinweber et al., 2023; Shorey & Ng, 2023), the review

offers a comprehensive account of midwives' contributions to normal birth. However, some limitations must be acknowledged. The included studies were predominantly from high-income countries, which may limit the generalisability of the findings to low-resource settings. Additionally, the heterogeneity of study designs and terminology used to describe midwifery approaches may have influenced the consistency of thematic synthesis. The review also relies on authors' interpretations of midwifery practice, which may reflect varying levels of subjectivity. Future research could address these gaps through comparative international studies and by including more diverse perspectives from midwives and service users.

Conclusions

This systematic review demonstrates that midwives employ complex, multifaceted approaches to facilitate normal physiological birth during the first stage of labour. The findings reveal seven interconnected themes that highlight how midwives create and maintain conditions conducive to normal birth. These elements work together to create an environment where women's innate birthing capabilities are respected and supported.

The review's findings have significant implications for midwifery education, practice, and research. While the identified practices are not necessarily novel, they provide valuable validation of core midwifery philosophies and approaches. The results emphasize that successful facilitation of normal birth requires both technical expertise and a deep philosophical commitment to physiological processes.

The [midwifery](#) philosophy of care advocates physiological childbirth and midwives in all settings consider a physiological approach to childbirth as fundamental to their role (International Confederation of Midwives, 2014, 2024, 2025). Midwifery programmes should focus on providing theoretical basis that supports student midwives in internalizing the midwifery philosophy of care, with the opportunity to observe midwifery support for physiological childbirth in real-life practice situations (Thompson et al., 2019). This requires to integrate not only a know-how, but also a strong and deep understanding of midwifery philosophical perspective and values, in order to develop midwives who can trust the childbirth process and women's intrinsic birthing capacities (Thompson et al., 2019). This entails attaining midwifery practice that is infused with the principles of honouring, promoting, and supporting the physiology of birth in all situations. (Renfrew et al., 2014) Future research should focus on quantifying the impact of these approaches on birth outcomes and developing evidence-based guidelines that support normal birth while maintaining safety standards.

This would strengthen the evidence base for physiological birth practices and help integrate these approaches more broadly into maternity care systems.

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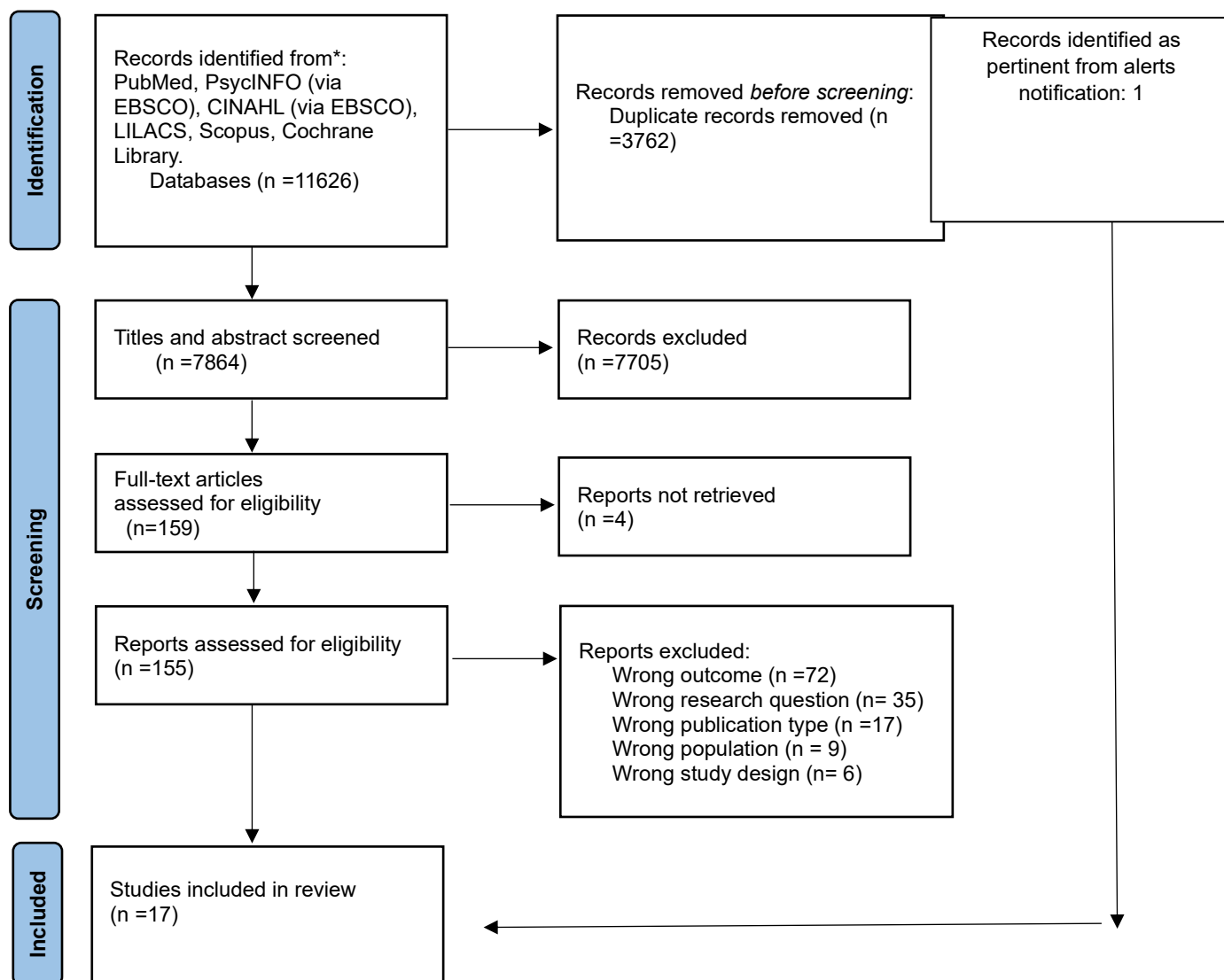


FIGURE 1 PRISMA flow diagram

Table 1

Search terms and inclusion/exclusion criteria mapped to the PEO framework.

Criteria	Inclusion criteria	Exclusion criteria	Search terms
Study population	midwives, obstetric nurses, nurse midwives	Students midwives, obstetrics, Physicians, Nurse	(("midw*" [Title/Abstract] OR "nurse midwi*" [Title/Abstract] OR "obstetric nurs*" [Title/Abstract] OR ("nurse midwives" [MeSH Terms] OR "midwifery" [MeSH Terms] OR "obstetric nursing" [MeSH Terms]))
Exposure to context	Childbirth process, labour or delivery		("labor" [Title/Abstract] OR "labour" [Title/Abstract] OR "obstetric lab*" [Title/Abstract] OR "normal birth" [Title/Abstract] OR "vaginal birth" [Title/Abstract] OR "physiological birth" [Title/Abstract] OR "spontaneous birth" [Title/Abstract] OR "natural birth" [Title/Abstract] OR "parturition*" [Title/Abstract] OR "childbirth" [Title/Abstract] OR "discharge" [Title/Abstract] OR "Parturition" [MeSH Terms] OR "delivery, obstetric" [MeSH

		Terms] OR "natural childbirth"[MeSH Terms] OR "labor, obstetric"[MeSH Terms])
outcome	Physiological care during first stage of labour is defined as the variety of emotional and physical actions midwives do during first stage of labour.	("skill*" [Title/Abstract] OR "practice*" [Title/Abstract] OR "method*" [Title/Abstract] OR "technique*" [Title/Abstract] OR "role" [Title/Abstract] OR "care" [Title/Abstract] OR "help" [Title/Abstract] OR "support*" [Title/Abstract] OR "supportive care" [Title/Abstract])) OR ("obstetric nursing/methods" [MeSH Terms] OR "midwifery/methods" [MeSH Terms]))
Date	No data restriction	
Birth setting	No data restriction	
Language	No language restriction	

Table 2 Results of review

Author, Year, Country,	Aim of the study	Design	Data collection method	Birth setting	Participants	Key findings
(Andrén et al., 2021) Sweden	To explore midwives experiences of how the birthing room affects them in their work to promote a normal physiological birth.	qualitative phenomenological, reflective lifeworld research approach	Open ended interview	Different birth places and settings	15 midwives Strategic sampling strategy. Midwives worked at four different hospitals and at six different labour wards. Two of the midwives also assisted at homebirths.	A birthing room can by its design either support a normal physiological birth or support a risk approach to childbirth. Four opposing constituents complete the essential meaning of the birthing rooms, and to which the midwives need to relate in their roles as guardians for normal birth: i) a private or a public room; ii) a home-like or hospital-like room; iii) a room promoting activity or passivity; iv) a room promoting the midwife 's presence or absence
(Kruger & McCann, 2018) Australia	explicate the processes midwives used when exercising their scope of practice during women's normal labour and birth and to develop a substantive theory of midwives' scope of practice.	Grounded theory guided by Strauss and Corbin's approach	semi-structured interviews, participant observation, and, accessing women's clinical records.	Public Hospital	17 midwives purposive and theoretical sampling	Findings comprised a core problem (Ambiguity in fulfilling their scope of practice), a core category (Promoting normal birthing: aspiring to develop a midwife-led scope of practice) and two interrelated categories (promoting and maintaining healthy birthing and optimising scope of practice).

(M. Hunter et al., 2018) New Zealand	What enables, safeguards and sustains midwives to provide labour care in midwife-led units	Phenomenology informed by Hiddegger and Gadamer	In depth, one to one, interview	freestanding midwifery-led units	14 participants: 11 midwives and 3 obstetricians Purposive and snowballing sampling	Confidence is necessary to provide intrapartum care in freestanding midwifery units. This confidence is cultivated by stepping into midwife-led units, keeping faith in the normal, the mood-of-unit, building and maintaining confidence, working as a team
(Aune et al., 2018) Norway	Gain a deeper understanding of the thoughts and experiences of midwives in the attempt to promote normal births	Qualitative approach	in depth interviews	Three different maternity ward with approximalty 500 birth per year	9 midwives, Purposeful sampling	Two main themes: (1)“Individualized maternity care” with two sub themes: The importance of adequate follow-up to promote a normal birth and Sufficient time to be present for the couple. (2)“A woman-centred and biomedical perspective - a dilemma” with two sub themes: Midwifery care based on a precautionary approach and Working in a maternity ward where different ideologies prevail - a threat to the normal birth process.

(Aune et al., 2017)Norway	Gain a deeper understanding of how midwives promote a normal birth in a home birth setting	Qualitative approach	in depth interviews	Home birth setting	9 midwives, Purposeful sampling	The findings were summarised in two main themes; (1)'The midwife's fundamental beliefs' with two subthemes: The trust in the superiority of the normal birth and the importance of strengthening the woman's faith in her own ability to give birth. (2) 'Working in line with one's ideology' with two subthemes: Do not disturb—it is all about patience and To be in a safe environment with people you know
(Butler, 2017)Canada	to examine the experiences of midwives of normal birth, the challenges that they experience to keeping birth normal and the strategies that they use in their practice	interpretive phenomenology	in depth interviews (face to face or online or by telephone)	Rural or Urbal, solo or shared (with family doctor) caseloading	14 midwives Selected from a list (Conveninece sampling)	An overarching theme: definition of normal birth and 7 subthemes: 1. Working with women from the early pregnancy, 2. Informing choice, 3. Managing early labour, 4. The birth environment, 5. Careful watching and waiting, 6. Helping the woman to cope with labour, and 7. Tools in the tool kit

(Reed et al., 2016) Australia	To describe midwifery practice during birth and how it intersected with women's experiences and need	Narrative inquiry methodology	face to face in depth interview	wide range of settings	10 midwives and 10 women purposive sampling	Two contrasting types of midwifery practice were identified: rites of passages (are synergic with women's experience and needs) and rites of protection (aimed at minimising risk and privileging the needs of insitution). Rites of passages: managing distractions and reflecting inner wisdom. Rites of protection: Distrupting alonenessand reinforcing externa wisdom, and Tending the need of the institution
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(Stone, 2012) Germany	to investigate the ideas, attitudes, and actual work of midwives working in a freestanding birth centre	Qualitative approach	semi-structured interviews and participant observation of births	freestanding midwifery-led units	5 midwives, 9 births	The midwives all had to re-learn birth assistance when commencing work outside of the hospital. The midwives acknowledged the benefits of birthing with only 'gentle' interventions. The midwives frequently seemed to juggle and negotiate birthing women's desires, while navigating within medical parameters. The birthing woman and midwife share authority at birth. The fetus is treated as an ally of the mother, suited for birth and cooperative. Through use of objective and subjective criteria, the midwives have their own approach to making physiological birth possible
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(Blix, 2011) Norway	to explore midwifery practice to promote normal birth	Grounded theory guided by Strauss and Corbin's approach	face to face interview or in groups of two or three	home birth setting	12 midwives	the core category 'avoiding disturbance' was identified during the analyses, indicating that the midwives prevented the woman from being disturbed and protected her from disturbance if it occurred during labour. The core category must be understood in the light of the midwives' attitudes towards and beliefs about labour and birth. The labour process could be disturbed by the midwife, the birthing woman, the partner and other supporting persons, and older children. The midwives regarded labour as work to be done by the woman, as a sexual process, and had a basic understanding that labour and birth usually had good outcomes.
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(J. A. P. Davis, 2010) USA	to explore midwives' understanding of the concept of normalcy as experienced during the care of women during labor and birth	phenomenologic hermeneutic method	one to one interview	hospital, freestanding birth center, homebirth	13 midwives Purposeful sampling	The midwives described normalcy in childbirth as 1) an expression of a complex physiologic psychologic process along a wide, interpretive continuum, and includes both process and outcome; 2) meaningful within the context of the individual woman's "nature," which includes both her physiologic capacity to give birth and her unique life circumstances; and 3) sensitive and responsive to environmental factors. Deep understanding of physiology and coping, extensive clinical experience, and commitment to midwifery's philosophical values were identified as essential to discerning differences between healthy, individualized variations and real or potential pathological developments during labor and birth.
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(Vague, 2004) New Zealand	To describe the experience of midwives working with women and their pain in labour	Phenomenology	In depth, one to one, interview	hospital and independent background	7 midwives Purposive Sampling	Three themes were identified: 1)“Leaping ahead” of a woman is a way midwives seek to prepare her for the pain of labour, try to anticipate what a woman might be feeling and explain it to her, this will make events recognizable and will help women cope with the events. “Leaping in”, by contrast, can be a way of executing care which is much more directive. It conveys a sense of taking over, doing things for the ‘other’ in a situation of more urgency. On the other hand is describes a midwife who is physically and emotionally present in the woman’s pain. 2) Working with time: time can be both an ally or an enemy 3) Sense of believing in women’s ability to cope with pain.
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(Kennedy & Shannon, 2004) USA	to describe the central process of being with the woman, in midwifery care during labour	qualitative study	interviews	hospital, birth center and home settings	14 midwives:11 Purposive sampling, 3 theoretical sampling on emerging findings	The midwives worked to create an environment of care to meet specific goals, based on the woman's desires and their assessment of the situation. The midwives enacted care by creating space for the woman that was physically and emotionally safe, and where women could experience their ability to give birth. 5 Subthemes were identified: Belief in the normalcy of birth, Tolerance for wide variations of "normal.", Belief and trust in the woman's strength, Presence: the physical act of being "with woman.", Teaching students to believe and trust in normal birth.
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(Kennedy et al., 2010) UK	to describe factors that foster or hinder the support of normal birth	ethnography and narrative methods	interviews and observation	hospital, birth centers, home birth	26 midwives, 6 obstetricians 1 anesthetist: purposive sampling	Three key areas were identified as consistent strategies to support the normalization of birth across both services: 1) an ethos of normality, 2) working the evidence, and 3) trusting women to make informed choices. Barriers to the normalization of birth included inappropriate use of technology, disregarding risk status when assigning women to units, lack of physician preparation in normal birth, and poor staffing levels.
(Kennedy,H P 2004) USA	to expand knowledge on the process and outcome of midwifery care	narrative analysis		hospital, birth center and home settings	14 midwives and 4 women: Theoretical sampling	3 themes were identified: 1) the midwife in relationship with the woman, 2) orchestration of an environment of care, and 3) the outcomes of care, called “life journeys” for the woman and the midwife.
(Thompson et al., 2016) Netherlands	To explore Dutch midwives’ attitudes and motives with regard to promoting physiological childbirth and identify the factors that encourage or inhibit this.	Exploratory, qualitative design	Focus groups	hospital and community-based midwives	37 midwives (14 hospital based midwives and 23 community based midwives)	Four major themes were found: (1) physiological birth as a continuum, (2) navigating diverse settings: community, transfer and hospital, (3) woman-centeredness, and (4) competence and confidence

(Costa et al., 2023) , Brazil	to identify the non-invasive technologies and care strategies used by obstetric nurses to encourage freedom of movement and positioning in the parturition process	descriptive, qualitative study	semi structured interview, online	public obstetric setting	20 nurse midwives, snowball sampling	Obstetric nurses use non-invasive technologies (TNICE) to promote freedom of movement and positioning during childbirth, such as encouraging ambulation, verticalized positions, and pelvic movements. They guide women about these technologies, respecting their choices, and maintain the non-invasive nature of TNICE to avoid violating women's bodily autonomy.
(Remvik-Larsen et al., 2023) Norway	to gain a deeper understanding of midwives' experiences of facilitating normal birth in midwifery-led units.	Qualitative design	Semi-structured individual interviews	midwifery-led units.	7 midwives Purposive Sampling	Three categories were identified: the first category concerned the importance of relationships, continuity and a safe atmosphere. The second concerned being a midwife in the hand, in the heart, and in the mind. The third related to having confidence in the physiological process of childbirth, midwifery autonomy, and a common ideology.

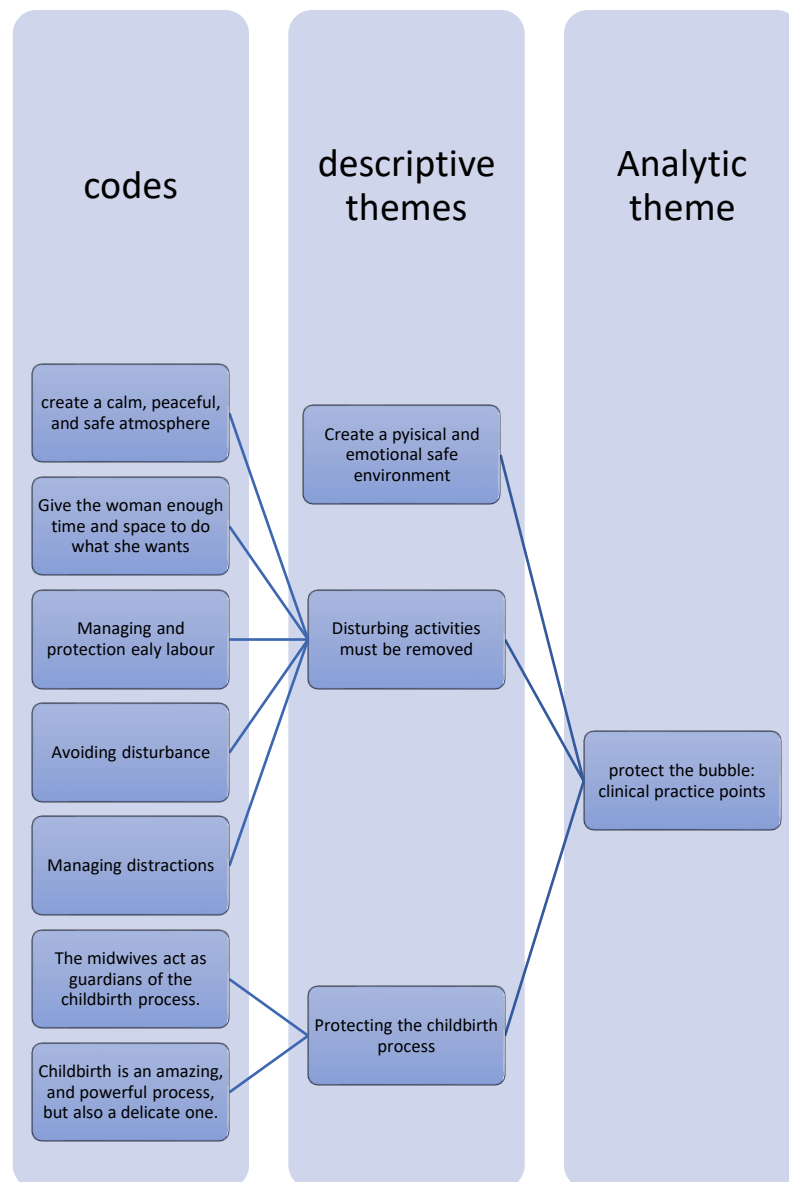


Fig. 2. Thematic map illustrating an example of the data synthesis process.

Chapter 2 Midwives' Physiological Approach at the Third Stage of Labour: A Scoping Review

This paper has been published

Tarlazzi E, Berini V, Brevi L, Ferrandino R, Tormen M, Parma D, Cappadona R, Fumagalli S, Nespoli A, Simonazzi G. Midwives' Physiological Approach at the Third Stage of Labour: A Scoping Review. *Birth*. 2026 Jan 6. doi: 10.1111/birt.70048. Epub ahead of print. PMID: 41492697.

Abstract

Introduction

The third stage of labour occurs between the birth of the foetus and the expulsion of the placenta. A major complication during this stage is postpartum haemorrhage, which poses a significant concern for maternal health. To mitigate this risk, active management strategies have emerged, raising concerns about the safety of physiological management following a physiological birth. Midwives play a vital role in ensuring a safe third stage of labour by minimizing medical intervention and preventing postpartum haemorrhage. This scoping review aims to map the evidence on midwifery practices that support a physiological third stage of labour.

Methods

We conducted a scoping review using the Joanna Briggs Institute methodology. We retrieved articles from PUBMED, PsycINFO (via EBSCO), CINAHL (via EBSCO), LILACS, SCOPUS, ClinicalTrials.gov, Open Science Framework, ProQuest Dissertations and Theses, Cochrane Library, and JBI.

Results

The search yielded 2,190 articles, with 1,779 remaining after duplicates were removed. Screening identified 80 articles for review; 63 were excluded, resulting in 17 articles defining key findings. Two articles contributed to a theoretical framework for a physiological approach. Ten articles further discussed how midwives provide care during this stage to maintain normalcy. Three articles debated the safety of expectant management for low-risk women, while three studies also suggested new risk factors for postpartum haemorrhage.

Conclusion

Midwifery care during the physiological third stage of labour must balance safety and trust in the woman's body. More research is needed to assess expectant management in home births and

midwifery-led units, with a focus on individual needs and the long-term impacts of a physiological approach.

Key Words

Labour Stage, Third; Midwifery; Natural Childbirth; Parturition; Professional Practice

Practitioner Key Points

- Research on placental birth interventions contradicts natural birth protection, focusing on quantitative outcomes and active labour management rather than midwifery care.
- Evidence of what constitutes midwifery care during a physiological placental birth is presented and discussed.

Introduction

Midwifery care has a key role in optimising the woman's reproductive psychophysiology during childbirth. As outlined by Renfrew et al. (2014), midwifery care effectively promotes the normal childbirth process and helps prevent complications. Experiencing a physiological labour and birth may contribute to positive outcomes for the mother, the baby, and the whole family (WHO, 2018). According to the WHO guidelines, a positive birth experience comes through respectful care, continuity of care, effective communication, and reduction of medical intervention.

In this context, postpartum haemorrhage (PPH) emerges as a significant global health concern, affecting millions of women annually and accounting for over 20% of maternal deaths worldwide (WHO, 2023). Despite its prevalence, most PPH-related fatalities are preventable, particularly in high-income countries where interventions have nearly eradicated these deaths. However, the widespread use of interventions during placental birth seems at odds with the growing focus on protecting physiological birth processes.

Midwives play a key role in keeping this stage of labour physiologic and safe (International Confederation of Midwives, 2023). While much research has focused on the active management of the third stage, midwives can significantly contribute to minimizing medical intervention and preventing postpartum haemorrhage by supporting natural physiological processes, as described in the hormonal and emotional pathways by Dixon et al. (2013). Additionally, many women consider a natural birth of the placenta an essential element of a physiological birth (Reed et al., 2019a).

According to the World Health Organisation (WHO) guidelines, expectant management includes avoiding the routine use of uterotonic drugs, delaying cord clamping until pulsation stops, and relying on maternal effort for placenta delivery (World Health Organisation, 2012). Recent updates

to a Cochrane systematic review (Begley et al., 2019) comparing active and expectant management of the third stage of labour have provided new insights. In high-income settings, active management appears to reduce mean maternal blood loss and the need for therapeutic uterotonics. However, it may also introduce negative effects, such as discomfort, bleeding complications, and postnatal hypertension. The review's conclusions differ from earlier versions (Begley et al., 2015), which declared that active treatment was "superior" to expectant management. Moreover, new insights on care during the third stage emerged from the review's conclusions. Firstly, there is no clear definition of what constitutes expectant management; therefore, practice varies widely. Secondly, both women at low and high risk of postpartum haemorrhage have been involved. Finally, not all midwives were equally skilled in expectant management of the third stage.

Given the complexity of managing the third stage of labour, our research group has conducted a scoping review to map available evidence on midwifery practices that support a physiological third stage of labour.

Materials and Methods

Study Design

Using a scoping review process, it was possible to map important concepts and features of the phenomena from a wide range of sources (Pollock et al., 2021). The review used the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018) and the Joanna Briggs Institute (JBI) scoping review methodology, which was improved by Peters et al. (2020). The review included the following five key phases: (1) identifying the research question, (2) identifying relevant studies, (3) study selection, (4) charting the data, and (5) collating, summarizing, and reporting the results. The optional 'consultation exercise' of the framework was not conducted. A detailed review protocol was published on Open Science Framework (doi:10.17605/OSF.IO/XHD35).

Review Question(s)

This scoping review aims to map the evidence on midwifery practices that support a physiological third stage of labour.

The subquestions defining the objectives of this study are:

1. What defines a normal third stage of labour?
2. How do midwives provide care during the third stage of labour to keep it normal?
3. What evidence supports a physiological approach to managing the third stage of labour?

Information Sources and Search Strategy

The search strategy was developed by the authors and a librarian at the University of Bologna. The research was conducted in the following databases: PUBMED, Psycinfo (via EBSCO), CINAHL (via EBSCO), LILACS, SCOPUS, ClinicalTrial.gov, Open Science Framework, ProQuest Dissertation and Thesis, Cochrane Library, and JBI. Midwifery-relevant journals have also been retrieved, such as Midwifery, Women and Birth, Birth, British Journal of Midwifery, BMC Pregnancy and Childbirth, as well as conference proceedings on birth physiology or midwifery care. Moreover, the reference lists of relevant studies identified throughout the search process were scanned.

The PCC (Population; Concept; Context) framework was utilised to facilitate the establishment of the inclusion and exclusion criteria as well as the search terms (see Table 1).

The PCC framework as applied to the scoping review included

Population

This scoping review considered all studies that focus on midwives caring for women during the third stage of labour. All over the world, midwifery education differs widely; therefore, we decided to include studies including midwives, obstetric nurses, nurse midwives and skilled birth attendants.

Concept

Physiological care is defined as the variety of emotional and physical actions midwives do when “being with the woman, in a watchful attendance” (de Jonge et al., 2021).

Context

Studies conducted in all clinical settings (home, hospital, midwifery Unit) and irrespective of the countries.

The search strategy combined indexed terms (MeSH) and free text terms for the concepts in the study. All research methodology, qualitative reviews, quantitative reviews, literature reviews, and unpublished literature have been included. Studies were included if they reported the description of midwifery care or the midwifery management of a normal third stage of labour, as well as the variety of emotional and physical actions midwives undertake when “being with the woman” (de Jonge et al., 2021) during the third stage of labour, in any clinical setting. Studies focusing only on PPH management and PPH prevention have been excluded, as have studies on women’s experiences of care during the third stage and those conducted in low-income countries. All over the world, midwifery education differs widely; therefore, researchers decided to include studies involving midwives, obstetric nurses, and nurse midwives. No data or language restrictions have been applied.

Study/Sources of Evidence Selection

The first author (ET) ran the database searches, with potentially relevant articles downloaded into Rayyan (a web-based tool that supports collaborative systematic reviews—<https://www.rayyan.ai/>). After duplication was removed, two authors (VB and LB) carried out title and abstract screening to weed out unrelated studies. Any disagreements were settled by discussing with a third author (ET) until an agreement was achieved. After that, two author couples (VB and LB or ET and RF) completed the entire text screening; once more, a third author (MT) was brought in to help with perspective and conflict resolution. Table 2 provides the PRISMA flow chart of the literature search process.

The initial database searches were undertaken in July 2023. Alerts were set up with the databases to ensure notification of recent publications related to the search terms. The literature search and screening process were conducted between July and December 2023

Data Extraction

Two authors (ET, RF) independently extracted data from full-text papers using a data extraction tool template. The data extracted included publication details such as authors, country, year of publication, methods, population, concept, context, and key findings and/or recommendations. For a chart of the listed studies, see Table 3.

Data Analysis

Data analysis was informed by a basic qualitative content analysis (Pollock et al., 2023) with the intent to identifying broad patterns, similarities, and original insights. Starting from the research questions, which serve as guiding parameters for subsequent data extraction, investigators engaged in a comprehensive data extraction process. The development and application of a coding scheme forms the cornerstone of the analysis, where researchers create and implement a structured framework to categorize extracted data systematically. This framework enables the identification of recurring patterns, themes, and relationships within the literature. The analysis culminates in a thorough synthesis of findings, where researchers integrate coded data to generate meaningful insights that address the initial research questions. The NVivo 15 software was employed.

Results

The search identified 2,190 articles; after the removal of duplicates, 1,779 records remained. Title and abstract screening resulted in 80 records identified for full text review. A further 63 records were removed at this point as they did not meet inclusion criteria, leaving 17 articles for the final review.

Characteristics of Studies

We found three systematic reviews (Baker & Stephenson, 2022; Dixon et al., 2011; Fahy, 2010), one narrative review (Baker et al., 2021), three retrospective cohort studies (Backer & Stephenson, 2022;

Dixon, Tracy, et al., 2013; K. Fahy, 2010), one prospective cohort study (Dixon et al., 2009), one latent class approach study (Erickson et al., 2019), one cross-sectional study (Tan et al., 2008), one exploratory study (Featherstone, 1999), two qualitative studies (Begley et al., 2012; Jangsten et al., 2010), two doctoral theses (Baker, 2020; Harris, 2005), and two theory description studies (Hastie & Fahy, 2009; Saxton et al., 2016). Studies were mainly from the United Kingdom (Baker, 2020; Baker & Stephenson, 2022; Begley et al., 2012; Harris, 2005) and New Zealand (Begley et al., 2012; Dixon et al., 2009; Dixon, Tracy, et al., 2013), with Fahy, Dixon, and Baker as the main researchers publishing on this topic. Most of the studies were conducted in multiple settings, including hospitals, midwifery units, and at home (Baker & Stephenson, 2022; Dixon et al., 2009; Dixon, Tracy, et al., 2013; Harris, 2005; Tan et al., 2008).

Key Findings

The results of the included studies offer a comprehensive description of expectant management during the third stage of labour, highlighting its complexity and nuances

From the data analysis, four key findings emerged based on the review questions:

1. The definition of a theoretical framework for a physiological approach to the third stage of labour.
2. What constitutes midwifery care during the third stage of labour to keep it normal: The midwifery balancing act—trusting the woman's body while preventing postpartum haemorrhage.
3. What evidence supports a physiological approach to managing the third stage of labour.
4. Suggestion of new risk factors for postpartum haemorrhage.

1. The Definition of a Theoretical Framework for a Physiological Approach to the Third Stage of Labour

Among the studies included in this scoping review, two theoretical frameworks were identified: the "Midwifery Guardianship Theory" (Hastie & Fahy, 2009) and the "Pronurturance Plus Theory" (Saxton et al., 2016), providing a deep and broad definition of what defines a normal third stage of labour.

These two theories provide new insights into how to approach the third stage of labour physiologically. Hastie & Fahy's (2009) theory aims to optimise a woman's reproductive psychophysiology by promoting and respecting her intrinsic power to birth. The theory suggests that the labour continues until the placenta is born and the uterus is fully contracted. Distractions should be avoided not only during the first and second stages of labour but also during the third, ensuring

a safe and warm environment. The woman should be actively engaged in the birth process, feeling empowered and focused on her baby, her body, and the experience of childbirth. Fear or hyper-vigilance should be avoided, as they can be potential risk factors for postpartum haemorrhage (PPH). The midwife, acting as a guardian, maintains watchful and positive expectations for a natural physiological placental birth while promoting and supporting maternal-infant love. The mother should hold the baby skin-to-skin, and the midwife will observe if the mother remains mindful of her body and uterine contractions. The woman will observe her baby, respond to its movements, and recognise signs of being ready to breastfeed.

The "Pronurturance Plus Theory," proposed by Saxton et al. in 2016, is a psycho-biologically based midwifery theory aimed at optimizing the third stage of labour for all women, regardless of their risk of postpartum haemorrhage. This theory promotes focused attention and parasympathetic dominance, enabling "eutony" and "eulochia" (Saxton et al., 2016). Pronurturance involves immediate skin-to-skin contact and breastfeeding within 30 minutes of birth. Midwifery care during this phase should be focused on warmth, safety, and a peaceful environment. Warmth and skin-to-skin contact promote endogenous oxytocin release during the third stage, allowing parasympathetic dominance and the emergence of innate nurturing behaviours. Midwives should monitor both mother and baby unobtrusively, minimising neocortical stimulation. The focus should be on mother and baby, with the baby's natural crawling towards the breast triggering further oxytocin release.

2. What Constitutes Midwifery Care During the Third Stage of Labour to Keep It Normal

Ten of the included articles addressed how midwives provide care during the third stage of labour to keep it normal (Baker, 2020; Dixon et al., 2009; Featherstone, 1999; Harris, 2001; Begley et al., 2012; Fahy, 2010; Hastie & Fahy, 2009; Jangsten et al., 2010; Dixon, Tracy, et al., 2013; Tan et al., 2008). These studies describe how midwives strike a balance between trusting the woman's body and ensuring safe care to prevent postpartum haemorrhage. This approach has been instrumental in shaping the understanding of midwifery care during this stage, described as follows.

"Trust the process and the woman's body" (Begley et al., 2012) is the first step to providing expectant management of the third stage of labour. Midwives are encouraged to carefully observe both the mother and baby during this time (Begley et al., 2012; Fahy, 2010; Hastie & Fahy, 2009; Jangsten et al., 2010) and recognize signs of well-being.

Encouraging an upright position during the third stage has been widely advocated (Begley et al., 2012; Fahy, 2010). Some midwives even suggest using the toilet as a practical method to help and support the physiological birth of the placenta (Begley et al., 2012).

Protect and guarantee prolonged skin-to-skin contact (Begley et al., 2012; Fahy, 2010; Hastie & Fahy, 2009).

The placenta should be born only thanks to the mother's efforts (Begley et al., 2012; Fahy, 2010; Dixon, Tracy, et al., 2013). Wait for signs of the placenta's separation and avoid touching the uterus (Fahy, 2010). However, studies suggest there is a debate among midwives on the opportunity to touch the uterus or not and how or when to do so, as described by Jangsten et al. (2010). Studies also suggest a debate on the opportunity to give prophylactic oxytocin to all women or only if necessary. This debate reflects two competing perspectives: adhering to policies and guidelines versus acting autonomously based on professional judgement (Jangsten et al., 2010). For some midwives, it is tough to accept that someone else tells them what to do when they are the primary responsible party for the process (Jangsten et al., 2010).

Delayed cord clamping and cutting, and avoiding cord traction (Begley et al., 2012; Dixon, Tracy, et al., 2013; Fahy, 2010) unless a gentle ease is used to help the placenta lift out if it is clear it has been separated and is sitting inside the vagina. Begley et al. (2012) described this as a "guilty secret." In fact, the researcher describes how textbooks and guidelines tend to state that cord traction should be avoided when using expectant management of the third stage of labour, but midwives describe this technique as something different. It is not real cord traction but a gentle easing of the placenta, only used when they see the insertion of the cord or the bulging of the vagina (Begley et al., 2012). Being prepared for complications, such as PPH, is essential during this stage. Midwives are trained to carefully monitor the mother's progress, observe for signs of placental detachment, and engage in open communication with the woman about her sensations and experiences (Jangsten et al., 2010). Moreover, this review reveals a wide range of ways midwives care for women during the third stage of labor, with at least nine different types of management presented (Featherstone, 1999). Midwives often lack confidence in managing the third stage in a completely physiological way but tend to prefer a more expectant approach compared to physicians (Featherstone, 1999; Tan et al., 2008). Most midwives do not believe active management should be used with women at low risk of PPH, and they use an upright position to facilitate the birth of the placenta, nipple stimulation to release oxytocin, and skin-to-skin contact (Tan et al., 2008). The studies included in the review highlight the difficulties midwives face in acting solely in accordance with guidelines and procedures. They suggest that when women are given information and empowerment to make informed decisions, a large proportion will choose the physiological third stage (Jangsten et al., 2010; Tan et al., 2008).

3: Is expectant management of the third stage safe? An open debate

This review investigates the ongoing debate regarding the clinical effectiveness of physiological third-stage care following a physiological labour and birth, focusing on low-risk women and those giving birth in non-hospital settings. This topic has been discussed since 2010, when Fahy reviewed existing RCTs comparing active and expectant management of the third stage of labour, particularly in terms of their applicability to low-risk women for postpartum haemorrhage (PPH). Fahy (2010) argued that the conclusions from existing trials should not be generalized to women at low risk.

In 2011, Dixon et al. conducted a new systematic literature review, demonstrating that expectant management of the third stage is both effective and safe for those with a physiological labour and birth if the woman is well and in good health. Later, Backer and Stephenson (2022) conducted a new literature review, identifying inconsistencies in studies comparing active and expectant management, as well as variations in blood loss outcomes for women at low risk of haemorrhage, particularly those assessed as having normal physiological parameters in midwifery-led units.

4: New risk factors for postpartum haemorrhage

Postpartum haemorrhage (PPH) is a significant global concern with various risk factors identified in the medical literature. These include a previous history of PPH, abnormal uterine anatomy, overdistended uterus, placental anomalies, antepartum haemorrhage, haemoglobin levels below 10 mg per litre, coagulation disorders, obstetric or anaesthetic interventions, intrapartum haemorrhage, uterine muscle exhaustion, intra-amniotic infection, and drug-induced uterine hypotonia. However, a physiological approach to the third stage requires a re-evaluation of these risk factors. Research by Fahy (2010) and Hastie & Fahy (2009) identified additional risk factors for PPH based on midwifery theories, such as an inappropriate birth environment, lack of midwifery guardianship, significant mental illness, drug use, lack of skin-to-skin contact, inappropriate stimulation of the prefrontal cortex, exhaustion, and disconnected maternal responses to the baby. These findings suggest that active management of the third stage should be recommended when these circumstances are present. Erickson et al. (2019) also observed that active management of the third stage of labour may not be beneficial for women undergoing physiological birth, as those with higher rates of physiological birth experienced lower rates of PPH and blood transfusion.

Discussion

This scoping review highlights the challenges midwives face in balancing adherence to protocols and recommendations (Tan et al., 2008) with their trust in the body's natural birthing processes. The findings suggest that midwives must navigate a delicate balance between providing safe care to

prevent postpartum haemorrhage and trusting the woman's physiological ability to give birth without intervention. This aligns with the philosophical underpinning of midwifery, which is woman-centred, promotes physiological birth, and advocates for minimal intervention in normal childbirth (ICM, 2024). The review identified a robust theoretical framework underpinning physiological third stage management, primarily through the "Midwifery Guardianship Theory" (Hastie & Fahy, 2009) and "Pronurturance Plus Theory" (Saxton et al., 2016). These frameworks emphasize creating an undisturbed environment that optimizes birthing physiology and mother-infant bonding. This aligns with previous research highlighting the importance of minimizing interventions during physiological birth (Reed et al., 2016). The findings demonstrate that midwives must balance safety considerations with trust in natural birthing processes, challenging the widespread adoption of active management protocols in hospital settings (Tan et al., 2008; Featherstone, 1999).

Significantly, the review expands our understanding of risk factors for postpartum haemorrhage beyond traditional medical indicators. Environmental and psychological factors, including inappropriate birth environments and disconnected maternal responses, emerge as important considerations (Fahy, 2010; Hastie & Fahy, 2009). This broadened perspective suggests the need for a more holistic approach to risk assessment and management during the third stage of labour.

Additionally, decisions regarding the management of the third stage of labour should be women-driven (Kearney et al., 2019). However, in many hospital settings, active management seems to be the norm, even for low-risk women. Despite this, most midwives do not believe that active management is necessary or mandatory for women at low risk of PPH (Dixon et al., 2009). Midwives, even those who may lack full confidence in managing the physiological third stage, often prefer an expectant approach over active management, unlike physicians who are more inclined to intervene (Featherstone, 1999; Tan et al., 2008).

Strengths and limitations

For many women, a physiological birth of the placenta is an intrinsic element of a normal birth, and active management is considered an intervention to be used if necessary (Reed et al., 2019b). One of the main contributions of this review is the redefinition of what constitutes expectant management of placental birth. The findings of this review offer a deeper understanding of what expectant management means in terms of a different way of doing it. In particular, it can be a starting point for rethinking what usually happens in a labour room soon after the baby is born. For example, in terms of noises and distractions, protecting and guaranteeing prolonged and uninterrupted skin-

to-skin contact, using an upright position for placental birth, and trusting the woman's body's ability to birth the placenta.

According to these results, the third stage of labour should involve careful observation, monitoring physiological indicators, and being prepared to manage postpartum haemorrhage if necessary. This approach can be defined as “watchful attendance” (de Jonge et al., 2021). Furthermore, the review provides new insights into the risk factors for postpartum haemorrhage. Beyond the well-known medical risks, factors such as an inappropriate birth environment, lack of midwife guardianship, serious mental illness, substance abuse, poor skin-to-skin contact, improper activation of the prefrontal brain, fatigue, and disjointed responses to the baby are identified as contributors to the risk of postpartum haemorrhage.

However, this review has certain limitations. Despite our best efforts to conduct an exhaustive literature review, we found it extremely difficult to bundle what constitutes midwifery care during the third stage. This was discussed widely among the researchers during the screening process. It is hoped that the definition derived from these data will serve as a foundation for a shared understanding of how to provide care during placental delivery. Additionally, our review focused on qualitative and quantitative studies, literature reviews, and unpublished works. In future studies, we suggest including position statements, guidelines, and policy documents to further enrich the understanding of midwifery care in this context.

This work aims to be a starting point for future research. Based on our findings, we strongly believe that future studies should prioritize investigating midwifery care practices that support the physiology of the third stage and the efficacy of expectant management in physiological birth. It would be particularly beneficial to explore these practices in different settings, such as home births or midwifery-led units. Ultimately, these findings can help guide care providers in discussing options with women and improving placental birth practices.

Conclusion

Midwifery care during the physiological third stage of labour is crucial for women, even during placental birth. The increasing introduction of active management of the third stage of labour has raised concerns about the safety of physiological management of the third stage of labour following a physiological birth. It is essential for midwives to balance safety, preventing postpartum haemorrhage, while trusting the woman's body to complete the process without intervention. Midwives’ decision-making regarding the third stage of labour should be women-driven, aligning with a woman-centred approach to care. However, in hospital settings, active management remains

the norm even for low-risk women, despite evidence suggesting that many midwives prefer a more expectant approach. This paradox highlights the need for more flexible hospital guidelines that recognize both women's preferences and the safety of physiological management.

A specific theoretical framework underpinning this care emphasizes the importance of a natural, undisturbed third stage to maximize birthing physiology and mother-infant bonding. Consequently, the midwife's role during this stage should involve creating a safe and calm environment, free of distractions, allowing the woman to focus on her baby, body, and the birthing process. Midwives should encourage mother-infant bonding while maintaining a vigilant but optimistic approach toward spontaneous placental birth. Based on these findings, further research is essential to explore the effectiveness of expectant management of the third stage in various birth settings, such as home births or midwifery-led units. Midwifery practice should evolve to meet the individual needs of women, especially in low-risk cases, while ensuring appropriate monitoring to prevent complications. Future studies should also focus on the long-term impact of a physiological approach, not only on maternal outcomes but also on neonatal well-being, particularly in terms of bonding and clinical results. Additionally, greater awareness of the environmental and psychological conditions influencing the third stage could significantly improve the quality of care provided, promoting a midwifery practice grounded in physiology and respectful of women's individual choices.

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Table 1

Search terms and inclusion/exclusion criteria mapped to the PEO framework.

Criteria	Inclusion criteria	Exclusion criteria	Search terms
Population	midwives, obstetric nurses, nurse midwives and skilled birth attendants	Students midwives, obstetrics, Physicians, Nurse	("midw*" [Title/Abstract] OR "nurse midwi*" [Title/Abstract] OR "obstetric nursing" [MeSH Terms]) OR "nursing" [MeSH Terms]
Exposure to context	Physiological care during third stage of labour is defined as the variety of emotional and physical actions midwives do.	Studies on PPH management and OR PPH prevention will be excluded, as well as studies on women's experience	((holistic care) OR (physiological care)) OR ("skill*" [Title/Abstract] OR "practice*" [Title/Abstract] OR "method*" [Title/Abstract] OR "technique*" [Title/Abstract] OR "role" [Title/Abstract] OR "care" [Title/Abstract] OR "help" [Title/Abstract] OR

"support*"[Title/Abstract] OR

"supportive

care"[Title/Abstract])) OR

("obstetric

nursing/methods"[MeSH

Terms] OR

"midwifery/methods"[MeSH

Terms]))))

AND

("Placenta"[Mesh]) OR

"Placenta/physiology"[Mesh])

OR (((third stage labor) OR

(third stage labour)) OR

(placent*[Text Word])) OR

("Labor Stage, Third"[Mesh]))

Date	No data restriction	
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Study type	All research	Personal opinion
	methodology,	
	qualitative reviews,	
	quantitative reviews,	
	literature reviews	

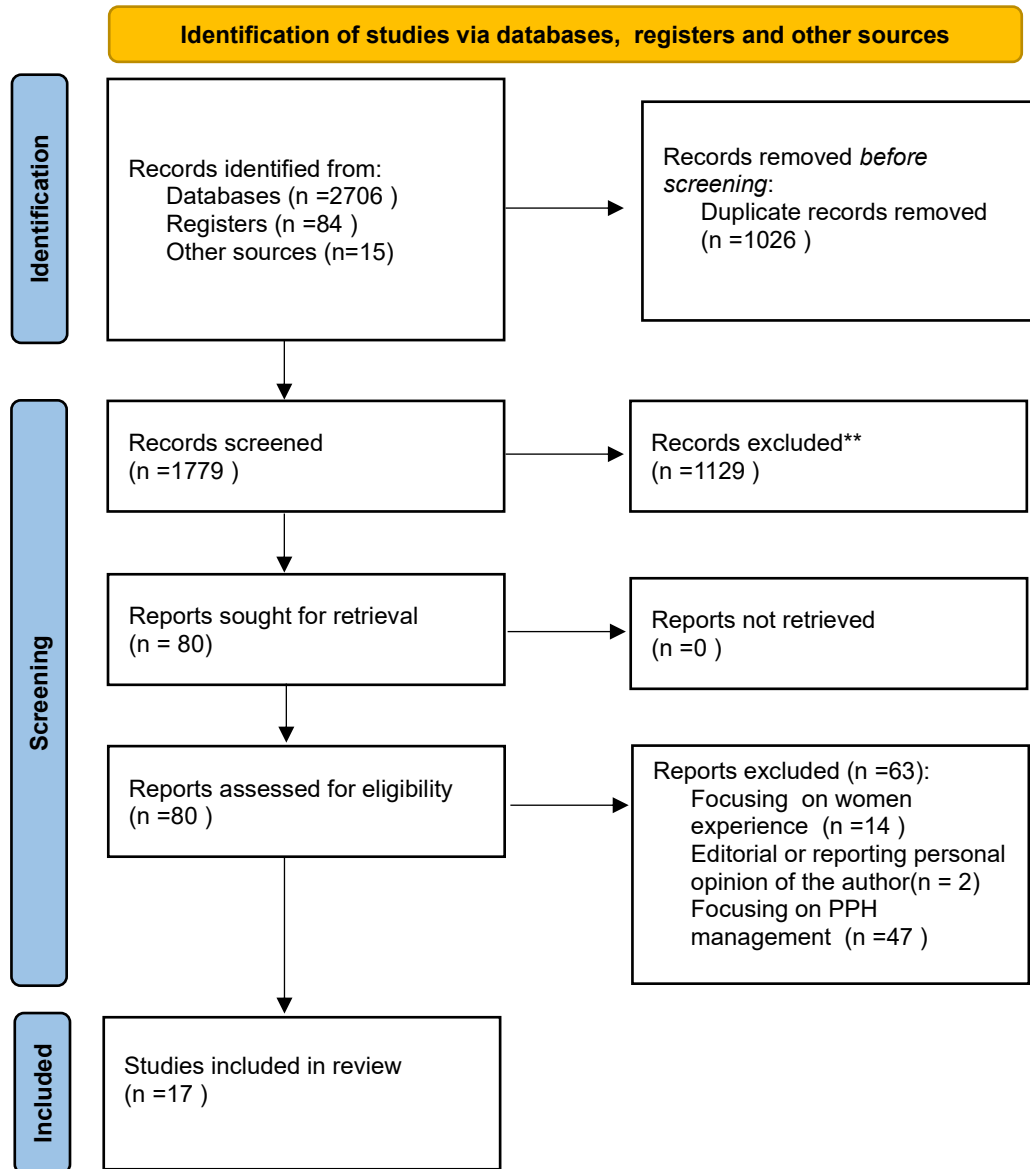
and unpublished
literature will be
included, as well as
guidelines, policy
documents, position
statements

Language

No language
restriction

Table 2 The PRISMA Flow diagram

PRISMA 2020 flow diagram for new systematic reviews which included searches of databases and registers only.¹



¹Source: Page MJ, et al. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.

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Table 3

Results of review

Author, Year, Country (if applicable)	Aim of the study	Design, Methods	Expectant management (EMTSL)	Active management (AMTSL)	Participants	Key fundings
Featherstone, 1999, UK	To find out to what extent midwives understand the conduct of a physiological third stage	Exploratory study, with a multiple choice questionnaire	Mother's informed choice. No cord traction. Await spontaneous separation and delivery of placenta. Give (intramuscular syntometrine if placenta remains undelivered after 40 minutes.	Nd	78 hospital midwives	The study divided management strategies into nine categories based on data and literature review. The categories included giving oxytocic agents, applying controlled cord traction, allowing placenta and membranes to be delivered by maternal effort and gravity, cutting and clamping the cord, feeling for the delivery by maternal effort and gravity, clamping and cutting the cord once pulsation ceases, releasing the clamp on the maternal end of the cord, not feeling for the delivery by maternal effort and gravity, and leaving the cord intact.
Harris, 2005	to explore the concept of practice variation in third stage management among midwives, focussing on what midwives do and why they do it.	Grounded Theory with multiple data collection	management without uterotonics (though these were often made ready just in case they were needed).	a package of care involving the administration of an uterotonic drug.	Fifty one midwives employed in two NHS midwives working in a wide range of environments, of differing levels of expertise, and with differing values and beliefs	Despite the naming of two categories of practice (expectant vs active management), midwives described multiple ways of managing the third stage of labour. The complexity of third stage care was revealed by the identification of 22 aspects or parts to care. A theory of contingent decision making for the third stage of labour was revealed which explained how midwives adopted different forms of care through a complex decision making process which was contingent on the learning opportunities midwives were exposed to, the context in which practice decisions were made and the philosophical underpinnings of midwifery care.
Tan, 2008; British Columbia	To compare practices of three maternity care provider disciplines in management of third-stage labor and the	cross-sectional survey with an online	NA	NA	287 out of 497 Obstetricians and family physicians and midwives	Midwives are less likely to perform early cord clamping and cutting, use prophylactic oxytocin for third-stage labour management, and perform uterine massage after placenta delivery compared to obstetricians and family

	justifications for their approach.	multiple choices questionnaire				physicians. Midwives wait for spontaneous separation and prefer the expectant approach.
Fahy, 2010	The study examines existing RCT evidence comparing physiological and active management of third stage labor care for low-risk women to evaluate its relevance and validity.	literature review	different description of what constitutes EMTSL	different definition of what constitute AMTSL	n.a.	Actual research doesn't provide evidence about what constitutes and the effectiveness of physiological third stage care.
Dixon, 2009, New Zealand	To describe, analyse, and compare the outcomes of expectant or active management for the third stage of labour following a normal physiological birth	Prospective cohort study	To promote a woman's body's endogenous oxytocin production through skin-to-skin contact, warmth, and calmness, aiming to enhance physiological processes for holistic health support, with only necessary treatment intervention.	Exogenous oxytocin administration	33,752 women in the NZCOM	The research involved 16,238 women who received physiological management (48.1%) and 17,514 (51.9%) who received active management for placental delivery. Women delivering at home or in primary birthing units were more likely to have a physiological third stage. Most women lost less than 500ml of blood, with the majority receiving physiological support (96.3%). 11.3% of the physiological management group required more time to complete the third step.
Hastie, 2009	To describe midwifery led care in the third stage of labour, based on the midwifery Guardianship theory	Theory description	n.a	n.a	n.a.	Placental birth is a crucial process that requires a safe environment for both mother and infant. The ideal psycho-physiological state for birth is a calm and connection state, where the parasympathetic system is dominant. Midwifery guardians should promote maternal-infant love ensuring a natural physiological placental birth.

Jangsten, 2010; Sweden	To explore Swedish midwives' experiences of management of the third stage of labour.	Qualitative design with focus group discussions	Prophylactic intravenous injection of 10 units of Oxytocin as soon as the infant is born to all women, but do not perform the entire active management third stage labour procedure	Active management third stage labour	32 midwives with more than 6 years' experience in labour room.	The analysis generated three categories: 'bring the process under control', 'protect normality and women's birthing experiences' and 'maintain midwives' autonomy'.
Fahy et al, 2010 Australia	To compare the PPH rates of a tertiary referral maternity unit, and a midwifery-led, freestanding birthing.	Retrospective cohort study	Holistic psychophysiological third stage care	I.M. Syntocinon should be given within 1 min of the birth of the baby; controlled cord traction is to be used followed by fundal massage after the placenta is born.	The total number of women who were at low risk of PPH was 3436 comprising 3075 at the tertiary unit and 361 at the midwifery-led unit, between July 2005 and August 2008	The intention-to-treat analysis shows a PPH rate of 11.2% for active management of the third stage of labour at the tertiary unit compared with 2.8% for holistic psychophysiological care at the midwife-led unit OR = 4.4, 95% CI [2.3, 8.4]
Dixon, 2011	To establish the clinical effectiveness of physiological third-stage care following a physiological labor and birth	systematic review			2 RCT 2 Observational study included, involving 35,455 healthy women	The study found minimal differences in blood loss volumes or PPH rates compared to an actively managed third stage of labour. Although longer third stages were more likely with physiological management, no significant differences were observed. Retained placenta levels and blood transfusion requirements were low. Hemoglobin measurement showed no significant differences. Increased uterotonic treatment was required in the physiological group.

Begley, 2012 Irish and New Zealand	To explore the views and the skills Irish and New Zealand midwives employ in expectant management of the third stage of labour (EMTSL)	Qualitative descriptive study, semi structured one-to-one interview	The carer anticipates natural uterine contractions and oxytocin rise at birth to separate and expel the placenta, without administering a prophylactic drug or using cord-clamping or controlled cord traction.	routine administration of a prophylactic uterotonic.	27 midwives who used EMTSL at least 30% of the time, and who averaged PPH rates of less than 4% in those births.	Four themes were identified: 'Going with the flow', 'Knowing it's separated,' 'Coping with the abnormal' and 'Letting it come.' These elements of EMTSL add to midwifery knowledge and provide a basis for further discussion on how normal physiology can be supported during the third stage.
Dixon, 2013; New Zealand	To describe, analyse and compare the midwifery care pathway and outcomes provided to a selected cohort of New Zealand women during the third stage of labour between the years 2004 and 2008.	retrospective cohort	No prophylactic drug is given, controlled cord traction is not used, clamping and cutting of cord is delayed, only maternal effort to expel placenta after signs of separation.	Uterotonic given (prophylaxis) following birth of baby or with anterior shoulder at birth, cord is cut and clamped, controlled cord traction after signs of separation		The rates of physiological third stage care (expectant) and active management within the cohort were similar (48.1% vs. 51.9%). Women who had active management had a higher risk of a blood loss of more than 500 mL, the risk was 2.761 when a woman was actively managed (95% CI: 2.441–3.122) when compared to physiological management. Women giving birth at home and in a primary unit were more likely to have physiological management.
Saxton, 2016	A psycho biologically based midwifery theory aimed at describing, explaining and predicting how to minimise the risk of PPH for individual women, and the rate of PPH for populations of childbearing women.	Theory description	Pronurturance care (skin to skin and breastfeeding within 30 minutes after birth)	NA	NA	Pronurturance Plus theory is designed to describe, explain and predict midwifery activity in the third and fourth stages of labour to create eutony and eulochia. Pronurturance promotes the woman's focussed attention and parasympathetic dominance which, together optimises her reproductive psychophysiology facilitating eutony and eulochia.
Erickson, 2019 USA	To examine risk for total postpartum blood loss, PPH, and blood transfusion, and evaluate outcomes associated with active management of the third	latent class approach	No AMTSL, No modified AMTSL	AMTSL: prophylactic oxytocin, controlled cord traction, and uterine massage after placental	2322 vaginal births were included in the generalized linear modeling and 15 physiologic birth	The study categorized women into four classes: physiologic (44%), dysfunctional (35%), preterm (44%), and multiparous (40%). The use of AMTSL for women with a physiologic birth was associated with higher risk for preterm pregnancies and prolonged third stage labor.

stage for women undergoing physiologic birth

delivery. "Modified and covariate AMTSL: oxytocin factors met being given after criteria to be the placenta was considered in delivered, or no latent class umbilical cord analysis traction for expediting third stage

Baker, 2020 Study two, UK	Study two: to explore the practicability of midwives conducting active and expectant management approaches in the midwife-led units	multi-method research Study Two: qualitative approach, using semi structured interviews	Support the woman during labor and birth by providing a warm, calm environment, encouraging skin-to-skin contact, and waiting for signs of placental separation. Breastfeeding or nipple stimulation can also stimulate the physiological release of oxytocin.	A prophylactic uterotonic drug (exogenous oxytocin) is given, together with delayed cord clamping and controlled cord traction after signs of separation of the placenta.	6 midwives were interviewed, using semi structured interviews	4 themes emerged: "The woman"; 'The Midwife'; 'Working within an organisation'; and 'Recent changes in childbirth' These themes suggested that the midwives interviewed see their third stage of labour practice as shaped by varied and sometimes contradictory considerations that influence their interactions with the women they cared for, the midwives themselves, their colleagues and also the wider organisational and ideological context
Backer, 2021	To review evidence on the effectiveness of active or expectant third stage management approaches for low-risk women in midwife-led units or home settings seeking minimal intervention.	Narrative critical literature review	Midwives monitor placental separation, ensuring spontaneous or gravity-assisted delivery and protect oxytocin release by the woman's body.	A prophylactic uterotonic drug is given, in association with delayed cord clamping, cutting of the cord and controlled cord traction	n.a	Research suggests expectant management risks may be due to practitioner's limited training, confidence, or experience, rather than the management approach. It may be more suitable for low-risk women in midwife-led units or home settings.

Baker, 2022 a, Northwest England	To examine the relationship between third stage of labour management approaches, and incidence of postpartum haemorrhage and severe postpartum haemorrhage in women birthing in midwife-led units.	retrospective cohort	No routine use of uterotonic drugs, no clamping of the cord until pulsation has stopped and delivery of the placenta by maternal effort.	Syntometrine is administered before cord clamping and cutting, usually within 5 minutes of birth, with controlled cord traction after placental separation.	1268 women who had a normal vaginal birth at a midwife-led units	Of the 765 women intending to receive active management and the 508 intending to receive expectant management, 9.54% and 14.0% experienced postpartum haemorrhage respectively (p=0.015). Severe postpartum haemorrhage was experienced by 14 (1.83%) women intending to receive active management and 16 (3.66%) intending to receive expectant management (p=0.134).
Backer, 2022b	To investigate the third stage management approaches, the incidence and treatment of postpartum haemorrhage in women giving birth solely in midwife-led units.	Systematic review	No routine use of uterotonic drug. No clamping of cord until cord has stopped pulsating and delivery of placenta by gravity or maternal effort	Use a prophylactic uterotonic drug, delayed or immediate cord clamping and controlled cord traction	9 identified studies	Active management has higher postpartum haemorrhage incidences compared to expectant management in all birth settings. However, twice as many women receiving expectant management receive further treatment for excessive blood loss compared to active management. Studies also show a lower incidence of postpartum haemorrhage in midwife-led units despite increased expectant management and reduced active management.

Chapter 3 Italian Translation and Cultural Validation of the Physiological Practices

Observation tool. A tool for midwifery care

This paper has been published

Tarlazzi, E., Darling, F., Longobucco, Y., Bertini, V., Marella, S., Simonazzi, G. (2025). Italian Translation and Cultural Validation of the Physiological Practices Observation Tool: A Tool for Midwifery Practice. *INTERNATIONAL JOURNAL OF CHILDBIRTH*, 15(4), 208-216 [10.1891/ijc-2025-0030].

Abstract

Objectives:

This study aimed to translate and culturally validate the Physiological Practices Observation (PPO) tool into Italian (PPO_ITA) to enable systematic observation of midwifery care practices that support physiological labour and birth in Italy. Given the high medicalisation of childbirth in Italy, the availability of a culturally adapted tool is essential for evaluating and improving midwifery-led care.

Methods:

The translation and adaptation process followed the five-step methodology proposed by Sousa and Rojjanasrirat: forward translation, synthesis, back translation, second synthesis, and cognitive debriefing. Two bilingual translators conducted independent forward and backward translations. A multidisciplinary expert panel reviewed discrepancies and ensured conceptual equivalence. Twelve Italian-speaking midwives participated in cognitive debriefing to assess clarity and content validity. Feedback informed revisions to produce the final PPO_ITA version.

Results:

The translation process revealed challenges in conveying midwifery-specific concepts such as “advocates” and “praising,” which lack direct Italian equivalents. Inclusive language (“donna/persona assistita”) was adopted to reflect evolving gender awareness. Cognitive debriefing led to the revision of Domain 6, aligning it with Italian national guidelines on postpartum care. One item was removed, and another revised, resulting in a final tool comprising 7 domains and 30 items.

Conclusions:

The PPO_ITA tool is a culturally adapted, linguistically validated instrument suitable for observing midwifery practices in Italy. It preserves the conceptual integrity of the original PPO while reflecting local clinical and cultural contexts. Its implementation may enhance research on physiological childbirth and support evidence-based midwifery care in diverse Italian settings.

Keywords

Midwifery care, Evaluation study, Translations, Quality Indicators, Health Care

Introduction

Unnecessary interventions in labour and birth continue to rise, despite most births worldwide involving women without risk factors for complications (Begley, 2014; Betrán et al., 2018; Maaløe et al., 2023; Spina, 2023). In the European context, Italy stands out for its high medicalisation during labour and childbirth, as well as its high rate of caesarean sections and low presence of midwifery units over the territory (Ministero della salute, 2025; Spina, 2023).

The Lancet series on midwifery highlights the efficiency of midwifery care and improved outcomes (Renfrew et al., 2014). The series underscored the potential of midwifery to significantly decrease both maternal and newborn deaths and illnesses. Moreover, midwifery care, particularly when provided through continuity of care models, was associated with higher rates of spontaneous vaginal birth, fewer interventions like caesarean sections and instrumental births, and potentially fewer episiotomies. In addition, women report a more positive birth experience and increased satisfaction with the care they receive. However, little is known about midwives' role in facilitating the physiological birth process and their various physical and emotional actions during labour (Kennedy et al., 2016).

In 2015, Escuriet et al. conducted a comprehensive literature review on tools and indicators used to assess maternity care performance across Europe. The review emphasized the need for an instrument capable of capturing the minimal intervention typically required during physiological labour. In response, the *Keeping Birth Normal* (KBN) tool was developed to support midwives in observing care practices that promote physiological labour and birth (Darling, 2016; Darling et al., 2021). Despite its strengths, the KBN tool's items were often highly descriptive, combining multiple elements within a single practice, which made systematic observation challenging. To address this, the tool was reorganized for clarity and ease of use, while preserving its core content. This restructuring was guided by updated recommendations from the National Institute for Health and Care Excellence (NICE, 2017), the World Health Organization (WHO), and recent literature on physiological labour and birth. Building on this foundation, the *Physiological Practices Observation* (PPO) tool was created in 2018 to systematically observe how midwives maintain physiological labour and birth in clinical settings (Darling et al., 2024). The PPO was initially piloted with 10 midwives to evaluate whether the listed practices supported physiological birth. A content validation process followed, involving 7 subject-matter experts and 8 women who rated each item using a four-point Likert scale. This led to the removal of three items, merging of others, and a total

of 40 item revisions. The updated version retained 12 domains and 45 items, achieving a S-CVI/Ave score of 1 (Darling and Collington, 2016), confirming its relevance for observing physiological care practices. The adaptation to improve ease, focus and as such accuracy of observation KBN tool resulted in 7 domains and 31 items, and renamed as the *Physiological Practices Observation (PPO)* tool. The seven domains include approach to care, early labour, environment, supporting woman, ongoing care, first hour of birth, involving woman in decision-making (Table 1_PPaR Original tool version). The research team selected the Physiological Practice Observing Tool (PPOT) for this study due to its alignment with the overarching aim of evaluating care processes that support non-intervention and physiological birth. Existing tools commonly employed in European intrapartum care research ()tend to prioritize technical and clinical dimensions, often overlooking the systematic and comprehensive assessment of midwifery practices that facilitate normal birth (Escuriet et al., 2015; Valley et al., 2023). In contrast, the PPO Tool enables a focused examination of practices associated with "watchful attendance"—a nuanced, relational form of care wherein midwives actively observe, support, and safeguard the physiological progression of labor without unnecessary intervention (de Jonge et al., 2021; Toda et al., 2025). The emphasis on relational aspects of midwifery care was deemed essential for capturing the complexity and value of practices that promote and protect normal birth. This focus is particularly urgent in highly medicalized contexts such as Italy, where routine interventions often overshadow the recognition and support of physiological birth processes.

In our increasingly globalized world, the need for well-translated and culturally validated research tools has become paramount. Translation and cultural validation are essential to ensure that the research tool measures the same concept in the same way across different cultural contexts, preserving its reliability and validity (Guillemin et al., 1993). When research instruments or questionnaires are developed in one language and culture, they must undergo a rigorous process of translation and validation before they can be effectively used in different linguistic and cultural contexts. This ensures that the tool maintains its reliability, validity, and intended meaning across different populations (Gjersing et al., 2010).

The translation and cultural validation of assessment tools is critical because it allows for meaningful comparisons of processes and outcomes across different populations and healthcare settings. Simply translating an instrument word-for-word can result in items that are confusing, culturally inappropriate, or fail to capture the intended concepts in the target language. A rigorous cultural validation process helps ensure that the translated version maintains the same measurement

properties as the original while being culturally relevant for the intended users (Poulsen et al., 2017). A poorly translated tool can lead to misunderstandings, inaccurate data collection, and compromised research outcomes. Therefore, implementing a systematic approach to translation and validation is crucial for maintaining the scientific integrity of research across different cultures. This helps guarantee that the translated version measures the same constructs as the original instrument.

The process of translation and cultural validation also serves to identify and address potential cultural biases or assumptions present in the original tool. What may be considered appropriate or relevant in one culture might not translate well to another. Many widely-used assessment tools were originally developed in English-speaking countries. To gather accurate data in non-English speaking populations, these instruments must undergo proper translation and cultural adaptation through established methodological approaches (Sousa & Rojjanasrirat, 2011). Through systematic validation procedures, researchers can adapt the tool to better reflect the target population's cultural context while maintaining the instrument's core measurement properties.

The aim of this article is to describe the process of performing an Italian translation, adaptation, and cross-validation of the Physiological Practices Observation tool.

Methods

The Translation and Cultural Adaptation Process

The translation process of the PPO was carried out in accordance to recent guidelines, utilizing the five steps of translation and cross-cultural adaptation developed by Sousa and Rojjanasrirat (2011). This process included translation, synthesis, back translation, second synthesis, and cognitive debriefing (Figure 1). Prior to conducting this study, approval was obtained from the author to use the tool, then translators and expert panel participants were recruited. A detailed review protocol was published on Open Science Framework (DOI 10.17605/OSF.IO/QVG48)

The following five steps were taken:

1. **Forward translation:** Two independent forward translations were performed. A professional translator conducted one, while a clinician with experience in the childbirth process conducted the other. Both forward translators were native Italian speakers fluent in English.
2. **Synthesis:** To achieve agreement on Italian version 1, an online meeting of the research team and the two translators was held. This team compared the two translations with the original version

of the tool to resolve ambiguities and discrepancies, ultimately generating the preliminary translated version of the instrument (Italian harmonized Version 1)

3. **Back translation:** Two independent translators produced a backward translation of the Italian harmonized version 1. A professional translator completed one, and a clinician with experience in the childbirth process completed the other. The translators were native English speakers fluent in Italian or had been living in the UK for nearly three years.

4. **Second Synthesis:** A multidisciplinary committee were convened to compare the back-translated versions with the original PPO tool. The committee included all four translators, a midwife with extensive experience in normal labour, and a methodologist/researcher. The teams discussed all discrepancies and ambiguities, until satisfaction was reached. This step resulted in the production of Italian version 2 of the PPO.

5. **Cognitive debriefing:** The aim of this stage was to determine whether the Italian version of the PPO tool was understandable and measured all clinically relevant issues from the clinicians' perspective. A pilot study was conducted on the draft version of the instrument to assess its content validity and clarity. A Microsoft forms questionnaire was used to gather input on these areas. Twelve Italian-speaking midwives were involved in the survey. Each participant was asked to rate the clarity of the instructions, the format of the response, or any item on a scale of clear or unclear. If something appeared unclear, participants were invited to suggest changes to improve the clarity of the language. Reassessment was required for instructions, response formats, and instrument items that at least 20% of participants found unclear. Subsequently, the expert panel of midwives was asked to evaluate each item on a scale for content equivalence using a four-step scale: 1 = not relevant; 2 = unable to assess relevance; 3 = relevant but needing minor alteration; 4 = very relevant and succinct. Items classified as 1 (not relevant) or 2 (unable to assess relevance) were to be revised. Feedback received was used to revise the scale. As this tool was designed for observing midwifery care, the involvement of women was not required—This decision was taken in alignment with other similar projects (Ross-Davie et al., 2013) and also because the Physiological Practice Observation Tool (PPO) was selected for use within a broader research project aimed at defining and measuring midwifery care practices that support the physiology of childbirth. The overarching objective of the project is to give visibility and recognition to the crucial work midwives perform in promoting and safeguarding normal birth, which often remains underrepresented in both clinical discourse and research. While a growing body of literature has begun to amplify women's voices in the context of childbirth, scholarly attention to the perspectives and practices of midwives remains comparatively limited.

6. **Final version:** The first author and a research assistant independently proofread the PPO version for spelling and grammatical errors, leading to the final Italian version of the PPO_ITA tool

Results

Title and instructions Translation

The original tool's name has been changed during development and over time from the Keeping Birth Normal tool (KBN) to the Physiological Practice Observation tool (PPO). Therefore, research panel opted to preserve the original name and abbreviation to eliminate repetition and make it easier for readers to identify the tool. To indicate that this is the Italian version of the utility, the acronym ITA was added. Hence, the final name adopted for the tool is PPO Tool_ITA.

Forward translation and First synthesis

The two independent forward translations were compared. Discrepancies reflected varying perspectives on the language and differing knowledge regarding the midwifery specific language and language reflecting a philosophy of care. The main discrepancies were in the translation of concepts related to the physiology of birth or very close to the midwifery philosophy of care, that could have the same nuances of respect and empowerment as in English. Words such as "advocates," "conveys" [her belief in the woman's ability to birth normally through positive words] (Domain 4 Item 4.4), and "praising" [and encouraging the woman's efforts to birth her baby] (Domain 5 Item 5.9) do not have direct equivalents in Italian that capture the same philosophical idea of respecting the physiology of birth. It required two meetings of the team to define and refine sentences that could effectively convey these concepts. During the first meeting, a more literal translation was established. In the second meeting, the team engaged in deeper reflection to identify Italian words that would more accurately express the underlying concepts, even if these terms were not literally aligned with the original version. After this second meeting the first Italian version of the PPO tool was defined.

This translation effort unfolded against the backdrop of a broader issue: the lack of a structured and inclusive debate in Italy regarding the terminology of birth. Internationally, the concept of "physiological birth" has gained significant traction, prompting efforts to define, standardize, and promote practices that support the innate biological processes of childbirth ((Henshall et al., 2024; White, 2022). Countries such as the United Kingdom, Canada, New Zealand, Australia, and the United States have developed consensus statements, national guidelines, and interdisciplinary frameworks to articulate what constitutes physiological or normal birth ((Henshall et al., 2024, 2025; Kennedy et al., 2015). These initiatives reflect a growing concern with the over-medicalization of

childbirth and a collective desire to re-center maternity care around evidence-based, woman-centered principles.

In contrast, Italy has yet to engage in a comparable public or professional discourse. The terminology surrounding birth—particularly “physiological birth,” “normal birth,” and related constructs—remains underdeveloped and inconsistently applied across clinical, educational, and policy domains. While some midwifery communities and academic groups have begun to explore these concepts, the conversation remains largely confined to niche circles, lacking the institutional support and interdisciplinary engagement seen elsewhere. This absence is particularly notable given the global momentum toward redefining childbirth in ways that prioritize autonomy, informed decision-making, and the minimization of unnecessary interventions.

The implications of this gap are significant. Without a shared language or conceptual framework, Italian maternity care providers may find it difficult to align their practices with international standards or to critically assess the impact of routine interventions on maternal and neonatal outcomes. Furthermore, the lack of public engagement with these issues limits opportunities for women and birthing people to actively shape their care experiences. As demonstrated by the Australian PRIMROSE Project, perceptions of physiological birth vary widely across stakeholder groups—including obstetricians, midwives, doulas, and birthing individuals—underscoring the need for inclusive, context-sensitive definitions that reflect both clinical realities and lived experiences (Henshall et al., 2025)

In this context, the translation and cultural adaptation of tools such as the PPO represent not only a linguistic exercise but also a critical opportunity to reflect on the philosophical foundations of maternity care in Italy. By engaging with the nuances of midwifery language and the values embedded in physiological birth, this process can contribute to a broader rethinking of how childbirth is understood, supported, and communicated within the Italian healthcare system.

Backward translation and Second synthesis

During this phase, two independent translators produced a backward translation of the Italian harmonized version of the PPO tool. After that the research team and all the four translators were convened to compare the back-translated versions with the original PPO tool. The two versions appeared to be consistent in terms of words and meaning. No item needed to be rephrased or revised. However, during the second synthesis phase, discrepancies reflected varying perspectives on the use of a gender inclusive language. At the end of the discussion, the research team decided to use the formula “donna/persona assistita” when talking about the woman to include both those

recognizing as women as well as those labouring people not identifying as a woman. That differed from the original version of the tool, as the PPO tool was developed before a discussion on the use of an inclusive language started to appear in midwifery. This phase led to the definition of the Italian Version 2 of the PPO.

Cognitive debriefing

This phase involved twelve Italian-speaking midwives to assess the content validity and clarity of the PPO. The participants included six clinicians with over one year of experience, two coordinators of a labour room ward, two independent midwives, and two educators. Each participant was asked to rate the clarity of the instructions, the format of the responses, or any item on a scale of clear or unclear. Three items raised some concerns by more than 20% of the participants. In more details, two items were deemed unclear (Dominio 4 Item 4.4 ; Dominio 6 Item 6.3), while one was regarded as “non relevant” (Dominio 6 Item 6.4). Table 1 synthesises the items and the decisions taken by the research team.

Based on these feedback, a deep revision of Domain 6 was required. Domain 6 concerns early hours after birth and contained 4 Items in the original tool. Therefore, the research panel decided to modify item 6.3 and remove item 6.4 from the PPO_ITA version. This decision was primarily influenced by the need to be in accordance with recommendations for third stage management present in the national guidelines (Istituto Superiore Sanità, 2016) ,

In 2016, the Istituto Superiore di Sanità developed an evidence based national guideline on prevention and management of post-partum haemorrhage. Based on this “In the absence of signs of foetal compromise, it is recommended not to clamp the umbilical cord until the end of the cord pulsations or even more if the woman desires” (Istituto Superiore Sanità. 2016; p.42) Therefore, the research team valued to adapt the tool in accordance with this recommendation for practice. Given this, Item 6.4 was removed from the tool because already contained in item 6.3.

Concerning Domain 4 Item 4.4, it was adapted in “L'Ostetrica trasmette la sua fiducia nella capacità della donna/persona assistita di partorire normalmente attraverso i suoi gesti e parole positive” (The midwife conveys her belief in the woman’s ability to birth normally through positive words and actions)based on suggestions from the expert panel. Table 1 represents a synthesis of major issues resolved in the translation and cultural adaptation process

In conclusion, the PPO_ITA tool is a 7 domains, 30 Items tool that permits to explore and describe midwifery care to promote physiological labour and childbirth. For each item, a 4-point Likert scale

(from 1 to 4) is associated, which describes the level of adherence to the recommended practice (1= never or rarely observed; 2=sometimes observed; 3=often observed; 4= always observed)

Discussion

The process of translating and culturally validating the Physiological Practice Observation tool from English to Italian revealed significant insights into the complexities of cross-cultural adaptation of healthcare assessment instruments. The systematic approach employed, following Sousa and Rojjanasrirat's guidelines (Sousa & Rojjanasrirat, 2011), demonstrated that mere linguistic translation is insufficient when adapting tools for different cultural contexts. This was particularly evident in the challenges encountered during the translation of midwifery-specific terminology and concepts related to birth philosophy.

A notable aspect of the cultural adaptation process was the modification of language to reflect contemporary social awareness and inclusivity. While the original PPO tool used gender-specific terminology, the Italian version (PPO_ITA) adopted more inclusive language by incorporating the phrase "donna/persona assistita" to acknowledge diverse gender identities among birthing individuals. This adaptation reflects evolving societal perspectives and demonstrates how cultural validation processes must consider current social dynamics beyond traditional linguistic equivalence.

The most substantial differences between the original PPO and PPO_ITA emerged in Domain 6, concerning early post-birth care. The deep revision of items 6.3 and subsequent the removal of item 6.4 from the Italian version highlighted how national healthcare guidelines and standard practices influence the cultural adaptation of assessment tools. Due to the need to adapt the tool to national guidelines recommendations, the majority of the stakeholders involved felt that the 6.3 item on third-stage care needed to be deeply modified to make it consistent with the recommendations of the guideline.

The translation challenges encountered with terms like "advocates," "conveys," and "praising" underscore the philosophical differences in midwifery care between cultures. The difficulty in finding Italian equivalents that captured the same nuances of empowerment and respect for physiological birth processes reveals how deeply cultural values and healthcare philosophies are embedded in professional language. This demonstrates that cultural validation must extend beyond linguistic accuracy to ensure the tool's relevance and effectiveness in its new context while maintaining its core measurement properties.

While women were involved in the content validation of the KBN tool, a limitation of the cultural validation is the absence of direct involvement of women.. The focus was placed on validation to observe and analyse midwifery practices that support physiological birth. and Future research should consider incorporating women's perspectives to enrich the cultural adaptation and contextual relevance of the observational tool.

The successful adaptation of the PPO tool into Italian points to the important need to replicate this process in other non-English-speaking countries to enable international comparisons of midwifery practices. for the purpose of measurement statistical validation is needed to assess the psychometric properties of the PPO_ITA tool and confirm its reliability and construct validity. Future research could investigate correlations between midwifery practices observed via the PPO_ITA and maternal and neonatal outcomes, contributing to evidence-based improvements in care. A study is currently underway using the PPO_ITA tool to explore how midwives support physiological childbirth in an Italian context.. Hopefully the dissemination of the PPO_ITA tool will support the development of numerous observational researches aiming to explore how midwives support physiological birth in diverse Italian healthcare contexts, including high-intervention and low-intervention settings. The original English version of the PPO, as well as the Italian version (PPO_ITA), will be available on the QMNC tool register . This project to make these tools and others available online for use in midwifery research is currently underway and progress can be followed on <https://www.qmnc.org/> or by contacting the authors Elena Tralazzi or Florence Darling on the QMNC site (<https://www.qmnc.org/>).

Conclusions

This study presents the successful translation and cultural validation of the Physiological Practices Observation (PPO) tool into Italian (PPO_ITA), offering a linguistically and contextually adapted instrument for evaluating midwifery care practices that support physiological labour and birth in Italy. Through a rigorous five-step methodology, the research team addressed linguistic challenges, conceptual ambiguities, and cultural nuances, particularly those embedded in midwifery philosophy and inclusive language. The adaptation process highlighted the importance of aligning observational tools with national clinical guidelines and evolving social perspectives, resulting in a final version comprising 7 domains and 30 items.

The study contributes to the growing body of research on physiological birth by providing a validated tool that can be used to systematically observe and document midwifery practices. It also underscores the broader need for structured discourse in Italy around birth-related terminology and

care philosophies, which remain underdeveloped compared to other international settings. By adapting the PPO tool to reflect Italian clinical realities and cultural values, this work lays the foundation for future research aimed at improving the visibility and recognition of midwifery-led care.

The PPO_ITA tool holds potential for widespread application in observational studies, quality improvement initiatives, and educational settings. Its use may facilitate comparative research across diverse healthcare environments and contribute to evidence-based strategies for promoting physiological birth. Further psychometric validation and outcome-based studies are recommended to assess its reliability and impact on maternal and neonatal outcomes. Ultimately, this work supports the advancement of midwifery care in Italy and contributes to the international dialogue on respectful, woman-centred childbirth practices.

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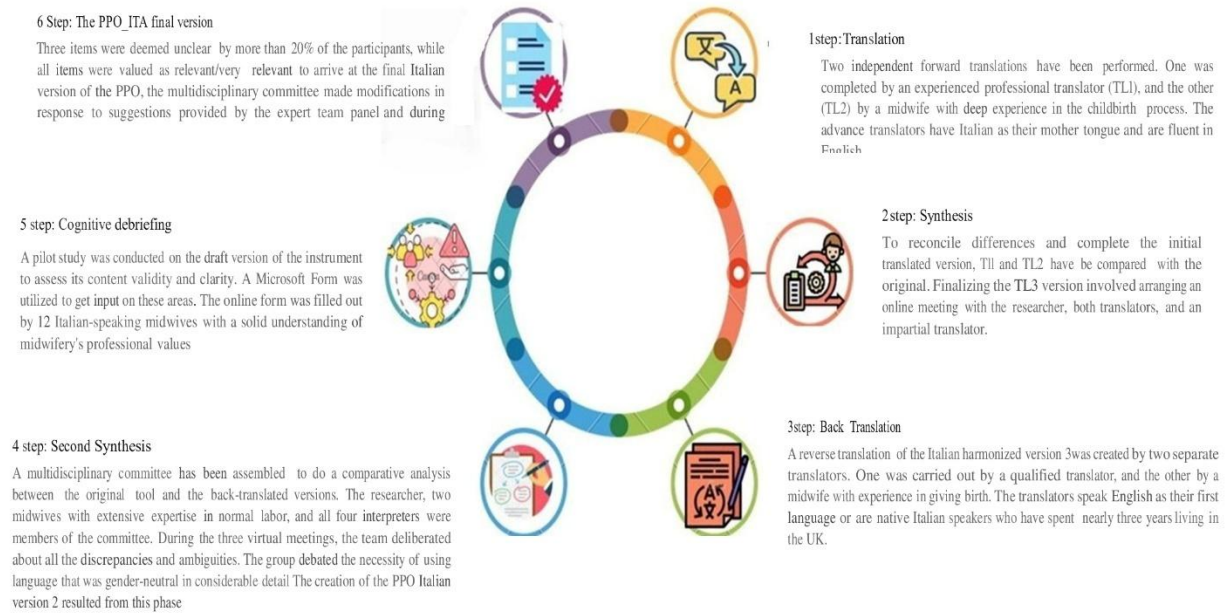
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Table 1 Synthesises of the items and the decisions taken by the research team.

Item number	Item in the original tool	Item in The PPO_ITA	Action
DOMINIO 4 ITEM 4.4	Conveys her belief in the woman's ability to birth normally through positive words and actions	L'Ostetrica trasmette la sua fiducia nella capacità della donna/persona assistita di partorire normalmente attraverso i suoi gesti e parole positive	Modified by the original translation, based on suggestions by the experts, to achieve clearness.
DOMINIO 6. ITEM 6.3	Clamps the baby's cord after a minute if the woman chooses an injection to birth her placenta or leaves the cord unclamped for as long as the woman wishes to wait	L'Ostetrica/o, lascia il cordone non clampato finché non cessa di pulsare o per tutto il tempo che la donna/persona assistita lo desidera, indipendentemente dalla somministrazione di uterotonico.	Modified by the original translation, based on suggestions by the experts, to align with national guidelines.
DOMINIO 6. ITEM 6.4	Leaves the cord unclamped if the woman chooses a physiological 3 rd stage	L'Ostetrica lascia il cordone non clampato se la donna/persona assistita sceglie la gestione fisiologica del terzo stadio.	Delated, because included in the above Item

Figure 1 The translation and cultural validation process



Chapter 4 Supporting physiological birth in Italian Hospital maternity care: findings from a Descriptive Observational Study

This paper is under consideration for publication in Midwifery

Abstract

Background

Physiological birth, characterised by minimal medical intervention, is associated with improved maternal and neonatal outcomes. Despite evidence-based recommendations supporting physiological approaches, their implementation is often constrained by cultural norms and organisational structures. In Italy, where childbirth remains highly medicalised and caesarean rates are persistently high, midwives face significant challenges in promoting physiological processes. Understanding how midwives support such practices within this context is essential for informing maternity care policy and practice.

Aim

This study aimed to describe midwifery practices and support strategies for physiological birth within the Italian hospital-based maternity care system.

Methods

A quantitative, descriptive observational design was employed. Fifty-one midwife–woman interactions were recorded using the Physiological Practice Observation Tool, comprising 30 items across seven domains rated on a four-point Likert scale. Each observation lasted at least one hour, resulting in a total of approximately 100–150 hours of data collection. The analysis examined adherence to evidence-based recommendations across domains and explored differences according to women’s clinical status and midwives’ years of experience.

Findings

Overall adherence to recommended physiological practices was high. The strongest alignment was observed in domains related to approach to care, environmental support, and early postnatal hours. No significant differences emerged according to women’s physiological or risk status at the onset of labour. Midwives with more than ten years of experience showed higher adherence in providing emotional support, labour care, and facilitating decision-making.

Conclusion

Midwives consistently supported physiological labour and birth even within a highly medicalised system. However, lower adherence in decision-making practices indicates persistent barriers to achieving fully woman-centred care.

Keywords Childbirth, midwifery care, Physiological, **observational study**

Statement of Significance

Problem or Issue	What is Already Known	What this Paper Adds
Limited evidence exists on how midwifery principles are enacted within highly medicalised maternity systems, and which conditions support or impede their application.	Midwives are known to promote physiological birth through continuous support, facilitation of women's autonomy, and individualised, relationship-based care.	Italian hospital-based midwives consistently support physiological birth using evidence-based practices; however, reduced adherence in decision-making processes reveals ongoing obstacles to achieving truly woman-centred care.

Introduction

Childbirth is a fundamental life event with significant implications for maternal and neonatal health, as well as for the psychological, emotional, and social well-being of women and families. Over recent decades, increasing attention has been given to promoting physiological birth as a cornerstone of high-quality maternity care (1). Physiological birth—understood as a process that unfolds through the body's innate mechanisms and is supported without unnecessary medical interventions—has been associated with improved maternal and neonatal outcomes, including reduced morbidity, enhanced emotional well-being, and more positive birth experiences (2,3). Despite this growing body of evidence, global trends continue to show rising rates of obstetric interventions, including induction of labour and caesarean section, which may disrupt physiological processes and increase short and long-term risks for women and newborns (4,5).

The concept of “normal physiological birth” is inherently complex and contested, extending beyond clinical indicators to encompass women's embodied experiences, relational care, and the sociocultural and organisational contexts in which birth occurs (6,7). Recent scholarship highlights that physiological labour and birth are not passive or self-sustaining processes, but dynamic phenomena that require active, skilled support from healthcare professionals and maternity care systems. Key elements such as continuity of caregiver, respectful communication, supportive environments, and judicious clinical decision-making play a crucial role in enabling physiological processes to unfold optimally (8). However, within modern maternity services, increasing emphasis on risk management, standardisation, and technological surveillance may inadvertently undermine

these conditions, contributing to the overuse of interventions even in healthy pregnancies. This tension reflects an ongoing challenge in aligning contemporary maternity care systems with the principles of physiological birth (8).

Although international guidelines advocate for evidence-based intrapartum care that prioritizes a positive childbirth experience and the minimisation of unnecessary interventions (1), their implementation remains inconsistent across settings. Organisational constraints, lack of training, and cultural norms favouring interventionist models continue to pose barriers to adopting physiological approaches (9,10). As a result, a persistent gap exists between policy recommendations and everyday clinical practice, highlighting the need for context-specific research to better understand how physiological birth can be actively supported within existing healthcare systems (11).

Italy represents a particularly relevant context in which to explore these issues. Despite favourable maternal and neonatal mortality indicators, Italy reports one of the highest caesarean section rates in Europe (12), with marked regional variability (13). This pattern reflects a deeply medicalized approach to childbirth, shaped by cultural expectation, organizational models of care, and concerns related to professional accountability and litigation (14). Midwives in Italy predominantly work within hospital-based, obstetric-led services, where their professional autonomy and capacity to implement midwifery-led, physiological models of care may be constrained. Understanding how midwives practice within these settings, and how they support normal birth despite systemic limitations, is therefore critical for informing strategies to improve maternity care and align practice within international recommendations.

Existing literature underscores the central role of midwives in facilitating physiological birth through strategies such as watchful attendance, promotion of women's agency, and individualised, relationship-based care (15,16). However, evidence remains limited regarding how these principles are operationalized in highly medicalised contexts and which organisational, professional, and cultural factors enable or hinder their implementation. Furthermore, while women's preferences and experiences of childbirth have been widely explored (6), fewer studies (17,18) have integrated midwives' perspectives with an analysis of the broader system in which care is delivered.

To address these gaps, this study aims to describe midwifery practices and support strategies for physiological birth within the Italian maternity care context. By examining how midwives conceptualise and enact support for physiological labour and birth in everyday clinical practice, this research seeks to generate contextually grounded insights that can inform policy, education, and

service development. Strengthening understanding of midwifery practice in this area is essential for promoting safe, respectful, and woman-centred childbirth care, while also contributing to efforts to reduce unnecessary interventions and support sustainable maternity care systems.

Methods

Study

Design

This study employed a quantitative descriptive observational design (19,20) to describe how midwives support physiological processes during labour and birth. This approach is particularly suited to exploring complex, context-dependent practices such as midwifery support during physiological labour, where the aim is to capture patterns, frequencies, and variations in real-world settings. By providing a comprehensive description of these practices, descriptive observational research facilitates a holistic understanding of the phenomenon and offers a foundation for future hypothesis-driven studies.

The investigation was conducted through systematic observation of routine clinical practice in an Italian hospital setting.

Setting

Clinical observations were carried out in one of the 5 Hospitals with a Maternity ward of the AUSL della Romagna. This maternity Unit welcomes nearly 1,636 newborns per year; attended by a team of 30 midwives, specifically employed in the labour ward. The unit provides services for both healthy and high-risk women, employing a one-to-one midwifery care approach for all labouring women. Upon admission, women are allocated to a specific care model based on obstetric risk, following regional guidelines. Healthy women are managed independently by midwives, whereas those with identified risk factors receive care within a shared model involving a multidisciplinary team comprising a midwife, obstetrician, anaesthesiologist, and neonatal staff. The Maternity Unit promotes normal childbirth through a care model that emphasizes maternal autonomy and competence. The assigned midwife monitors and supports labour progression through midwifery care. Midwives engage in continuous education during their careers to uphold and advocate for the physiological process of birth. Compared to national data, the research setting is characterized by a moderate use of medical interventions, such as 46% epidural analgesia, 1% episiotomy rate and 20.4% caesarean section rate. Totally, more than 25% of births occurred without any interventions, of these, 9% are water births.

Instrument

The PPO_ITA (Physiological Practices Observation – Italian version) tool was used to assess midwifery adherence to practices that promote physiological childbirth.

The PPO tool was developed in 2018 for observing the use of care practices to support physiological labour and birth (21). The 7 domains and 31 items tool was assessed as relevant to observing physiological care practices. The 7 domains include approach to care, early labour, environment, supporting woman, ongoing care, first hour of birth, involving woman in decision-making.

The PPO_ITA tool underwent rigorous translation and cultural validation prior to its use in the Italian clinical setting; details of this process are reported elsewhere (22). The instrument comprises **7 domains and 30 items**, designed to explore and describe midwifery care practices that promote physiological labor and childbirth. Each item is rated on a 4-point Likert scale, indicating the level of adherence to recommended practices (1 = never or rarely observed; 2 = sometimes observed; 3 = often observed; 4 = always observed).

Participants and Data Collection

A sample of fifty midwife–woman interactions during labour care was selected. Assuming each episode lasted between two and three hours, the total observation time ranged from approximately 100 to 150 hours. This duration aligns with the sample size used in comparable systematic observation studies conducted in maternity care settings.(17,23).

Upon receiving preliminary approval, the research project will be formally presented to the midwives working in the Labour ward. Written informed consent will be obtained from each participant prior to data collection. Midwives were recruited based on two inclusion criteria: they had to be employed—either on a permanent or temporary basis—within the Obstetric Unit, and must have completed the mandatory orientation period required for clinical practice in the Labour Ward. Women were eligible for inclusion if they had a full-term pregnancy, a singleton foetus in cephalic presentation, and were able to understand Italian.

All observations were conducted by the principal investigator (ET), who was responsible for data collection and analysis in this study, and who is a midwife with more than ten years of experience working with pregnant individuals and providing hospital-based midwifery care in Italian labour and delivery units. In addition to her clinical expertise, she also had extensive experience in designing and conducting applied qualitative and quantitative health research studies.

Data Analysis

Sample characteristics were summarised using frequency tables and percentages for categorical variables, and means with standard deviations (SD) for continuous variables. The distribution of continuous variables was visually inspected to assess approximate normality prior to analysis. Comparisons between groups were conducted using the chi-square test for categorical variables and the independent-samples t-test for continuous variables, as appropriate. All statistical tests were two-sided, and a p-value < .05 was considered statistically significant. Responses to each criterion, measured on a four-point Likert scale (ranging from 1 to 4), were described using bar charts to illustrate the distribution of scores, with higher values indicating greater support for physiological care. To assess adherence to recommended practice, a score of 4 was defined a priori as full compliance with the PPO_ITA standards, representing the optimal level of care. The proportion of observations achieving full compliance was calculated for each item. Differences in adherence to recommended practices were explored by comparing observations involving women with physiological labour at admission to those with non-physiological conditions at the onset of labour. In addition, associations between full adherence to PPO_ITA standards (score = 4), midwives' years of professional experience, and physiological pregnancy status at labour onset were examined using the chi-square test. All analyses were performed using R statistical software (version 3.6.0).

Ethical

Considerations

The study protocol received ethical approval from the University of Bologna Ethics Committee on July 29, 2024 (Protocol No. 0217330). All procedures were conducted in accordance with ethical standards for research involving human participants.

Results

Fifty-one observations of intrapartum care were observed between December 2024 and August 2025. Table 1 describes the characteristics of the observed women and of the observed midwives. Observational data indicate that certain midwives engaged in repeated interactions with multiple labouring women (n=28), whereas only a single woman was documented as interacting with two distinct midwives (n=51). Additionally, the findings are consistent with the median socio-demographic and obstetric history of the women who typically frequent this labour room (6)

One hundred and eleven hours of direct intrapartum observation were undertaken. The median number of observation hours was 2.00, with an IQR ranging from 1.00 to 3.00 hours.

During data collection, some items were deemed not applicable due to the specific characteristics of individual situations. Complete observation of all phases of labour was possible in 13 cases. Most

non-applicable data concerned observations during the third stage of labour, which could not be fully assessed due to the end of the observer's shift.

During the observed period, in over 30% of cases, the decision-making domain was not observed, mostly because it wasn't required to discuss any modifications to the care that women anticipated receiving. Table 2 reports the percentage of observations for items that included elements deemed non-assessable. All remaining items were consistently observed across all cases.

Table 3 illustrates the distribution of midwives' practices across the four point Likert scale levels. Indicators shown in brown (Level 4) and violet (Level 3) reflect strong adherence to recommended standards; while, practices represented by orange (Level 1) and light blue (Level 2) reveal significant gaps.

The observed midwives exhibited a generally high level of compliance with recommended care practices, as evidenced by adherence scores exceeding level 3 in more than 70% of observations across all evaluated items (with the exception of the items 4.4, 5.2 and 7.3). This finding suggests a strong alignment with evidence-based guidelines in routine clinical practice.

Among the domains, the highest levels of adherence were observed in domains 1 (Approach to care), 3 (Environment), and 6 (first hours of birth) indicating particularly robust compliance in these areas. The highest level of adherence was observed in item 6.3 where only values more than 3 are reported; with a 93% of "level 4" (always observed).

Domain 4 (supporting women) and 7 (advocacy) include the majority of items with the lowest overall score compared to the others.

For example, item 4.4 has a proportion of responses at levels 1 and 2 reached 41.2%, indicating that a substantial number of midwives did not consistently communicate confidence in the woman's capacity to give birth. Observation data indicate the need to strengthen midwives' confidence in practices included in Domain 7, which pertains to the involvement of women in decision-making, as this domain reported the lowest overall score compared to the others, with approximately 30% of observations rated at level 1 or 2.

When we consider the physiological pregnancy status at the beginning of labour, the results revealed no significant differences across clinical scenarios. Midwives consistently safeguarded and promoted the physiological process irrespective of the initial risk status (Table 4). The only statistically significant variation was observed in Item 5.2 ("keeps the woman informed about the baby's well-being"), which was applied more consistently in high-risk pregnancies.

As a final step, the analysis explored whether adherence to practices supporting physiological birth was influenced by years of professional experience. The analysis revealed that midwives with more than 10 years of experience showed higher adherence to recommended practices, particularly in domains related to emotional support, care during labour (Domain 5), and involvement of women in decision-making (Domain 7).

For all items showing statistically significant differences, adherence to practices supporting physiological labour was higher among more experienced midwives, suggesting that professional experience may have a protective role.

Discussion

This study contributes to the growing body of evidence on how midwives support physiological labour and birth within contemporary maternity services. Overall, the findings demonstrate a high level of adherence to practices that safeguard physiological processes, irrespective of women's clinical condition at the onset of labour. This observation aligns with the Quality Maternal and Newborn Care framework, which identifies midwifery-led supportive care as central to promoting normal birth within diverse clinical settings (24).

The highest adherence was observed in practices related to environmental and relational support, such as facilitating mobility, encouraging oral intake, and creating a calm, comfortable birth environment. These results are consistent with international evidence emphasising the importance of contextual and relational elements in supporting physiological birth and improved outcomes (7,25).

Studies highlight that such practices are not merely procedural but reflect core aspects of professional identity and woman-centred care (26). Furthermore, recent global guidance from the World Health Organization underscores that midwifery models of care, which include continuity and strong communication, are associated with higher rates of spontaneous vaginal birth and greater maternal satisfaction, reinforcing the practice patterns observed in this study.

In contrast, lower adherence was observed for practices related to women's involvement in decision-making. This finding may be partially explained by the absence of continuity of care in the study setting, where women were typically supported during labour by midwives they had not previously met. Continuity of midwifery care has been consistently shown to foster trust, shared understanding, and women's active participation in decision-making processes during childbirth (27,28). According to the World Health Organization, midwifery models of care—characterized by continuous support

from pre-pregnancy through the postnatal period—promote women’s involvement in decision-making, empowerment, and informed choice (29)

Additionally, the limited use of birth plans and structured shared decision-making tools may further restrict opportunities for informed choice, particularly during active labour, when time pressure and clinical demands can reduce meaningful dialogue (30). This study also highlights the challenge of capturing the subtle and often invisible work that underpins midwifery support for physiological birth. Practices such as skilled non-intervention, attentive presence, and situational awareness are central to midwifery care but remain difficult to quantify through task-focused observational measures. Qualitative research describes these dimensions as integral to midwives’ professional judgement and relational competence, contributing to women’s sense of safety, confidence, and trust during labour (Hunter et al., 2022; Shorey & Ng, 2023). These findings resonate with the present study and underline the value of observational approaches that attempt to document not only what midwives do, but how they support physiological processes through presence, restraint, and responsiveness to women’s cues.

In this study data suggest that midwives play a central role in supporting physiological processes in childbirth, regardless of whether labour is classified as low or high risk. The midwifery model of care is grounded in the recognition that physiological birth remains possible and meaningful even in the presence of clinical risk, provided that care is individualised, responsive, and adequately monitored (31). Supporting physiology does not imply the absence of intervention but rather a professional commitment to optimise normal processes while integrating necessary medical care when indicated (24). Evidence suggests that midwife-led and woman-centred models of care promote appropriate use of interventions, enhance women’s experiences, and improve clinical outcomes across diverse risk profiles. In this context, midwifery care seeks to maintain continuity, informed decision-making, and respect for women’s embodied knowledge, ensuring that safety measures are balanced with trust in the physiological capacity of the woman throughout labour and birth (1).

Finally, midwives with more than ten years of professional experience demonstrated higher adherence to practices supporting emotional safety, labour care, and involving women in decision-making. While some earlier studies reported lower support for physiological birth among more experienced clinicians, this discrepancy may reflect changes in midwifery education, clinical exposure to birth settings, and evolving professional expectations (32). Emerging literature suggests that newly qualified midwives may encounter fewer opportunities to routinely support physiological birth, potentially undermining confidence and skill development in intervention-oriented systems

(33–35)) . These results highlight the importance of organisational and educational strategies to ensure early-career midwives gain sufficient exposure and mentorship in physiological support practices.

A key strength of this study is the use of systematic direct observation to examine midwifery practices in real-world clinical settings, providing insights into routine intrapartum care that are rarely captured through self-reported methods. The structured observational framework, grounded in evidence-based standards, enhanced the consistency and transparency of data collection.

Several limitations should be acknowledged. The study was conducted in a single hospital setting, which may limit transferability to other organisational or cultural contexts. Observations of second- and third-stage care were limited, restricting conclusions about these phases of labour. In addition, while observation captures observable behaviour, it may not fully reflect the cognitive, emotional, and relational dimensions of midwifery work, particularly those related to watchful attendance and clinical reasoning. Finally, although the use of a single experienced observer enhanced consistency, the potential for observer bias cannot be entirely excluded.

Conclusions

This study demonstrates that midwives working within an Italian hospital-based maternity care system consistently support physiological labour and birth through practices aligned with evidence-based recommendations, regardless of women's clinical risk status at labour onset. Strong adherence was observed in domains related to supportive and environmental care, highlighting the role of midwives in protecting physiological processes even within highly medicalised contexts. However, lower levels of adherence were identified in practices related to women's involvement in decision-making, pointing to persistent challenges in delivering fully woman-centred care.

Based on these findings, several recommendations can be made. First, maternity care organisations should strengthen models of care that promote continuity of midwifery support, as this appears critical for enhancing women's participation in decision-making and relational aspects of care. Second, education and professional development initiatives should prioritise sustained exposure to physiological birth, particularly for early-career midwives, to foster confidence, clinical judgement, and skills in supporting normal processes. Third, policies and clinical guidelines should explicitly recognise and value the relational and interpretive dimensions of midwifery practice—often described as “watchful attendance”—alongside technical competencies.

Finally, future research should expand observational approaches to include all stages of labour and further explore how organisational and cultural contexts shape midwives' ability to support physiological birth. Together, these actions may contribute to strengthening midwifery practice, reducing unnecessary interventions, and improving women's childbirth experiences within contemporary maternity care systems.

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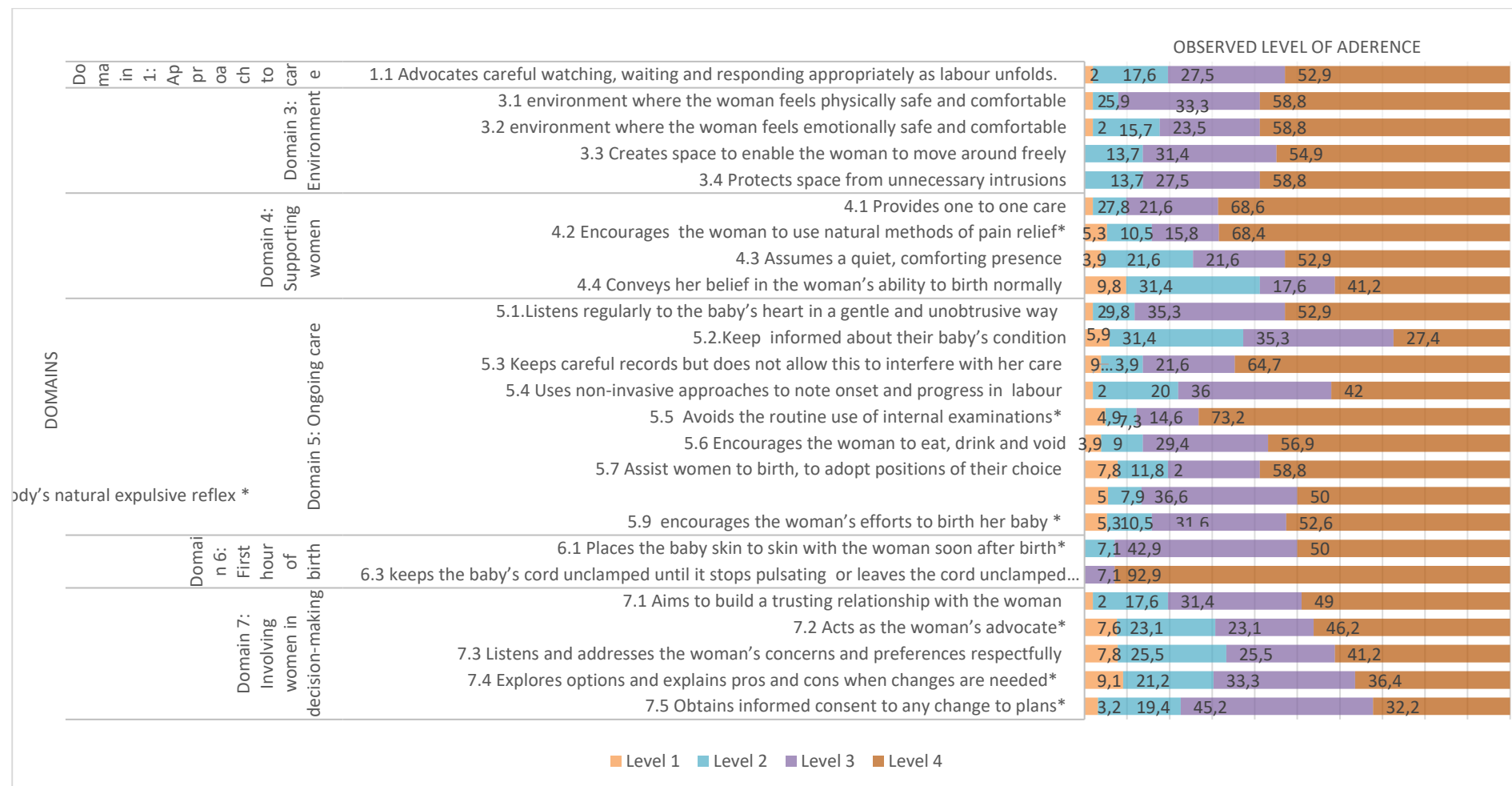
Characteristics of the observed midwives		N (n=28)	%
Years of Professional Experience in maternity ward	≤ 10 years:	20	39.2
	> 10 years	31	60.8
Education Level (%)	Bachelor Degree	46	90.2
	Master Degree	2	3.9
	Clinical Master Degree	3	5.9
	Mediam	1Q	3 Q
Years of Professional Experience	10.00	6	19
Characteristics of the observed women		N (n=50)	%
Physiological labour at the beginning	Yes	14	28
	No	36	72
Parity (%)	1	33	66
	2	12	24
	> 3	5	10%

Table 1: Characteristics of the observed women and of the observed midwife

		% Observed
Domain 4: Supporting women	4.2 Encourages the woman to use natural methods of pain relief	74,5
Domain 5: Ongoing care	5.5 Avoids the routine use of internal examinations	80,4
	5.8 Awaits and supports the woman to use her body's natural expulsive reflex	74,5
	5.9 encourages the woman's efforts to birth her baby	74,5
Domain 6: First hour of birth	6.1 Places the baby skin to skin with the woman soon after birth	27,5
	6.3 keeps the baby's cord unclamped until it stops pulsating or leaves the cord unclamped for as long as the woman wishes	27,5
Domain 7: Involving women in decision-making	7.2 Acts as the woman's advocate	76,5
	7.4 Explores options and explains pros and cons when changes are needed	64,7
	7.5 Obtains informed consent to any change to plans	60,8

Table 2: Observed Percentages of Items with Non-Assessable Elements

Table 3 Distribution of midwives' practices across the four point Likert scale levels



Legend: Items with* are Items with Non-Assessable Elements. Refer to table 2 for full description

Table 4: Statistically Significant Differences in Midwifery Practices whether the woman presented with a physiological labour at onset

Domain	Item	Level	Overall	Physiological (n=14)		Not Physiological (=31)		p
				N	%	N	%	
Domain 1: Approach to care	1.1 Advocates careful watching, waiting and responding appropriately as labour unfolds.	Yes	27	6	42.9	21	58.3	0.503
Domain 3: Environment	3.1 Environment where the woman feels physically safe and comfortable	Yes	30	5	35.7	25	69.4	0.062
	3.2 Environment where the woman feels emotionally safe and comfortable	Yes	30	6	42.9	24	66.7	0.222
	3.3 Creates space to enable the woman to move around freely	Yes	28	7	50	21	58.3	0.829
	3.4 Protects space from unnecessary intrusions	Yes	30	7	50	23	63.9	0.563
Domain 4: Supporting women	4.1 Provides one to one care	Yes	35	11	78.6	24	66.7	0.630
	4.2 Encourages the woman to use natural methods of pain relief*	Yes	26	7	63.6	19	73.1	0.857
	4.3 Assumes a quiet, comforting presence	Yes	27	7	50.0	20	55.6	0.970
	4.4 Conveys her belief in the woman's ability to birth normally	Yes	21	5	35.7	16	44.4	0.808
Domain 5: Ongoing care	5.1.Listens regularly to the baby's heart in a gentle and unobtrusive way	Yes	27	5	35.7	22	61.1	0.193
	5.2.Keep informed about their baby's condition	Yes	14	0	0.0	14	38.9	0.016
	5.3 Keeps careful records but does not allow this to interfere with her care	Yes	33	9	64.3	23	63.9	1.000
	5.4 Uses non-invasive approaches to note onset and progress in labour	Yes	21	5	35.7	16	45.7	0.749
	5.5 Avoids the routine use of internal examinations*	Yes	30	7	63.6	22	75.9	0.706
	5.6 Encourages the woman to eat, drink and void	Yes	29	6	42.9	23	63.9	0.301
	5.7 Assist women to birth, to adopt positions of their choice	Yes	29	8	57.1	21	58.3	1.000
	5.8 Awaits and supports the woman to use her body's natural expulsive reflex *	Yes	19	6	54.5	13	48.1	1.000
	5.9 Encourages the woman's efforts to birth her baby *	Yes	20	4	36.4	16	59.3	0.356
Domain 6: First hour of birth	6.1 Places the baby skin to skin with the woman soon after birth*	Yes	7	2	33.3	5	62.5	0.589
	6.3 keeps the baby's cord unclamped until it stops pulsating or leaves the cord unclamped for as long as the woman wishes *	Yes	13	5	83.3	8	100.0	0.881
Domain 7: Involving women in decision-making	7.1 Aims to build a trusting relationship with the woman	Yes	24	6	42.9	18	50.0	0.890
	7.2 Acts as the woman's advocate*	Yes	18	5	41.7	13	48.1	0.979
	7.3 Listens and addresses the woman's concerns and preferences respectfully	Yes	21	5	35.7	16	44.4	0.808
	7.4 Explores options and explains pros and cons when changes are needed*	Yes	12	3	27.3	9	40.9	0.701
	7.5 Obtains informed consent to any change to plans*	Yes	10	4	36.4	6	30.0	1.000

Legend: Items with* are Items with Non-Assessable Elements. Refer to table 2 for full description

Table 5 Statistically Significant Differences in Midwifery Practices by Years of Professional Experience

Domain	Item	level	Overall	Work experience <10 y (n=20)		Work experience >10 y (n=30)		p
				N	%	N	%	
Domain 1: Approach to care	1.1 Advocates careful watching, waiting and responding appropriately as labour unfolds.	Yes	27	8	40	19	61.3	0.230
Domain 3: Environment	3.1 Environment where the woman feels physically safe and comfortable	Yes	30	8	40.0	22	71.0	0.057
	3.2 Environment where the woman feels emotionally safe and comfortable	Yes	30	7	35.0	23	74.2	0.013
	3.3 Creates space to enable the woman to move around freely	Yes	28	9	45.0	19	61.3	0.394
	3.4 Protects space from unnecessary intrusions	Yes	30	11	55.0	19	61.3	0.877
Domain 4: Supporting women	4.1 Provides one to one care	Yes	35	14	70.0	21	67.7	1.000
	4.2 Encourages the woman to use natural methods of pain relief*	Yes	26	8	50.0	18	81.8	0.084
	4.3 Assumes a quiet, comforting presence	Yes	27	5	25.0	22	71.0	0.003
	4.4 Conveys her belief in the woman's ability to birth normally	Yes	21	3	15.0	18	58.1	0.006
Domain 5: Ongoing care	5.1.Listens regularly to the baby's heart in a gentle and unobtrusive way	Yes	27	6	30.0	21	67.7	0.019
	5.2.Keep informed about their baby's condition	Yes	14	2	10.0	12	38.7	0.055
	5.3 Keeps careful records but does not allow this to interfere with her care	Yes	33	10	50.0	23	74.2	0.143
	5.4 Uses non-invasive approaches to note onset and progress in labour	Yes	21	2	10.0	19	63.3	0.001
	5.5 Avoids the routine use of internal examinations*	Yes	30	9	56.2	21	84.0	0.111
	5.6 Encourages the woman to eat, drink and void	Yes	29	9	45.0	20	64.5	0.278
	5.7 Assist women to birth, to adopt positions of their choice	Yes	29	9	45.0	20	64.5	0.278
	5.8 Awaits and supports the woman to use her body's natural expulsive reflex *	Yes	19	2	13.3	17	73.9	0.001
	5.9 Encourages the woman's efforts to birth her baby *	Yes	20	4	26.7	16	69.6	0.024
Domain 6: First hour of birth	6.1 Places the baby skin to skin with the woman soon after birth*	Yes	7	2	28.6	5	71.4	0.285
	6.3 keeps the baby's cord unclamped until it stops pulsating or leaves the cord unclamped for as long as the woman wishes *	Yes	13	6	85.7	7	100.0	1.000
Domain 7: Involving women in decision-making	7.1 Aims to build a trusting relationship with the woman	Yes	24	3	15.0	21	67.7	0.001
	7.2 Acts as the woman's advocate*	Yes	18	3	20.0	15	62.5	0.024
	7.3 Listens and addresses the woman's concerns and preferences respectfully	Yes	21	5	25.0	16	51.6	0.111
	7.4 Explores options and explains pros and cons when changes are needed*	Yes	12	0	0.0	12	63.2	0.001
	7.5 Obtains informed consent to any change to plans*	Yes	10	1	7.7	9	50.0	0.036

Legend: Items with* are **Items with Non-Assessable Elements**. Refer to table 2 for full description

Acknowledgments

I would like to express my deepest gratitude to the midwives and the women whose participation made this study possible. My sincere thanks go to Claudia Cavicchi, librarian at the University of Bologna, for her unwavering support and invaluable guidance in developing the search strategies. I am also grateful to everyone who took the time to read, reflect on, and contribute thoughtful suggestions to this work.

A heartfelt thank-you to my supervisor for her constant support, and to my family, who found creative and innovative ways to accompany me throughout this journey.

