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WHO recommendations in intrapartum care for a positive childbirth experience

The World Health Organization has issued new recommendations for global standards in care at birth for healthy pregnant women, with a view to reducing unnecessary medical interventions.

This comprehensive and consolidated guideline on essential intrapartum care brings together 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 are neither country- nor region-specific but they 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.

Worldwide, an estimated 140 million births take place every year. Most of these occur without complications for women and their babies. Yet, over the past 20 years, practitioners have increased the use of interventions that were previously only used to avoid risks or treat complications, such as caesarean births or oxytocin infusion to speed up labour.

“We want women to give birth in a safe environment with skilled birth attendants in well-equipped facilities. However, the increasing medicalization of normal childbirth processes are undermining a woman's own capability to give birth and negatively impacting her birth experience,” says Dr Princess Nothemba Simelela, WHO Assistant Director-General for Family, Women, Children and Adolescents.

“If labour is progressing normally, and the woman and her baby are in good condition, they do not need to receive additional interventions to accelerate labour,” she says. Childbirth is a normal physiological process without complications for the majority of women and babies. However, studies show a substantial proportion of healthy pregnant women are often subjected to needless and potentially harmful routine interventions.

The new WHO guideline includes 56 evidence-based recommendations for the care needed throughout labour and immediately after for the woman and her baby, including:

- having a companion of choice during labour and childbirth
- ensuring respectful care and good communication between women and health providers
- maintaining privacy and confidentiality
- enabling women to make decisions about their pain management, labour and birth positions and natural urge to push, among others.

It is recognised that every labour and childbirth is unique and that the duration of the active first stage of labour varies from one woman to another. In a first labour, it usually does not extend beyond 12 hours. In subsequent labours it usually does not extend beyond 10 hours.

To reduce unnecessary medical interventions, the WHO guideline states that the previous benchmark for cervical dilation rate at 1 cm/hour during the active first stage of labour may be unrealistic for some women and is inaccurate in identifying women at risk of adverse birth outcomes. The guideline emphasizes that a slower cervical dilation rate alone should not be a routine indication for intervention to accelerate labour or expedite birth.

> “Many women want a natural birth and prefer to rely on their bodies to give birth to their baby without the aid of medical intervention,” says Ian Askew, WHO Director, Department of Reproductive Health and Research. “Even when a medical intervention is wanted or needed, the inclusion of women in making decisions about the care they receive is important to ensure that they meet their goal of a positive childbirth experience.”

Unnecessary labour interventions are widespread in low-, middle- and high-income settings, putting a strain on already scarce resources in some countries, and further widening of the equity gap.

As more women give birth in health facilities with skilled health professionals and timely referrals, they should receive better quality of care. About 830 women die from pregnancy- or childbirth-related complications around the world every day and the majority of deaths could be prevented with high-quality care in pregnancy and during childbirth.

Disrespectful and undignified care is prevalent in many health facilities, violating human rights and preventing women from accessing care services during childbirth. In many parts of the world, the health provider controls the birthing process, which further exposes healthy pregnant women to unnecessary medical interventions that interfere with the natural childbirth process.

Achieving the best possible physical, emotional, and psychological outcomes for the woman and her baby requires a model of care in which health systems empower all women to access care that focuses on the mother and child.

While most women want a natural labour and birth, they also acknowledge that birth can be an unpredictable and risky event and that monitoring and interventions may be necessary. Even when

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interventions are needed or wanted, women usually wish to retain a sense of personal achievement and control by being involved in decision making, and by rooming in with their baby after childbirth.

http://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/.

Safe Childbirth Checklist study shows no improvement to childbirth care

The Safe Childbirth Checklist is a WHO-branded tool developed by frontline health workers and technical experts in maternal health, newborn health, checklist-based programs, quality improvement, and implementation science. It took several years to develop, including field-testing for usability and a pilot study of its impact on health worker practices,

A multicentre trial, testing the BetterBirth approach to Checklist implementation, was set up in India, to assess the effectiveness of the program in reducing avoidable maternal, fetal, and newborn harm. This randomised controlled study recorded outcomes for more than 300,000 women and babies in primary care facilities in Uttar Pradesh, India – an area with one of the highest birth-related mortality rates in the country.

Sixty birth attendants and managers were enrolled in an eight-month coaching programme on how to use the WHO Safe Childbirth Checklist, with 60 rural health centres in Uttar Pradesh being used as controls. The study found that the Safe Childbirth Checklist, developed by the World Health Organization, did not lead to a reduction in the overall death rate for women and babies.

Care providers at the birth included doctors (around 14% at both intervention and control sites); nurses (81%); auxiliary nurse midwives (just over 18%); and small numbers described as 'others'.

Co-author of the paper, Professor Lisa Hirschhorn, commented on the study saying: "The team is looking into why the improvements did not translate into reduction of maternal and neonatal harm". She suggested some possibilities might include:

- causes of death which are not preventable by the checklist items
- need for more complex care such as care for premature infants
- other quality of care challenges and gaps in higher-level care for women and their neonates with complications.

The Safe Childbirth Checklist addresses the major causes of death through the promotion of 28 essential birth practices such as clean gloves to prevent infection, monitoring blood pressure to prevent eclampsia and steps to prevent maternal haemorrhage.

Two months into the study, researchers found that birth attendants and midwives at the intervention sites had performed 73% of the essential birth practices, in comparison to 42% performed by controlled health centres. However, the results of the study showed no noticeable improvement in childbirth care with the use of the Safe Childbirth Checklist. Researchers also found no significant impact on perinatal and mortality rates, or complications between both the intervention and control sites.

The BetterBirth study was supported by the Bill & Melinda Gates Foundation, and led by Adriadne Labs, a joint centre of the Harvard T.H. Chan School of Public Health and Brigham and Women's Hospital in Boston, in partnership with the Governments of India and Uttar Pradesh.

The outcomes of the 'BetterBirth' study can be found at http://www.nejm.org/doi/pdf/10.1056/NEJMoa1701075.

UNICEF publishes 'Every child alive: the urgent need to prevent newborn deaths'

UNICEF's global Every Child ALIVE campaign is an urgent appeal to governments, businesses, health-care providers, communities and individuals to fulfil the promise of universal health coverage (UHC) and keep every child alive. The campaign, which aims to build consensus for the principle that every mother and every baby deserves affordable, quality care, supports UNICEF and partners as they work together to realize the promise of 'Place, People, Products and Power' in 10 focus countries: Bangladesh, Ethiopia, Guinea-Bissau, India, Indonesia, Malawi, Mali, Nigeria, Pakistan and the United Republic of Tanzania. Together, these countries account for more than half of the world's newborn deaths.

Every year, 2.6 million babies die before turning one month old and another 2.6 million are stillborn: the vast majority of these losses are preventable. More than 80 per cent of newborn deaths are the result of premature birth, complications during labour and delivery and infections such as sepsis, meningitis and pneumonia. Similar causes, particularly complications during labour, account for a large share of stillbirths.

Deaths among children aged 1 month to 5 years old have fallen dramatically in recent decades. But progress in reducing the deaths of newborn babies – those aged less than 1 month – has been less impressive, with 7000 newborns still dying every day. This is partly because newborn deaths are difficult to address with a single drug or intervention – they require a system-wide approach. It is also due to a lack of momentum and global commitment to newborn survival.

As this report shows, the risk of dying as a newborn varies enormously depending on where a baby is born. Babies born in Japan stand the best chance of surviving, with just 1 in 1000 dying during the first 28 days. Children born in Pakistan face the worst odds: of every 1000 babies born, 46 die before the end of their first month – almost 1 in 20.

Newborn survival is closely linked to a country's income level. High-income countries have an average newborn mortality rate (the number of deaths per thousand live births) of just 3. In comparison, low-income countries have a newborn mortality rate of 27. This gap is significant: If every country brought its newborn mortality rate down to the high-income average, or below, by 2030, 16 million newborn lives could be saved.

However, a country's income level explains only part of the story. In Kuwait and the United States of America, both high-income countries, the newborn mortality rate is 4. This is only slightly better than lower-middle-income countries such as Sri Lanka and Ukraine, where the newborn mortality rate is 5. Rwanda, a low-income country, has more than halved its newborn mortality rate in recent decades, reducing it from 41 in 1990 to 17 in 2016, which puts the country well ahead of upper-middle-income countries like the Dominican Republic, where the newborn mortality rate is 21. This illustrates that the existence of political will to invest in strong health systems that prioritize newborns and reach the poorest and most marginalized is critical and can make a major difference, even where resources are constrained.

Moreover, national mortality rates often mask variations within countries: babies born to mothers with no education face almost twice the risk of dying during the newborn period as babies born to mothers with at least a secondary education. Babies born to the poorest families are more than 40 per cent more likely to die during the newborn period than those born to the least poor.

If we consider the root causes, these babies are not dying from medical causes such as prematurity or pneumonia. They are dying because their families are too poor or marginalized to access the care they need. Of all the world's injustices, this may be the most fundamental.

The good news is that progress is possible, even where resources are scarce. Successes in countries like Rwanda offer hope and lessons for other countries committed to keeping every child alive. Specifically, they show that two steps are critical: increasing access to affordable health care and improving the quality of that care.

Low levels of access to maternal and newborn health services provided by skilled health providers correlate strongly with high newborn mortality rates. In Somalia, a country with one of the world's highest newborn mortality rates (39), there is only one doctor, nurse or midwife for every 10,000 people.

In the Central African Republic, where the newborn mortality rate