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# Healthy Birth Practice #2: Walk, Move Around, and Change Positions Throughout Labor

## 健康分娩实践#2: 在待产时行走、移动和改 变姿势

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### ABSTRACT

#### 摘要

In the United States, obstetric care is intervention intensive, resulting in 1 in 3 women undergoing cesarean surgery wherein mobility is treated as an intervention rather than supporting the natural physiologic process for optimal birth. Women who use upright positions and are mobile during labor have shorter labors, receive less intervention, report less severe pain, and describe more satisfaction with their childbirth experience than women in recumbent positions. This article is an updated evidence-based review of the “Lamaze International Care Practices That Promote Normal Birth, Care Practice #2: Freedom of Movement Throughout Labor,” published in *The Journal of Perinatal Education*, 16(3), 2007.

美国的产科照护遭受的干预程度很高, 导致每 3 位女性中有 1 位会经历剖腹产, 在这个过程中移动被视为一种干预手段, 而不是支持最佳分娩的自然生理过程的一种方法。采取直立姿势并且在待产时保持活动的女性, 产程更短, 受到的干预更少, 感受的疼痛更少, 分娩体验的满意度比躺卧的女性更高。本文是对《围产教育杂志》里发表的《倡导正常分娩的国际拉玛泽照护实践, 照护实践#2: 在待产时自由移动》2007, 16(3)的最新循证综述。

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Keywords: mobility, first stage of labor, upright positions, position change

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关键词: 活动、产程第一阶段、直立姿势、姿势改变

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A 2012 consensus statement by The American College of Nurse-Midwives (ACNM), Midwife Alliance of North America, and the National Association of Certified Professional Midwives entitled “Supporting Healthy and Normal Physiologic Childbirth” defines a normal physiologic labor and birth as “one that is powered by the innate human capacity of the woman and fetus” (p. 2). It includes supportive care practices and low-technology techniques that facilitate the normal biological process of childbirth (Goer & Romano, 2012). Freedom to be mobile in labor is more likely to be safe and healthy because it does not disrupt the

normal physiologic processes (Romano & Lothian, 2008). The physiologic process of birth is hormonally designed so that when labor starts, the uterine muscle responds to oxytocin. Women respond to the pain of uterine contractions by moving around to reduce their pain. In the ideal scenario, the pain response signals the brain to continue to release more oxytocin and contractions become more effective. In an environment where women feel safe, beta-endorphins help a woman respond to pain by using coping strategies. Movement is one coping strategy for pain, and freedom to be mobile in labor is a safe, healthy coping strategy in part because it does not disrupt the

normal physiologic processes (Romano & Lothian, 2008). In an environment where women feel stressed and fearful, the stress hormones (catecholamines)

can increase, slowing the process of the first stage of labor. Understanding the role of hormones of labor, as well as the role of movement in comfort and the progress of labor, can give women more confidence in the process of labor and birth and in their own ability to manage labor.

一份由美国护士-助产士协会 (ACNM)、北美助产士联盟和全国认证专业助产士学会联合发布的共识声明《支持健康和正常的生理性分娩》，将正常的生理性待产和分娩定义为“由女性和胎儿的人类固有本能所驱动的待产和分娩” (p. 2)。这份声明中包含支持性的照护实践和并不复杂的技能，都能推进分娩的正常生理过程(Goer & Romano, 2012)。待产时如果能活动，分娩就会更安全健康，因为活动不会干扰正常的生理过程(Romano & Lothian, 2008)。分娩的生理过程受到荷尔蒙的控制，因此一旦产程开始，子宫的肌肉就对催产素做出反应。女性对于宫缩疼痛的反应就是通过活动来减痛。在理想状态下，疼痛反应向大脑传送信号，释放更多的催产素，宫缩也就变得更有效。若女性所处的环境令她感到安全，贝塔内啡肽帮助她采取应对策略来减痛。移动是减痛的一种应对策略，在待产时移动是一种安全健康的减痛方法，因为活动不会干扰正常的生理过程(Romano & Lothian, 2008)。若女性所处的环境令她感到压力和害怕，压力荷尔蒙（儿茶酚胺）就会上升，减缓第一产程。女性若了解荷尔蒙在分娩中的作用，移动减痛作用以及产程的相关知识，她就能在分娩时更加自信，对自己管理疼痛的能力也有信心。

Women value the choice to be mobile during labor, and most feel that the process of birth should not be interfered with unless medically necessary (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2013; Scotland, McNamee, Cheyne, Hundley, & Barnett, 2011). The percentage of polled women who believe that birth should not be interfered with increased from 46% in 2003 to 59% in 2013 (Declercq et al., 2013). Although women reported experiencing less pain when they were able to be mobile in 2003, the 2013 follow-up survey, *Listening to Mothers III*, reported that only 40% of mothers changed positions in labor and only 43% walked after admission to the hospital (Declercq et al., 2013; Declercq, Sakala, Corry, Applebaum, & Risher, 2002). The norm in the United States is medicalized birth that restricts a woman's mobility in labor, despite no study ever reporting that walking in labor is harmful to healthy women or their babies (Storton, 2007). The practice of restricting women's movement in labor is contrary to the recommendations of the World Health Organization (1996) and La-

maze International's Healthy Birth Practices (Shilling, 2009; Shilling, Romano, & DiFranco, 2007). The aim of this article is to provide an updated review of the literature on movement during labor and a discussion of factors in the current medical and social environment which could lead to practice change and support the adoption of freedom of movement as a birth practice that facilitates the normal physiology of labor and birth.

女性希望能在分娩时移动。大部分女性认为除非有医疗需要，分娩的过程不应受到干扰(Declercq, Sakala, Corry, Applebaum, & Herrlich, 2013; Scotland, McNamee, Cheyne, Hundley, & Barnett, 2011)。调查显示，认为分娩不应受到干扰的女性从 2003 年的 46% 上升到 2013 年的 59%(Declercq 等, 2013)。尽管 2003 年的调查显示，女性觉得移动让她们的疼痛得以减弱，但是 2013 年的跟进调查《倾听母亲 III》显示，只有 40% 的女性在待产时变换体位，只有 43% 的女性在入院后走动。(Declercq 等, 2013; Declercq, Sakala, Corry, Applebaum, & Risher, 2002)。尽管并没有研究显示待产时走动会对健康的母婴造成危害，但是在美国分娩往往是一种医疗事件，女性在待产时的移动自由受到限制(Storton, 2007)。限制女性待产时移动这种做法与世界卫生组织 (1996) 和国际拉玛泽健康分娩实践(Shilling, 2009; Shilling, Romano, & DiFranco, 2007)的建议背道而驰。本文旨在对待产时移动的研究文献做最新综述，并且讨论当前医疗和社会环境下的种种因素，这些因素也许可以带来实践上的改变，将自由移动纳入分娩实践，以此支持待产和分娩的正常生理过程。

## EVIDENCE BASIS FOR MOVEMENT IN LABOR

### 待产时移动的证据基础

The review of the literature included an updated Cochrane Database of Systematic Reviews confirming previous findings: “[W]e believe wherever possible, women should be informed of the benefits of upright positions, encouraged and supported to take up whatever positions they choose, and should not have their freedom of movement options restricted unless clinically indicated” (Lawrence, Lewis, Hofmeyr, & Styles, 2013, p. 13). The researchers examined 25 randomized or quasirandomized trials of 5,218 women. The reported findings use average risk ratio (RR) for categorical data

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女性若了解荷尔蒙在分娩中的作用，移动的减痛作用以及产程的相关知识，她就能在分娩时更自信，对自己管理疼痛的能力也更自信。

and mean difference (MD) for continuous data. In the comparison of upright and ambulant positions versus recumbent positions during the first stage, the conclusion is that labor is shorter by approximately 1 hr and 22 min for women randomized to upright as opposed to recumbent positions (average MD 21.36, 95% confidence interval [CI] 22.22–20.51; 15 studies, 2,503 women; random effects,  $T^2 = 2.39$ ,  $\chi^2 = 203.55$ ,  $df = 14$ , [ $p < .00001$ ],  $I^2 = 93\%$ ). Women who were upright were also less likely to have cesarean surgery (RR 0.71, 95% CI [0.54–0.94]; 14 studies, 2,682 women) and less likely to have an epidural (RR 0.81, 95% CI [0.66–0.99]; 9 studies, 2,107 women; random-effects,  $T^2 = 0.02$ ,  $I^2 = 61\%$ ; Lawrence et al., 2013).

文献综述参考了最新的《系统性综述考科蓝数据库》，该文证实了之前的研究结论：“我们认为应该尽可能告知女性直立姿势的好处，鼓励和支持她们选择自己喜欢的姿势，在没有临床指征的情况下不限制她们移动的自由。” (Lawrence, Lewis, Hofmeyr, & Styles, 2013, p. 13)。研究者针对 5218 名女性做了 25 组随机或类随机试验。实

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验结果对分类数据统计风险率，对连续数据统计平均差。在第一产程中，随机采用直立姿势和能够行走的女性与躺卧的女性相比，产程大约缩短了 1 小时 22 分钟（平均差 21.36, 95% 置信区间 22.22–20.51; 15 项研究, 2053 名女性; 随机效应,  $T^2 = 2.39$ ,  $\chi^2 = 203.55$ ,  $df = 14$ , [ $p < .00001$ ],  $I^2 = 93\%$ )。采用直立姿势的女性也更少需要硬膜外镇痛 (RR 0.81, 95% CI [0.66–0.99]; 9 项研究, 2107 名女性, 随机效应,  $T^2 = 0.02$ ,  $I^2 = 61\%$ ; Lawrence 等, 2013)。

The authors questioned the methodological quality of the trials. Another problem with the data from the Cochrane review is that the studies were conducted over a 50-year period in 13 different countries where many cultural changes in the management of labor and women's expectations about birth, as well as an increase in the use of technology, have occurred. In the studies that included women who received epidural anesthesia, there were no differences in the duration of labor in groups that compared upright and ambulant position versus recumbent. Only one of the studies reported examined results of upright positioning on the baby. It concluded lower admissions to a neonatal intensive care unit (RR 0.20, 95% CI [0.04–0.89]; 200 women) for upright and ambulant women.

研究者们质疑了这些试验的方法学质量。这项考柯蓝综述在数据方面的另一个问题是，这些研究涉及 13 个国家，时长达 50 年，在这期间，产程管理的理念和女性对分娩的期待都产生了变化，运用的技术也越来越发达。在另外一组涉及接受硬膜外麻醉女性的研究里，并未发现直立、移动的女性之产程相较于躺卧的女性有何差别。只有一项研究报告了直立姿势对于宝宝的影响：采取直立和移动姿势的女性娩出的婴儿，进入新生儿重症监护室的比例更低 (RR 0.20, 95% CI [0.04–0.89]; 200 名女性)。

Although there is a lack of well-conducted studies, it seems logical that the actual benefits of mobility in the first stage of labor could be greater than reported in the mobility studies analyzed by the authors of the Cochrane review and others (Hollins-Martin & Martin, 2013). Participants in randomized controlled trials (RCTs) are assigned to a group and remain in that group whether they walk or not. This is the nature of RCTs, which must be analyzed according to “intent to treat.” The participants of the trials have to remain in their group. This makes it harder to find a significant difference in clinical trials related to mobility in labor (Goer, 2013). An

important finding is that no studies report maternal activity in labor lengthening labor.

尽管还缺乏良好的研究，但在第一产程中移动的实际益处貌似比考柯蓝综述的作者和其他研究者所做的移动研究中发现的益处更多 (Hollins- Martin & Martin, 2013)。随机对照试验的参与者被分配到某组后，无论其是否行走都要留在该组。这就是随机对照试验的性质，要根据“治疗意向”进行分析。参与者必须要一直留在自己组。这就让我们更加难以在与产程行走有关的临床试验中找出显著差异 (Goer, 2013)。一个重要的研究结果是，没有任何研究发现女性在产程中保持活动会延长产程。

There are several studies that do find advantages to movement in labor. Women who use upright positions during labor have shorter labors, receive less intervention, report less severe pain, and describe more satisfaction with their childbirth experience than women in semirecumbent or supine positions (Priddis, Dahlen, & Schmied, 2012). In a study published in *Nursing Research*, laboring women experienced more lower back pain when recumbent (Adachi, Shimada, & Usai, 2003). Changing positions not only helps women cope with the pain of labor; upright positions use gravity to bring the baby down, whereas changing position frequently moves the bones of the pelvis, helping the baby find the best fit (Simkin & Ancheta, 2011; Storton, 2007).

有几项研究的确发现了待产时移动的好处。待产时采用直立姿势的女性，产程更短、接受干预更少、疼痛感降低，并且与半卧和平躺的女性相比，她们对分娩体验的满意度更高 (Priddis, Dahlen, & Schmied, 2012)。在《护理研究》里发表的一项研究显示，产妇在躺卧时的下背部疼痛更明显 (Adachi, Shimada, & Usai, 2003)。改变姿势不止帮女性应对产痛；直立的姿势利用地心引力让胎儿下降，经常变换姿势可以让骨盆的骨头调整位置，帮助胎儿找到最佳位置 (Simkin & Ancheta, 2011; Storton, 2007)。

#### **BARRIERS TO MOBILITY IN LABOR** 妨碍待产时移动的因素

Hospital protocols, although often providing instruction for position change, conflict with those policies that demand the use of technology such as continuous fetal monitoring and intravenous infusions that restricts mobility (Hollins-Martin & Martin, 2013). Current labor management protocols that use partograms to measure the process of labor based on the Friedman curve are unrealistic measures based on current evidence and recom-

mendations of the length of the first stage of labor (Laughon, Branch, Beaver, & Zhang, 2012). These practices are among those targeted in the Obstetric Care Consensus Report on Safe Prevention of the Primary Cesarean (American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine, 2014). The report concludes that cesarean surgery results in more risk than vaginal birth. Mortality from cesarean surgery occurs in 2.7% of births, compared to 0.9% of vaginal births (American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine, 2014). In addition, the associated increase of morbidity to mothers who undergo cesarean surgery raises the risk of admission to neonatal intensive care units and perinatal death. The consensus recommendations for the first stage of labor include the following: “A prolonged latent phase (e.g., greater than 20 hours in nulliparous women and greater than 14 hr in multiparous women) should not be an indication for cesarean delivery; slow but progressive labor in the first stage of labor should not be an indication for cesarean delivery; cervical dilation of 6 cm should be considered

the threshold for the active phase for most women in labor; thus, cesarean delivery for active phase arrest in the first stage of labor should be reserved for women at or beyond 6 cm of dilation with ruptured membranes who fail to progress” (American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine, 2014, p. 7). The recommendations do not address mobility in the first stage of labor, but looking at the leading factors that have led to the rise in the U.S. cesarean rate, (a) labor dystocia, (b) abnormal or indeterminate fetal heart rate tracings, and (c) fetal malpresentation, all can be potentially positively affected by mobility in labor.

尽管医院条例经常会为变换姿势提供指导，但是变换姿势会与采用技术手段相关的规定相冲突。这些技术手段包含持续的胎儿监护和静脉注射，这都会限制产妇的移动 (Hollins-Martin & Martin, 2013)。现今的产程管理条例是按照产程图 Friedman 曲线来衡量产程，根据目前有关第一产程时长的证据和建议，该条例已不再实用。(Laughon, Branch, Beaver, & Zhang, 2012)。这些做法是《关于安全预防首次剖宫产的产科共识报告》所关注的(美国妇产科学会，美国母胎医学会，2014)。报告指出，剖宫产的风险比顺产要大。剖宫产的婴儿死亡率是 2.7%，而顺产只有 0.9% (美国妇产科学会，美国母胎医学会，2014)。此外，剖宫产的妈妈会有更高的发病率，这就增加进入新生儿重症监护室和围产儿死亡的风险。对第一产程的共识建议包括：

“延长的产程潜伏期(初产妇超过 20 小时，经产妇超过 14 小时)不应被视为剖宫产指征；缓慢但却在推进中的第一产程，也不应被视为剖宫产指征；宫口开 6cm 应被视为大部分待产女性进入产程活跃期的起点；因此，第一产程活跃期停滞所导致的剖宫产应该只适于宫口开到 6cm、胎膜已破、产程不再推进的女性(美国妇产科学会，美国母胎医学会，2014)。这些建议没有涉及第一产程移动的问题，但是如果看看美国剖宫产上升的主要原因(a)难产、(b)胎心率监测结果不正常或不确定正常和(c)胎位不正，待产时保持移动对这些问题都可能积极影响。

## OVERCOMING BARRIERS TO MOBILITY IN LABOR

### 克服待产时移动的阻碍

A barrier to promoting mobility in labor is the lack of the understanding of the physiologic process of birth by both women and their care providers. To achieve optimal care in labor, the barriers to receiving and providing that care need to be overcome. The term “optimal care” originates from the concept of optimality in maternity care derived from the ACNM (Goer & Romano, 2012). Freedom of movement is one practice in achieving optimal care in labor. Traditionally, childbirth educators have discussed the three Ps—the power of the uterine contractions; the passenger, which is the size and position of the fetus’s presenting part; and the passage-way of the mother—as the keys to

progress in labor. In *Optimal Care in Childbirth*, Goer and Romano (2012) suggest an alternative list of Ps. Those four factors that must be present to support the laboring women’s autonomy and mobility are permission, physical environment, practices, and people (Goer & Romano, 2012).

推广在待产时保持移动的一个阻碍，是女性及其照护者缺乏关于分娩生理过程的知识。为实现分娩时的最佳照护，就要克服妨碍接受和提供这种照护的因素。“最佳照护”这一说法源自于 ACNM 里的最佳妇产护理理念(Goer & Romano, 2012)。自由移动是实现待产时最佳照护的一种方法。分娩教育者传统上认为推进产程的关键在于 3 个 P——宫缩的力量 (power)，胎儿先露部分的大小和位置 (passenger)，以及母亲的产道 (passageway)。在《分娩的最佳照护》中，Goer 和 Romano (2012)提出了另一套 4 个 P：允许 (permission)，物理环境 (physical environment)，实践 (practices) 和人 (people)——这些是支持产妇的自主性和移动性的必备要素(Goer & Romano, 2012)。

Women need to perceive that they have permission to move and select the position of their choosing without providers limiting choice unless an actual medical indication occurs. Informed choice is part of a shared decision-making process between a woman and her care provider to review the risks, benefits, and alternatives of a recommended practice—in this case, a restriction in mobility with which the care provider desired the woman to comply.

女性要意识到，除非有实际的医学指征，她们可以移动并且选择自己喜欢的姿势，而无需受到照护者的限制。知情选择是女性及其照护者进行共同决策的一部分，他们通过共同决策来审视一项推荐做法的风险、益处以及替代方案—在本情况中，推荐做法指照护提供者希望女性遵守的活动限制。

The physical environment needs to be large enough to support freedom of movement. In a pilot study conducted at two Canadian hospitals, laboring women were randomly assigned to a regular labor room or to an “ambient room.” The intention of the ambient room was to create an environment of calm

to promote relaxation, including tools that assisted mobility. The results were that the laboring women spent 50% less time in bed and used less augmentation of labor with oxytocic infusions (Hodnett, Stremler, Weston, & McKeever, 2009). Another example is a California hospital that encourages mothers to use birth balls to “rock and roll” in labor. The goal of this program is to increase the success of trials of labor in women seeking a vaginal birth after cesarean (CBS News, 2013). A study demonstrated that the use of the birth ball for rocking movements significantly reduced the pain scores of the birth ball group in active labor, consistent with previous studies indicating that lower back pain is reduced in upright positions between 6 and 8 cm (Adachi et al., 2003; Traavoni, Abdolahian, Haghani, & Neysani, 2011).

物理环境要足够大，让女性可以自由移动。在一项于加拿大两所医院进行的初步研究中，产妇被随机分配到标准待产室或“环境室”。环境室旨在创造一种安静平和的环境来帮助产妇放松，里面有帮助产妇移动的工具。结果显示，环境室的产妇呆在床上的时间少了 50%，也更少注射催产素 (Hodnett, Stremler, Weston, & McKeever, 2009)。另一个例子中，加拿大的一家医院鼓励产妇待产时用分娩球来摇晃摆动。该项目旨在提高有剖宫产史的女性本次阴道顺产的几率 (CBS News, 2013)。研究发现，运用分娩球做摇摆动作极大减少了分娩球组产妇在产程活跃期的疼痛评分，这与之前的研究结论是相一致的：宫口开 6-8 cm 时，直立姿势可以减少腰部疼痛。

Women also need *permission* to avoid *practices* that interfere with mobility. Examples of those practices are (a) intravenous catheters that could be reserved for delivery of medications, allowing women to have oral fluids and calories and, when needed, inserted in the arm rather than the hand so as not to restrict mobility and (b) unless medically indicated, using intermittent monitoring or telemetry for electronic fetal surveillance so women can be mobile. Evidence-based nonpharmacological practices that are known to reduce labor pain need to be recognized and encouraged as adjuncts to mobility. Those practices are relaxation, massage, acupuncture, and immersion in water (Jones et al., 2012). In addition, in an RCT, warm showers were an effective nonpharmacological pain reduction method as well as being cost effective, convenient, and supportive of the upright posture (Lee, Liu, Lu, & Gau, 2012). Many other practices that are used by childbirth educators and doulas can be used safely with support, although not all have been researched for

their efficacy. Some of many are pelvic rocks, lunges, slow dancing, and stair climbing. These interventions help women to participate fully in the birthing process and feel cared for and comforted.

女性也需要得到允许来避开阻碍移动的医疗做法，比如(a)可以保留的静脉药物注射导管。女性可以通过口服的方式补充液体和卡路里，并且在需要时，经手臂而不是手部进行注射，这样不会限制移动；(b)除非有医学指征，采用间歇监测或远程监测来进行电子胎儿监护，这样也不限制女性的移动。要认识到循证的非药物减痛方法的重要性并加以提倡，而且和保持活动结合起来。这些非药物减痛方法包括放松、按摩、针灸和水疗 (Jones 等, 2012)。此外，在一组随机对照试验里显示，热水淋浴也是有效且经济、方便的非药物减痛方法，还会用到直立姿势 (Lee, Liu, Lu, & Gau, 2012)。我们可以支持分娩教育者和导乐安全使用其他方法，尽管其中某些方法的有效性并没有经过科学研究。这些方法包括骨盆摆动、弓步、慢舞、以及走楼梯。这些干预措施帮助女性充分参与分娩过程，让她们感到备受呵护和舒适放松。

The most important “P” is *people*. The health-care providers who care for laboring women need to believe in the physiologic process. Nonjudgmental, supportive, and accommodating behaviors by care providers include those that first, respect women’s choices; second, aid in her achieving her wishes; and third, advocate to other health-care providers on her behalf. The fear of labor is a significant inhibitor of progress in labor. In a study, 2,206 women who wished to deliver vaginally were enrolled in a fear of

childbirth assessment (Wijma Delivery Expectancy/ Experience Questionnaire). The results determined that labor averaged 47 min longer in women who scored high in the assessment (Adams, Eberhard- Gran, & Eskild, 2012). Women need childbirth education to help them understand and believe in the physiologic process. In a discrete choice survey, Scotland et al. (2011) reported that women valued vaginal birth. Most influential in their values were their previous birth experiences. There were some contradictions in this study, where women both wanted the highest level of interventions to be available and ideally preferred to experience the lowest levels available. Some trade-offs were acceptable such as being sent home if they were not in active labor to avoid time in the hospital and to reduce the likelihood of interventions (Scotland et al., 2011).

最重要的“p”是人 (people)。照顾产妇的医疗提供者需要对生理过程有信心。照顾者不带成见、支持和帮助性的行为首先包括尊重女性的选择；其次，帮她实现自己的意愿；第三，在其他医疗提供者面前维护她。对分娩的恐惧是阻碍产程的重要因素。一项研究对 2206 位希望顺产的女性进行了对分娩恐惧的评估(Wijma 分娩期待/体验问卷)。研究结果显示，在评估中得分高的女性，产程平均要延长 47 分钟 (Adams, Eberhard- Gran, &

Eskild, 2012)。女性需要分娩教育来帮助她们了解生理过程，并且对该生理过程建立信心。在一项离散选择调查中，Scotland 等人(2011)指出，女性重视阴道顺产，之前的分娩经历会对她们价值观产生极大影响。这项调查中有些矛盾的地方：女性希望能够获得最大程度的干预措施，但是又希望自己会经历最少的干预措施。有些权衡取舍是可接受的，比如还没进入产程活跃期的时候就被送回家，这样减少在医院的时间，降低干预的可能性(Scotland 等, 2011)。

Hospitals are people, too. An example of a hospital policy that is needed is one deterring latent labor admission based on the consensus report that active labor begins at 6 cm (Laughon et al., 2012). Women who recently gave birth indicate that they would accept attempts to reduce early admissions to labor wards if they resulted in reductions in the duration of time spent on the labor ward and reduced the chance of being immobilized during labor (Scotland et al., 2011). Obviously, policies aimed at addressing early admission and intervention during labor should include efforts to educate women about the potentially long duration of the latent phase of labor, about the appropriate timing of admission, and that a long labor is not in itself a sign that intervention is necessary (Scotland et al., 2011). In addition, women need the tools and confidence to work with their latent labor at home and, after admission, freedom of movement to reduce the need of invasive interventions.

医院就其性质而言也是“人”。举一个医院规定的例子：虽然共识报告将宫口开到 6cm 作为活跃期开始的标志，但是医院让处在产程潜伏期的产妇入院(Laughon 等, 2012)。最近分娩过的女性指出，如果可以缩短产程、在待产时的移动不受阻碍，那么她们愿意尝试不那么早进入待产室(Scotland 等, 2011)。显然，避免过早入院和干预分娩的规定应该包括：教育女性产程潜伏期可能会持续很久，告诉女性入院的合适时机，让她们知道产程持续时间长本身并不是需要干预的信号(Scotland 等, 2011)。此外，在家待产的女性需要工具和信心来应对产程潜伏期中的问题。入院之后，女性需要自由移动来降低创伤性干预措施的可能。

## SUMMARY

### 小结

There is an optimal way to give birth and it is supporting the physiologic process (ACNM et al., 2012; Goer & Romano, 2012; Lothian, 2009). No study has ever shown that walking in labor is harmful in healthy women with normal labors, which is the evidence-based conclusion of the mother-friendly birth practice to provide the birthing woman with the freedom to walk, move about, and assume the positions of her choice during labor issued by the



Coalition for Improving Maternity Services (Storton, 2007). “A woman’s position in labor, mobility, and fear and anxiety or, conversely, confidence may influence her experience of pain” (Jones et al., 2013, para. 1). Current practice, which is intervention intensive, has contributed to the high U.S. cesarean rate of almost one-third of women and has resulted in increased maternal morbidity and mortality (American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine, 2014). Because dystocia is the most common indication for cesarean surgery, efforts to reduce the cesarean rate must include efforts to support the physiologic process in which the women’s ability to be mobile is key. Women need to feel that they can labor in a supportive environment that decreases their fear of pain by supporting their ability to cope with the pain of labor, including having the freedom to walk, move, and change position throughout labor.

分娩的最佳方式就是支持分娩的生理过程(ACNM 等, 2012; Goer & Romano, 2012; Lothian, 2009)。尚无研究显示, 健康女性在正常待产时走路和移动会对分娩产生危害, 这是利于母亲的分娩实践的循证结论。该分娩实践由“促进妇产服务联合会”发起, 鼓励产妇自由走动、选择自己喜欢的姿势。(Storton, 2007)。“女性待产时的姿势、移动、恐惧、焦虑, 甚至信心, 都可能影响她对疼痛的体验”(Jones 等, 2013, para. 1)。当前高干预的医疗做法导致美国剖宫产率居高不下, 几乎三分之一的女性都是剖宫产, 这也增加了产妇发病率和死亡率(美国妇产科学会, 美国母胎医学会, 2014)。难产是剖宫产手术的最常见指征。要降低剖宫率, 就必须支持分娩的正常生理过程, 女性

能自由移动的能力是关键。女性需要认识到: 如果有一个支持在待产中行走、移动和变换姿势的环境, 可帮她应对产痛、消除对疼痛的恐惧, 她是能够完成分娩的。

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## IMPLICATIONS FOR EVIDENCE-BASED PRACTICE

### 循证实践的意义

The philosophies and preferences of maternity care providers—doctors, midwives, nurses, doulas, and childbirth educators—influence the recommendations they make to laboring women. Some care models and birth settings use mobility more often than others. Although there is evidence that walking and upright positions reduce the duration of the first stage of labor, there is a need for better quality studies to demonstrate the significance to providers and direct them on more precise recommendations for ambulation and movement. There is insufficient understanding of what facilitates or inhibits a woman's use of physiologic birth positioning (Priddis et al., 2012). The Cochrane review related to mobility leaves some important questions to answer, such as management after ruptured membranes and epidural anesthesia (Goer, 2013; Lawrence et al., 2013). Based on the current information, we can encourage women to choose the positions of their choice. More research into both the factors and practices within the current health systems that facilitate or inhibit women to adopt various positions during labor and birth is the suggestion of Hollins-Martin and Martin (2013). The answers to three research questions would provide both care providers and women with more clarity on how to use movement and positioning to not only shorten labor but also provide pain

relief. The research questions that Hollins-Martin and Martin propose are as follows:

妇产照护者（医生、助产士、护士、导乐和分娩教育者）的理念和偏好影响他们对产妇所提的建议。某些照护模式和分娩环境更注重待产时的移动。尽管有证据证实走动和直立姿势能减少第一产程的持续时间，我们还是需要更高质量的研究来向照护者证实这种做法的重要性，并指导他们向产妇提出有关步行和移动的更精确的建议。我们还不够了解到底什么能协助、什么会阻碍女性运用生理分娩的姿势(Priddis等,2012)。有关产妇活动的考科兰综述给我们留下了一些重要的问题，比如如何管理那些胎膜已破或采取了硬脊膜外麻醉的产妇(Goer, 2013; Lawrence等, 2013)。我们可以根据现有的信息鼓励产妇选择其喜欢的姿势。Hollins-Martin和Martin(2013)建议，我们需要进一步研究当前的医疗体系，看看哪些做法和因素帮助（或阻碍）女性在待产和分娩时移动。这些研究结果会让医疗提供者和女性更了解：如何通过移动和变换姿势来缩短产程，还有减痛。Hollins-Martin and Martin 提出要对如下方面进行研究：

1. *What are women's qualitative experiences of ambulating or being confined to semirecumbent bed rest during the first stage of labor?*

女性对于第一产程中走动或半卧床的定性体验是什么？

2. *What are the environmental, educational, and cultural influences that persuade/dissuade women from being physically active during the first stage of labor?*

哪些环境、教育或文化方面的影响因素会鼓励/阻碍女性在第一产程中保持活动？

3. *What detailed maternal positions and activity are effective at progressing the first stage of labor? (p. 48)*

产妇哪些具体的姿势和活动对于推进第一产程有效？

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