November 2024

Using the WHO Labour Care Guide

for a positive childbirth experience

Participant worksheets

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Acknowledgements

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Using the LCG for a positive childbirth experience

Participant Worksheets

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Contents

Overview of the course **1**
Objectives of this course 1
Target audience 1
Sections of the WHO LCG **2**
Structure of the WHO LCG **3**
Completing the LCG **4**
Key clinical practices when completing the LCG **5**
Action Plan - Quick reminder **6**

Learning activity A **7**
Section 1: Identifying information and labour characteristics at admission 8
Section 2: Supportive care 8
Section 3: Care of the baby 9
Section 4: Care of the woman 10
Section 5: Labour progress 11
Section 6: Medication 12
Section 7: Shared decision-making 12

Learning activity B : Case study – Ms. Elizabeth **13**

Learning activity C : Case study – Ms. Zakia **15**

Team Action Plan – to improve care for labour and birth **17**

Annex 1. WHO Labour Care Guide: Quick Guide **18**

Annex 2. Key – Learning activities B and C **27**

LDHF ACTIVITIES **30**

SESSION ANSWERS **38**

Overview of the course

Objectives of this course

By the end of this two-day course, participants will be able to:

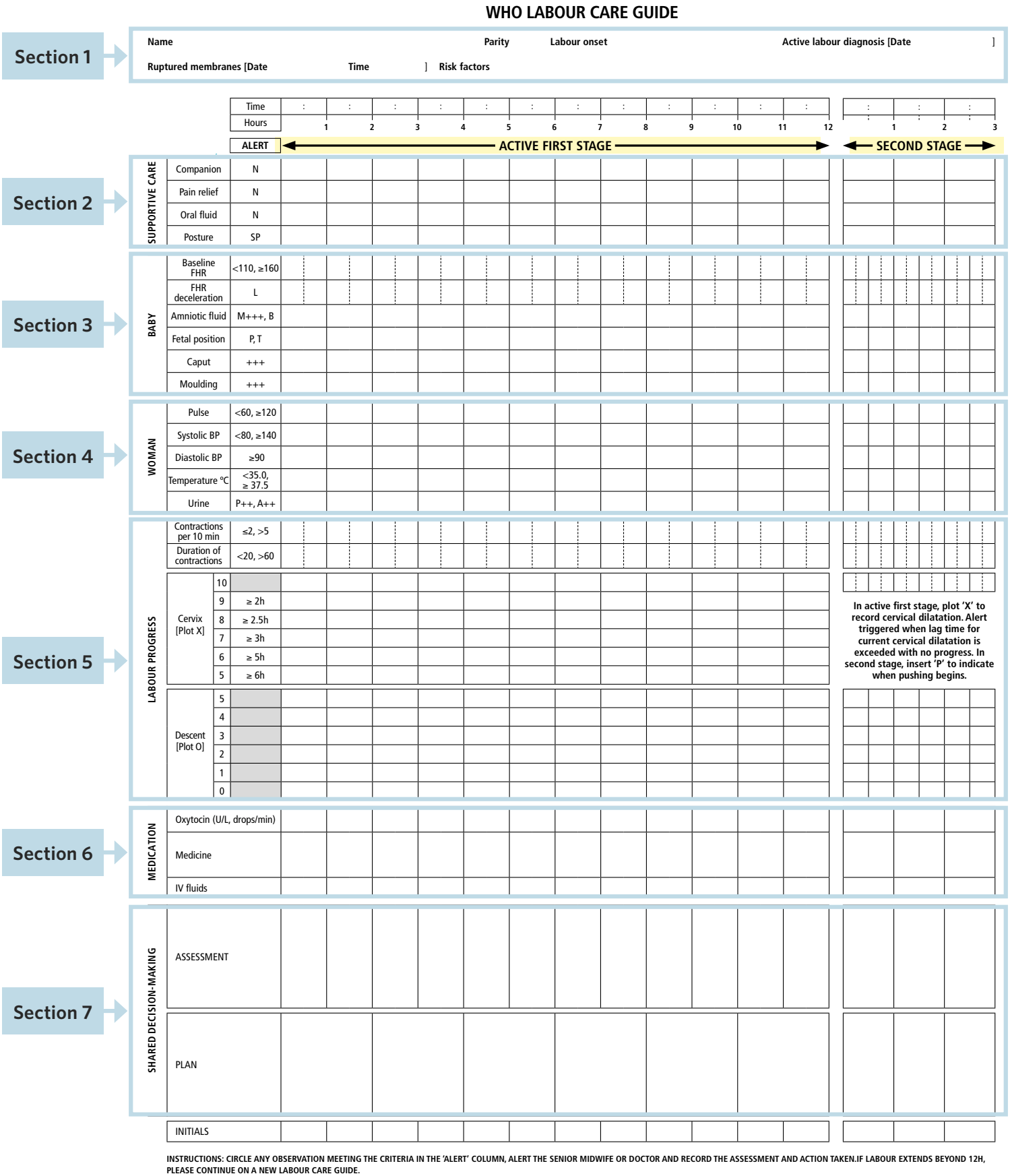
- List the principal aims of the LCG.
- Identify for whom, when, and where the Labour Care Guide (LCG) can be used
- Recognize the principal elements and sections of the LCG
- Competently and confidently assess all parameters in the LCG
- Correctly fill out the LCG
- Competently use the reference thresholds (alert signs) to trigger reflection and specific action(s)
- Make an assessment based on findings from the evaluation
- Make a plan of care after each assessment with the woman and her companion
- Identify additional resources that are available

Target audience

- The primary target audience for this course is skilled health personnel directly providing labour and childbirth care in all settings. This includes midwives, nurses, general medical practitioners and obstetricians.
- The course will also be of interest to staff involved in training health care personnel, health-care facility managers, implementers and managers of maternal and child health programmes, nongovernmental organizations (NGOs), and professional societies involved in the planning and management of maternal and child health services.

Sections of the WHO LCG

The WHO Labour Care Guide (LCG) consists of 7 sections covering the Active first stage of labour, and a section on the second stage of labour.

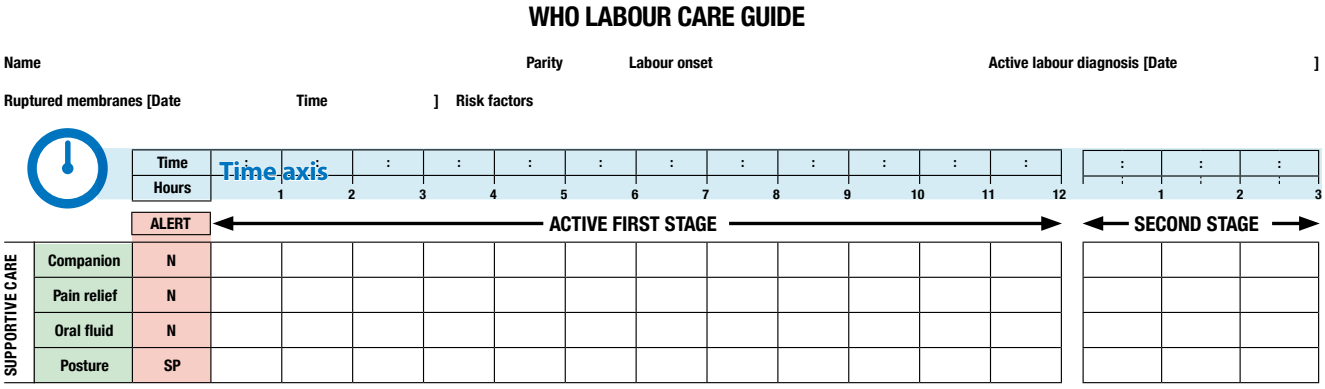


INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERT' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN.IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE.

Abbreviations: **Y** – Yes, **N** – No, **D** – Declined, **U** – Unknown, **SP** – Supine, **MO** – Mobile, **E** – Early, **L** – Late, **V** – Variable, **I** – Intact, **C** – Clear, **M** – Meconium, **B** – Blood, **A** – Anterior, **P** – Posterior, **T** – Transverse, **P+** – Protein, **A+** – Acetone

Structure of the WHO LCG

- **Time axis**
- Column indicating the parameters to be assessed
- Column displaying the alert values (i.e. normal values that can be found for each parameter are not included)
- Cells for documentation of findings.



Completing the LCG

Each time you assess labour, do the following:

- **Assess** parameters (at relevant intervals, depending on the individual)
- **Record** your findings by using numbers or abbreviation letters (refer to the WHO LCG User's Manual or the bottom of the LCG)
- **Compare** your finding with the criteria in the "Alert column" and circle any observation meeting the criteria
- Review protocols for managing any alert values
- Record any medication and IV fluids being given
- Write your assessment
- Discuss findings and options for care with the woman and her companion
- Agree on a **plan of care** with the woman and her companion and get consent
- Record the plan of care
- Record your initials

Key clinical practices when completing the LCG

The parameters to assess during the first and second stage of labour provide information on the woman's and baby's well-being and progress of labour. Therefore, assessment and documentation of ALL parameters should be accurate.

Planned care must consider findings from your assessment, the woman's personal attributes and choices. When assessment is not accurate or providers feel pressured to document findings they did not actually assess, changes in the woman's or fetus' status may be missed and quality of care may be compromised.
Some of the skills to assess the parameters may be new or need refreshing, this may need practice and mentorship to achieve competence.

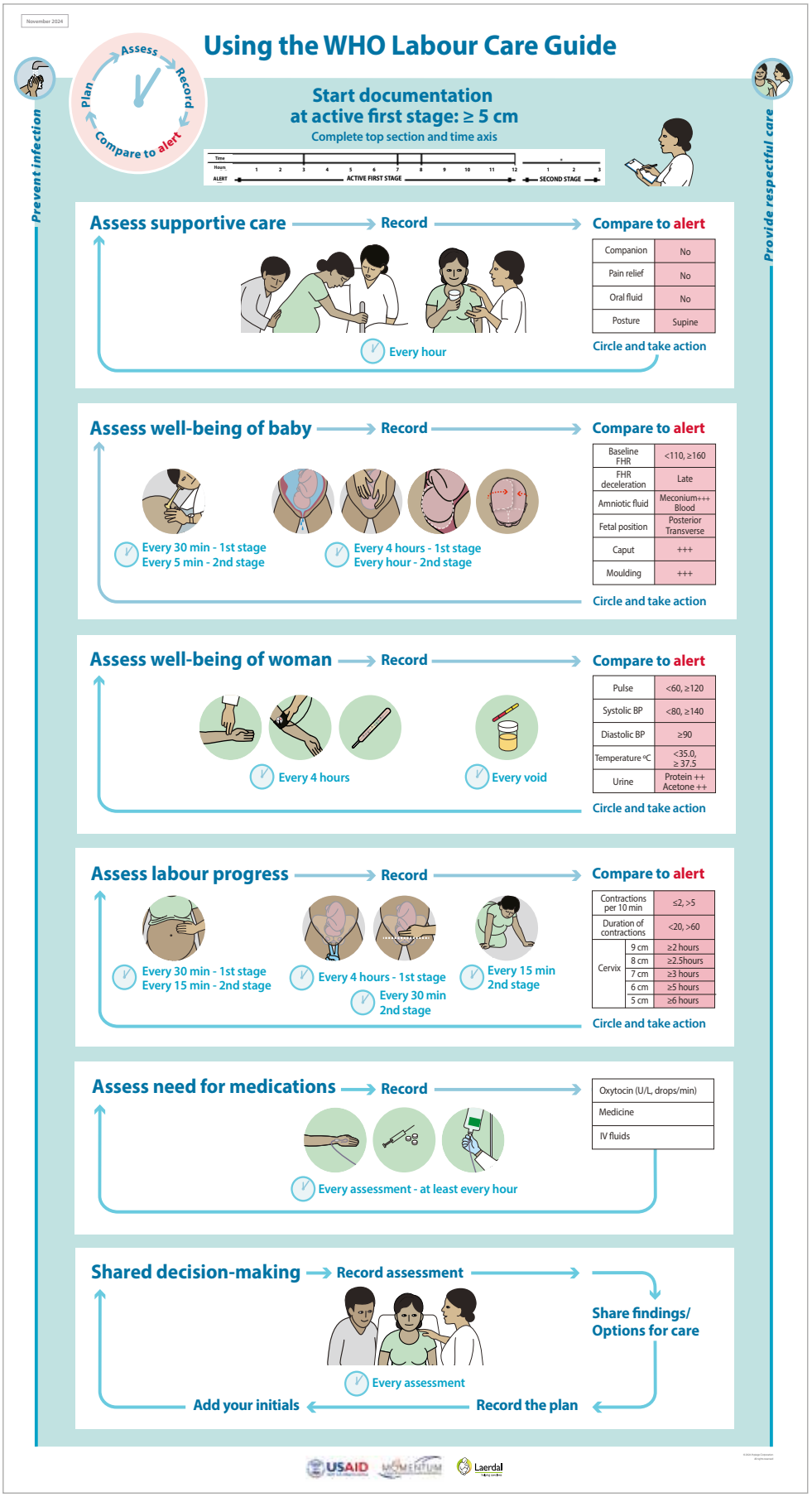
If do not feel confident or competent to assess any of the parameters:

- Ask a more senior provider to assist you and validate your assessment while you are monitoring a woman in labour.
- If a more senior provider is not immediately available to assist you, ask for assistance as soon as one is available.
- Ask for a mentor to work with you until you feel confident and competent to assess all parameters.
- Take opportunities to follow experienced providers and learn from them.
- Ask to participate in on-the-job training activities to strengthen your capacity to assess all parameters.
- Ask for simulation equipment to be made available for all staff to be able to practice skills.

If you were unable to assess the parameter, it is better to document this using an agreed upon symbol, for example a "-", then to not document your findings or to document findings that may not be accurate. When a cell is left blank at a time an assessment should be conducted, the assumption is made that no effort was made to conduct the assessment.

Action Plan - Quick reminder

This Action Plan helps you to take the right steps at the right time to complete the WHO LCG.
Make sure you have a print hanging on the wall in the labour ward.



Learning activity A

You are working on the labour ward and attend to Mary Jane, who presents in labour at your facility.

1. Work in groups of 2-3. Read the information provided and fill in the LCG.

2. Record findings from the worksheet on the LCG. **Circle any "alert" findings with a red pen on the LCG.**

3. Check if you have correctly filled in each section by comparing your work with Mary Jan'es completed labour care guide on **page 22 of the WHO LCG User's Manual.** **[For your own learning, do not look at the correctly completed labour care guide until you have attempted filling in Mary Jane's labour care guide.]**

4. When you are deciding on the plan of care, refer to the pages below in the **WHO LCG User's Manual** or the **WHO Quick Guide** in the Participant's Worksheets for guidance on whether and what type of intervention is recommended.

Section	***WHO LCG User's Manual***	***WHO Quick Guide in Participant's Worksheets***
Section 1: Identifying information and labour characteristics at admission	*Pages 8-9*	*Page 19*
Section 2: Supportive care	*Pages 9-11*	*Page 20*
Section 3: Care of the baby	*Pages 11-14*	*Pages 21-22*
Section 4: Care of the woman	*Pages 14-16*	*Page 23*
Section 5: Labour progress	*Pages 17-20*	*Pages 24-25*
Section 6: Medication	*Pages 20-21*	*Page 25*
Section 7: Shared decision-making	*Page 21*	*Page 25*

5. After checking your LCG, look at the completed LCG on page 22 and fill in the blanks from findings on the LCG in the worksheet.

Section 1 Identifying information and labour characteristics at admission

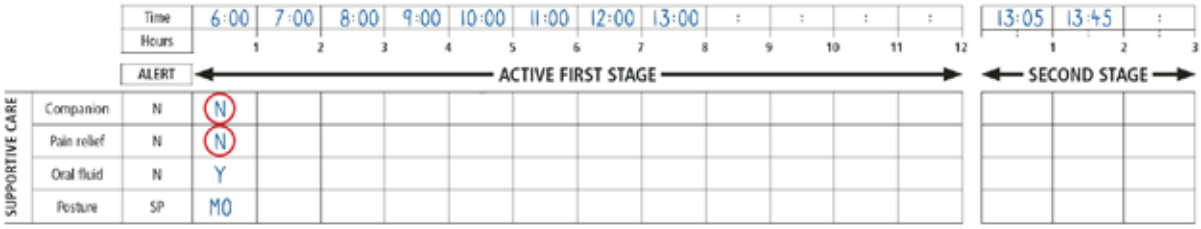
This section is reviewed on pages 8-9 in the WHO LCG User's Manual.

Scenario 1:

Date: June 07, 2020. Time: 06:00 Name: Mary Jane presented with contractions and reports that she has experienced leakage of fluid from the vagina for the last hour. Her gestational age is 38 weeks. This is her fourth pregnancy. She previously had two births, one of a live baby and one of a stillbirth at term. She also had a miscarriage. She is taking oral iron to treat anaemia. Cervical dilatation was 5 cm at 06:00 am.

Section 2 Supportive care

Supportive care is reviewed on pages 9-11 in the WHO LCG User's Manual.



Companionship	Y=Yes (the woman has a companion of her choice) N=No (the woman does not have a companion of her choice) D=Woman declines a companion
Pain relief	Y=Yes (the woman is not distressed by pain and/or is receiving pharmacological or non-pharmacological pain relief) N=No (the woman is distressed by pain and is not receiving pharmacological or non-pharmacological pain relief) D=Woman declines to receive pharmacological or non-pharmacological pain relief
Oral fluid	Y=Yes (the woman is taking oral fluids) N=No (the woman is not taking any oral fluids) D=Woman declines oral fluids
Posture	SP=Supine MO=Mobile (includes walking, swaying or any non-supine position, e.g. left lateral, squatting, kneeling, standing)

Record the findings below on the blank LCG:

Date: June 07, 2020.

Time: 06:00. Mary Jane is not accompanied by a relative or someone from her social network. She reports feeling significant pain due to the uterine contractions, and requests pain relief. She drank a fruit juice and is walking.

Time 07:00. Mary Jane is with her sister and using relaxation techniques for pain relief with good results. She has been drinking water when thirsty, and Mary Jane is now lying in bed in a supine position.

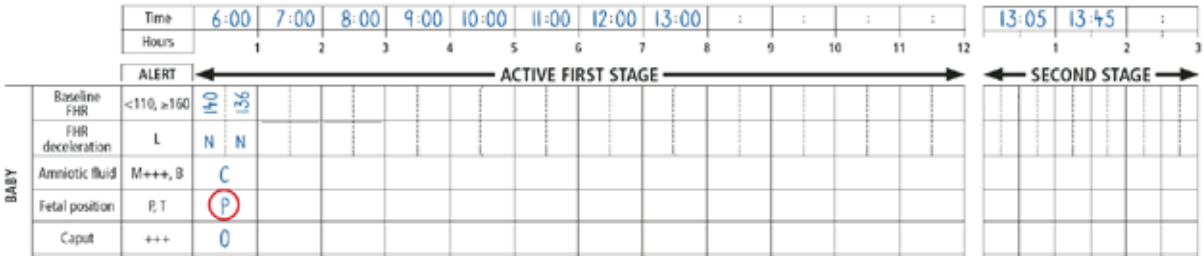
Time 11:00. Mary Jane's sister is back and massaging her back while Mary is standing, leaning against the bed; Mary Jane says the massage is enough for her pain. She is drinking water.

Fill in the blanks from the completed LCG on page 22 of the WHO LCG User's Manual:

Time 08:00. Companionship:____. Pain relief: ____. Oral fluid:____. Posture:____.
Time 10:00. Companionship:____. Pain relief: ____. Oral fluid:____. Posture:____.
Time 13:00. Companionship:____. Pain relief: ____. Oral fluid:____. Posture:____.
Time 13:05. Companionship:____. Pain relief: ____. Oral fluid:____. Posture:____.

Section 3 Care of the baby

Care of the baby is reviewed on pages 11-14 in the WHO LCG User's Manual.



FHR deceleration	**N**=No **E**=Early (FHR lowers below baseline usually at the start of a contraction, reaches the lowest point (nadir) at the peak of the contraction, and then increases after the peak of a contraction) **L**=Late (FHR lowers below baseline usually ***after*** the peak of a contraction) **V**=Variable (The timing of low FHR and return to baseline in relation to the contraction is variable)
Amniotic fluid	**I**=Intact membranes C=Membranes ruptured, clear fluid **M**=Meconium-stained fluid: record + (non-significant), ++ (medium), and +++ (thick) **B**=Blood-stained meconium
Fetal position	**A**=Any occiput anterior position **P**= Any occiput posterior position **T**= Any occiput transverse position
Caput	**0**=None **+** **++** **+++**=Marked
Moulding	**O**=None **+**=Sutures apposed **++**=Sutures overlapped but reducible **+++**=Sutures overlapped and not reducible

Record the findings below on the blank LCG:

Date: June 07, 2020.

Time: 06:00. The baby moves during monitoring and has a heart rate of 140 beats per minute (bpm). There are no decelerations. Vaginal examination shows 5 cm cervical dilatation, cephalic presentation. There is no caput or moulding and the fetal position is occiput posterior. Amniotic fluid is clear.

Time 07:00. FHR 132 bpm. There are variable decelerations.

Time 08:00. FHR 133 bpm. There are no decelerations.

Time 09:00. FHR 138 bpm. There are no decelerations.

Time 10:00. FHR 151 bpm. There are variable decelerations. Occiput transverse position. 1+ caput and 1+ moulding. Amniotic fluid shows meconium 1+.

Time 11:00. FHR 149 bpm. There are no decelerations.

Time 12:00. FHR 153 bpm. There are no decelerations.

Time 13:00. FHR 132 bpm. There are no decelerations. M+. Occiput anterior position. 1+ caput and 2+ moulding. Amniotic fluid shows meconium 1+.

Second stage:

Time 13:05. FHR 145 bpm without decelerations

Time 13:20. FHR 128 bpm. The FHR goes down to 112 at the start of a contraction, is 108 bpm at the peak of the contraction, and then increases back to 128 bpm after the peak of a contraction.

Time 13:30. FHR 118 bpm. The FHR goes down to 100 at the start of a contraction, is 98 bpm at the peak of the contraction, and then increases back to 118 bpm after the peak of a contraction.

Fill in the blanks from the completed LCG on page 22 of the WHO LCG User's Manual (put N/A if not recorded):

Time 07:30.
Baseline FHR:____. FHR decelerations:____. Amniotic fluid:____. Foetal position:____. Caput:____. Moulding:____.

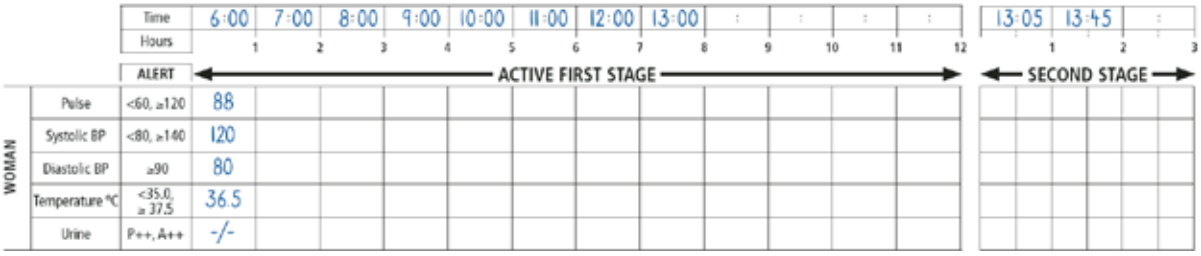
Time 09:30.
Baseline FHR:____. FHR decelerations:____. Amniotic fluid:____. Foetal position:____. Caput:____. Moulding:____.

Time 10:30.
Baseline FHR:____. FHR decelerations:____. Amniotic fluid:____. Foetal position:____. Caput:____. Moulding:____.

Time 12:30.
Baseline FHR:____. FHR decelerations:____. Amniotic fluid:____. Foetal position:____. Caput:____. Moulding:____.

Section 4 Care of the woman

Care of the woman is reviewed on pages 14-16 in the WHO LCG User's Manual.



Proteinuria	**P- = No proteinuria** **P trace = Trace of proteinuria** **P1+** **P2+** **P3+**
Acetonuria	**A- = No proteinuria** **A trace = Trace of proteinuria** **A1+** **A2+** **A3+**

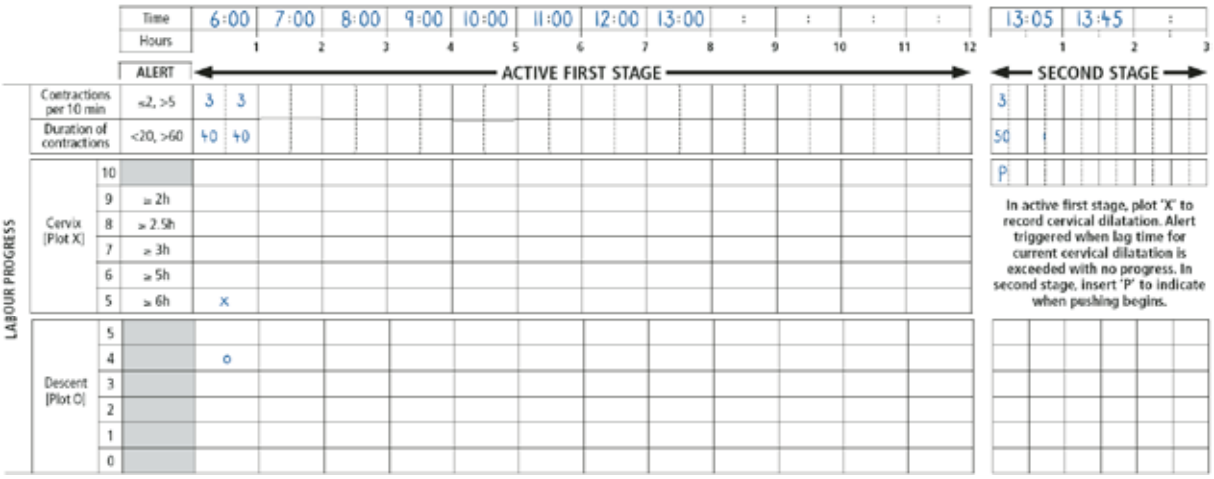
Record the findings below on the blank LCG:
Date: June 07,2020.

Time 06:00. Mary Jane's pulse rate is 88 bpm, with blood pressure of 120/80 mmHg. Her temperature is 36.5°C. She passed urine at admission, without proteinuria or acetone.

Time 10:00. Mary Jane's pulse is 96 bpm, with blood pressure of 128/84 mmHg. Her temperature is 36.9°C. She passed urine again, without proteinuria or acetone.

Section 5 Labour Progress

Labour progress is reviewed on pages 17-20 in the WHO LCG User's Manual



Record the findings below on the blank LCG:

Date: June 07, 2020

Time 06:00. At the time of admission, Mary Jane presented with three uterine contractions every 10 minutes, lasting 40 seconds. Vaginal examination shows 5 cm cervical dilatation. Fetal descent is 4/5.

Time 07:00. Three contractions in 10 minutes, lasting 40 seconds

Time 08:00. Three contractions in 10 minutes, lasting 40 seconds

Time 09:00. Three contractions in 10 minutes, lasting 40 seconds

Time 10:00. Mary Jane has three strong contractions in 10 minutes, lasting 50 seconds each. Fetal descent is 3/5. Cervical dilatation is 8 cm.

Time 11:00. Three contractions in 10 minutes, lasting 50 seconds

Time 12:00. Three contractions in 10 minutes, lasting 50 seconds

Time 13:00. Mary Jane maintains three contractions in 10 minutes, lasting 50 seconds each. Fetal descent is 2/5. Cervical dilatation is 10 cm.

Time 13:05. Mary Jane begins pushing. Mary Jane has three contractions in 10 minutes, lasting 50 seconds each. Fetal descent is 0/5.

Time 13:15. Mary Jane begins pushing. Mary Jane has four contractions in 10 minutes, lasting 50 seconds each

Time 13:30. Mary Jane maintains four contractions in 10 minutes, lasting 50 seconds each.
Childbirth takes place vaginally at 13:45.

Fill in the blanks from the completed LCG on page 22 of the WHO LCG User's Manual (put N/A if not recorded):

Time 08:30. Contractions/10 min:_____. Duration of contractions: _____. Cervix: _____cm. Descent: _____/5.

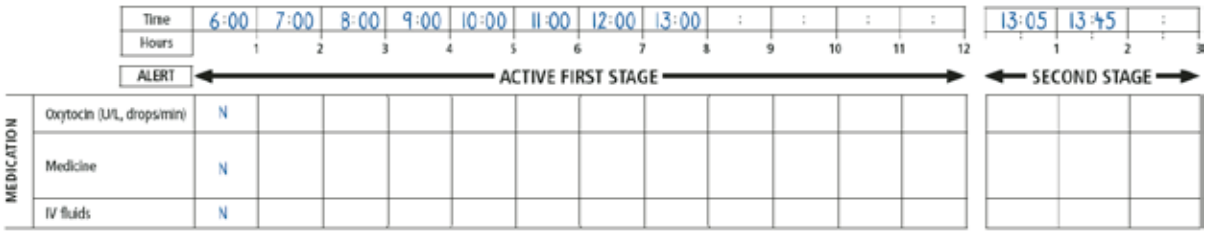
Time 10:30. Contractions/10 min:_____. Duration of contractions: _____. Cervix: _____cm. Descent: _____/5.

Time 11:30. Contractions/10 min:_____. Duration of contractions: _____. Cervix: _____cm. Descent: _____/5.

Time 12:30. Contractions/10 min:_____. Duration of contractions: _____. Cervix: _____cm. Descent: _____/5.

Section 6 Medication

The medication section is reviewed on pages 20-21 in the WHO LCG User's Manual.



Oxytocin	**N=No oxytocin being given** **Y=Yes, oxytocin being given. If yes, U/L and drops/min**
Medication	**N=No medications being given** **If yes, describe medication name, dose and route of administration**
IV fluids	**N=No IV fluids being given** **If yes, describe type of IV fluids and perfusion rate**

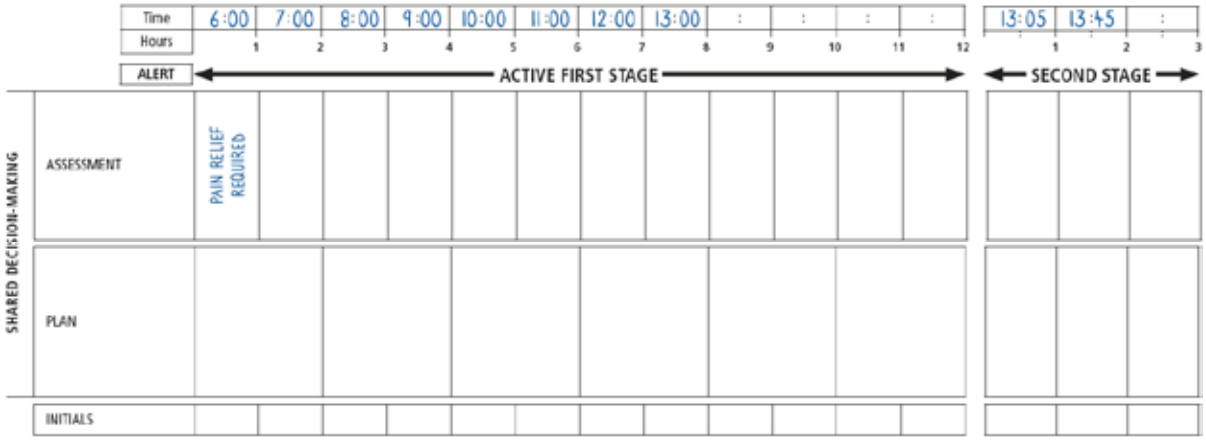
REMEMBER: Your decision to augment labour using oxytocin, give medications, or give IV fluids should be based on your assessment of findings and your identification of an abnormal observation that has triggered reflection and requires a specific action(s).

Review the medications recorded on the LCG and ask yourself:

1) Do you agree with the decisions made about medications listed on the LCG?
2) If you do agree, why? If you don't agree, what medication interventions may have been useful?

Section 7 Shared decision-making

Shared decision-making is reviewed on page 21 in the WHO LCG User's Manual.



REMEMBER: When you identify an abnormal observation, you should: 1) Review protocols for managing any alert values, 2) Discuss findings and options for care with the woman and her companion, 3) Agree on a plan of care with the woman and her companion and get consent, and 4) Record the plan of care.

Review the assessments and plan recorded on the LCG and ask yourself:

1) Do you agree with the assessments recorded on the LCG? If you do agree, why?
   If you don't agree, how would you have recorded the assessment?
2) Do you agree with the plan of care recorded on the LCG? If you do agree, why?
   If you don't agree, how would you change the plan of care?

Learning activity B

Case study: Elizabeth

Individually, complete the LCG using the findings below. You must review findings, make an assessment, decide on and record the plan of care and then initial the LCG. Remember to circle any alert values. Raise your hand after you have recorded the findings and the question about assessment/plan of care is asked – we will discuss the assessment and plan as a group. You must then record your assessment and the plan of care and then initial the LCG.

Check 1 - **On January 23rd, 2023 Elizabeth presents to you. You make her comfortable and start your assessment at 06:00.**

You find the following: Elisabeth says she has been having contractions for approximately six hours and reports that she has experienced leakage of clear fluid from the vagina for the last two hours. Her gestational age is 39 weeks. This is her fifth pregnancy. She previously had three spontaneous vaginal births at term to two live baby girls and one boy; and one spontaneous abortion at 13 weeks. Her haemoglobin at her first ANC visit was 8.7 g/dl and at most recent ANC visit at 36 weeks was 10.2g/dL and she is taking oral iron. Elizabeth has come to the health centre with her mother.

She reports feeling significant pain due to the uterine contractions, is unable to talk during the contractions, and requests pain relief. Her mother makes sure she drinks fruit juice and Elizabeth says she has been trying to be as mobile as possible.

Elizabeth's pulse rate is 86 bpm, with blood pressure of 132/72 mmHg. Her temperature is 37.3°C. She passed urine at admission, without protein or acetone.

The baby moves during monitoring and baseline FHR is 140 beats per minute (bpm); there are no decelerations. There is no caput and you note that the foetal skull bones are separated and the sutures can be felt easily. Amniotic fluid is clear.

There are three uterine contractions every 10 minutes, lasting 40 seconds. Fetal descent is 2/5. Vaginal examination shows 7 cm cervical dilatation, cephalic presentation, occiput posterior position.

What is your assessment? How will you plan to care for Elizabeth?

Check 2 – 06:30. You check how Elizabeth and the baby are doing: Baseline FHR 136 bpm; there are no decelerations. Elizabeth has three contractions every 10 minutes, lasting 40 seconds.

Check 3 – 07:00. Elizabeth is with her mother and using relaxation techniques for pain relief with good results. She has been drinking water and fruit juice when thirsty, and Elizabeth is now lying in bed on her left side after walking around with her mother. The FHR is 132 bpm. You listen over three contractions and there are variable decelerations. Elizabeth has three contractions in 10 minutes, lasting 40 seconds.

What is your assessment? How will you plan to care for Elizabeth?

Check 4 – 07:30. Baseline FHR is 148 bpm; there are no decelerations. Her contractions are three in 10 minutes, lasting 40 seconds.

Check 5 – 08:00. Elizabeth is with her mother and tolerating contractions using relaxation techniques for pain relief. She has been drinking water or juice when thirsty, and Elizabeth is walking around with her mother. You also check Elizabeth's pad and observe that the amniotic fluid is clear. Baseline FHR is 133 bpm; there are no decelerations. She has four contractions in 10 minutes, lasting 50 seconds.

What is your assessment? How will you plan to care for Elizabeth?

Check 6 – 08:30. Baseline FHR is 145 bpm; there are no decelerations. She is having three contractions in 10 minutes, lasting 45 seconds. She passed urine again, without protein or acetone.

Check 7 – 09:00. Elizabeth is with her mother who is helping her with relaxation techniques for pain relief with good results. She is not thirsty and is declining liquids, and Elizabeth is on hands and knees. She tells you she has the urge to push but has not yet started pushing. Baseline FHR is 138 bpm; the FHR does not vary at the beginning, peak, or at the end of the contraction. Elizabeth has four contractions in 10 minutes, lasting 50 seconds. Foetal descent is 0/5. On vaginal examination you find that she is now fully dilated; the baby is still in occiput posterior position; adjacent foetal skull bones are touching each other, but are not overlapping; there is no caput; amniotic fluid is clear.

What is your assessment? How will you plan to care for Elizabeth?

Check 8 – 09:15. Baseline FHR is 128 bpm; there are early decelerations. Elizabeth begins pushing on hands and knees. She is pushing well and is supported by her mother. Her mother offers her sips of fruit juice between contractions. Elizabeth has four contractions in 10 minutes, lasting 50 seconds each.

Check 9 – 09:30. Baseline FHR is 118 bpm; there are no decelerations. Elizabeth continues pushing on hands and knees, is pushing well and is supported by her mother. Elizabeth takes sips of fruit juice between contractions. Elizabeth maintains four contractions in 10 minutes, lasting 50 seconds each

Childbirth takes place vaginally at 09:45.

Learning activity C

Case study: Ms. Zakia

Individually, complete the LCG using the findings below. Remember to circle any alert values. You must record findings, your assessment and the plan of care and then initial the LCG.

Date: June 07, 2023

Presenting with abdominal and back pain

Time 7:00 AM

- 23-year-old G1 P0 at 38 + 2 weeks gestation.
- Regular antenatal care, uncomplicated pregnancy
- Taking oral iron supplementations for mild iron deficiency anaemia.
- Nil significant past medical or surgical history.
- Rhesus positive and the placenta was clear from the os at anatomy ultrasound.
- Zakia has brought her labour companion, her sister Jamila.
- Admitting complaints: Abdominal pain started yesterday morning at 10 am; Pain is now more intense and frequent ; Zakia feels otherwise well.
- Baby is moving, no PV fluid or blood loss
- **Maternal Vital Signs:** HR 88 bpm, BP 117/73 mmHg, Temperature 36.5°C
- Urine = negative for proteinuria/acetonuria.
- **Maternal Examination:** Contractions: Regular (3:10) and lasting 30 seconds; Fetal lie: longitudinal; Presentation: cephalic (occiput posterior); Engagement/descent: 4/5th palpable (Fetal station: - 2); Cervical dilation: 5cm; **Membranes intact.**
- **Fetal Monitoring:** FHR 145 b/minute and there were no decelerations heard.
- Zakia declines pain relief after all available options were explained
- She is drinking water and is walking around the room
- The midwife explains how Jamila (labour companion) can assist by giving Zakia small sips of water, supporting her breathing during a contraction, and massaging her back for pain relief.

Time 7:30 – 10:30 AM

	7:30	8:00	8:30	9:00	9:30	10:00	10:30
Companion		Yes		Yes		Yes	
Pain Relief		Not receiving		Massage		Declined	
Oral Fluid		Water		Declined		Declined	
Posture		Standing		Standing		Supine	
Baseline FHR	138	123	154	155	162	117	126
FHR Deceleration	No	No	No	No	Early	Early	No
Contractions / 10 mins	3	3	3	3	3	4	4
Duration of contraction	30	30	30	40	30	40	40

Time 11: 00 AM

- Jamila is with her and caring for her. Zakia taking sips of water and is kneeling.
- Contractions are now much stronger - occurring 4: 10 and lasting 40 seconds
- Pacing around the room in significant pain. Midwife offers her pain relief, and after explaining each available medication woman opted for massage.
- Fetal movements felt.
- Zakia 'feels wet'
- **Maternal Vital Signs:** HR 97 bpm, BP 130/80 mmHg, Temperature 36.9°C
- Urine = Negative for Acetone or Protein
- **Maternal Examination:** Fetal lie: longitudinal, Presentation: cephalic (occiput transverse), Engagement: 2/5th palpable (Fetal station: at spines (0)), Cervical dilatation: 8cm, Caput: +, Moulding: +
- **Confirmation of ruptured membranes.** Liqour lightly stained with meconium (1+), Fetal heart rate = 135 b/min with no decelerations

Time 11:00 – 12:30 AM

	11:00	**11:30**	**12:00**	**12:30**
Companion			Yes	
Pain Relief			Declined	
Oral Fluid			Declined	
Posture			Supine	
Baseline FHR	135	143	158	170
FHR Deceleration	No	No	No	Variable
Contractions / 10 mins	4	4	4	5
Duration of contraction	40	40	40	45

Time 12: 40 PM

- Contractions are strong, 5: 10 and lasting 45 seconds. Zakia has the urge to push.
- Lying in bed on her left side with sister Jamila providing support
- Massage is providing adequate relief
- **Maternal Vital signs:** HR 104 bpm, BP 135/82 mmHg, Temperature 36.9°C.
- **Maternal Assessment:** Presentation: cephalic (Occiput Anterior), Engagement: 0/5th palpable, Cervical dilation: 10cm, Fetal descent: Caput: ++, Moulding: ++, Amniotic fluid = 1+ Mec, PV blood noted.
- The FHR is now 165 b/min with variable decelerations.

Time 12: 45-12:58 PM

- Zakia is pushing on hands and knees
- Her sister Jamila is giving her sips of water between contractions
- She is supporting her pain with breathing as she pushes.

	Baseline FHR	**FHR Deceleration**	**Maternal Pushing**	**Contractions / 10 mins**	**Duration of contractions**
1245	160	No	Pushing	5	45
1250	158	No	Pushing		
1255	160	No	Pushing		
1258	BIRTH				

Team Action Plan – to improve care for labor and birth

To do/Action	*S.M.A.R.T Goals*	*Person responsible*	*Timeframe*
	S ..... **M** ..... **A** ..... **R** ..... **T**	....	....
	S ..... **M** ..... **A** ..... **R** ..... **T**	....	....
	S ..... **M** ..... **A** ..... **R** ..... **T**	....	....

Annex 1.
WHO Labour Care Guide: Quick Guide

The Labour Care Guide (LCG) Quick Guide was developed by the WHO and adapted for this learning resource package to facilitate quick consultation for health care providers who have received training in the use of the LCG. If you do not find the answer to your query in this document or for more details on using the LCG, please refer to the *User's Manual*.

For whom should the LCG be used?
- All women in labour.
- Women at high risk of developing labour complications may require additional monitoring and
- interventions or individualized labour and childbirth care.

When should I start using the LCG?
- When women have entered the active phase of the first stage (i.e., cervical dilatation of 5 cm or more).
- During the latent, monitoring should be documented in the medical records.

Where can the LCG be implemented?
- The LCG is designed for use at all levels of care in health facilities.
- The LCG can facilitate early identification of potential complications; hence, it should contribute to timely referrals when required.

How to use the Labour Care Guide: 4 steps

1. **Assess**: assess the well-being of the woman and her baby and the progress of labour. The LCG lists the parameters that should be evaluated, which serve as reminders.

2. **Record**: document labour observations each time you complete an assessment during the first and second stages of labour.

3. **Check reference threshold:** compare labour observations with reference values in the "Alert" column. The decision to intervene in the course of labour should be primarily based on a deviation from expected observations during the assessments. Health providers should circle any observations meeting the threshold to highlight those observations that require special attention.

4. **Plan:** decide and document whether and what interventions are required or if you only need to continue monitoring (in case of normal progress). Involve the woman and her companion in the decision-making process

Additional considerations
- The LCG is intended as a guide and is not a substitute for good clinical judgment. Variations may be appropriate, considering local clinical guidelines, available resources, level of care, individual women's circumstances, risk status, and preferences.
- Decisions should not be based on findings from individual observations but rather on an overall assessment of the woman and her baby.
- It is important that health personnel adapt the monitoring frequencies to each particular clinical case. It is expected that the

How to complete Section 1

Variable	Step 1: Assess	Step 2: Record
Name	Ask the woman her full name.	▪ Record the woman's full name and verify that it matches the name on her medical record.
Parity	Extract from medical records the number of times the woman has given birth to a baby after the age of viability (as per local guidelines).	▪ Use the local coding system to record parity, e.g., Parity (or P) = number of babies born (after the local definition of viability).
Labour onset	Was the onset of labour spontaneous or induced (using any artificial means)?	▪ Record "Spontaneous" if the woman achieved the active first stage of labour without any artificial stimulation of labour onset (either through pharmacological or non-pharmacological means). ▪ Record "Induced" if the onset of labour was artificially stimulated by administering oxytocin or prostaglandins to the pregnant woman, artificially rupturing the amniotic membranes, applying a balloon catheter into the cervix, or any other means.
Active labour diagnosis	On what date and at what time was the active first stage of labour diagnosed?	▪ Date of active labour diagnosis. Use local format to record dates (e.g. dd/mm/yy, or mm/dd/yy, or dd/mm/yyyy).
Ruptured membranes	On what date and at what time were amniotic membranes ruptured (if membranes have ruptured before admission)?	▪ Date and time [hh: mm] that rupture of membranes occurred. The woman or her companion could report these data or be extracted from medical records if membranes ruptured after admission but before initiating the LCG. ▪ Use local format to record time. ▪ Record "U" or "unknown" if rupture of membranes is confirmed and the woman cannot report the date and/or time, and there is no documentation in the medical record.
Risk factors	Risk factors	▪ Known obstetric, medical, and social risk factors with implications for care provision and potential outcome of labour management. For example, pre-existing medical conditions (e.g., chronic hypertension), obstetric conditions (e.g., pre-eclampsia), woman's advanced age, adolescent pregnancy, preterm labour, and group B *Streptococcus* colonization.

How to complete Section 2

	Step 1: Assess	Step 2: Record	Step 3: Check the threshold	Step 4: Plan
Companion	Does the woman have a companion of her choice present and providing support at the time of assessment?	**Y=Yes** (the woman has a companion of her choice) **N=No** (the woman does not have a companion of her choice) **D=Woman declines** a companion	**Alert: N = No**	▪ If you recorded "No," offer to find a companion of the woman's choice. ▪ If you recorded "Yes" or "Declines," continue to assess her preference during the progress of labour and childbirth.
Pain relief	Has the woman received any form of pain relief?	**Y=Yes** (the woman is not distressed by pain and/or is receiving pharmacological or non-pharmacological pain relief) **N=No** (the woman is distressed by pain and is not receiving pharmacological or non-pharmacological pain relief) **D=Woman declines** to receive pharmacological or non-pharmacological pain relief	**Alert: N = No**	▪ If you recorded "No," provide pain relief according to the woman's preferences, availability of pain relief, and provider's experience. ▪ You can offer an epidural at the lowest effective local anaesthetic concentration to avoid complications or opioids such as fentanyl, diamorphine, and pethidine. Relaxation techniques such as muscle relaxation, breathing, music, mindfulness, and manual techniques can also be used, based on the woman's preferences.
Oral fluid	Has the woman taken oral fluid on demand since her last assessment?	**Y=Yes** (the woman is taking oral fluids) **N=No** (the woman is not taking any oral fluids) **D=Woman declines** oral fluids	**Alert: N = No**	▪ If you recorded "No," encourage the woman to take a light diet and drink as she wishes during labour.
Posture	What posture is the woman adopting during labour and childbirth?	**SP = Supine** **MO = Mobile** (includes walking, swaying, or any non-supine position, e.g., left lateral, squatting, kneeling, standing)	**Alert: SP = Supine**	▪ If you recorded "SP", encourage the woman to walk around freely during the first stage of labour. ▪ Support the woman's choice of position (left lateral, squatting, kneeling, standing supported by a companion) for each labour stage.

How to complete Section 3

<table>
<tr><th></th><th>Step 1: Assess</th><th>Step 2: Record</th><th>Step 3: Check the threshold</th><th>Step 4: Plan</th></tr>
<tr><td>Baseline FHR</td><td>Listen to the FHR for a minimum of 1 minute. Auscultate during a uterine contraction and continue for at least 30 seconds after the contraction. Assess the woman's pulse to differentiate between the heartbeat of the woman and that of the baby.
NOTE: 50% of stillbirths occur intrapartum.</td><td>Record the baseline FHR (as a single counted number of beats in 1 minute).
For the second stage, record the most clinically significant value within the 15-minute timeframe.</td><td>Alert: <110, ≥160*
Very slow FHR in the absence of contractions or persisting after contractions is suggestive of fetal distress.
In the absence of a rapid maternal heart rate, a rapid FHR should also be considered a sign of fetal distress.</td><td>If FHR is <u><110 or ≥160</u>, ask the woman to turn on her left side, alert a senior care provider and follow clinical guidelines.
If FHR ranges between <u>110 and 159</u>, continue to assess FHR every 30 minutes during the first stage and every 5 minutes during the second stage of labour.
If fetal heartbeat is not heard: 1) Ask others to listen, 2) Use a Doppler stethoscope, 3) Confirm fetal death by ultrasound.</td></tr>
<tr><td colspan="5">Intermittent auscultation of the FHR with either a Doppler ultrasound device or a Pinard fetal stethoscope is recommended for healthy pregnant women in labour.</td></tr>
<tr><td>FHR deceleration</td><td>Listen to the FHR for a minimum of 1 minute. Auscultate during a uterine contraction and continue for at least 30 seconds after the contraction.</td><td>Record the presence of decelerations using:
N = No
E = Early
L = Late
V = Variable</td><td>Alert: L = Late</td><td>If <u>Late</u> decelerations or a single prolonged deceleration are present, ask the woman to turn on her left side, perform prolonged auscultation, alert a senior care provider and follow clinical guidelines.
If <u>NO</u> decelerations are present, continue monitoring FHR every 30 minutes during the first stage and every 5 minutes during the second stage.</td></tr>
<tr><td>Care if absent FHR</td><td colspan="4">At the time of diagnosis Refer to: Why we need to talk about losing a baby
▪ Once fetal death has been confirmed, the mother/parents should be informed in person, as soon as possible, in an empathetic and straightforward manner, in surroundings where they can react privately. Make sure the woman is not alone and, if possible, make it possible for a religious leader/priest to be present to support and provide counselling to the parents.
▪ Provide information in clear and simple language. You may need to repeat it.
▪ Make it very clear that there is nothing the woman did, ate or did not do that caused the fetal death.
▪ Be aware of and respect parents' individual and changing emotional needs. Validate emotions.
▪ Discuss what parents can expect. Where will the woman give birth and where will she be cared for after? Explain how the baby may look and what will happen to the baby.
▪ Provide options for labour, birth and postpartum procedures and care.
At birth and immediately postpartum
▪ Treat the baby with respect. Respect the parents' preferences about seeing and holding the baby. Seeing the stillborn is proof of the baby's birth, existence, and death. Holding the baby helps in the grieving process.
Postpartum
▪ After birth, examine the fetus and placenta and explain the findings to the parents. Only provide information on cause of death if one is known.
▪ Consider placing a symbol or similar marker on the door or at the woman's private space to denote that the parents have suffered a stillbirth.
▪ Help the parents collect items that may help with grief such as photographs, hand and footprints, locks of hair, hospital wristband.
▪ Provide information about referrals to psychologists, social workers, counsellors, and organizations that the parents can contact if and when they want.</td></tr>
</table>

	Step 1: Assess	Step 2: Record	Step 3: Check the threshold	Step 4: Plan
Perform gentle vaginal examination using an aseptic technique after obtaining the woman's consent and ensuring privacy. Do not start the examination during a contraction. Assess all parameters that require a vaginal examination at the same time.				
Amniotic fluid	Note the status of the membranes. If the membranes have ruptured, note the colour of the draining amniotic fluid. Amniotic fluid may also be assessed without conducting a vaginal examination.	**I = Intact membranes** **C = Membranes ruptured, clear fluid** **M** = Membranes ruptured, **meconium-stained fluid**: use +, ++ and +++ to represent non-significant, medium and thick meconium, respectively **B** = Membranes ruptured, **blood-stained fluid**	**Alert: M+++ (thick meconium), B = Blood** *The presence of thick meconium indicates the need for close monitoring and possible intervention for management of fetal distress. Bloody amniotic fluid is common in placental abruption, placenta praevia, vasa praevia or uterine rupture.*	If blood-stained fluid or thick meconium is present, alert a senior care provider and follow clinical guidelines. If membranes are Intact or ruptured and amniotic fluid is Clear, assess amniotic fluid during the next vaginal examination in 4 hours, unless otherwise indicated.
Fetal position	When performing vaginal examination to assess other clinical parameters, assess the fetal position. Assess fetal presentation and position during abdominal examination and confirm during vaginal examination.	**A = Occiput anterior position** **P = Occiput posterior position** **T = Occiput transverse position**	**Alert: P = Occiput posterior, T = Occiput transverse** *With descent, the fetal head rotates so that the fetal occiput is anterior in the maternal pelvis. Failure of a fetal occiput transverse or posterior position to rotate to an occiput anterior position should be managed as abnormal fetal position.*	If Occiput posterior or Occiput transverse position is detected, alert a senior care provider and follow clinical guidelines. If Occiput anterior position is diagnosed, reassess position during next vaginal examination in 4 hours, unless otherwise indicated.
Caput	When performing vaginal examination to assess other clinical parameters, evaluate the presence of caput succedaneum (diffuse swelling of the scalp).	Grade caput from 0 (none) to **+, ++ or +++** (marked).	**Alert: +++** *If the presenting part has large caput succedaneum, this (along with other abnormal observations), it could be a sign of obstruction.*	If caput = +++, alert a senior provider and follow local protocols. If caput = 0 to ++, repeat the assessment during the next vaginal examination in 4 hours, unless otherwise indicated.
Moulding	When performing vaginal examination to assess other clinical parameters, evaluate the shape of the fetal skull and the degree of overlapping fetal head bones during labour.	Grade from **0** (none) to +++ (marked). Assign: **+** (sutures apposed), **++** (sutures overlapped but reducible), **+++** (sutures overlapped and not reducible).	**Alert: +++** *Third degree moulding (along with other abnormal observations) could indicate obstructed labour.*	If moulding = +++, alert a senior provider and follow local protocols. If moulding = 0 to ++, usually signs of normality (mainly if ++ is developed in the later stages of labour), reassess during next vaginal examination in 4 hours, unless otherwise indicated.

How to complete Section 4

-

	Step 1: Assess	Step 2: Record	Step 3: Check the threshold	Step 4: Plan
Pulse	Count the woman's pulse rate for at least one full minute.	Record woman's pulse (bpm).	**Alert: <60, ≥120** *If the woman's pulse is increasing, she may be dehydrated or in pain, she may be developing a fever, or it could be a sign of bleeding or shock. Maternal bradycardia should trigger a series of maternal (and fetal) assessments to identify the probable cause, including use of specific medications, supine position, pain, bleeding or cardiac disease.*	▪ If pulse <60, ≥120 bpm, alert a senior care provider and follow local guidelines. ▪ If pulse ≥60 or <120 bpm, assess pulse rate every 4 hours.
Systolic BP	Measure blood pressure in a sitting position.	Record woman's systolic blood pressure (SBP) in mmHg.	**Alert: <80, ≥140** *Low blood pressure could be a sign of haemorrhagic shock, septic shock, occult or frank haemorrhage. Systolic blood pressure of 140 mmHg could be a sign of hypertension (further assessments are required to reach a diagnosis).*	▪ If SBP = <80, ≥140, alert a senior provider and follow local guidelines. ▪ If SBP ≥80 or <140, assess SBP every 4 hours.
Diastolic BP		Record woman's diastolic blood pressure (DBP) in mmHg.	**Alert: ≥90** *Diastolic blood pressure ≥90 could be a sign of hypertension (further assessments are required to reach a diagnosis).*	▪ If DBP = ≥90, alert a senior care provider and follow local guidelines. ▪ If DBP <90, assess DPB every 4 hours.
Temperature	Measure axillary temperature.	Record woman's temperature in degrees Celsius.	**Alert: <35.0, ≥ 37.5** *Temperature should be monitored throughout labour to assess the well-being of the woman and identify risks for adverse birth outcomes.*	▪ If temperature <35.0, ≥37.5, alert a senior care provider and follow local guidelines. ▪ If the temperature is between 35.5 and 37 degrees, assess the temperature every 4 hours.
Urine	Check protein and acetone in urine with a reagent strip.	Record readings of protein (P) and acetone (A) as **Negative, Trace, +, ++, +++, ++++.**	**Alert: P++, A++** *A 2+ protein (P++) could guide further management, although confirmation may be done with a second dipstick of 2+ at the next urine void. Proteinuria could be a sign of pre-eclampsia, urinary tract infection, severe anaemia, or previously undiagnosed renal or cardiac disease. Ketonuria could be a sign of dehydration secondary to reduced fluid intake or excessive losses (vomiting or diarrhoea), prolonged labour or previously undiagnosed diabetes.*	▪ If P++, A++, or more, interpret measurements in the context of a complete clinical examination. Alert a senior provider and follow local guidelines. ▪ If P = Negative, Trace or +, assess every 4 hours or each time the woman voids during labour.

How to complete Section 5

	Step 1: Assess	Step 2: Record	Step 3: Check the threshold	Step 4: Plan
Contractions per 10 min	Count the number of uterine contractions over 10 minutes.	Record the absolute number of contractions.	**Alert: ≤2, >5** *If contractions are inefficient, suspect inadequate uterine activity. Continuous contractions are a sign of obstructed labour.*	▪ If contractions are ≤2, >5 per 10 minutes, verify the number of contractions over another 10 minutes. If the frequency is confirmed, alert a senior care provider and follow clinical guidelines. ▪ If contractions are 3–5 per 10 minutes, record uterine contractions every 30 minutes during the first stage of labour and every 15 minutes during the second stage.
Duration of contractions	Assess the duration of contractions.	Record duration of contraction in seconds.	**Alert: <20, >60** *Short contractions could indicate inadequate uterine activity. More than five contractions in 10 minutes or continuous contractions are signs of obstructed labour or hyperstimulation.*	▪ If contractions last <20 or >60 seconds, verify the number of contractions over another 10 minutes. If the duration is confirmed, alert a senior provider and follow local clinical guidelines. ▪ If contractions last >20 and ≤60, record contractions every 30 minutes during the first stage of labour and every 15 minutes during the second stage.
Cervix	When performing vaginal examination to assess other clinical parameters, assess cervical dilatation. Evidence shows important variations in the distribution of cervical dilatation patterns among women without risk factors for complications, with many women progressing more slowly than 1cm / hour for the most part of their labour and yet still achieving vaginal birth with normal birth outcomes.	In the active first stage of labour, plot "**X**" in the cell that matches the time and the cervical dilatation each time you perform a vaginal examination. In the second stage, insert "P" to indicate when pushing begins.	**Alert values for the first stage** **5 cm = ≥6 h** (cervical dilatation remains at 5 cm for ≥ 6 hours) **6 cm = ≥5 h** (cervical dilatation remains at 6 cm for ≥ 5 hours) **7 cm = ≥3 h** (cervical dilatation remains at 7 cm for ≥ 3 hours) **8 cm = ≥2.5 h** (cervical dilatation remains at 8 cm for ≥ 2.5 hours) **9 cm = ≥2h** (cervical dilatation remains at 9 cm for ≥ 2 hours) **Alert value for the second stage** **≥3h in nulliparous women; ≥2h in multiparous women** *(birth is not completed by 3 hours from the start of the active second stage in nulliparous and 2 hours in multiparous women)*	▪ Alert triggered when the lag time for current cervical dilatation is exceeded with no progress. ▪ During the first stage, if labour progresses as expected, assess cervical dilatation every 4 hours unless otherwise indicated. When performing a vaginal examination less than 4 hours after the previous assessment, ensure that the examination will add important information to the decision-making process.

	Step 1: Assess	Step 2: Record	Step 3: Check the threshold	Step 4: Plan
Descent	Assess descent by abdominal palpation; refer to the part of the head (divided into five parts) palpable above the symphysis pubis.	Plot "**O**" in the cell that matches the time and the level of descent. Plot an "O" at every vaginal examination. 5/5, 4/5, 3/5, 2/5, 1/5, and 0/5 should be used to describe the fetal station by abdominal palpation.	There are no reference thresholds for this observation, which will vary in each case.	▪ During the first stage, assess descent every 4 hours before performing a vaginal examination, unless otherwise indicated. ▪ During the second stage, consider the woman's behaviour, the effectiveness of pushing, and the baby's position and well-being when deciding the timing of a decent assessment.

How to complete Section 6

	Step 1: Assess	Step 2: Record
Oxytocin	Is oxytocin currently being administered to the woman?	▪ Record **N = No, if oxytocin is not being administered**, ▪ If oxytocin is being administered, record the amount of oxytocin in units per litre (U/L) and drops per minute (drops/min). ▪ When oxytocin is used, record the amount being administered every 60 minutes.
Medicine	Is the woman receiving any other medication?	▪ Record **N = No, if no other medication is being administered.** ▪ Record the name, dose, and route of administration of any additional medication administered to the woman during the active first or second stage of labour (e.g., 50 mg pethidine, intramuscular (IM)).
IV fluid	Is the woman on IV fluids?	Record: **Y = Yes** **N = No**

How to complete Section 7

	Record
Assessment	▪ Record the overall assessment and any additional findings not previously documented but important for labour monitoring.
Plan	▪ Record the plan following assessment. For example: – continuation of routine monitoring – prescription of diagnostic tests – augmentation of labour with oxytocin infusion – procedures, such as artificial rupture of membranes – assisted birth with vacuum or forceps – caesarean birth. ▪ Take into consideration that women should be involved in discussions and be allowed to make informed decisions. ▪ Each time a clinical assessment of the woman's and baby's well-being is completed, record the plan based on the shared decision.

Additional educational resources

- *WHO labour care guide: user's manual*
- *WHO labour care guide: user's manual slideshow*

Related documents

- *Labour Care Guide*
- *WHO recommendations: intrapartum care for a positive childbirth experience*
- I*ntrapartum care recommendations slideshow*

References

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   https://www.who.int/publications/i/item/9789241565493

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   Geneva: World Health Organization; 2015.
   Pregnancy, Childbirth, Postpartum, and Newborn care:
   https://www.who.int/publications/i/item/9789241549356

3. WHO labour care guide: user's manual. Geneva: World Health Organization;2020.
   User's Manual: *https://www.who.int/publications/i/item/9789240017566*

Annex 2.
Learning activities B and C

WHO LABOUR CARE GUIDE

Name Elizabeth **Parity** 3 **Labour onset** Spontaneous **Active labour diagnosis [Date** Jan 23, 2023 **]**

Ruptured membranes [Date Jan 23, 2023 **Time** 04:00 **]** **Risk factors** Anaemia

ACTIVE FIRST STAGE

Section	Item	ALERT	06 : 00	07: 00	08 : 00	09 : 00	:	:	:	:	:	:	:	:
	Hours		1	2	3	4	5	6	7	8	9	10	11	12
SUPPORTIVE CARE	Companion	N	Y	Y	Y	Y								
SUPPORTIVE CARE	Pain relief	N	N (circled)	Y	Y	Y								
SUPPORTIVE CARE	Oral fluid	N	Y	Y	Y	D								
SUPPORTIVE CARE	Posture	SP	MO	MO	MO	MO								
BABY	Baseline FHR	<110, ≥160	140 ¦ 136	132 ¦ 148	133 ¦ 145	138								
BABY	FHR deceleration	L	N ¦ N	V ¦ N	N ¦ N	N								
BABY	Amniotic fluid	M+++, B	C		C	C								
BABY	Fetal position	P, T	P (circled)			P (circled)								
BABY	Caput	+++	0			0								
BABY	Moulding	+++	0			+								
WOMAN	Pulse	<60, ≥120	86											
WOMAN	Systolic BP	<80, ≥140	132											
WOMAN	Diastolic BP	≥90	72											
WOMAN	Temperature °C	<35.0, ≥ 37.5	37.3											
WOMAN	Urine	P++, A++	-/-		-/-									
LABOUR PROGRESS	Contractions per 10 min	≤2, >5	3 ¦ 3	3 ¦ 3	4 ¦ 3	4								
LABOUR PROGRESS	Duration of contractions	<20, >60	40 ¦ 40	40 ¦ 40	50 ¦ 45	50								
LABOUR PROGRESS	Cervix [Plot X] 10					X								
LABOUR PROGRESS	Cervix [Plot X] 9	≥ 2h												
LABOUR PROGRESS	Cervix [Plot X] 8	≥ 2.5h												
LABOUR PROGRESS	Cervix [Plot X] 7	≥ 3h	X											
LABOUR PROGRESS	Cervix [Plot X] 6	≥ 5h												
LABOUR PROGRESS	Cervix [Plot X] 5	≥ 6h												
LABOUR PROGRESS	Descent [Plot O] 5													
LABOUR PROGRESS	Descent [Plot O] 4													
LABOUR PROGRESS	Descent [Plot O] 3													
LABOUR PROGRESS	Descent [Plot O] 2		O											
LABOUR PROGRESS	Descent [Plot O] 1													
LABOUR PROGRESS	Descent [Plot O] 0					O								
MEDICATION	Oxytocin (U/L, drops/min)		N	N	N	N								
MEDICATION	Medicine		N	N	N	N								
MEDICATION	IV fluids		N	N	N	N								
SHARED DECISION-MAKING	ASSESSMENT		Needs pain relief. OP. Good support. Findings normal	Good support. Findings normal	Good support. Findings normal	Urge to push. In second stage.								
SHARED DECISION-MAKING	PLAN		Offer pain options. Support labour. Dr A consult.	Support labour. Rtn monitoring	Support labour. Rtn monitoring	Encouage liquids. Begin pushing								
	INITIALS		SE	SE	SE	SE								

SECOND STAGE

Item	09 : 15	09 : 45	:
Hours	1	2	3
Companion	Y		
Pain relief	Y	BIRTH	
Oral fluid	Y		
Posture	MO		
Baseline FHR	128 ¦ 118		
FHR deceleration	E ¦ E		
Amniotic fluid	C		
Fetal position	P (circled)		
Caput	0		
Moulding	+		
Pulse			
Systolic BP			
Diastolic BP			
Temperature °C			
Urine			
Contractions per 10 min	4 ¦ 4		
Duration of contractions	50 ¦ 50		
Pushing	P ¦ P		
Descent 5			
Descent 4			
Descent 3			
Descent 2			
Descent 1			
Descent 0			
Oxytocin (U/L, drops/min)	N		
Medicine	N		
IV fluids	N		
ASSESSMENT	NORMAL PROGRESS		
PLAN	Labour support		
INITIALS	GP	GP	

In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.

INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERT' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN.IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE.
Abbreviations: Y – Yes, N – No, D – Declined, U – Unknown, SP – Supine, MO – Mobile, E – Early, L – Late, V – Variable, I – Intact, C – Clear, M – Meconium, B – Blood, A – Anterior, P – Posterior, T – Transverse, P+ – Protein, A+ – Acetone

WHO LABOUR CARE GUIDE

Name Zakia **Parity** 0 **Labour onset** Spontaneous **Active labour diagnosis [Date** June 7, 2023]

Ruptured membranes [Date June 7, 2023 **Time** 11:00] **Risk factors** Iron-deficiency anaemia

			07:00	08:00	09:00	10:00	11:00	12:00	:	:	:	:	:	:	12:45	12:58	:
	Time																
	Hours		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
	ALERT		← ACTIVE FIRST STAGE →												← SECOND STAGE →		
SUPPORTIVE CARE	Companion	N	Y	Y	Y	Y	Y	Y							Y		
	Pain relief	N	D	N	Y	D	Y	D							Y	BIRTH	
	Oral fluid	N	Y	Y	D	D	Y	D							Y		
	Posture	SP	MO	MO	MO	SP	MO	SP							MO		
BABY	Baseline FHR	<110, ≥160	145 138	123 154	155 162	117 126	135 143	158 170							160 160		
	FHR deceleration	L	N N	N N	N E	E N	N N	N V							N N		
	Amniotic fluid	M+++, B	I				M+	M+/B									
	Fetal position	P, T	P				T	A									
	Caput	+++					+	++									
	Moulding	+++					+	++									
WOMAN	Pulse	<60, ≥120	88				97	104									
	Systolic BP	<80, ≥140	117				130	135									
	Diastolic BP	≥90	73				80	82									
	Temperature °C	<35.0, ≥ 37.5	36.5				36.9	36.9									
	Urine	P++, A++	-/-				-/-										
LABOUR PROGRESS	Contractions per 10 min	≤2, >5	3 3	3 3	3 3	4 4	4 4	4 5							5		
	Duration of contractions	<20, >60	30 30	30 30	40 30	40 40	40 40	40 45							45		
	Cervix [Plot X]	10						X							P P		
		9	≥ 2h														
		8	≥ 2.5h				X										
		7	≥ 3h														
		6	≥ 5h														
		5	≥ 6h	X													
	Descent [Plot O]	5															
		4		O													
		3															
		2					O										
		1															
		0						O									
MEDICATION	Oxytocin (U/L, drops/min)		N	N	N	N	N	N							N		
	Medicine		N	N	N	N	N	N							N		
	IV fluids		N	N	N	N	N	N							N		
SHARED DECISION-MAKING	ASSESSMENT		Active labour. Findings within normal limits.	Needs pain relief. Findings normal	Findings normal. Fetal tachy at 9:30.	Fetal tachy resolved.	Spontaneous ROM w/ M+. Fetus OK.	Urge to push at 12:40. In 2nd stage							Good support. Pushing well.		
	PLAN		Offer pain options Support labour. Routine monitoring.		Enc. fluids. Reassess FHR every 15mins. Enc. upright positions.		Reassess FHR every 15 mins.	Offer pain options. Enc. fluids & upright positions.							Labour support. Routine monitoring.		
	INITIALS		PT	PT	PT	PT	AJ	AJ							AJ		

In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.

INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERT' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN.IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE.

Abbreviations: **Y** – Yes, **N** – No, **D** – Declined, **U** – Unknown, **SP** – Supine, **MO** – Mobile, **E** – Early, **L** – Late, **V** – Variable, **I** – Intact, **C** – Clear, **M** – Meconium, **B** – Blood, **A** – Anterior, **P** – Posterior, **T** – Transverse, **P+** – Protein, **A+** – Acetone

LDHF ACTIVITIES

What is "continued practice "and why is it important?
Training alone is not enough to improve care. Regular practice and other activities are needed to reinforce new knowledge and skills. Practice also improves teamwork and clinical decision-making.

Who helps you practice?
One or two people from your facility will be asked to coordinate these "low dose high frequency" (LDHF) practice sessions. The coordinator will guide the sessions. She/he is a colleague who has learned how to support these activities. *Remember, though, you and your peers must work on the facility action plan to improve care and use of the LCG!*

Session objectives
The objectives of each session link to key learning objectives.

Session preparation
Each session plan includes a list of items you need how you should prepare. Practice coordinators are responsible for making sure everything is ready. Session plans also include instruction for coordinators and providers about how to run the session. You will need this for reference.

When conducting LDHF activities, coordinators will:
- Establish a safe learning environment
- Provide constructive feedback
- Conduct organized debrief
- Support discussion to improve learning
- Identify and explore gaps
- Help providers transfer what they learned into clinical practice

Debrief
During debrief, coordinators guide providers to analyze their own performance and performance of the team. Coordinators and providers should be constructive and avoid embarrassing each other. The goal is self-reflection and team improvement.

Proposed responses
Where needed, proposes responses to questions can be found in the blue section following the description of sessions.

Session 1:
Revisiting Taking Action! and auditing the LCG. 60 minutes

Read objectives aloud:
- Review personal and team commitments to quality improvement goals.
- Update commitments.
- Audit 3 LCGs and make a plan to improve its completion and use.

Preparation:
- Obtain the team's Taking Action! Commitment from the LCG training activity. Have it ready to review with the team.

Materials:
- Marker/pens/paper
- Taking Action! Plan
- LCG Audit Tool

Activities:
Part I: Review and Update the facility's Taking Action! Plan

The coordinator will serve as the facilitator for this activity and discussion. All labor ward staff who are on duty the day of the session and, if possible, the maternity in-charge should participate.

Begin by asking providers who attended the LCG training activity to recall the closing activity. During that activity, they committed to improve select areas of care after the training activity. Ask them to take a moment to remember the personal commitments they made. These do not need to be shared with the group. However, for team members who have been able to progress with personal commitments and who wish to share them, this is a great opportunity for recognition and motivation!

Ask providers, "Do you remember which SMART objectives we agreed to work together to improve?" Share the completed Taking Action! Plan and ask a volunteer to review it with the group. Pause after each objective and ask the group:
- Has the team progressed on this objective since the training? Why or why not?
- Have any planned activities or tasks taken place? Why or why not?
- Do any of the interventions, point people, or timelines need to be adjusted?
- Does the team need any additional resources or support to achieve the objectives? How will the team work to secure additional resources/ support?

- Update the written action plan, or draft a new one, based on today's agreements about activities, roles, and timelines. Tell providers that you will come together every week to review progress.

Part II: Audit of 3 completed LCGs

- After updating the action plan, the coordinator should tell the team, "Now, we are going to review 3 LCGs. We want to see how our providers complete and interpret the LCG, and respond to alert values. The goal of the activity is to evaluate how we, as a team, are using the LCG and, together, make a plan to improve use of the LCG to ensure women receive quality and respectful care during labor and childbirth."

As a team, complete the audit for 3 randomly chosen LCGs, including writing up comments about each LCG audited.

Part III: Debrief of LCG audits and plan for improvement
Discuss as a group and write suggestions on the audit sheet:

- How can we, as a team, improve how the LCG is completed and used?
- How can we maintain confidentiality and privacy for women here?
- What can we do to accommodate companions for all women?
- What do we need to do to make sure that providers can conduct all the examinations they need to complete the LCG?
- What do we need to do to make it as easy as possible to call team members to help if a provider needs help completing the LCG?
- What do we need to do to make it as easy as possible to call a senior provider when there is an alert value the provider cannot manage?
- What do we need to do to make sure a senior provider comes as quickly as possible to respond after a provider has called for a consultation?
- Do all providers have access to the LCG User's Manual?
- Is the LCG Action Plan posted in the labor and delivery rooms? Does it help remind providers of all the parameters that need to be evaluated?

Revise and/or update the Take Action! plan based on the LCG audit and the debriefing discussion.

Session 2: Auditing the LCG and reviewing a completed LCG. 60 minutes

Read objectives aloud:

- Audit 3 LCGs and make a plan to improve its completion and use
- Review progress made on the team's Taking Action! plan
- Use the Quick Guide to analyze and develop a plan to improve Aisha's care

Materials:

- Marker/pens/paper
- Taking Action! Plan
- LCG Audit Tool

Preparation:

- Review the facility's Taking Action! plan

Activities:
Part I: Audit of 3 completed LCGs
See Session 1 for instructions

Part II: Debrief of LCG audits and plan for improvement
See Session 1 for instructions

Part III: Briefly Review progress made on the team's
Taking Action! plan.
See Session 1 for instructions

Part IV: Aisha's case study
In groups of 2, review Aisha's LCG on the next page. Then:

1. Circle any "alert" values.

2. Respond to the following questions about Aisha's case:
   - What is your general impression about care provided and completion of the LCG?
   - What alert values have you circled?
   - What could you have done at 10:00 when she was admitted with two contractions in 10 minutes, each lasting 10 seconds?

3. Record your assessment for 14:00 on Aisha's LCG.

4. Review possible actions to take for any alert signs identified. Then respond to the following questions:
   - What is your assessment?
   - What care options will you offer Aisha?

5. **Now, carry out a role play to discuss care options for Aisha at 14:00 - one learner should play the role of the provider; the others should play the role of the woman and the companion.**

6. Then, record the agreed upon plan of care on Aisha's LCG and initial the LCG.

Debrief
What can be done at our facility to improve care and make sure that mistakes made with Aisha's care don't happen in our facility?

WHO LABOUR CARE GUIDE

Name Aisha **Parity** 3 **Labour onset** Spontaneous **Active labour diagnosis [Date** Jan 2, 2023 **]**

Ruptured membranes [Date **Time** **]** **Risk factors** History of stillbirth

			Time	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	:	:	:
			Hours	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →												← SECOND STAGE →		
SUPPORTIVE CARE	Companion	N		D				N				Y			Y			
	Pain relief	N		D				D				N			N			
	Oral fluid	N		Y				N				Y			Y			
	Posture	SP		MO				SP				SP			SP			
BABY	Baseline FHR	<110, ≥160		142	138		152	136		142		158			138			
	FHR deceleration	L																
	Amniotic fluid	M+++, B		C				M+				M			M			
	Fetal position	P, T		A				A				A			A			
	Caput	+++													+			
	Moulding	+++													+			
WOMAN	Pulse	<60, ≥120		82				88				82			92			
	Systolic BP	<80, ≥140		124				118				116			106			
	Diastolic BP	≥90		72				68				64			56			
	Temperature °C	<35.0, ≥ 37.5		37				37.6				37.8			38.5			
	Urine	P++, A++		-/-				A3+/P-				A+/P-			A-/P-			
LABOUR PROGRESS	Contractions per 10 min	≤2, >5		2				1				2			2			
	Duration of contractions	<20, >60		10				20				10			20			
	Cervix [Plot X]	10																
		9	≥ 2h															
		8	≥ 2.5h															
		7	≥ 3h															
		6	≥ 5h					X				X			X			
		5	≥ 6h	X														
	Descent [Plot O]	5		0				0				0			0			
		4																
		3																
		2																
		1																
		0																
MEDICATION	Oxytocin (U/L, drops/min)																	
	Medicine																	
	IV fluids																	
SHARED DECISION-MAKING	ASSESSMENT																	
	PLAN																	
	INITIALS																	

In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.

INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERT' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN.IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE.
Abbreviations: **Y** – Yes, **N** – No, **D** – Declined, **U** – Unknown, **SP** – Supine, **MO** – Mobile, **E** – Early, **L** – Late, **V** – Variable, **I** – Intact, **C** – Clear, **M** – Meconium, **B** – Blood, **A** – Anterior, **P** – Posterior, **T** – Transverse, **P+** – Protein, **A+** – Acetone

Session 3:
Auditing the LCG and reviewing a completed LCG. 60 minutes

Read objectives aloud:
- Audit 3 LCGs and make a plan to improve its completion and use
- Review progress made on the team's Taking Action! plan
- Use the Quick Guide to develop a plan of care for Betty's case study

Materials:
- Marker/pens/paper
- Taking Action! Plan
- LCG Audit Tool

Preparation:
- Review the facility's Taking Action! Plan

Activities:
Part I: Audit of 3 completed LCGs
See Session 1 for instructions

Part II: Debrief of LCG audits and plan for improvement
See Session 1 for instructions

Part III: Briefly Review progress made on the team's Taking Action! plan.
See Session 1 for instructions

Part IV: Betty's case study
In groups of 2, review Betty's LCG on the next page. Then:

1. Circle any "alert" values.
2. Record your assessment on Betty's LCG.
3. Respond to the following questions about Betty's case:
   - What alert values have you circled?
   - What is your assessment?
   - How do you identify late decelerations?
   - What are the possible causes of late decelerations?
   - What care options will you offer Betty?
4. **Now, carry out a role play to discuss care options for Betty - one learner should play the role of the provider; the others should play the role of the woman and the companion.**
5. Then, record the agreed upon plan of care and initial Betty's LCG.

WHO LABOUR CARE GUIDE

Name Betty **Parity** 0 **Labour onset** Spontaneous **Active labour diagnosis [Date** Jan 2, 2023]

Ruptured membranes [Date Jan 2, 2023 **Time** 18:00] **Risk factors** None

			Time	19:00	:	:	:	:	:	:	:	:	:	:	:	:	:	:
			Hours	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →												← SECOND STAGE →		
SUPPORTIVE CARE	Companion	N		Y														
	Pain relief	N		D														
	Oral fluid	N		Y														
	Posture	SP		MO														
BABY	Baseline FHR	<110, ≥160		122														
	FHR deceleration	L		L														
	Amniotic fluid	M+++, B		C														
	Fetal position	P, T		T														
	Caput	+++		0														
	Moulding	+++		0														
WOMAN	Pulse	<60, ≥120		72														
	Systolic BP	<80, ≥140		132														
	Diastolic BP	≥90		72														
	Temperature °C	<35.0, ≥ 37.5		36.8														
	Urine	P++, A++		-/-														
LABOUR PROGRESS	Contractions per 10 min	≤2, >5		4														
	Duration of contractions	<20, >60		50														
	Cervix [Plot X]	10																
		9	≥ 2h															
		8	≥ 2.5h															
		7	≥ 3h	X														
		6	≥ 5h															
		5	≥ 6h															
	Descent [Plot O]	5																
		4																
		3																
		2		0														
		1																
		0																
MEDICATION	Oxytocin (U/L, drops/min)																	
	Medicine																	
	IV fluids																	
SHARED DECISION-MAKING	ASSESSMENT																	
	PLAN																	
	INITIALS																	

In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.

INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERT' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN.IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE.

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Session 4:
Auditing the LCG and reviewing actions to take for abnormal observations.
60 minutes

Read objectives aloud:
- Audit 3 LCGs and make a plan to improve its completion and use
- Review progress made on the team's Taking Action! plan
- Review how to respond to alert values

Materials:
- Marker/pens/paper
- Taking Action! Plan
- LCG Audit Tool
- Job aid for assessing caput and moulding

Preparation:
- Review the facility's Taking Action! plan

Activities:
Part I: Audit of 3 completed LCGs
See Session 1 for instructions

Part II: Debrief of LCG audits and plan for improvement
See Session 1 for instructions

Part III: Briefly Review progress made on the team's Taking Action! plan.
See Session 1 for instructions

Part IV: Review actions to take for abnormal observations
Ask providers to refer to the Quick Check guide on pages 17-26 in this document. Facilitate a discussion on actions to take for the following findings *(they should base their responses on local protocols and/or actions suggested in the Quick Guide):*

What options for care will you propose to women if you find:

1. The woman is anxious and/or fearful
2. The woman is requesting pain relief or appears distressed by pain
3. There are late decelerations.
4. FHR is ≥160 bpm or <110 bpm.
5. Cervical dilatation is 5 cm at two vaginal examinations conducted 4 hours apart.
6. Uterine contractions are 2 contractions in 10 minutes each lasting 10-20 seconds.
7. The woman says she is too tired to be mobile and prefers lying on her back because pain is less in this position.

Session 5:
Auditing the LCG and reviewing providers' experience with the LCG.
60 minutes

Read objectives aloud:
- Audit 3 LCGs and make a plan to improve its completion and use
- Review progress made on the team's Taking Action! plan

Materials:
- Marker/pens/paper
- Taking Action! Plan
- LCG Audit Tool

Preparation:
- Review the facility's Taking Action! plan

Activities:
Part I: Audit of 3 completed LCGs
See Session 1 for instructions

Part II: Debrief of LCG audits and plan for improvement
See Session 1 for instructions

Part III: Briefly Review progress made on the team's Taking Action! plan.
See Session 1 for instructions

Part IV: Review providers' experience with the LCG.
Facilitate a discussion on providers' experience with using the LCG.
- ***What did you find positive about the LCG?***
- ***What did you find challenging about completing the LCG?***
- ***Were there any areas on which you want further training?***
- ***What do you feel may be some challenges to LCG completion on the labour ward?***
- ***What are some solutions to these challenges?***

For providers who need more training, provide immediate feedback and, if needed, plan for mentorship. Update and/or revise the Taking Action! plan based on the discussion.

Session 6:
Auditing the LCG and preparing for continued implementation. 60 minutes

Read objectives aloud:
- Audit 3 LCGs and make a plan to improve its completion and use
- Review progress made on the team's Taking Action! plan
- Make a plan for continued efforts for quality improvement

Materials:
- Marker/pens/paper
- Taking Action! Plan
- LCG Audit Tool

Preparation:
- Review the facility's Taking Action! plan

Activities:
Part I: Audit of 3 completed LCGs
See Session 1 for instructions

Part II: Debrief of LCG audits and plan for improvement
See Session 1 for instructions

Part III: Make a plan for continued work on the team's Taking Action! plan and implementing the LCG.

SESSION ANSWERS

Session 2: Auditing the LCG and reviewing a completed LCG. 60 minutes

Review of Aisha's LCG:

- **What is your general impression about care provided and completion of the LCG?**
  - Information about labour onset and time that membranes ruptured is missing. Caput/moulding are not regularly assessed. Decelerations are not recorded. Supportive care, FHR, and contractions are not monitored as recommended.
  - No action seems to have been taken for alert values.

- **What alert values have you circled?**
  - Supportive care: Posture at 14:00, 18:00, 21:00. Pain relief at 18:00.
  - Woman: Urine at 14:00. Temperature at 14:00, 18:00, and 21:00.
  - Labour progress: Contractions at 10:00, 14:00, 18:00, and 21:00. Cervix at 18:00 and 21:00.

- **What could you have done at 10:00 when she was admitted with two contractions in 10 minutes, each lasting 10 seconds?**
  - Encourage mobility and provide general labour support including pain management, labour companion, hydration/nutrition, and management of anxiety/fear that may improve contractions.

- **What is your assessment at 14:00?**
  - Inefficient contractions
  - Possible dehydration given acetonuria 3+ and not taking fluids.
  - Mostly supine which may contribute to poor contractions and labour progress.
  - Elevated temperature with other vital signs within normal limits.

- **What care options will you offer Aisha at 14:00?**
  - Evaluate and manage cause of elevated temperature.
  - Treat dehydration.
  - Contact a senior provider and conduct a comprehensive examination to confirm presentation and rule-out cephalopelvic disproportion or obstructed labour.
  - Encourage mobility and provide general labour support including pain management, labour companion, hydration/nutrition, and management of anxiety/fear.
  - In 30 minutes, evaluate if interventions have resulted in a change in frequency and duration of contractions. If not, consult a senior provider.
  - Assess caput and moulding at the next vaginal examination.
  - Monitor the woman, baby, and labour progress per standards.

Debrief

What can be done at our facility to improve care and make sure that mistakes made with Aisha's care don't happen in our facility?

Proposed responses:

- Ensure all providers can competently assess all parameters.
- All providers should monitor ALL parameters per protocols.
- The clinical environment should facilitate presence of a companion and ensure confidentiality and privacy.
- Providers should respond immediately when there are alert values.

Session 3:
Auditing the LCG and reviewing a completed LCG. 60 minutes

Review of Betty's LCG:

- **What alert values have you circled?**
  - Baby: Late decelerations and transverse position.

- **What is your assessment?**
  - Maternal status reassuring.
  - Late decelerations with baseline FHR within normal limits and no other signs of foetal distress.
  - Transverse position at 7 cm dilatation and 2/5 descent

- **How do you identify late decelerations?**
  - Late deceleration: The FHR lowers below baseline usually after the peak of a contraction.

- **What are the possible causes of late decelerations?**
  - The cause of late decelerations is uteroplacental insufficiency (UP I) due to: Uterine hyperactivity; Maternal hypotension, hypertensive disorders; Chorioamnionitis; Placental abruption, Placenta previa; Maternal DM, anaemia, SS anaemia, cardiac disease, smoking; IUGR, post-term gestation; Rh isoimmunization

- **What care options will you offer Betty?**
  - Ask the woman to turn on her left side, perform prolonged auscultation.
  - Alert a senior care provider and follow clinical guidelines.

Session 4:
Auditing the LCG and reviewing actions to take for abnormal observations. 60 minutes

Care options to propose to women if you find:

1. **The woman is anxious and/or fearful because of pain:**
   - Facilitate the presence of a companion of her choice. Make sure the companion knows how to support the woman, and when and how to call for help.
   - Work with the woman and companion to prevent and manage anxiety and fear:
     - Ensure privacy and confidentiality.
     - Listen and be sensitive to her feelings.
     - Praise, encourage, and reassure her.
     - Explain her progress, what to expect and care options so she understands how she and the fetus are doing.

2. **The woman is requesting pain relief or appears distressed by pain:**
   - Suggest a change of position, encourage her to move or walk around. Encourage her companion to massage her back, hold her hand, sponge her face between contractions or place a cool cloth at the back of her neck.
   - Explain to her how to use breathing techniques.
   - Encourage her to take a warm bath or shower.
   - Offer other pain management options according to woman's preferences, availability and provider's experience (epidural or opioid analgesia).

3. **There are late decelerations.**
   - If Late decelerations or a single prolonged deceleration are present, ask the woman to turn on her left side, then perform a prolonged auscultation, alert a senior care provider and follow clinical guidelines.

4. **FHR is >160 bpm or <110 bpm.**
   - Prop up the woman or place her on her left side. Stop oxytocin if it is being given. Give oxygen 4–6 L.
   - Check maternal vital signs, amniotic fluid, and uterus for signs of infection; check for vaginal bleeding; check for signs of maternal dehydration.
   - Check contractions (More than five contractions in 10 minutes, or if any contraction lasts longer than 60 seconds / Continuous uterine contractions that do not allow the uterus to relax / Constant pain that persists between contractions or is sudden in onset / Contractions cease altogether)
   - Review any medications the woman is receiving that may affect the fetal heart rate (oxytocin, terbutaline)
   - Treat any identified maternal conditions such as fever
   - Recheck in 5 minutes between contractions.
   - If a maternal cause is not identified and the fetal heart rate remains abnormal throughout at least three contractions, perform a vaginal examination to check for explanatory signs of distress: If the cord is below the presenting part or in the vagina, manage as prolapsed cord
   - Make sure the laboring woman is not in a supine position.

5. **Cervical dilatation is 5 cm at two vaginal examinations conducted 4 hours apart.**
   - Cervical dilatation is not considered slower than normal in active phase if cervical dilatation remains at 5 cm for less than 6 hours.
   - Assess if the frequency and duration of contractions are within normal limits (3-5 occurring every 10 minutes, lasting more than 40 seconds each).
   - Evaluate hydration status (signs of dehydration and ketonuria), presence of anxiety or fear, mobility, position of the woman
   - Evaluate the 4 Ps (Patient – Power – Passenger – Passage) to rule-out cephalopelvic disproportion and obstructed labour.
   - Provide support and reassurance, provide pain relief if needed, manage dehydration if needed, encourage the presence of a companion, oral fluids, mobility and upright positions.
   - Provide general methods of labour support, which may accelerate progress.
   - Reassess in 2 hours.

6. **Uterine contractions are 2 contractions in 10 minutes each lasting 10-20 seconds.**
   - Conduct a rapid evaluation
   - Recount contractions over a period of 10 minutes
   - Evaluate hydration status (signs of dehydration and ketonuria), presence of anxiety or fear, mobility, position of the woman
   - Provide support and reassurance, provide pain relief if needed, manage dehydration if needed, encourage mobility and upright positions
   - Provide general methods of labour support, which may improve contractions and accelerate progress
   - Augment labor with oxytocin if there are no signs of cephalopelvic / fetal pelvic disproportion or obstruction and other measures to address identified problems have failed

7. **The woman says she is too tired to be mobile and prefers lying on her back because pain is less in this position.**
   - Explain how lying on her back can reduce oxygen to her baby and slow down labour progress.
   - If the woman is tired, encourage her to try the following positions that might be less tiring than walking or standing: left lateral, kneeling, hands-and-knees.
   - Rule-out dehydration and encourage her to take a light diet and drink as she wishes during labour.

Notes

Notes

Notes

This information is made possible by the U.S. Agency for International Development (USAID) and MOMENTUM Country and Global Leadership, led by Jhpiego and partners, and does not reflect the views of USAID or the United States Government.