New recommendations for managing labour

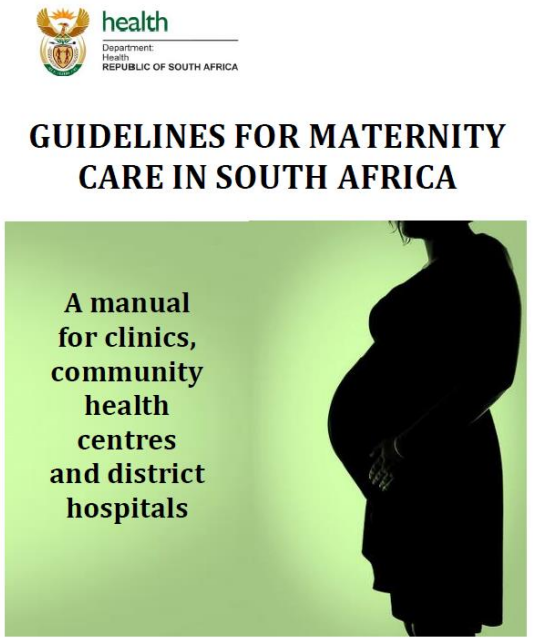
SAMRC

Introduction

Current practice

- active management of labour

- focus on partogram: alert & action lines
  - LPL: 8 hours
  - APL: 1cm/hour



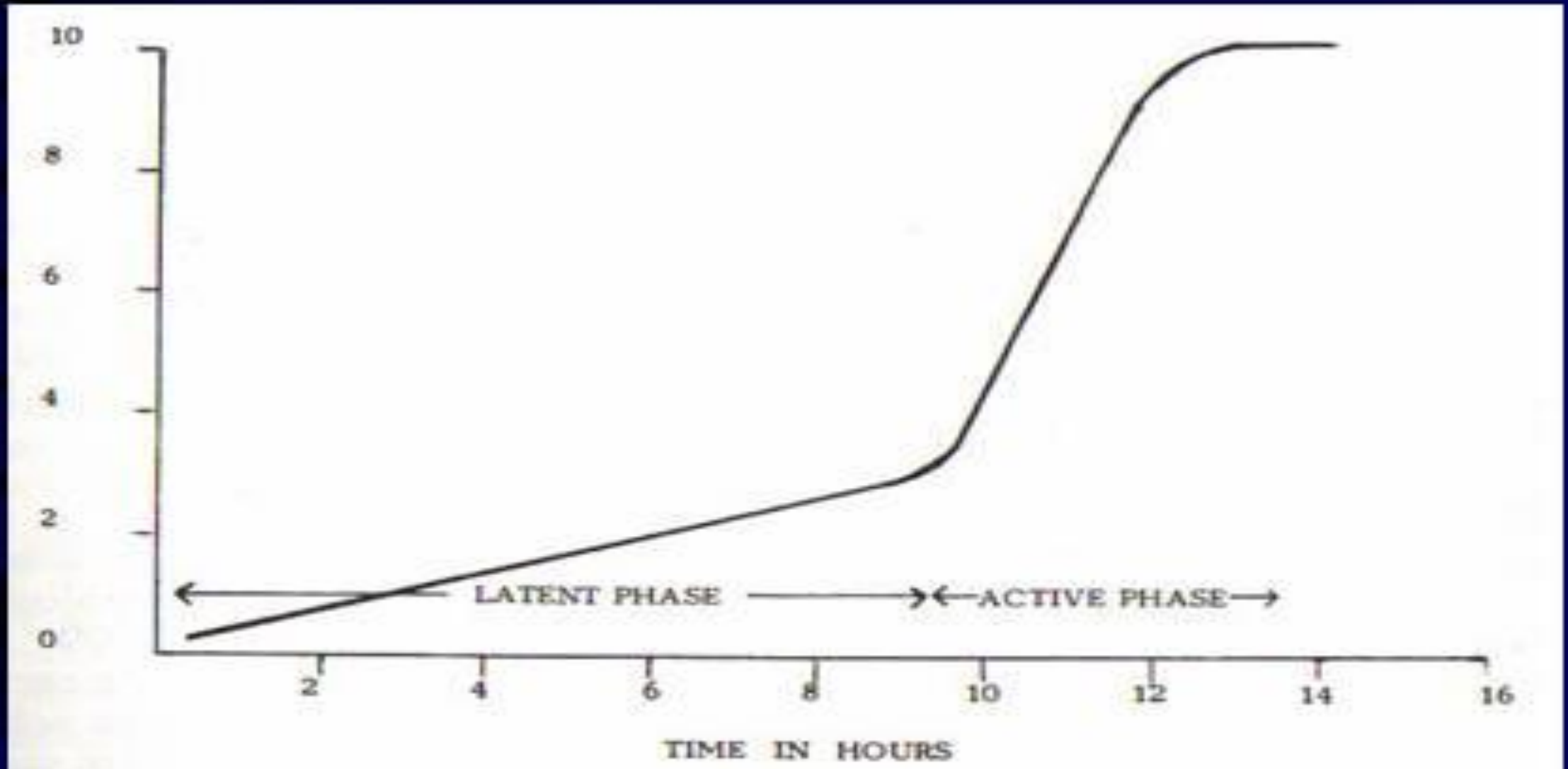


Figure 1. Friedman's cervical dilatation time curve.

Introduction & background

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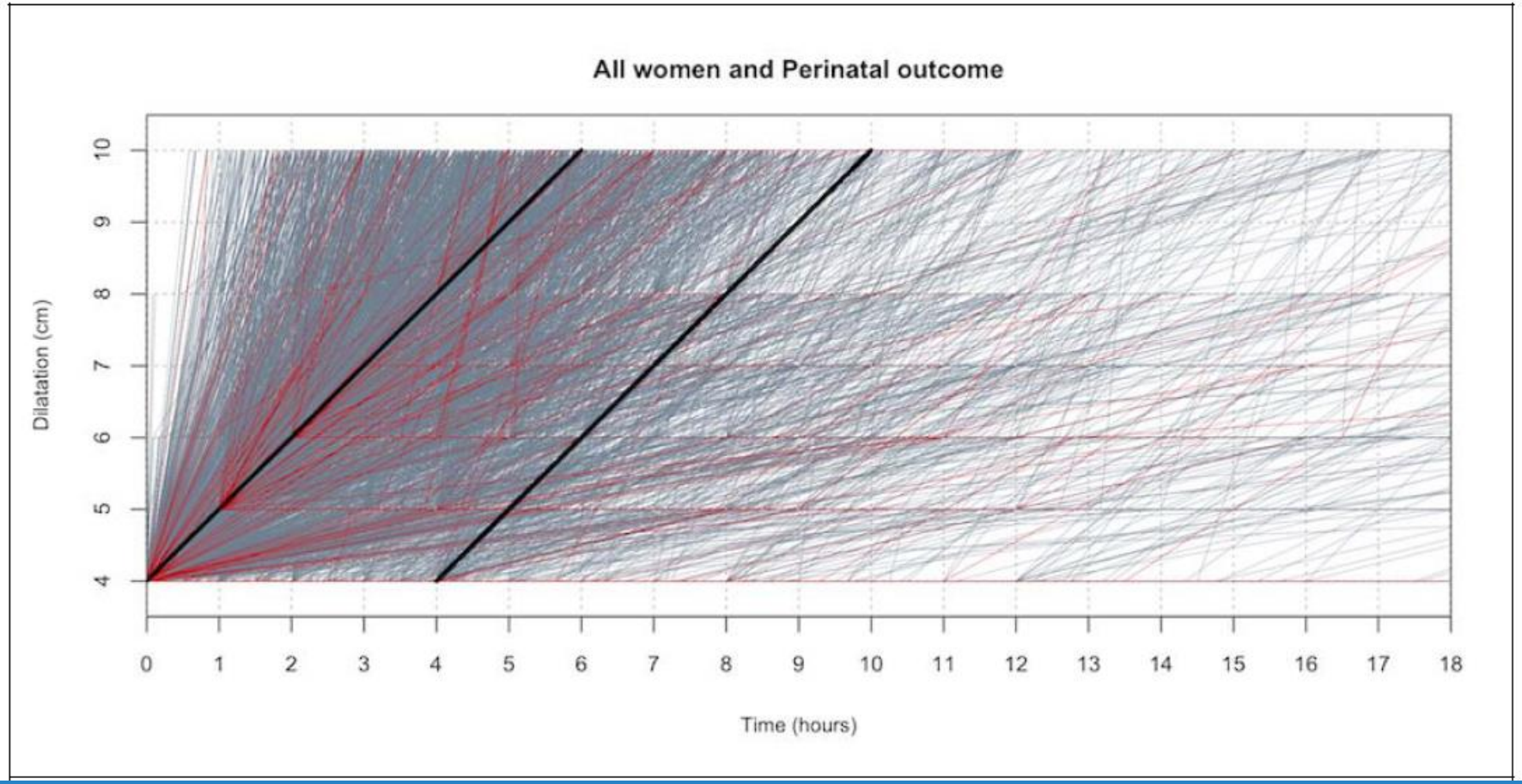
BJOG. 2018 Jul;125(8):991-1000. doi: 10.1111/1471-0528.15205. Epub 2018 Apr 17.

Cervical dilatation over time is a poor predictor of severe adverse birth outcomes: a diagnostic accuracy study.

Souza JP[1], Oladapo OT[1], Fawole B[2], Mugerwa K[3], Reis R[4]



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CONCLUSION:

- Labour is a very variable phenomenon

- Cervical dilatation is a poor predictor of adverse birth outcomes

Introduction & background

Int J Gynaecol Obstet. 2017 Dec;139 Suppl 1:4-16. doi: 10.1002/ijgo.12378. Epub 2017 Dec 7.

Defining quality of care during childbirth from the perspectives of Nigerian and Ugandan women: A qualitative study.

Bohren MA[1], Titiloye MA[2], Kyaddondo D[3], Hunter EC[4], Oladapo OT[1], Tunçalp Ö[1], Byamugisha J[5], Olutayo AO[6], Vogel JP[1], Gülmezoglu AM[1], Fawole B[7], Mugerwa K[5].

Women value:

- **Effective communication (building rapport, positive language, updates on progress)**
- **Respect & dignity (privacy, empathy)**
- **Emotional support (reassurance & encouragement, companionship)**
- **Competent healthcare worker**

Major implications of WHO recommendations intrapartum care for a positive childbirth experience

1. Focus on supportive care in labour
2. Duration of latent stage of labour is characterized by a slow progression, no standard duration established
3. Start of active phase at 5cm
4. 1cm/hour threshold for cervical dilatation rate might be unrealistically fast and should not be used to identify normal labour progression

GOAL:

1. Every woman should have a positive childbirth experience

2. Labour should be as physiological as possible, avoiding unnecessary interventions

Implementation of respectful, supportive care in ALL birthing facilities

- Companion of choice throughout labour
- Create and respect privacy of all labouring women
- Communication: introduction of all HCWs, address woman by name, no shouting
- Allow mobilisation and adopting a comfortable position
- Allow intake of food and fluid
- Attention to the need of pain relief
- Allow bathing
- Participatory decision making & obtaining verbal consent for every procedure done

Diagnosis of labour

- Regular painful contractions WITH
  - Cervical changes, OR
  - Rupture of membranes, OR
  - Show

- Latent phase of labour: less than 5cm dilated

- Active phase of labour: **starting at 5cm**

Management of **suspected labour** (when labour is not confirmed)

- Full history and clinical examination on admission
- Introduction of a checklist: reassuring maternal & fetal condition
- When to repeat all observations:
  - 2-hourly FHR, maternal HR and palpation of contractions
  - 6-hourly maternal vitals & vaginal examination
  - If NO contractions are palpated, vaginal examination can be repeated after 4 hours to discharge the woman

Management of **suspected labour** (when labour is not confirmed)

Discharge only if:

- Reassuring maternal and fetal condition
- No increase in contractions / irregular contractions, contractions have ceased
- No rupture in membranes
- No cervical changes or descent of the fetal head since admission
- Warning signs have been explained, the mother has been counselled and the HCW has verified the mother understands

Introduction of discharge checklist

Management of **latent phase** of labour

- Duration extended to **24 hours**
- Full history and clinical examination on admission
- Introduction of a checklist: reassuring maternal & fetal condition
- When to *repeat all observations*?
  - 2-hourly FHR, maternal HR and palpation of contractions
  - 6-hourly maternal vitals & vaginal examination

Management of **latent phase** of labour

- When to *repeat the vaginal examination earlier*?
  - If the frequency / intensity / duration of contractions changes
  - If HCW has subjective impression that the woman is in APL
  - If there is a request for opiate analgesia
  - If the woman has an urge to bear down
  - If non-reassuring maternal or fetal condition
  - ROM: speculum examination and checking of the FHR

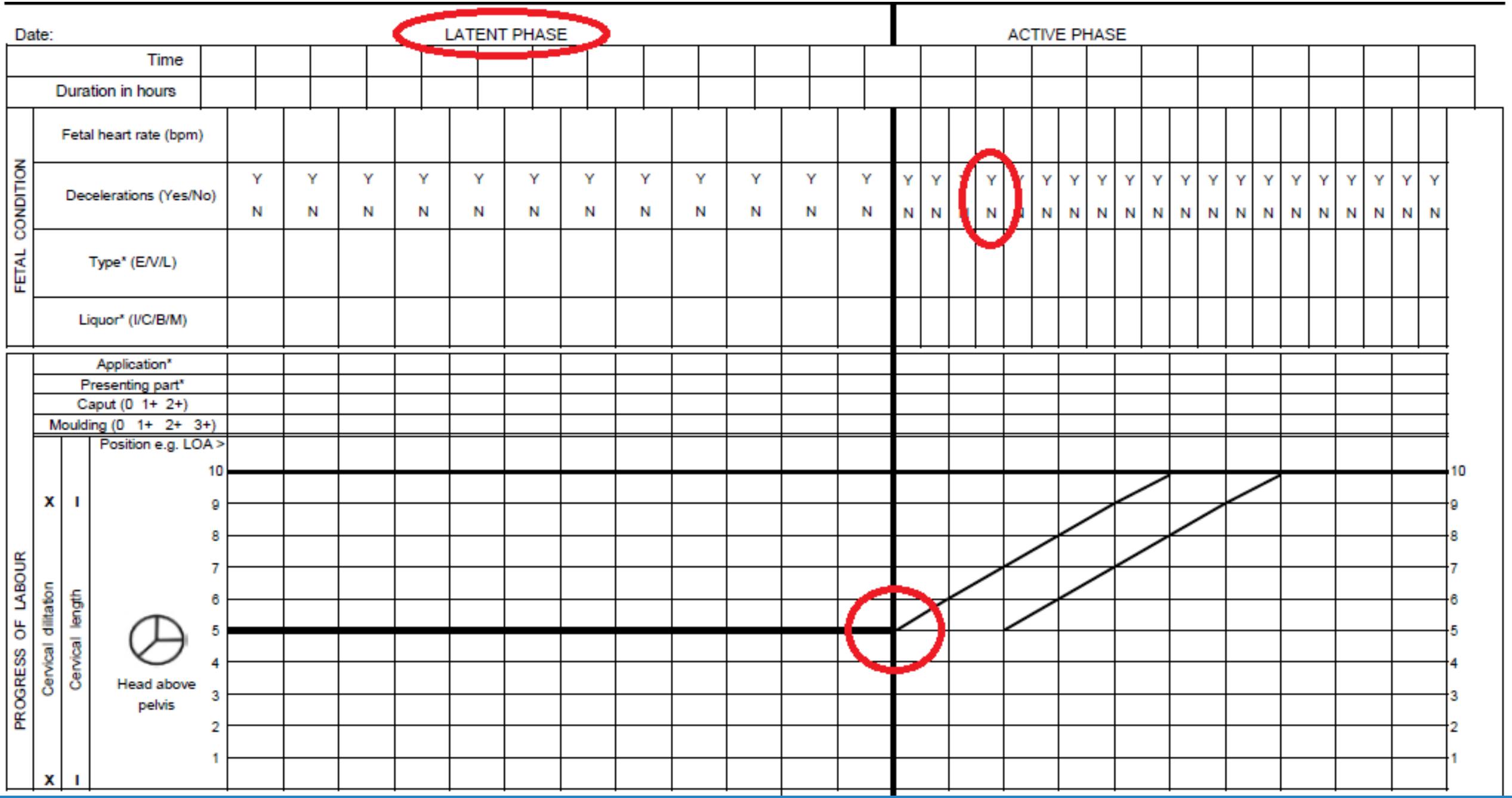
Management of **latent phase** of labour

- When to *call a doctor or refer*?
  - If non-reassuring maternal or fetal condition
  - If ROM > 12 hours and still in latent phase
  - If MSL draining (all MSL)
  - If vaginal bleeding is diagnosed
  - If 5cm is not reached after 24 hours (MOUs can refer after 12 hours if needed)

Management of **active phase** of labour

- Active phase of labour usually does not extend beyond
  - 12 hours for a nulliparous woman
  - 10 hours for a multiparous woman

- When to *repeat all observations*
  - Every 30 minutes: FHR and maternal heartrate
  - Every 2 hours: palpation of contractions
  - Every 4 hours: maternal vitals (urine: when passed)
  - Vaginal examination: 4-hourly intervals – 2-hourly from 8cm onwards


Date:
LATENT PHASE
ACTIVE PHASE
Time
Duration in hours
FETAL CONDITION
Fetal heart rate (bpm)
Decelerations (Yes/No)
Y
N
Type* (E/V/L)
Liquor* (I/C/B/M)
PROGRESS OF LABOUR
Application*
Presenting part*
Caput (0 1+ 2+)
Moulding (0 1+ 2+ 3+)
Position e.g. LOA >
Cervical dilatation
Cervical length
X
I
10
9
8
7
6
5
4
3
2
1
Head above pelvis

Management of the **second stage** of labour

- Before active pushing: observations as during the first stage

- If fully dilated and no urge to bear down => allow 1 hour for head to descend (rule out CPD)

- Maternal vitals: at start of active pushing

- FHR: **every 5 minutes or every 2 contractions** (whichever comes first)

Management of the **second stage** of labour

- Assisted vaginal delivery checklist

- HCW skilled etc.

When to *refer during the second stage of labour*

- No urge to bear down after being fully dilated for 1 hour
- Fetal distress and woman is not eligible for AVD
- Poor progress and woman is not eligible for AVD
- Signs of CPD (3+ sagittal moulding)
- No descent of fetal head after 15 minutes of effective pushing
- P0: not delivered after 45 minutes (and not eligible for AVD)
- P>0: not delivery after 30 minutes (and not eligible for AVD

Management of the **third stage** of labour

- Mother and baby skin-to-skin!
- Active management
- Delayed cord clamping (if no immediate resuscitation required)
- Uterotonic of choice: 10IU oxytocin IMI after birth of the baby (additional uterotonics can be given if woman at risk of PPH)
- Controlled cord traction recommended if skilled birth attendant present
- Sustained massaging of uterus not recommended
- Use of early warning chart
  - Check vitals and pads every 15 minutes for first hour after delivery
  - Check vitals and pads every 30 minutes for second hour after delivery

Management of the **third stage** of labour

- Use of a discharge checklist for both mother and baby
- Contraception counselling
- Follow-up dates provided
- Warning signs explained
- **Discharge minimum of 6 hours after delivery (⇔ WHO recommendation)**

Implication

Need increased space in labour wards to accommodate extra women with uncertain labour or in the latent phase. More staff to manage active phase and facilities that can accommodate accompanying persons. Better postnatal facilities to accommodate WHO recommendations of a 24 hour postpartum stay