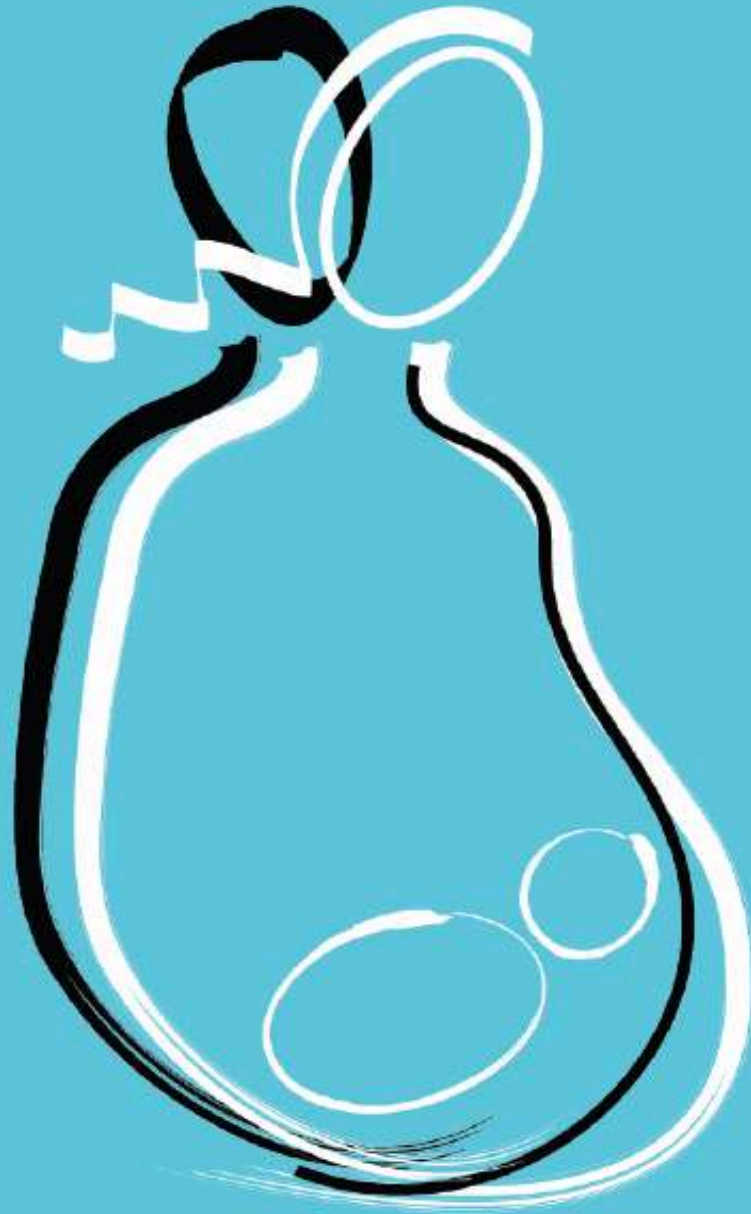
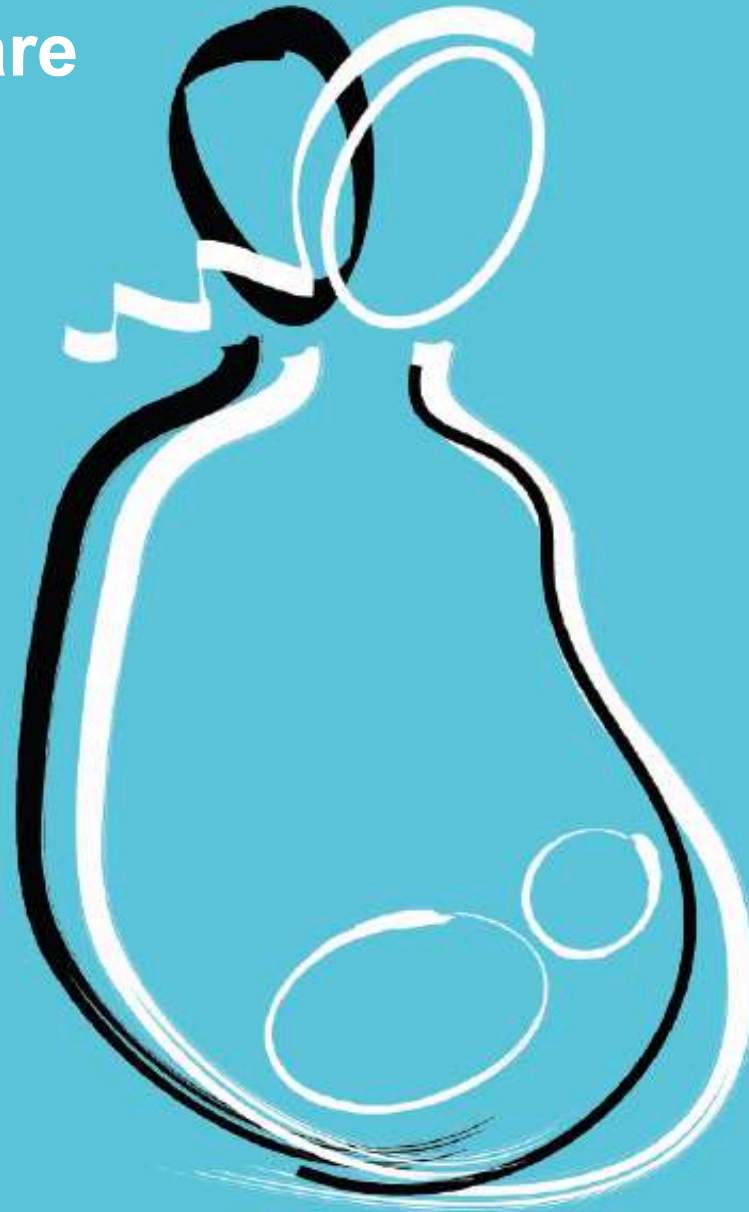


What's in a  
good birth?



World Health  
Organization

WHO recommendations  
**Intrapartum care  
for a positive  
childbirth  
experience**



World Health  
Organization

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  - + *Medicalization of Childbirth*
  - + *Labour Progression: What's Normal?*
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01

# CHILDBIRTH AND THE 2030 AGENDA FOR SUSTAINABLE DEVELOPMENT



Globally, approximately 140 million births occur every year.

The type and degree of risk related to labour and childbirth, and the early weeks of life differ between countries and settings.

*Majority of births occur among pregnant women with no identified risk factors for complications, either for themselves or their babies, at the beginning and throughout labour.*

Nevertheless, the time of birth is critical to the survival of mothers and their babies, as the risk of morbidity and mortality could increase considerably if complications arise.

*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 well-being.***

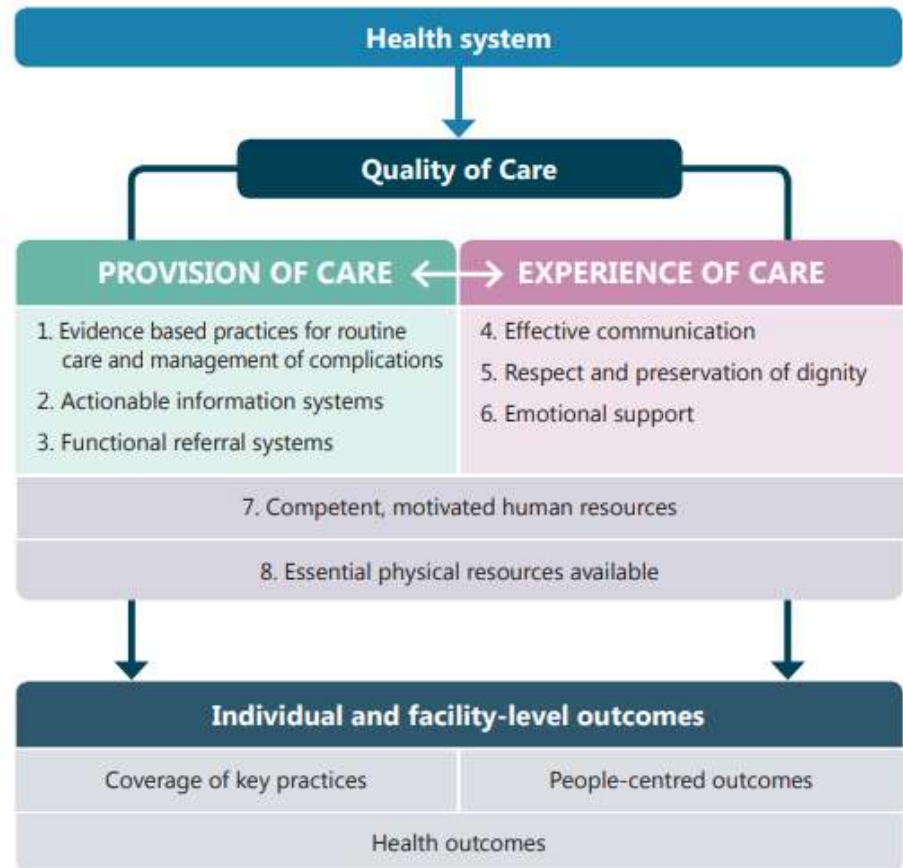
Improving the quality of care around the time of birth has been identified as the most impactful strategy for reducing stillbirths, maternal and newborn deaths, compared with antenatal or postpartum care strategies.



# QUALITY OF INTRAPARTUM CARE

*Every mother and newborn receives quality care throughout the pregnancy, childbirth and postnatal periods – WHO vision*

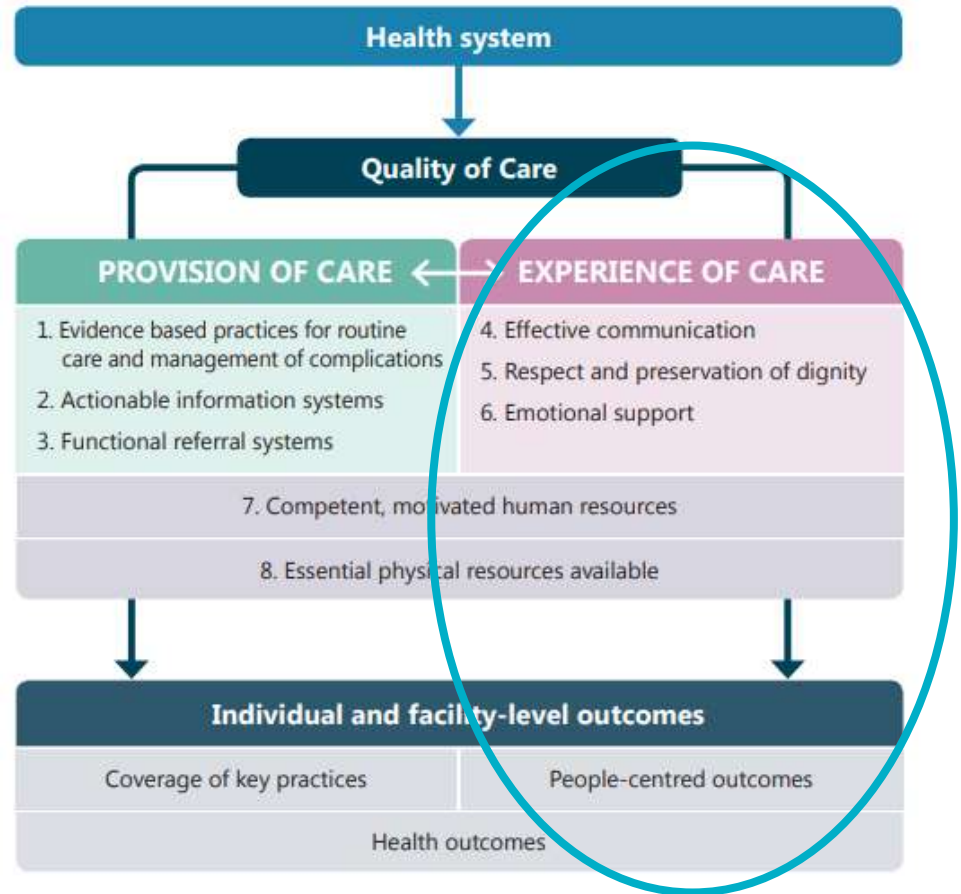
- Quality of care is multidimensional
- Persistent issues in intrapartum care are not mutually exclusive



# QUALITY OF INTRAPARTUM CARE

*Every mother and newborn receives quality care throughout the pregnancy, childbirth and postnatal periods – WHO vision*

- Quality of care is multidimensional
- Persistent issues in intrapartum care are not mutually exclusive





# MEDICALIZATION OF CHILDBIRTH

Despite years of research, the concept of “normality” in labour and childbirth is not universal or standardized.

The predominant model of care in many parts of the world, is the one where a health provider controls the birthing process.

*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 process of labour.*

*Over-medicalization of childbirth processes tends to undermine the woman’s own capability to give birth and negatively impacts her childbirth experience.*

Healthy pregnant women continue to be subjected to ineffective and potentially harmful routine labour interventions such as perineal shaving, enema, amniotomy, intravenous fluids, antispasmodics, and antibiotics for uncomplicated vaginal births.

- + [LINK: INCREASING TREND IN CS RATES](#)
- + [LINK: WITHIN COUNTRY INEQUALITY IN CS](#)
- + [LINK: INTERVENTIONS IN LOW-RISK WOMEN](#)

There is evidence that a substantial proportion of women undergo at least one obstetric intervention during labour and childbirth.

# LABOUR PROGRESSION: WHAT'S NORMAL?

*The validity of one of the most important components of the partograph, the alert and action lines, has been called into question in the last decade, as findings of several studies suggest that labour can indeed be slower than the limits proposed in the 1950s by Emmanuel Friedman.*

+ [LINK: S/REVIEW OF LABOUR PROGRESSION](#)

+ [LINK: PERFORMANCE OF THE "ALERT LINE"](#)



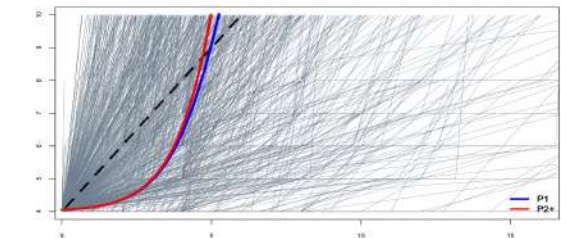
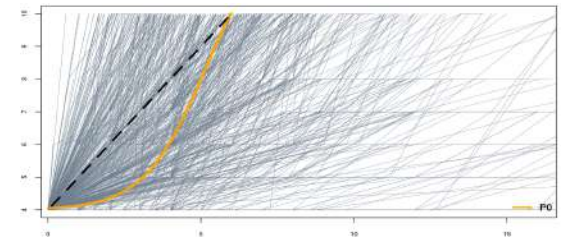
iStock by Getty Images. All rights reserved.

To safely monitor labour and childbirth, a clear understanding of what constitutes normal labour onset and progress is essential.

Consensus around the definitions of the onset and duration of the different phases and stages of normal labour is lacking.

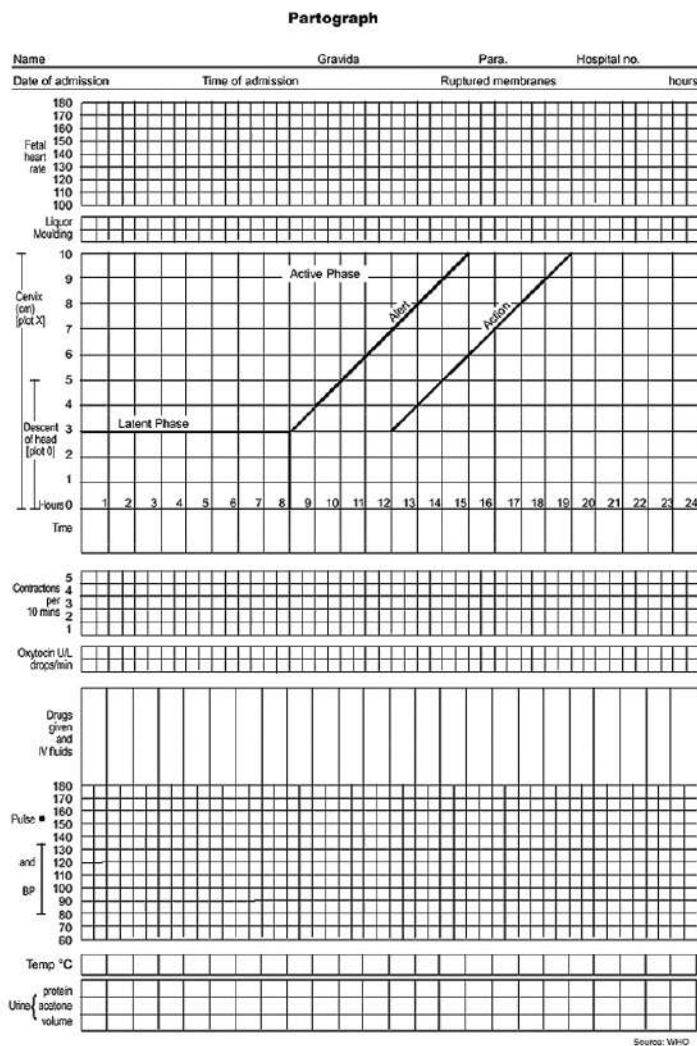
In practice, there are considerable variations in how normal labour progress is defined in terms of cervical dilatation pattern and safe time limits.

The question of whether the current cervicograph design can safely and unequivocally identify healthy labouring women at risk of adverse outcomes has become critical to clinical guidance on intrapartum care.



*Cervical dilatation patterns (grey lines) in women with normal birth outcomes versus alert line (dashed line).*

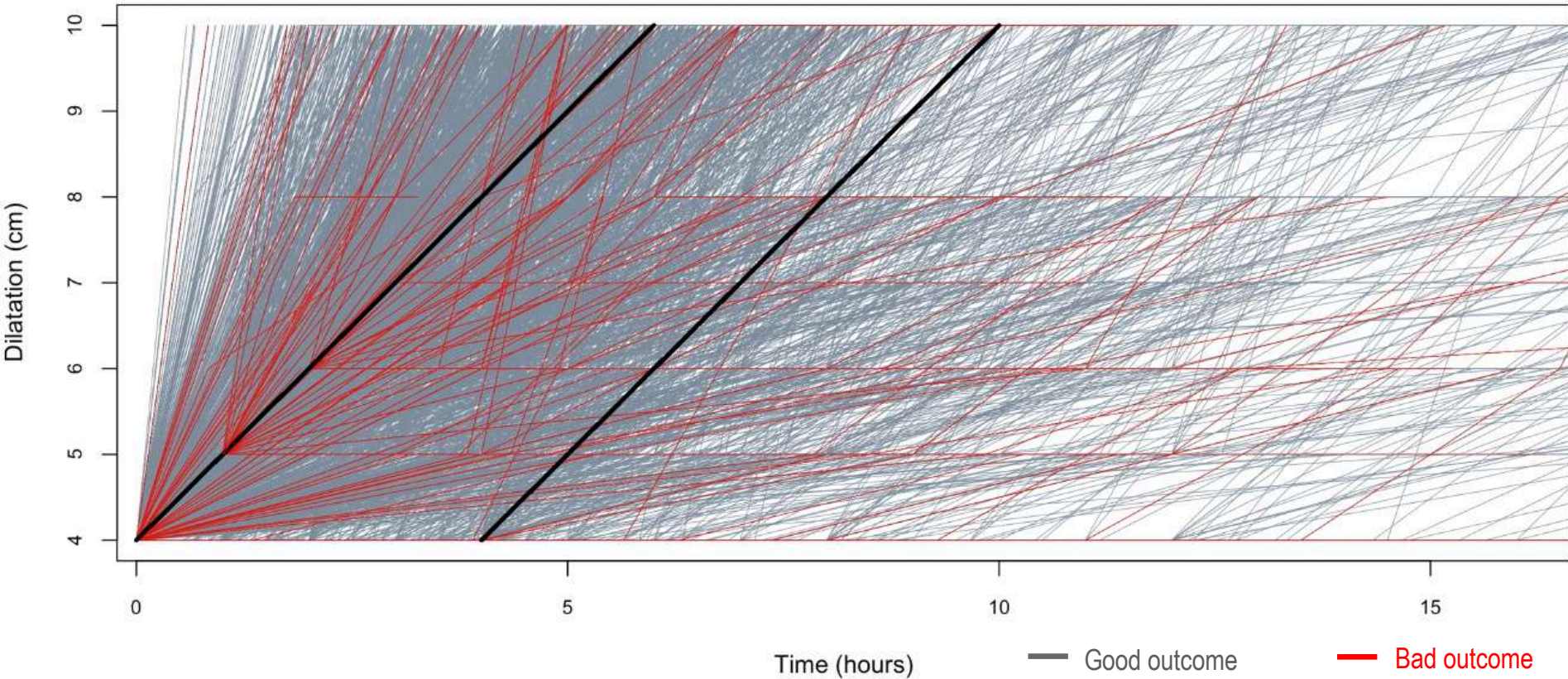
# LABOUR PROGRESSION PROFILES OF ≈10,000 WOMEN VERSUS ALERT LINE





# LABOUR PROGRESSION PROFILES OF $\approx 10,000$ WOMEN VERSUS ALERT LINE

All women and Perinatal outcome



# GUIDELINE SCOPE: WHO & WHAT?

*This guideline focuses on the care of all healthy pregnant women and their babies during labour and childbirth in any health care setting. “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 management of pregnant women who develop labour complications and those with high-risk pregnancies who require specialized intrapartum care is outside the scope of this guideline.

The guideline covers essential care that should be provided throughout labour and childbirth, and interventions specific to the first, second, and third stages of labour.





# Methods

- 
- + *Guideline Contributors*
  - + *Priority Questions: Focusing on What Matters to Women*
  - + *Confidence in Evidence: The GRADE Approach*
  - + *Making of the Recommendations*

02



# PRIORITY QUESTIONS: FOCUSING ON WHAT MATTERS TO WOMEN

RESEARCH ARTICLE

## What matters to women during childbirth: A systematic qualitative review

**Soo Downe<sup>1</sup>\*, Kenneth Finlayson<sup>1</sup>, Olufemi Oladapo<sup>2</sup>‡, Mercedes Bonet<sup>2</sup>‡, A. Metin Gülmezoglu<sup>2</sup>**

**1** Research in Childbirth and Health (ReaCH) group, University of Central Lancashire, Preston, United Kingdom, **2** UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), Department of Reproductive Health and Research, World Health Organization, Geneva, Switzerland

# PRIORITY QUESTIONS: FOCUSING ON WHAT MATTERS TO WOMEN

The guideline focus was based on a scoping process that identified woman-centred interventions and outcomes for intrapartum care. This included a systematic qualitative review to understand what women want, need and value during childbirth. The findings show that:

*Women want a positive childbirth experience that fulfils or exceeds their prior personal and sociocultural beliefs and expectations.*

Therefore, WHO used a consultative process to identify priority questions related to the effectiveness of clinical and non-clinical practices aimed at helping women achieve their expectations of childbirth.



Two bottom photos: iStock by Getty Images. All rights reserved



*Here are some of the views shared by women included in the systematic review.*

# Recommendations

---

- + *Care Throughout Labour and Birth*
- + *First Stage of Labour*
- + *Second Stage of Labour*
- + *Third Stage of Labour*
- + *Care of the Woman and Newborn After Birth*

03

# 56 RECOMMENDATIONS IN TOTAL...

*This guideline includes 26 new recommendations adopted by the GDG at the 2017 meetings, and 30 existing recommendations from previously published WHO guidelines.*

*Recommendations are grouped and presented according to the timing of the practice ranging from labour onset through to the immediate postnatal period.*

Additional remarks are included where needed to ensure that recommendations are correctly understood and applied in practice.



# RESPECTFUL MATERNITY CARE

*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.*



Photo: Global Health Project

# RESPECTFUL MATERNITY CARE

*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.*

## ***RMC is for everyone***

- Regardless of:
  - The risk status for labour complications - ‘low’ or ‘high’
  - Birth settings – home or hospital
  - Cadres of health care provider
  - Country income level – high, middle, or low



# RESPECTFUL MATERNITY CARE

*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.*

## **dignity, privacy and confidentiality...**

- In accordance with a human-rights-based approach to reducing maternal morbidity and mortality
- Requires interventions at the interpersonal level between a woman and her health care providers
- Interventions should aim to ensure a respectful and dignified working environment for those providing care

# EFFECTIVE COMMUNICATION

*Effective communication between maternity care providers and women in labour, using simple and culturally acceptable methods, is recommended.*



iStock by Getty Images. All rights reserved.

# EFFECTIVE COMMUNICATION

*Effective communication between maternity care providers and women in labour, using simple and culturally acceptable methods, is recommended.*

## **Effective communication should include:**

- Introducing themselves to the woman and her companion and addressing the woman by her name
- Offering the woman and her family the information they need in a clear and concise manner, avoiding medical jargon, and using pictorial and graphic materials
- Responding to the woman's needs, preferences and questions with a positive attitude
- Ensuring that procedures are explained to the woman, and that verbal and, when appropriate, written informed consent for pelvic examinations and other procedures is obtained from the woman

# COMPANIONSHIP DURING LABOUR AND CHILDBIRTH

*A companion of choice is recommended for all women throughout labour and childbirth.*



iStock by Getty Images. All rights reserved.

# COMPANIONSHIP DURING LABOUR AND CHILDBIRTH

*A companion of choice is recommended for all women throughout labour and childbirth.*

## *Who is a companion in this context?*

- Any person chosen by the woman to provide her with continuous support during labour and childbirth and may be someone from the woman's family or social network, such as:
  - Spouse/partner
  - Female friend or relative
  - Community member (such as a female community leader, health worker or traditional birth attendant)
  - Doula
- It is important that women's wishes are respected, including those who prefer not to have a companion.

# DEFINITION AND DURATION OF THE LATENT AND ACTIVE FIRST STAGES OF LABOUR

*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*



Photo: Lieve Blancquaert



# DEFINITION AND DURATION OF THE LATENT AND ACTIVE FIRST STAGES OF LABOUR

*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.*

***... and how long does this stage usually take?***

*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.*

# DEFINITION AND DURATION OF THE LATENT AND ACTIVE FIRST STAGES OF LABOUR

*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*



Photo: Lieve Blancquaert

# DEFINITION AND DURATION OF THE LATENT AND ACTIVE FIRST STAGES OF LABOUR

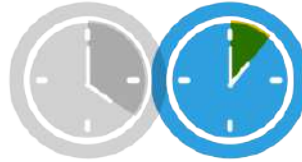
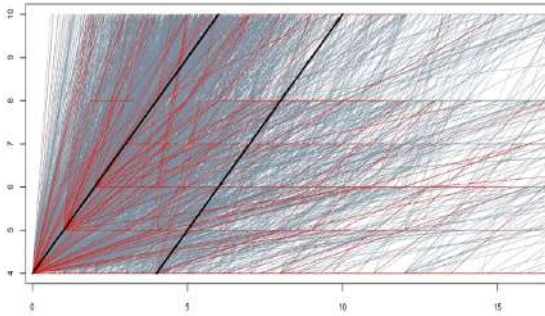
*The active first stage is a period of time characterized by regular painful uterine contractions, a substantial degree of cervical effacement and more rapid cervical dilatation from 5 cm until full dilatation for first and subsequent labours.*

*... and how long does this stage usually take?*

*The duration of active first stage usually does not extend beyond **12 hours** in first labours, and usually does not extend beyond **10 hours** in subsequent labours.*

# PROGRESS OF THE FIRST STAGE OF LABOUR

*There is insufficient evidence to support the use of the partograph alert line as a classifier to detect women at risk of adverse birth outcomes.*

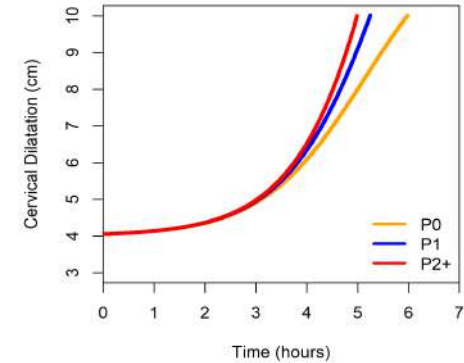


## 1 cm per hour rule inaccurate

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.

## < 1 cm/hour ≠ obstetric intervention

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.



## Every birth is unique

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.

# ROUTINE ASSESSMENT OF FETAL WELL-BEING

*Routine cardiotocography is not recommended for the assessment of fetal well-being on labour admission or during labour in healthy pregnant women undergoing spontaneous labour.*



iStock by Getty Images. All rights reserved.

# ROUTINE ASSESSMENT OF FETAL WELL-BEING

*Routine cardiotocography is not recommended for the assessment of fetal well-being on labour admission or during labour in healthy pregnant women undergoing spontaneous labour.*

## ***But why?***

- The GDG placed its emphasis on evidence that suggests that both admission and continuous cardiotocography increase the risk of caesarean section and other medical interventions without improving substantive birth outcomes.
- **Continuous cardiotocography restricts other beneficial interventions during labour, such as having a choice of labour and birth positions, and being able to walk around freely, and can be stressful for women.**

# PAIN RELIEF DURING LABOUR

*It is likely that the care context and the type of care provision and care provider have a strong effect on the need for labour pain relief, and on the choices women make in relation to this need.*



## *Relaxation and Massage Techniques*

Most women desire some form of pain relief during labour, and qualitative evidence indicates that relaxation techniques can reduce labour discomfort, relieve pain and enhance the maternal birth experience.



## *Epidural Analgesia*

Epidural analgesia appears to be the more effective pain relief option but compared with opioid analgesia it also requires more resources to implement and to manage its adverse effects, which are more common with epidural analgesia.



## *Parenteral Opioids*

Despite being widely available and used, pethidine is not the preferred opioid option, as shorter-acting opioids tend to have fewer undesirable side-effects

Before use, health care providers should counsel women about the potential side-effects of opioids, including maternal drowsiness, nausea and vomiting, and neonatal respiratory depression, and about the alternative pain relief options available.



# DEFINITION AND DURATION OF THE SECOND STAGE OF LABOUR

*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.*



Photo: UNICEF/Noorani

# DEFINITION AND DURATION OF THE SECOND STAGE OF LABOUR

*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.*

***... and how long does this stage usually take?***

- *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**.*

# BIRTH POSITIONS

*For women with or without epidural analgesia, encouraging the adoption of a birth position of the individual woman's choice, including upright positions, is recommended.*



Photo: UNICEF/Noorani

# BIRTH POSITIONS

*For women with or without epidural analgesia, encouraging the adoption of a birth position of the individual woman's choice, including upright positions, is recommended.*

## *Individual woman's choice means...*

- Any particular position is not forced on the woman and that she is encouraged and supported to adopt any position that she finds most comfortable.
- The health care professional should ensure that the well-being of the baby is adequately monitored in the woman's chosen position. Should a change in position be necessary to ensure adequate fetal monitoring, the reason should be clearly communicated to the woman.

# BIRTH POSITIONS

*For women with or without epidural analgesia, encouraging the adoption of a **birth position of the individual woman's choice**, including upright positions, is recommended.*

*And when she is ready to push...*

*Women in the expulsive phase of the second stage of labour should be encouraged and supported to follow their own urge to push.*



# EPISIOTOMY POLICY

*Routine or liberal use of episiotomy is not recommended for women undergoing spontaneous vaginal birth.*



# FUNDAL PRESSURE

*Application of manual fundal pressure to facilitate childbirth during the second stage of labour is not recommended.*

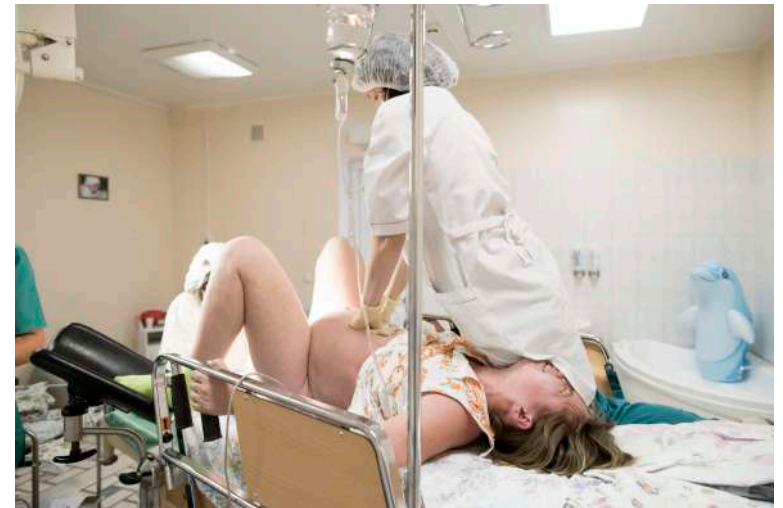


Photo: Lieve Blancquaert

# CARE OF THE NEWBORN

*Newborns without complications should be kept in skin-to-skin contact (SSC) with their mothers during the first hour after birth to prevent hypothermia and promote breastfeeding.*

This recommendation has been integrated from the WHO recommendations for management of common childhood conditions: evidence for technical update of pocket book recommendations, in which the GDG for that guideline determined it to be a strong recommendation based on low-quality evidence.



iStock by Getty Images. All rights reserved.

# CARE OF THE NEWBORN

*All newborns, including low-birth-weight (LBW) babies who are able to breastfeed, should be put to the breast as soon as possible after birth when they are clinically stable, and the mother and baby are ready.*

This recommendation has been integrated from the WHO recommendations on newborn health. The evidence supporting this recommendation can be found in the WHO guidelines on optimal infant feeding for low birth weight infants in low- and middle-income countries. This recommendation was determined to be a strong recommendation based on low-quality evidence.



Photo: Lieve Blancquaert

# CARE OF THE WOMAN AFTER BIRTH

*Routine antibiotic prophylaxis is not recommended for women with uncomplicated vaginal birth. And likewise for women with episiotomy.*

The GDG was concerned about the potential public health implications of the high rate of routine use of antibiotics following vaginal birth without any specific risk factors in some settings. The group places emphasis on the negative impact of such routine use on the global efforts to contain antimicrobial resistance and, therefore, made a strong recommendation against routine antibiotic prophylaxis.



Photo: UNICEF/Christine Nesbitt



# Implementation

- 
- + *Putting the Guideline into Context*
  - + *WHO Intrapartum Care Model*
  - + *Considerations Specific to Individual Recommendations*

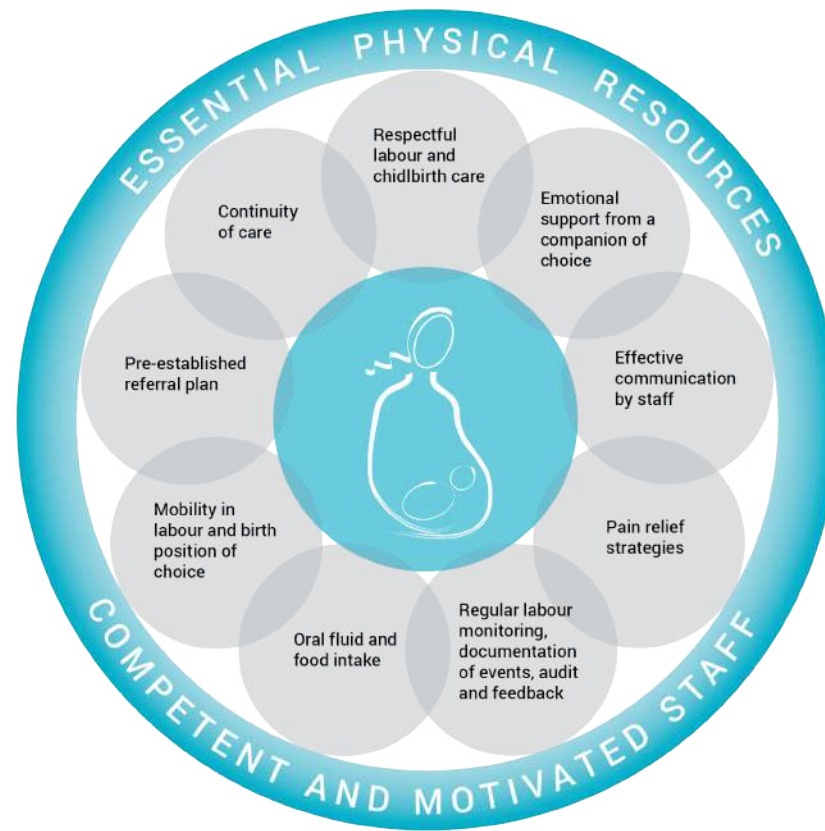
04

# INTRODUCING THE WHO INTRAPARTUM CARE MODEL

*The recommendations should be implemented as a package of care in all facility-based settings, by kind, competent and motivated health care professionals who have access to the essential physical resources.*

The principles guiding the 2018 guideline that includes 56 evidence-based recommendations include the following:

- Labour and childbirth should be individualized and woman-centred
- No intervention should be implemented without a clear medical indication
- Only interventions that serve an immediate purpose and proven to be beneficial should be promoted
- A clear objective that a positive childbirth experience for the woman, the newborn and her family should be at the forefront of labour and childbirth care at all times



# Dissemination

---

- + *Global Launch With Press Release*
- + *International Conferences*
- + *WHO Web Resources*
- + *Social Media*
- + *Translations*

06

# DISSEMINATION CHANNELS

*WHO and other partners will support national and subnational working groups to adapt and implement this guideline.*



*Press release*



*FAQs*



*Web stories &  
Commentaries*



*Translations*



*Infographics*



*Additional info*



*Conferences*



*Implementation tools*



# Applicability issues

---

- + *Potential Barriers at Country Level*
- + *Organization of Care : What Needs to Change*
- + *Monitoring and Impact Evaluation*

07

# MONITORING AND IMPACT EVALUATION

## *How do we track the performance and improve results?*

The implementation and impact of these recommendations should be monitored at the health-service, regional and country levels.

The WHO publication [Standards for improving quality of maternal and newborn care in health facilities](#) provides lists of prioritized input, output and outcome measures, that can be used to define quality of care criteria and indicators with locally agreed targets.

The Monitoring & Evaluation teams of the WHO Departments of Reproductive Health and Research; and Maternal, Newborn, Child and Adolescent Health, will be collect and evaluate data on country- and

regional-level implementation of the recommendations in the short to medium term to assess their impact on national policies of individual WHO Member States.





# MANY THANKS TO...

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