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Technical Brief

2018 WHO RECOMMENDATIONS: INTRAPARTUM CARE FOR A POSITIVE CHILDBIRTH EXPERIENCE

Highlights and Key Messages for the 26 New Recommendations

BACKGROUND

Over a third of maternal deaths and a substantial proportion of pregnancy-related, life-threatening conditions are due to complications that arise during labour, childbirth, or the immediate postpartum period, often as a result of haemorrhage, obstructed labour, or sepsis.[1,2] Therefore, improving the quality of care around the time of birth is essential for reducing stillbirths and maternal and newborn deaths.

Global agendas, such as 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) 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 line with this objective, the World Health Organisation (WHO) developed *Recommendations: Intrapartum Care for a Positive Childbirth Experience* in 2018 to bring together existing and new recommendations that address not only the clinical requirements for a safe labour and childbirth but also meet the psychological and emotional needs of women and newborns. To facilitate effective implementation of the 2018 intrapartum care recommendations, the WHO developed the *Labour Care Guide* and *User's Manual* in 2020 to replace the partograph.

Key Messages

- The World Health Organisation guideline recognizes a "positive childbirth experience" as a significant goal for all women while in labour and while giving birth.
- The recommendations aim to:
  - Promote "normality"
  - Reduce variation in care
  - Promote nonclinical intrapartum practices that optimise quality of care and improve women's comfort, maternal and perinatal outcomes, and the experience of care
  - Highlight unnecessary, non-evidence-based, and potentially harmful intrapartum care practices

The 2018 intrapartum care guideline includes **26 new and 30 existing evidence-based recommendations** detailing the clinical and nonclinical care that is needed throughout labour and immediately afterwards for "healthy" women and newborns. For these recommendations, 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 to be healthy.

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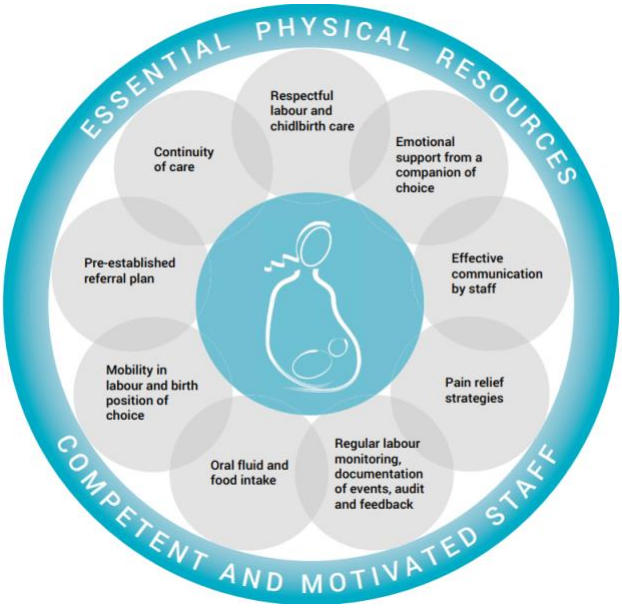
Delivering the recommendations for essential clinical and nonclinical practices that support a positive childbirth experience as a package will ensure person-centred, quality, and evidence-based care **at all levels of health care and in all country settings.**

FIGURE 1. SCHEMATIC REPRESENTATION OF THE WHO INTRAPARTUM CARE MODEL



The aim of the WHO guideline is to promote quality essential intrapartum care within the context of person-centred health and well-being as part of a broader, rights-based approach. The ultimate goal is to improve maternal, foetal, and newborn outcomes. The guideline 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. In the 2018 intrapartum care guideline, the WHO introduced a global model of intrapartum care that subscribes to all domains of the WHO quality of care framework for maternal and newborn health and places the woman and her baby at the centre of care provision. The recommended practices need to be delivered within this model of care, which can be adapted to different countries, local contexts, and the individual woman (Figure 1). It is based on the premise that care during labour can only be supportive of a woman's own capability to give birth without unnecessary interventions when interrelated evidence-based components are not fragmented but are delivered together. By doing so, the woman is able to achieve a positive experience while at the same time ensuring timely and appropriate identification and management of complications if they arise. The model acknowledges the differences across settings in terms of existing models of care and is flexible enough for adoption without disrupting the current organisation of care.

This technical brief reviews the **26 new recommendations** from the WHO's 2018 recommendations[1] on intrapartum care for a positive childbirth experience and are highlighted and discussed in the sections below. In addition, the briefer reviews policy and programme considerations for countries adopting, adapting, and implementing the recommendations.

NEW DEFINITIONS OF LATENT AND ACTIVE PHASES OF LABOUR AND WHAT CONSTITUTES NORMAL LABOUR DURATION AND PROGRESS

To safely monitor labour and childbirth in any setting, a clear understanding of what constitutes normal labour onset and progress is essential. The validity of the most important components of the partograph, the alert and action lines, has been called into question as the findings of several studies suggest that labour can indeed be slower than the limits of the alert and action lines, particularly when the active phase is defined as starting at 4 cm or less of cervical dilatation. The 2018 recommendations have provided new definitions of latent and active phases of the first stage of labour, as well as what can be considered normal duration and progress of labour (see Table 1).

[1] References for the evidence on which the recommendations are based are available in the WHO's 2018 *Recommendations: Intrapartum Care for a Positive Childbirth Experience*.

TABLE 1. COMPARISON OF NEW AND PREVIOUS RECOMMENDATIONS ON DEFINITIONS OF LATENT AND ACTIVE PHASES OF FIRST STAGE, DURATION OF EACH PHASE AND STAGE, AND SATISFACTORY PROGRESS OF LABOUR

Phase/stage	2018 recommendations			Previous recommendations (no longer included in guideline)
	Definition	**Duration**	**Satisfactory progress of labour**	
Latent phase: First stage	**R5.** Painful contractions, variable changes of the cervix, including effacement, slow dilatation **up to 5 cm** for first and subsequent labours.	**R6. Standard duration may vary widely.**	**R9**. Labour may not naturally accelerate until a cervical dilatation threshold of 5 cm is reached.	• Previous recommendations defined this phase as cervix dilated less than 4 cm. • Duration less than 8 hours of regular contractions for cervix to be dilated to 4 cm. • Satisfactory progress was defined as the cervix dilating beyond 4 cm after 8 hours or less of regular contractions.
Active phase: First stage	**R5.** Regular painful contractions, substantial effacement, more rapid dilatation **from 5 cm until full dilatation** for first and subsequent labours.	**R6.** Active phase of first stage of labour usually does not exceed **12 hours in first** labours and **10 hours in subsequent** labours. The median duration of active first stage is **4 hours in first** labours and **3 hours in second and subsequent** labours, when the reference starting point is 5 cm cervical dilatation.	**R7**. In spontaneous labour, cervical dilatation of 1 cm/hour during active phase as depicted by the alert line is inaccurate in identifying women at risk of adverse birth outcomes.	• Previous guidance defined this phase as the cervix dilated 4 cm up to 10 cm and onset of foetal descent. • Duration was described as 6 hours with cervical dilatation of 1 cm/hour from 4 to 10 cm and total time in labour not >12 hours. • Satisfactory progress was previously described as rate of dilatation 1 cm/hour or more (cervical dilatation on or to the left of the alert line).
Second stage		**R33. In first** labours**, birth is usually completed within 3 hours whereas in subsequent** labours, **birth is usually completed within 2 hours.**		• Previous guidance described second stage as steady descent of the foetus through the birth canal and onset of expulsive (pushing) phase.

The **critical implications for practice** of these new definitions and reference thresholds are as follows:

- Health care professionals should advise healthy pregnant women that the duration of labour is highly variable and depends on their individual physiological process and pregnancy characteristics.
- Health care professionals should support pregnant women with spontaneous labour onset to experience labour and childbirth according to their own natural process and progress without interventions to shorten the duration of labour, provided the condition of the woman and baby is reassuring, there is progressive cervical dilatation, and the expected duration of labour is within the recommended limits.
- The decision to intervene when the first stage of labour appears to be prolonged **must not be taken on the basis of duration alone**:
  - **Before considering any medical interventions**, health care providers should carefully evaluate women with suspected delay in labour progression to identify the most likely cause, rule out developing complications (e.g., cephalopelvic disproportion [CPD], obstruction, or malposition/malpresentation requiring caesarean birth), determine whether their emotional, psychological, and physical needs in labour are being met, and manage the cause. The plan of care should be based on the most likely cause.

Reminder: Causes of prolonged labour can include anxiety or fear, exhaustion, dehydration, ineffective uterine contractions, poor maternal positioning (persistently/only supine), infection, malposition/malpresentation, obstruction, or CPD.

  - **R8.** A minimum cervical dilatation rate of 1 cm/hour **from 5 to 10 cm dilatation** is unrealistically fast for some women. A slower than 1 cm/hour rate **alone** should not be a routine indication for obstetric interventions
  - R9. Labour may not naturally accelerate until a cervical dilatation threshold of 5 cm is reached. As long as foetal and maternal conditions are reassuring, DO NOT use medical interventions to accelerate labour before 5 cm dilatation (e.g., oxytocin augmentation, artificial rupture of membranes, or caesarean birth).
  - **Only augment labour with oxytocin if there are clear indications, no contraindications, and the facility meets criteria for safe augmentation** (refer to the 2014 *WHO Recommendations for Augmentation of Labour*).
- In second stage of labour, there are no grounds for intervention when the woman's condition is satisfactory, the foetus is in good condition, there is evidence of progress in the descent of the foetal head, and labour has not extended beyond the standard duration (i.e., **3 hours in first** labours or **2 hours in subsequent** labours).
  - However, when the second stage has extended beyond these standard durations, the chance of spontaneous birth within a reasonable time decreases, and intervention to expedite childbirth should be considered.
- Whenever possible, the WHO Labour Care Guide should be adopted to facilitate implementation of the new intrapartum care guideline. The Labour Care Guide does not have "action" or "alert" lines, but has evidence-based time limits at each centimetre of cervical dilatation in the active phase of labour.
  - However, if the partograph is still in use, plotting on the cervicograph should **commence from a cervical dilatation of 5 cm**, which signifies the onset of the active phase of the first stage of labour for most women. In health care facilities where interventions such as augmentation and caesarean operation cannot be performed and where referral-level facilities are difficult to reach, the alert line could still be used for triaging women who may require referral and/or additional care.

NONCLINICAL INTRAPARTUM PRACTICES

As highlighted in the WHO framework for improving quality of care for pregnant women during childbirth, experience of care is as important as clinical care provision in achieving the desired person-centred outcomes. The following nonclinical aspects of labour and childbirth care are essential components of care that should complement any necessary clinical interventions to optimise the quality of care provided to the woman and her family and improve women's comfort, maternal and perinatal outcomes, and the experience of care.

Photo: Global Health Project

R1. Provide respectful maternity care (RMC), which refers to care organised for and provided to all women and newborns 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.

- Provision of RMC is in accordance with a human rights-based approach to reducing maternal and newborn morbidity and mortality. RMC can improve women's experience of labour and childbirth and address health inequalities.
- Maternity care providers need to be supported to provide the best quality care they can to women and newborns in stressful circumstances, which has a profound influence on their health and well-being. Interventions should aim to ensure a respectful, dignified, and enabling working environment for those providing care. It is also important to acknowledge and help address disrespect and abuse in the workplace and/or violence at home or in the community that staff may be experiencing.
- Resources are available for promoting respectful care, including the *Respectful Maternity Care Operational Guidance*, developed under the U.S. Agency for International Development-funded Maternal Child Survival Program.

R2. Ensure effective communication between maternity care providers and women in labour, using simple and culturally acceptable methods

- Effective communication between maternity care staff and women during labour and childbirth should consist of several key elements, including (but not limited to) respecting and responding to the woman's needs, preferences, and questions with a positive attitude, empathy, and encouragement, and supporting the woman's choices.

R3. Facilitate the presence of a companion of choice for all women throughout labour and childbirth.

- The companion in this context can be any person chosen by the woman to provide her with continuous support during labour and childbirth.
- If labour companionship is implemented in settings where labour wards have more than one bed per room, care should be taken to ensure that privacy and confidentiality is maintained for all women (e.g., by consistent use of dividers/curtains).
- It is important that women's wishes are respected, including those who prefer not to have a companion.
- Finding a companion of choice to support labour might not be easy for marginalised or vulnerable women, or if women live far from health care facilities, or if the companion requires payment. Health care facilities need to take this into account and consider steps to ensure that support is always available for all women during labour.

NEW RECOMMENDATIONS FOR CARE ON ADMISSION IN LABOUR

When a woman presents at a facility, it is essential that a health care professional conduct a comprehensive maternal and foetal assessment to exclude undiagnosed or developing complications. Most women, especially those giving birth for the first time, are apprehensive about childbirth and certain interventions. Applying potentially unpleasant obstetric practices that have limited or uncertain benefit for healthy women in spontaneous labour to a woman presenting in labour can increase her anxiety and diminish her experience of care. To optimise the experience of care without compromising the quality of care, only obstetric practices with clear evidence of benefit for healthy women in spontaneous labour should be applied. Table 2 outlines new recommendations around care on admission in labour.

TABLE 2. RECOMMENDATIONS FOR INTERVENTIONS ON ADMISSION IN LABOUR

Recommended	Rationale
R13. Auscultate the foetal heart rate using a Doppler ultrasound device or Pinard foetal stethoscope to assess foetal well-being on labour admission.	• Assessment of foetal condition at admission by auscultating the foetal heart rate is a vital and integral part of providing quality intrapartum care. • Evidence shows that cardiotocography (CTG) on admission in labour probably increases the risk of caesarean operation without improving birth outcomes. • CTG increases the likelihood of a woman and her baby receiving a cascade of other interventions, including continuous CTG and foetal blood sampling, which adds to costs and might negatively impact childbirth. • There is no evidence to support the view that CTG is better at identifying at-risk babies than auscultation.
R12. **DO NOT** routinely use CTG to assess foetal well-being on labour admission in healthy pregnant women presenting in spontaneous labour.	
R11. DO NOT conduct routine clinical pelvimetry on admission of healthy pregnant women in labour.	• Indirect evidence derived from studies of X-ray pelvimetry suggests that routine clinical pelvimetry in healthy pregnant women on admission in labour may increase caesarean operation without a clear benefit for birth outcomes. • Clinical pelvimetry, which can be more uncomfortable than a standard pelvic examination for assessment of progress of labour, could deter women facing gender-based constraints from giving birth in a facility and further reduce equity.

NEW RECOMMENDATIONS FOR MONITORING THE FOETAL HEART RATE IN LABOUR

Monitoring the foetal heart rate during labour is essential to help detect changes in the normal heart rate pattern that may indicate the foetus is not tolerating labour. Having an accurate foetal heart rate will ensure that steps can be taken to treat the underlying problem but can also help prevent unnecessary interventions. A normal foetal heart rate can reassure both the provider and the woman that it is safe to continue labour if no other problems are present.

Photo by Kate Holt

While the importance of monitoring the foetal heart rate is not contested, the methods for monitoring—continuous vs. intermittent, internal vs. external—are frequently under discussion, with many providers considering the more "high tech" continuous foetal monitoring as being "superior." The 2018 guideline, however, clearly recommends intermittent external foetal heart monitoring over continuous CTG (see Table 3).

TABLE 3. RECOMMENDATIONS FOR MONITORING FOETAL HEART RATE IN LABOUR

Recommended	Rationale
R18. For healthy pregnant women in labour, **perform intermittent auscultation** of the foetal heart rate with either a Doppler ultrasound device or Pinard foetal stethoscope.	• There is some evidence to suggest that intermittent auscultation with a handheld Doppler ultrasound device, CTG, or strict monitoring with Pinard foetal stethoscope could increase the detection of foetal heart rate abnormalities, which may in turn reduce hypoxia-ischaemia outcomes. • Continuous CTG increases caesarean operation and other medical interventions, without being cost-effective and with varying acceptability and feasibility. • Continuous CTG can restrict 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.
R17. In healthy pregnant women undergoing spontaneous labour, **DO NOT** perform continuous CTG for assessment of foetal well-being.	

Regardless of the method or device used for intermittent auscultation:

- Women should receive a clear explanation of the technique and its purpose.
- The foetal heart rate should be regularly monitored during labour, with strict adherence to clinical protocols.
- Each auscultation should last at least 1 minute and continue for at least 30 seconds after the contraction.
- If the foetal heart rate is not in the normal range (i.e., 110–160 bpm), auscultation should be prolonged to cover at least three uterine contractions.
- The provider should record the baseline foetal heart rate (as a single counted number in beats per minute) and the presence or absence of accelerations and decelerations.
- To enable shared decision-making, the provider should clearly explain the findings of the auscultation and the subsequent course of action to the woman.

NEW RECOMMENDATIONS FOR CARE DURING SECOND STAGE

The second stage of labour is regarded as the climax of the birth by the woman giving birth, her partner, and the care provider. Recommendations about the provision of skilled care and avoidance of complications during the second stage of labour have been relatively neglected but have changed markedly over the years. These recommendations (see Table 4) are intended to enable providers to attend to women in the second stage of labour in line with current evidence-based recommendations for practice to optimise outcomes for the woman and her baby.

FIGURE 2. ALTERNATE BIRTH POSITIONS

Source: HMS Essential Care during Labor and Birth

TABLE 4. CARE DURING THE SECOND STAGE OF LABOUR

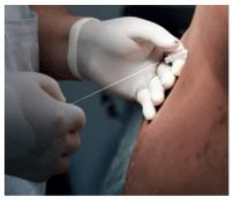
Recommended	Rationale
R34. For women without epidural analgesia, **encourage the adoption of a birth position of the individual woman's choice,** including upright positions.	• Having a choice of birth positions during the second stage of labour might positively impact maternal birth experience. • Offering women birthing options that include those that are acceptable within their local customs and norms could positively impact equity by increasing facility-based births in settings where women generally avoid hospital birth because of the lack of alternative birthing options. • It is important not to force any particular position on the woman and to encourage and support her to adopt any position 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 foetal monitoring, the reason should be clearly communicated to the woman.
R35. For women with epidural analgesia**, encourage the adoption of a birth position of the individual woman's choice,** including upright positions.	• Upright positions with traditional epidural analgesia, which provides a dense neuraxial block, might not be feasible. • When epidural analgesia is "low dose" and "mobile", this should enable a choice of birth positions.
R36. Encourage and support women **in the expulsive phase of the second stage** of labour **to follow their own urge to push**.	• Second stage has two phases: – Early (nonexpulsive) phase: The cervix is fully dilated (10 cm), foetal descent continues, and there is no urge to push – Late (expulsive): The cervix is fully dilated (10 cm), the presenting part of the fetus reaches the pelvic floor, and the woman has the urge to push • Health care providers should avoid imposing directed pushing on women in the second stage of labour, as there is no evidence of any benefit with this technique. • Encouraging women to use their own natural, physiological method of pushing in the second stage might help them to feel more in control of their childbirth experience and empower them to enjoy their reproductive rights.
R38. Use techniques to reduce perineal trauma and facilitate spontaneous birth: Perineal massage, warm compresses, and/or "hands on" guarding of the perineum, **based on the woman's preference.**	Evidence suggests that: • Perineal massage may increase the chance of keeping the perineum intact and reduces the risk of serious perineal tears. • Warm perineal compresses reduce third- and fourth-degree perineal tears. • The "hands on" approach (guarding) probably reduces first degree perineal tears.
R39. DO NOT perform routine or liberal use of episiotomy for women undergoing spontaneous vaginal birth.	• At the present time, there is no evidence supporting the need for episiotomy in any situation. • A review of findings suggests that women preferred to minimise the level of pain experienced from cutting and stitching, as well as the level of discomfort experienced following episiotomy.

NEW RECOMMENDATIONS FOR PAIN RELIEF DURING LABOUR AND CHILDBIRTH

RMC is a fundamental human right of pregnant women, and access to pharmacological and nonpharmacological pain relief is one component of RMC. Supportive care measures, including pain relief measures, should be offered and evaluated continuously during labour. No two labours are exactly alike—and no two women have the same degree of labour pain. A woman's need for labour pain relief and the choices she makes in relation to this need will be influenced by the care context, the type of care she receives, and her care provider**.** While the pain relief methods that can be offered will depend on what is available at a facility, **the best approach to labour pain relief depends on the woman's preferences and how her labour progresses.** For a woman to make an informed choice about what pain relief measures to accept and to facilitate shared decision-making, providers need to provide her with accurate, comprehensive information about **options** (see Table 5), including each option's advantages, disadvantages, and side effects.

FIGURE 3. PAIN RELIEF DURING LABOUR

Relaxation and Massage Techniques



Epidural Analgesia

Parenteral Opioids

Source: WHO IPC guideline slide deck

TABLE 5. LABOUR PAIN RELIEF OPTIONS

Recommended	Rationale
R19. Where available and depending on a woman's preferences, **offer epidural analgesia** as a labour pain relief option to healthy pregnant women requesting pain relief during labour. **NOTE:** Encourage the adoption of the birth position of the individual woman's choice, including upright positions, even when the woman has epidural analgesia.	• Health care professionals should be aware that a woman's desire for epidural analgesia might be moderated by the clinical context in which she receives antenatal and intrapartum care, whether labour is spontaneous or not, and her access to and knowledge of a range of other forms of pain relief measures. • Epidural analgesia appears to be more effective than opioid analgesia, but requires significant resources to implement and manage its adverse effects. • To avoid complications and preserve as much motor function as possible, the lowest possible effective concentration of local anaesthetic should be used when administering epidural analgesia.

Recommended	Rationale
R20. Where available and depending on a woman's preferences, **offer parenteral opioids, such as fentanyl, diamorphine, and pethidine**, as a labour pain relief option to healthy pregnant women requesting pain relief during labour.	• The evidence suggests that opioids probably provide some relief from pain during labour, despite having some undesirable side effects, such as drowsiness, nausea, and vomiting. • 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 drowsiness (that can impact breathing, heartrate and breastfeeding in the first few hours after birth), and about the alternative pain relief options available. • Health care providers need to be trained to manage side effects if they arise and must be aware that opioid medication should be securely stored with a register kept of its dispensing to reduce the risk of abuse.
R21. Depending on a woman's preferences, **offer relaxation techniques, including progressive muscle relaxation, breathing, music, mindfulness, and other techniques**, as labour pain relief options to healthy pregnant women requesting pain relief during labour.	• Qualitative evidence indicates that relaxation techniques can reduce labour discomfort, relieve pain, and enhance the maternal birth experience. • Care providers should inform women that while relaxation techniques are unlikely to be harmful, the beneficial effects have very low certainty. • Women might find some nonpharmacological pain relief options soothing that are not considered in this guideline, such as water immersion, hypnobirthing, acupuncture, and cultural and traditional practices.
R22. Depending on a woman's preferences, **offer manual techniques, such as massage or application of warm packs**, as labour pain relief options to healthy pregnant women requesting pain relief during labour.	• Qualitative evidence indicates that massage can reduce labour discomfort, relieve pain, and enhance the maternal birth experience. • In a review of qualitative studies related to labour pain coping techniques, women valued massage techniques as a form of pain relief when these techniques enabled them to relax and feel calm, and to retain control over childbirth.

NEW RECOMMENDATION TO BE IMPLEMENTED 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 can address unanswered questions and uncertainties related both to the effectiveness of the intervention or option, and its acceptability and feasibility.

R10. 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.**

- This recommendation seeks to avoid unnecessary interventions. In some instances, admitting women in latent phase of first stage of labour may result in unnecessary interventions to accelerate labour.
- When a labouring woman arrives at a facility, a health care professional should conduct a comprehensive maternal and foetal assessment to ensure undiagnosed or developing complications are excluded prior to delaying admission.
- It should be clear that this recommendation refers to delaying admission to the labour ward (i.e., to the childbirth area). However, when implementing this recommendation, providers **should NOT delay**:
  - first contact with a health care provider OR
  - assessment on admission OR
  - admission to the maternity waiting areas, where women in early labour await active labour OR
  - admission to the health care facility.

NEW RECOMMENDATION TO BE IMPLEMENTED 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.

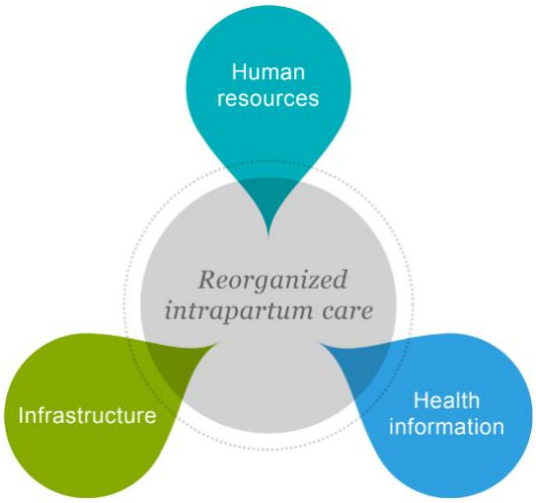
R37: For women with epidural anaesthesia, delay pushing for one to two hours after full dilatation or until the woman regains the sensory urge to bear down **in contexts where resources are available to support a longer stay in second stage and perinatal hypoxia can be adequately assessed and managed.**

- Evidence on effects suggests that delaying pushing probably increases the likelihood of spontaneous vaginal birth after a slightly longer labour.
- Health care providers should avoid imposing immediate pushing on women in the second stage of labour, as there is no evidence of any benefit with immediate pushing and the practice might lead to further medical intervention.

POLICY AND PROGRAMME RECOMMENDATIONS

Effective implementation of the 2018 intrapartum care recommendations will require leadership, the engagement of key actors across the health system, and adequate financial resources to fund activities to reorganize intrapartum care (see figure 4).

FIGURE 4. ANTICIPATED IMPACT ON ORGANIZATION OF CARE



Source: WHO IPC guideline slide deck

Activities to consider include:

1. A careful study of which recommendations can be realistically and feasibly adopted.
2. Updating policies, clinical protocols, and standards for intrapartum care to reflect the newly adopted recommendations
3. Development of an implementation strategy. This may require a phased-in approach to ensure that an appropriate enabling environment is in place for providers to apply the recommendations at each level of the health care system. The enabling environment should include:
    - Communities, companions, and pregnant/labouring women sensitized about RMC, facility-based practices that lead to improvements in women's childbirth experience, and unnecessary birth practices that are not recommended for healthy pregnant women and are no longer practiced in facilities.
    - Adequate human resources with the necessary expertise and skills to:
        - Correctly implement the recommendations;
        - Coach and mentor providers newly trained in the new recommendations;
        - Monitor women's experience of care during labour and childbirth;
        - Monitor QoC indicators for intrapartum care.
    - Infrastructure updates to support recommended practices, e.g. physical space for labour companions, comfortable waiting rooms for women in early labour.
    - Adequate equipment, supplies, and medicines to support implementing the recommendations.
    - A health information management system designed to document and monitor recommended practices.

To ensure these recommendations are taken to scale and optimize the quality of essential intrapartum care with the ultimate goal of improving maternal, fetal and newborn outcomes at a national and local level, the WHO is currently developing two implementation toolkits that will soon be available online – a country-level toolkit and a facility-level toolkit. The WHO Intrapartum Care Implementation Toolkits aim to: 1) assist policy makers, maternity services administrators, programme managers, and providers to adopt WHO's intrapartum care recommendations at the health system or service level, and effectively implement these recommendations into routine clinical practice in health facilities (**Country-level toolkit**); 2) help/support facilities to take a more systematic approach to implementation, considering wide range of potential barriers and enablers to implementing guideline recommendations and matching choice of intervention approach to identified barriers and enablers (**Facility-level toolkit**).

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