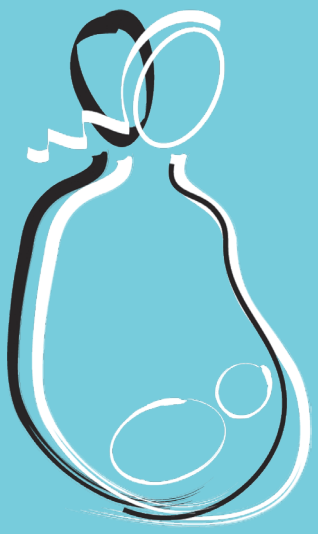


World Health Organization

WHO recommendations

Intrapartum care for a positive childbirth experience

Transforming care of women and babies for improved health and well-being

Executive summary

Introduction

The majority of approximately 140 million births that occur globally every year are among women without risk factors for complications for themselves or their babies at the beginning and throughout labour. Nevertheless, the time of birth is critical to the survival of women and their babies, as the risk of morbidity and mortality could increase considerably if complications arise. In line with the targets of Sustainable Development Goal 3 – ensure healthy lives and promote well-being for all at all ages – and the new Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), global agendas are expanding their focus to ensure that women and their babies not only survive labour complications if they occur but also that they thrive and reach their full potential for health and life.

In spite of the considerable debates and research that have been ongoing for several years, the concept of "normality" in labour and childbirth is not universal or standardized. There has been a substantial increase over the last two decades in the application of a range of labour practices to initiate, accelerate, terminate, regulate or monitor the physiological process of labour, with the aim of improving outcomes for women and babies. This increasing medicalization of childbirth processes tends to undermine the woman's own capability to give birth and negatively impacts her childbirth experience. In addition, the increasing use of labour interventions in the absence of clear indications continues to widen the health equity gap between high- and low-resource settings.

This guideline addresses these issues by identifying the most common practices used throughout labour to establish norms of good practice for the conduct of uncomplicated labour and childbirth. It elevates the concept of experience of care as a critical aspect of ensuring high-quality labour and childbirth care and improved woman-centred outcomes, and not just complementary to provision of routine clinical practices. It is relevant to all healthy pregnant women and their babies, and takes into account that childbirth is a physiological process that can be accomplished without complications for the majority of women and babies.

The guideline recognizes a "positive childbirth experience" as a significant end point for all women undergoing labour. It defines a positive childbirth experience as one that fulfils or exceeds a woman's prior personal and sociocultural beliefs and expectations, including giving birth to a healthy baby in a clinically and psychologically safe environment with continuity of practical and emotional support from a birth companion(s) and kind, technically competent clinical staff. It is based on the premise that most women want a physiological labour and birth, and to have a sense of personal achievement and control through involvement in decision-making, even when medical interventions are needed or wanted.

This up-to-date, comprehensive and consolidated guideline on essential intrapartum care brings together new and existing World Health Organization (WHO) recommendations that, when delivered as a package, will ensure good-quality and evidence-based care irrespective of the setting

or level of health care. The recommendations presented in this guideline are neither country nor region specific and acknowledge the variations that exist globally as to the level of available health services within and between countries. The guideline highlights the importance of woman-centred care to optimize the experience of labour and childbirth for women and their babies through a holistic, human rights-based approach. It introduces a global model of intrapartum care, which takes into account the complexity and diverse nature of prevailing models of care and contemporary practice.

Target audience

The recommendations in this guideline are intended to inform the development of relevant national- and local-level health policies and clinical protocols. Therefore, the target audience includes national and local public health policy-makers, implementers and managers of maternal and child health programmes, health care facility managers, nongovernmental organizations (NGOs), professional societies involved in the planning and management of maternal and child health services, health care professionals (including nurses, midwives, general medical practitioners and obstetricians) and academic staff involved in training health care professionals.

Guideline development methods

Throughout this guideline, the term "healthy pregnant women" is used to describe pregnant women and adolescent girls who have no identified risk factors for themselves or their babies, and who otherwise appear healthy. The guideline was developed using standard operating procedures in accordance with the process described in the *WHO handbook for guideline development*. Briefly, these procedures include: (i) identification of priority questions and outcomes; (ii) evidence retrieval and synthesis; (iii) assessment of the evidence; (iv) formulation of the recommendations; and (v) planning for implementation, dissemination, impact evaluation and updating of the guideline. The quality of the scientific evidence underpinning the recommendations was graded using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) and Confidence in the Evidence from Reviews of Qualitative research (CERQual) approaches, for quantitative and qualitative evidence, respectively. Up-to-date systematic reviews were used to prepare evidence profiles for priority questions. The GRADE evidence-to-decision (EtD) framework, an evidence-to-decision tool that includes intervention effects, values, resources, equity, acceptability and feasibility criteria, was used to guide the formulation of recommendations by the Guideline Development Group (GDG) – an international group of experts assembled for the purpose of developing this guideline – at two technical consultations in May and September 2017. In addition, relevant recommendations from existing WHO guidelines approved by the Guidelines Review Committee (GRC) were systematically identified and integrated into this guideline for the purpose of providing a comprehensive document for end-users.

Recommendations

The WHO technical consultations led to 56 recommendations on intrapartum care: 26 of these are newly developed recommendations and 30 are recommendations integrated from existing WHO guidelines. Recommendations are presented according to the intrapartum care context to which they are relevant, namely, care throughout labour and birth, care during the first stage of labour, care during the second stage of labour, care during the third stage of labour, immediate care of the newborn, and immediate care of the woman after birth. Based on assessments of the GRADE EtD criteria, which informed the direction, and in some instances the specific context of the recommendation, the GDG classified each recommendation into one of the following categories defined below:

- **Recommended:** This category indicates that the intervention or option should be implemented.
- **Not recommended:** This category indicates that the intervention or option should not be implemented.
- **Recommended only in specific contexts:** This category indicates that the intervention or option is applicable only to the condition, setting or population specified in the recommendation, and should only be implemented in these contexts.
- **Recommended only in the context of rigorous research:** This category indicates that there are important uncertainties about the intervention or option. In such instances, implementation can still be undertaken on a large scale, provided that it takes the form of research that is able to address unanswered questions and uncertainties related both to effectiveness of the intervention or option, and its acceptability and feasibility.

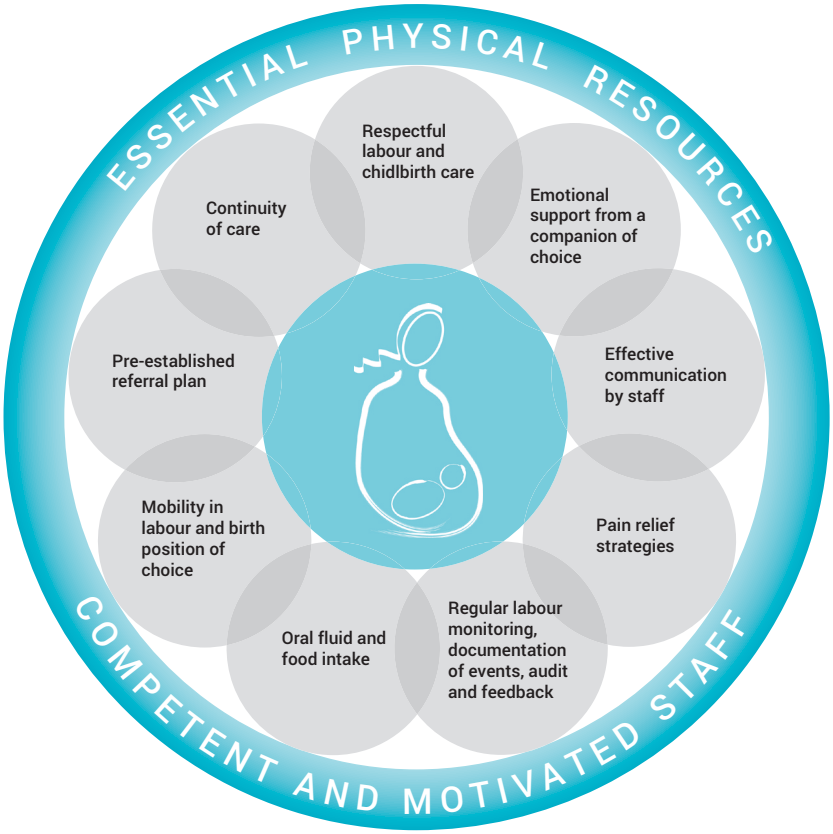
To ensure that each recommendation is correctly understood and applied in practice, the contributing experts provided additional remarks where needed. Where the GDG recommended an intervention or option only in specific contexts or only in the

context of rigorous research, further detail was included about the particular context and which key issues needed to be examined, respectively. Users of the guideline should refer to these remarks, which are presented directly beneath each recommendation in the full version of the guideline. The recommendations on intrapartum care for a positive childbirth experience are summarized in the table below.

At the technical consultations, the implementation considerations for individual recommendations and for the guideline as a whole were discussed. The GDG agreed that, to achieve a positive childbirth experience for women and their babies, the recommendations in this guideline should be implemented as a package of care in all settings, by kind, competent and motivated health care professionals working where essential physical resources are available. Health systems should aim to implement this WHO model of intrapartum care (fig. 1) to empower all women to access the type of woman-centred care that they want and need, and to provide a sound foundation for such care, in accordance with a human rights-based approach.

Derivative products of this guideline will include labour monitoring tools for its application at different levels of care. In accordance with the process for updating WHO maternal and perinatal health guidelines, a systematic and continuous process of identifying and bridging evidence gaps following guideline implementation will be employed. In the event that new evidence (that could potentially impact the current evidence base for any of the recommendations) is identified, the recommendation will be updated. WHO welcomes suggestions regarding additional questions for inclusion in future updates of the guideline.

Fig. 1 Schematic representation of the WHO intrapartum care model



Summary list of recommendations on intrapartum care for a positive childbirth experience

Care option	Recommendation	Category of recommendation
Care throughout labour and birth		
Respectful maternity care	1. Respectful maternity care – which refers to care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth – is recommended.	Recommended
Effective communication	2. Effective communication between maternity care providers and women in labour, using simple and culturally acceptable methods, is recommended.	Recommended
Companionship during labour and childbirth	3. A companion of choice is recommended for all women throughout labour and childbirth.	Recommended
Continuity of care	4. Midwife-led continuity-of-care models, in which a known midwife or small group of known midwives supports a woman throughout the antenatal, intrapartum and postnatal continuum, are recommended for pregnant women in settings with well functioning midwifery programmes.[a]	Context-specific recommendation
First stage of labour		
Definitions of the latent and active first stages of labour	5. The use of the following definitions of the latent and active first stages of labour is recommended for practice. — The latent first stage is a period of time characterized by painful uterine contractions and variable changes of the cervix, including some degree of effacement and slower progression of dilatation up to 5 cm for first and subsequent labours. — The active first stage is a period of time characterized by regular painful uterine contractions, a substantial degree of cervical effacement and more rapid cervical dilatation from 5 cm until full dilatation for first and subsequent labours.	Recommended
Duration of the first stage of labour	6. Women should be informed that a standard duration of the latent first stage has not been established and can vary widely from one woman to another. However, the duration of active first stage (from 5 cm until full cervical dilatation) usually does not extend beyond 12 hours in first labours, and usually does not extend beyond 10 hours in subsequent labours.	Recommended
Progress of the first stage of labour	7. For pregnant women with spontaneous labour onset, the cervical dilatation rate threshold of 1 cm/hour during active first stage (as depicted by the partograph alert line) is inaccurate to identify women at risk of adverse birth outcomes and is therefore not recommended for this purpose. 8. A minimum cervical dilatation rate of 1 cm/hour throughout active first stage is unrealistically fast for some women and is therefore not recommended for identification of normal labour progression. A slower than 1-cm/hour cervical dilatation rate alone should not be a routine indication for obstetric intervention. 9. Labour may not naturally accelerate until a cervical dilatation threshold of 5 cm is reached. Therefore the use of medical interventions to accelerate labour and birth (such as oxytocin augmentation or caesarean section) before this threshold is not recommended, provided fetal and maternal conditions are reassuring.	Not recommended Not recommended Not recommended

[a] Integrated from *WHO recommendations on antenatal care for a positive pregnancy experience*.

Care option	Recommendation	Category of recommendation
Labour ward admission policy	10. For healthy pregnant women presenting in spontaneous labour, a policy of delaying labour ward admission until active first stage is recommended only in the context of rigorous research.	Research-context recommendation
Clinical pelvimetry on admission	11. Routine clinical pelvimetry on admission in labour is not recommended for healthy pregnant women.	Not recommended
Routine assessment of fetal well-being on labour admission	12. Routine cardiotocography is not recommended for the assessment of fetal well-being on labour admission in healthy pregnant women presenting in spontaneous labour. 13. Auscultation using a Doppler ultrasound device or Pinard fetal stethoscope is recommended for the assessment of fetal well-being on labour admission.	Not recommended Recommended
Perineal/pubic shaving	14. Routine perineal/pubic shaving prior to giving vaginal birth is not recommended.[a]	Not recommended
Enema on admission	15. Administration of enema for reducing the use of labour augmentation is not recommended.[b]	Not recommended
Digital vaginal examination	16. Digital vaginal examination at intervals of four hours is recommended for routine assessment of active first stage of labour in low-risk women.[a]	Recommended
Continuous cardiotocography during labour	17. Continuous cardiotocography is not recommended for assessment of fetal well-being in healthy pregnant women undergoing spontaneous labour.	Not recommended
Intermittent fetal heart rate auscultation during labour	18. Intermittent auscultation of the fetal heart rate with either a Doppler ultrasound device or Pinard fetal stethoscope is recommended for healthy pregnant women in labour.	Recommended
Epidural analgesia for pain relief	19. Epidural analgesia is recommended for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences.	Recommended
Opioid analgesia for pain relief	20. Parenteral opioids, such as fentanyl, diamorphine and pethidine, are recommended options for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences.	Recommended
Relaxation techniques for pain management	21. Relaxation techniques, including progressive muscle relaxation, breathing, music, mindfulness and other techniques, are recommended for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences.	Recommended
Manual techniques for pain management	22. Manual techniques, such as massage or application of warm packs, are recommended for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences.	Recommended
Pain relief for preventing labour delay	23. Pain relief for preventing delay and reducing the use of augmentation in labour is not recommended.[b]	Not recommended
Oral fluid and food	24. For women at low risk, oral fluid and food intake during labour is recommended.[b]	Recommended
Maternal mobility and position	25. Encouraging the adoption of mobility and an upright position during labour in women at low risk is recommended.[b]	Recommended
Vaginal cleansing	26. Routine vaginal cleansing with chlorhexidine during labour for the purpose of preventing infectious morbidities is not recommended.[a]	Not recommended
Active management of labour	27. A package of care for active management of labour for prevention of delay in labour is not recommended.[b]	Not recommended

[a] Integrated from *WHO recommendations for prevention and treatment of maternal peripartum infections*.
[b] Integrated from *WHO recommendations for augmentation of labour*.

Care option	Recommendation	Category of recommendation
Routine amniotomy	28. The use of amniotomy alone for prevention of delay in labour is not recommended.[a]	Not recommended
Early amniotomy and oxytocin	29. The use of early amniotomy with early oxytocin augmentation for prevention of delay in labour is not recommended.[a]	Not recommended
Oxytocin for women with epidural analgesia	30. The use of oxytocin for prevention of delay in labour in women receiving epidural analgesia is not recommended.[a]	Not recommended
Antispasmodic agents	31. The use of antispasmodic agents for prevention of delay in labour is not recommended.[a]	Not recommended
Intravenous fluids for preventing labour delay	32. The use of intravenous fluids with the aim of shortening the duration of labour is not recommended.[a]	Not recommended
Second stage of labour		
Definition and duration of the second stage of labour	33. The use of the following definition and duration of the second stage of labour is recommended for practice. — The second stage is the period of time between full cervical dilatation and birth of the baby, during which the woman has an involuntary urge to bear down, as a result of expulsive uterine contractions. — Women should be informed that the duration of the second stage varies from one woman to another. In first labours, birth is usually completed within 3 hours whereas in subsequent labours, birth is usually completed within 2 hours.	Recommended
Birth position (for women without epidural analgesia)	34. For women without epidural analgesia, encouraging the adoption of a birth position of the individual woman's choice, including upright positions, is recommended.	Recommended
Birth position (for women with epidural analgesia)	35. For women with epidural analgesia, encouraging the adoption of a birth position of the individual woman's choice, including upright positions, is recommended.	Recommended
Method of pushing	36. Women in the expulsive phase of the second stage of labour should be encouraged and supported to follow their own urge to push.	Recommended
Method of pushing (for women with epidural analgesia)	37. For women with epidural analgesia in the second stage of labour, delaying pushing for one to two hours after full dilatation or until the woman regains the sensory urge to bear down is recommended in the context where resources are available for longer stay in second stage and perinatal hypoxia can be adequately assessed and managed.	Context-specific recommendation