

No.	Care option	Recommendation	
44	Delayed umbilical cord clamping	Delayed umbilical cord clamping (not earlier than 1 minute after birth) is recommended for improved maternal and infant health and nutrition outcomes (6).	Recommended
45	Controlled cord traction (CCT)	In settings where skilled birth attendants are available, controlled cord traction (CCT) is recommended for vaginal births if the care provider and the parturient woman regard a small reduction in blood loss and a small reduction in the duration of the third stage of labour as important (7).	Recommended
46	Uterine massage	Sustained uterine massage is not recommended as an intervention to prevent postpartum haemorrhage (PPH) in women who have received prophylactic oxytocin.	Not recommended
Care of the newborn			
47	Routine nasal or oral suction	In neonates born through clear amniotic fluid who start breathing on their own after birth, suctioning of the mouth and nose should not be performed.	Not recommended
48	Skin-to-skin contact	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 (8).	Recommended
49	Breastfeeding	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 (9).	Recommended
50	Haemorrhagic disease prophylaxis using vitamin K	All newborns should be given 1 mg of vitamin K intramuscularly after birth (i.e. after the first hour by which the infant should be in skin-to-skin contact with the mother and breastfeeding should be initiated) (10).	Recommended
51	Bathing and other immediate postnatal care of the newborn	Bathing should be delayed until 24 hours after birth. If this is not possible due to cultural reasons, bathing should be delayed for at least 6 hours. Appropriate clothing of the baby for ambient temperature is recommended. This means one to two layers of clothes more than adults, and use of hats/caps. The mother and baby should not be separated and should stay in the same room 24 hours a day (11).	Recommended
Care of the woman after birth			
52	Uterine tonus assessment	Postpartum abdominal uterine tonus assessment for early identification of uterine atony is recommended for all women (12).	Recommended
53	Routine antibiotic prophylaxis for episiotomy	Routine antibiotic prophylaxis is not recommended for women with uncomplicated vaginal birth.	Not recommended
54	Routine antibiotic prophylaxis for episiotomy	Routine antibiotic prophylaxis is not recommended for women with episiotomy.	Not recommended
55	Routine postpartum maternal assessment	All postpartum women should have regular assessment of vaginal bleeding, uterine contraction, fundal height, temperature and heart rate (pulse) routinely during the first 24 hours starting from the first hour after birth. Blood pressure should be measured shortly after birth. If normal, the second blood pressure measurement should be taken within 6 hours. Urine void should be documented within 6 hours (13).	Recommended
56	Postnatal discharge following uncomplicated vaginal birth	After an uncomplicated vaginal birth in a health care facility, healthy mothers and newborns should receive care in the facility for at least 24 hours after (2, 12).	Recommended

⁶ Integrated from WHO guideline: delayed cord clamping for improved maternal and infant health and nutrition outcomes
⁷ Recommended category indicates intervention or option should be implemented
⁸ Integrated from WHO recommendations for management of common childhood conditions: evidence for technical update of pocket book recommendations
⁹ Integrated from WHO recommendations on newborn health
¹⁰ Integrated from WHO recommendations for management of common childhood conditions: evidence for technical update of pocket book recommendations
¹¹ Integrated from WHO recommendations on postnatal care of the mother and newborn
¹² Integrated from WHO recommendations for the prevention and treatment of postpartum haemorrhage
¹³ Integrated from WHO recommendations on postnatal care of the mother and newborn
¹⁴ For the newborn, this includes an immediate assessment at birth, a full clinical examination around one hour after birth and before discharge

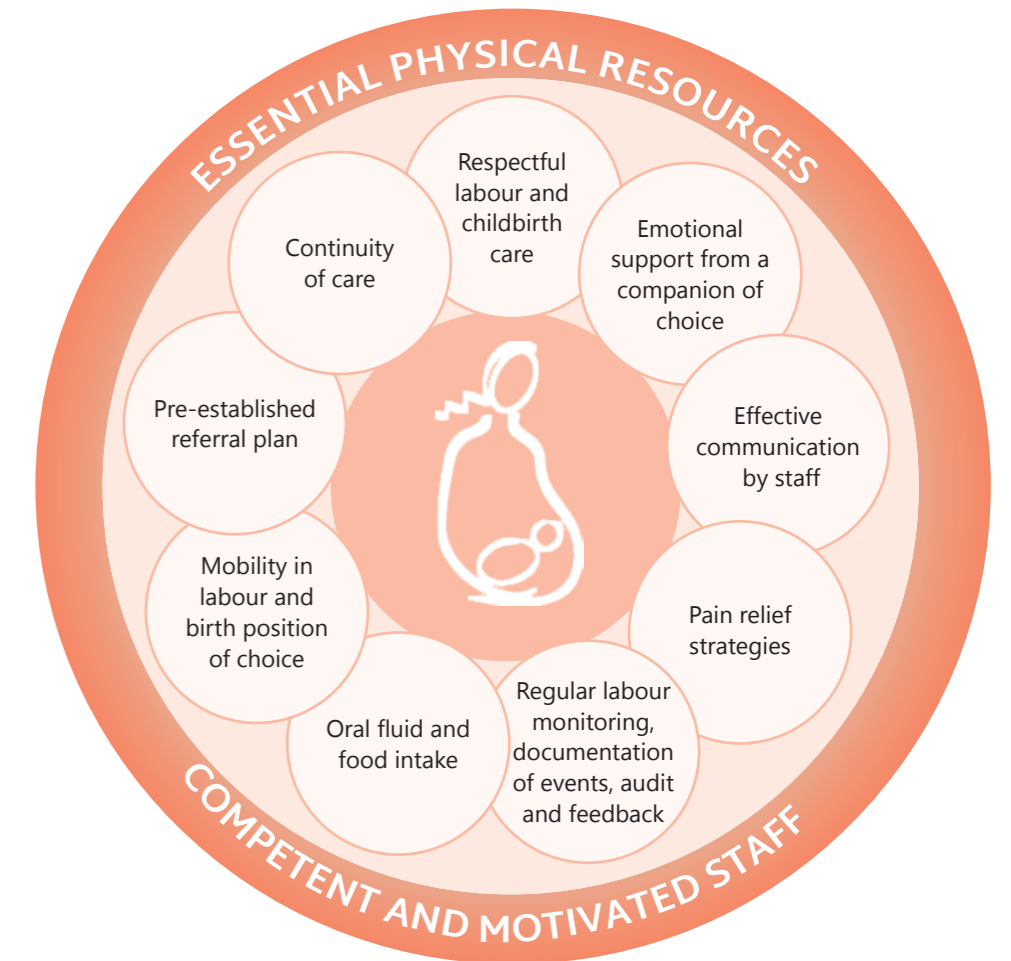


WHO Recommendations: Intrapartum Care for “A Positive Childbirth Experience”

Positive childbirth experience

Women want a positive childbirth experience that fulfils or exceeds their prior personal and sociocultural beliefs and expectations. This includes giving birth to a healthy baby in a clinically and psychologically safe environment with continuity of practical and emotional support from birth companion(s) and kind, technically competent clinical staff. 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.

Schematic representation of the WHO intrapartum care (IPC) model



“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.”

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.

Effective implementation of the recommendations in this guideline may require reorganization of care and redistribution of health-care resources.

Summary list of actions on IPC for a positive childbirth experience (1)

No.	Care option	Recommendation	
Care throughout labour and birth			
1	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.	Recommended
2	Effective communication	Effective communication between maternity care providers and women in labour, using simple and culturally acceptable methods, is recommended.	Recommended
3	Companionship during labour and childbirth	A companion of choice is recommended for all women throughout labour and childbirth.	Recommended
4	Continuity of care	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*	Context-specific recommendation
First stage of labour			
5	Definitions of the latent and active first stages of labour	The use of the following definitions of the latent and active first stages of labour is recommended for practice: <ul style="list-style-type: none"> 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
6	Duration of the first stage of labour	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
7	Progress of the first stage of labour	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.	Not recommended
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.	Not recommended
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
10	Labour ward admission policy	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

* Recommended category indicates intervention or option should be implemented

No.	Care option	Recommendation	
11	Clinical pelvimetry on admission	Routine clinical pelvimetry on admission in labour is not recommended for healthy pregnant women.	Not recommended
12	Routine assessment of fetal well-being on labour admission	Routine cardiotocography is not recommended for the assessment of fetal well-being on labour admission in healthy pregnant women presenting in spontaneous labour.	Not recommended
13	being on labour admission	Auscultation using a Doppler ultrasound device or Pinard fetal stethoscope is recommended for the assessment of fetal well-being on labour admission.	Research-context recommendation
14	Perineal/pubic shaving	Routine perineal/pubic shaving prior to giving vaginal birth.	Not recommended
15	Enema on admission	Administration of enema for reducing the use of labour augmentation is not recommended.	Not recommended
16	Digital vaginal examination	Digital vaginal examination at intervals of four hours is recommended for routine assessment of active first stage of labour in low-risk women (2).	Recommended
17	Continuous cardiotocography during labour	Continuous cardiotocography is not recommended for assessment of fetal well-being in healthy pregnant women undergoing spontaneous labour.	Not recommended
18	Intermittent fetal heart rate auscultation during labour	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
19	Epidural analgesia for pain relief	Epidural analgesia is recommended for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences.	Recommended
20	Opioid analgesia for pain relief	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
21	Relaxation techniques for pain management	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
22	Manual techniques for pain management	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
23	Pain relief for preventing labour delay	Pain relief for preventing delay and reducing the use of augmentation in labour is not recommended.	Not recommended
24	Oral fluid and food	For women at low risk, oral fluid and food intake during labour is recommended (3).	Recommended
25	Maternal mobility and position	Encouraging the adoption of mobility and an upright position during labour in women at low risk is recommended ¹ .	Recommended
26	Vaginal cleansing	Routine vaginal cleansing with chlorhexidine during labour for the purpose of preventing infectious morbidities is not recommended.	Not recommended
27	Active management of labour	A package of care for active management of labour for prevention of delay in labour is not recommended	Not recommended
28	Routine amniotomy	The use of amniotomy alone for prevention of delay in labour is not recommended	Not recommended
29	Early amniotomy and oxytocin	The use of early amniotomy with early oxytocin augmentation for prevention of delay in labour is not recommended	Not recommended

² Integrated from WHO recommendations for prevention and treatment of maternal peripartum infections

³ Integrated from WHO recommendations for augmentation of labour

No.	Care option	Recommendation	
30	Oxytocin for women with epidural analgesia	The use of oxytocin for prevention of delay in labour in women receiving epidural analgesia is not recommended.	Not recommended
31	Antispasmodic agents	The use of antispasmodic agents for prevention of delay in labour is not recommended.	Not recommended
32	Intravenous fluids for preventing labour delay	The use of intravenous fluids with the aim of shortening the duration of labour is not recommended.	Not recommended
Second stage of labour			
33	Definition and duration of the second stage of labour	The use of the following definition and duration of the second stage of labour is recommended for practice: <ul style="list-style-type: none"> 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
34	Birth position (for women without epidural analgesia)	For women without epidural analgesia, encouraging the adoption of a birth position of the individual woman's choice, including upright positions, is recommended.	Recommended
35	Birth position (for women with epidural analgesia)	For women with epidural analgesia, encouraging the adoption of a birth position of the individual woman's choice, including upright positions, is recommended.	Recommended
36	Method of pushing	Women in the expulsive phase of the second stage of labour should be encouraged and supported to follow their own urge to push.	Recommended
37	Method of pushing (for women with epidural analgesia)	For women with epidural analgesia in the second stage of labour, delaying pushing for 1 to 2 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
38	Techniques for preventing perineal trauma	For women in the second stage of labour, techniques to reduce perineal trauma and facilitate spontaneous birth (including perineal massage, warm compresses and a "hands on" guarding of the perineum) are recommended, based on a woman's preferences and available options.	Recommended
39	Episiotomy policy	Routine or liberal use of episiotomy is not recommended for women undergoing spontaneous vaginal birth.	Not recommended
40	Fundal pressure	Application of manual fundal pressure to facilitate childbirth during the second stage of labour is not recommended.	Not recommended
Third stage of labour			
41	Prophylactic uterotonics	<ul style="list-style-type: none"> The use of uterotonics for the prevention of postpartum haemorrhage (PPH) during the third stage of labour is recommended for all births (4). 	Recommended
42		<ul style="list-style-type: none"> Oxytocin (10 IU, IM/IV) is the recommended uterotonic drug for the prevention of postpartum haemorrhage (PPH)(5). 	Recommended
43		<ul style="list-style-type: none"> In settings where oxytocin is unavailable, the use of other injectable uterotonics (if appropriate, ergometrine/ methylergometrine, or the fixed drug combination of oxytocin and ergometrine) or oral misoprostol (600 µg) is recommended(5). 	Recommended

⁴ Integrated from WHO recommendations for the prevention and treatment of postpartum haemorrhage.

⁵ Recommended category indicates intervention or option should be implemented