

STANDARD OPERATING PROCEDURE

Normal Labour

Special Region (1)

Union of Myanmar

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Normal Labour

Management of normal labour

Diagnosis of labour

The onset of labour can be defined as the presence of strong regular painful contractions resulting in progressive cervical change. Differentiating points between true and false labour are shown in the following table:

True Labour	False Labour
Contractions occur at regular intervals	Contractions occur at irregular intervals
Interval gradually shortens	Interval remains irregular
Intensity of pain gradually increases	Intensity of pain remains the same
There is progressive cervical effacement and dilatation	There is no progress in cervical effacement and dilatation
Progress of labour not stopped by sedation	Usually painful contractions are relieved by sedation and there is no progress in labour

Stages of Labour Labour can be divided into three stages: First stage

- The time from the diagnosis of labour to full dilatation of the cervix (10 cm).
- It takes about 10 - 14 hours in primigravida and about 6 - 8 hours in multipara.

Second stage

- Begins with full cervical dilatation and ends with the delivery of the fetus or fetuses.
- For nulliparous women, birth would be expected to take place within 3 hours of the active

second stage.

- For multiparous women, birth would be expected to take place within 2 hours of the start
- of the active second stage.

Third stage

- Begins after delivery of the fetus and ends with the delivery of the placenta and the

membranes.

- A third stage lasting more than 30 minutes is defined as abnormal.

Fourth stage

- One hour immediately after expulsion of the placenta and membranes.

Management of first stage of labour

General Principles of Management

- Initial assessment
- Observation and intervention if labour becomes abnormal
- Close monitoring of the fetal and maternal condition
- Providing supportive care throughout labour

Initial Assessment

- Aim: Identify high-risk pregnancies starting from the booking visit
- Includes taking a detailed history of present and past pregnancies

General Examination

- Assess general condition (pallor, jaundice, blood pressure, pulse, temperature, oedema)
- Evaluate cardiovascular status
- Note hydration state and urinary output

Abdominal Examination

• Assess uterine contractions by palpation (frequency and duration every 30 minutes) over a 10-minute period

- Measure fundal height
- Note level of presenting part and estimate head level in 'fifths'
- Monitor fetal heart rate for a minimum of 1 minute and at least every 15 minutes in the

first stage and every 5 minutes in the second stage of labour Vaginal Examination (VE)

- Ensure consent, privacy, dignity, and comfort
- Note:
 - Abnormal vaginal discharge
 - Color and quantity of amniotic fluid (clear, blood-stained, or meconium)
 - Cervix consistency, position, effacement, and dilation
 - Presenting part in relation to ischial spines, caput, and molding of the head

Investigations

- Urine tests for protein, ketones, and sugar

- Blood group/Rh check and hemoglobin percentage if required

Close Monitoring of the Fetal and Maternal Condition

- One-to-one care if possible
- Partographic monitoring

The Place of Partograph in Management of labour (Hospital based) The WHO Model partogram is a graphic presentation of the events of labour plotted against time in hours. The partogram has three main components: the foetal record, maternal record, and progress of labour. Points to remember:

- The latent phase is from 0 – 4 cm dilatation and is accompanied by gradual shortening of the cervix. It should normally not last longer than 8 hours.

- The active phase is from 4 – 10 cm and dilatation should be at the rate of at least 1 cm/hour.

- When labour progresses, the dilatation should not cross to the right of the alert line.

- When admission to hospital takes place in the active phase, the admission dilatation is immediately plotted on the alert line.

- When labour goes from latent to active phase, plotting of dilatation is immediately transferred from the latent phase area to the alert line.

- To assess the progress of labour, VE should be done every 3 to 4 hours.

Consider intervention when:

- The latent phase is more than 8 hours despite augmentation.
- Cervical dilatation less than 1 cm per hour.
- The partogram's action line is crossed.
- Second stage has lasted for more than 2 hr in parous or 3 hr in Nulliparous (with epidural insitu).

- Active labour has lasted for more than 12 hr.

MATERNAL AND FETAL MONITORING ❖ MATERNAL MONITORING

- Note vital signs on admission (BP, Pulse, temp, urine proteins and ketones)
- Monitor every hour if not in active labour (cervical dilatation 0 – 4 cm, contractions are weak, less than 2 in 10 minutes)

- Frequency, intensity and duration of contractions
- Record time of rupture of membranes and colour of amniotic fluid
- Temp, pulse, BP
- Pain Note Chart
- Respectful maternal care
- Give supportive care
- Never leave the woman alone
- Should accompanied by attendant during the first stage
- In active labour – Cervical dilatation 4 cm or greater
- Monitor first stage of labour
- Monitor every 30 minutes as above
- Cervix dilated 10 cm or bulging perineum, manage as in second stage of labour
- After 8 hours if:
 - contractions stronger and more frequent but no progress in cervical dilatation with
 - r without membranes ruptured – URGENT action to be taken (in community

level – referral to hospital) Signs and symptoms of maternal distress

- Tachycardia
- Tachypnoea and dyspnoea
- Pyrexia
- Dehydration with reduced urine output
- Ketone bodies in urine
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❖ FETAL MONITORING Fetal assessment in labour takes four forms:

- Observation of the colour of the liquor (clear, meconium and blood stained)
- Intermittent auscultation (IA) using a Pinard stethoscope or a hand-held Doppler
- Intermittent or Continuous electronic foetal monitoring
- Foetal scalp blood sampling if indicated where facilities available

Pregnancies being monitored by IA should be converted to continuous EFM in the following conditions:

- meconium stained liquor
- abnormal FHR detected by IA (less than 110 beats per minute; greater than 160 bpm; any

deceleration after a contraction)

- maternal pyrexia (defined as 38.0°C once or 37.5°C on two occasions 2 hr apart)
- fresh bleeding developing in labour
- oxytocin use for augmentation

Electronic Fetal Monitoring / Cardiotocographic monitoring (CTG) Admission CTG should be done if the facility is available. CTG signs suggestive of foetal compromise (NICE):

- Fetal tachycardia (more than 160 bpm)
- Loss of variability
- Recurrent late decelerations
- Persistent variable decelerations
- Fetal bradycardia (< 100 bpm for more than 3 minutes)

Resuscitating the foetus in labour If Fetal Heart Rate (FHS) < 110 or > 160 Beats per Minute:

- Position the woman on her left side
- If membranes are ruptured, look at vulva for prolapsed cord
- See if liquor was meconium stained
- Repeat FHR count after 15 minutes
- If FHR returns to normal within 15 minutes – monitor FHR every 15 minutes
- If FHR remains < 110 or > 160 bpm after 30 minutes observation:
- If early labour – refer the woman urgently to hospital
- If late labour – Monitor after every contraction. If FHR does not return to normal

in 15 minutes, prepare for urgent delivery and newborn resuscitation SUPPORTIVE TREATMENT FOR MATERNAL AND FETAL DISTRESS

- INTRAUTERINE RESUSCITATION:
- Change position, avoid supine position, oxygen inhalation
- Correct dehydration
- Omit oxytocin if patient is on oxytocin
- Offer digital scalp stimulation which leads to an acceleration in FHS
- Urgent referral to hospital if there is no facility and delivery is not imminent

SUPPORTIVE CARE THROUGHOUT LABOUR (Respectful Maternity Care – RMC) Communication

- Explain all procedures, seek permission, and discuss findings with the women.
- Keep her informed about the progress of labour.
- Praise her, encourage and reassure her that things are going well.

- Ensure and respect privacy during examinations and discussions.
- If known HIV positive, keep confidentiality.

Cleanliness

- Encourage the women to bathe, shower or wash herself and genitalia.
- Wash the vulva and perineal areas before each examination.
- Wash your hands with soap before and after each examination. Use sterile gloves for vaginal examination.
- Ensure cleanliness of labour and birthing area(s).

Mobility

- Encourage the women to walk around freely during the first stage of labour.
- Support the women's choice of position (left lateral, squatting, kneeling, standing supported by the companion) for each stage of labour and delivery. Urination
- Encourage the women to empty her bladder frequently. Remind her every 2 hours.

Bowels

- No routine enema.

Oral Intake and Diet in labour

- Encourage the women to eat and drink as she wishes throughout labour.
- Nutritious liquid drinks and light diet should be allowed apart from high risk for caesarean section (Mendelson's syndrome). Breathing technique

- Teach her to notice her normal breathing.
- Encourage her to breathe out more slowly, making a sighing nose, and to relax with breath.

- To prevent pushing at the end of first stage of labour, teach her to pant, to breathe with an open mouth, to take in 2 short breaths followed by a long breathe out.
- During delivery of the head, ask her not to push but to breathe steadily or to pant.

Pain and discomfort

- Suggest change of position
- Encourage mobility, as comfortable for her

- Encourage companion to: o massage the women's back if she finds this helpful o hold the women's hands and sponge her face between contractions

- Encourage her to use the breathing technique

Simple analgesic technique:

- Support during labour
- Oral analgesia, antispasmodic

Pharmacological analgesia in labour:

- Systemic opioid analgesia - IM Pethidine (50 mg)
- Keep Naloxone in hand
- Inhalational analgesia - Nitrous oxide (Entonox, a 50:50 oxygen: nitrous oxide mixture)

if facilities available 1.2.1. Regional analgesia in labour (Painless labour)

Management of Second stage of labour

Deliver the baby and give immediate newborn care When cervix 10 cm dilated or bulging perineum and head visible.

- Monitor every 5 minutes: o Frequency, intensity and duration of contractions o Foetal

heart rate o Perineum thinning and bulging o Visible descent of foetal head during contractions Deliver the baby

- Ensure all delivery equipment and supplies, including new born resuscitation equipments

are available and place of delivery is clean o ensure bladder is empty o assist the woman into a comfortable position of her choice, as upright as possible o stay with her and offer her emotional and physical support o allow her to push as she wishes with contractions o wait until head visible and perineum distending o Wash hands with clean water and soap. Put on gloves just before delivery o Universal precautions during labour and delivery if HBs Ag, HCV and HIV positive

- Ensure controlled delivery of the head: o Keep one hand on the head as it advances with

contractions o Support perineum with other hand and cover anus with pad held in position by side of hand during delivery o leave the perineum visible (between thumb and first finger) o Ask the mother to breathe steadily and not to push during delivery of the head o Encourage rapid breathing with mouth open

- Feel gently around baby's neck for the cord
- Check if the face is clear of mucus and membranes
- Await spontaneous rotation of shoulders and delivery (within 1 - 2 minutes)

- Apply gently downward pressure to deliver top shoulder
- Then tilt baby up, towards the mother's abdomen to deliver lower shoulder
- Place baby on abdomen or mother's arm
- Note time of delivery
- Thoroughly dry the baby immediately - Wipe eyes. Discard wet cloth.
- Assess baby's breathing while drying
- If the baby is not crying, observe breathing ○ breathing well (chest rising)? ○ not

breathing or gasping?

- Exclude second baby, Palpate mother's abdomen
- Watch for vaginal bleeding
- Change gloves. If not possible, wash gloved hands.
- Clamp and cut the cord. (Delayed cord clamp 30 - 60 second after delivery unless there is

concern about the integrity of the cord or the baby has a heart rate below 60 beats / minute and infection cases) ○ Clamp or tie tightly around the cord at 2 cm and 5 cm from baby's abdomen ○ cut between ties with sterile instrument ○ observe for oozing blood

- Keep baby on the mother's chest skin to skin contact at least one hour.
- Place identification label
- Warm up the baby, cover the head with a cloth
- Encourage initiation of breast feeding

Management of Third stage of labour

- Palpate the abdomen to exclude undiagnosed 2nd twin.
- Monitor mother every 15 minutes ○ Feel if uterus is well contracted ○ Time since third

stage began (time since birth) ○ Record findings, treatments and procedures in labour record and partograph ○ Give supportive care ○ Never leave the woman alone Active management of third stage should be recommended to all women

- 10 units of oxytocin is given intramuscularly immediately after birth
- Monitor uterine contraction
- Delay cord clamping (1 - 3 minutes)
- Controlled cord traction after signs of separation of the placenta
- Deliver the placenta

If there is no prophylactic administration of uterotonic during the third stage of labour misoprostol can be used in a single dose of 600 mcg orally administered during the third stage of labour.

- Check that placenta and membranes complete
- Check the uterus is well contracted and there is no heavy bleeding
- Repeat check every 5 minutes
- Examine perineum, lower vagina and vulva for tears
- Collect, estimate and record blood loss throughout third stage and immediately

afterwards

- Clean the woman and the area beneath her. Put sanitary pad or folded clean cloth under her buttocks to collect blood. Help her to change clothes if necessary.

- Dispose of placenta in the correct, safe and culturally appropriate manner.

Fourth stage

- keep the mother and baby in fourth stage room for a minimum of one hour after delivery
- f placenta
- Note BP, P/R, bleeding P/V and uterine contraction
- Early assessment of the woman's emotional and psychological condition in response to

labour and birth

- Give oral fluid
- Routine antibiotic prophylaxis is not recommended.

References

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