WHO recommendation on continuous companionship during labour

13 May 2014

Recommendation

Continuous companionship during labour is recommended for improving labour outcomes.

(Strong recommendation, moderate quality of evidence)

Publication history

First published: May 2014

Updated: prioritized for updating in 2018

Assessed as up-to-date: May 2014

Remarks

- The GDG acknowledged that continuous psychosocial support may not necessarily reduce the need for labour augmentation but made the recommendation on the basis of other substantial benefits for women and their babies.

- The GDG noted that countries and policy-makers are often reluctant to implement this intervention in practice in spite of the supporting evidence, which has been available for many years. The group agreed that extra efforts are needed to encourage potential implementers at various levels of health care delivery.

- The GDG discussed the issues of privacy, cultural inclinations and resource use often raised as concerns to implementing this intervention and agreed that simple measures to allow female relatives to accompany women during labour could be used as cost-effective and culturally sensitive ways to address these concerns.

- The evidence supports the use of any type of culturally appropriate companion, including husband and lay professionals, such as doulas.
**Background**

Difficult labour (or dystocia) is characterized by abnormally slow labour progress arising from inefficient uterine contractions, abnormal fetal presentation or position, inadequate bony pelvis or abnormalities of the pelvic soft tissues of the mother. (1, 2) Evidence suggests that up to one third of first-time mothers experience delay in the first stage of labour. (3)

Augmentation of labour is the process of stimulating the uterus to increase the frequency, duration and intensity of contractions after the onset of spontaneous labour. It has commonly been used to treat delayed labour when uterine contractions are assessed to be insufficiently strong or inappropriately coordinated to dilate the cervix. Labour augmentation has traditionally been performed with the use of intravenous oxytocin infusion and/or artificial rupture of amniotic membranes (amniotomy). The procedure aims to shorten labour in order to prevent complications relating to undue prolongation, and to avert caesarean section. There is evidence that a significant proportion of women with uncomplicated pregnancies are subjected to routine augmentation of labour with oxytocin. (4)

While augmentation of labour may be beneficial in preventing prolonged labour, its inappropriate use may cause harm. Augmentation with synthetic oxytocin may result in uterine hyperstimulation, with adverse effects such as fetal asphyxia and uterine rupture, and thus increase the risk of a cascade of interventions during labour and delivery. (5)

**Methods**

The recommendation was developed using standardized operating procedures in accordance with the process described in the "WHO handbook for guideline development", guided by the GRADE approach.(6) Outcomes used for this recommendation were aligned with the prioritized outcomes from the WHO recommendations on augmentation of labour (2014).(7)

A Cochrane systematic review was conducted, on use of the partograph as a monitoring tool to identify when intervention becomes indicated during labour.(8) In the review, randomized controlled trials relevant to the key question were screened by review authors, and data on relevant outcomes and comparisons were extracted. Evidence profiles (in the form of GRADE tables) were prepared for comparisons of interest, including the assessment and judgments for each outcome, and the estimated risks.

WHO convened a Guideline Development Group (GDG) meeting on recommendations on augmentation of labour in September 2013, where this recommendation was developed. The GDG comprised of a group of independent experts, who used the evidence profiles to assess evidence on effects on the pre-specified outcomes. GDG members discussed the balance between desirable and undesirable effects, overall quality of supporting evidence, values and preferences of stakeholders, resource requirements, cost-effectiveness, acceptability, feasibility and equity, to formulate the recommendation. Remarks were added to clarify the recommendation, and aid implementation.

Further information on procedures for developing this recommendation are available [here](#).

**Recommendation question**

For this recommendation, we aimed to answer the following question:

- In pregnant women in labour (P), does continuous companionship (I), compared to no intervention (C), improve maternal and perinatal outcomes (O)?
Evidence Summary

Evidence was extracted from a Cochrane systematic review of 22 trials (>15,000 women). The trials were conducted in low-, middle- and high-income countries across the world (USA, Canada, Belgium, France, Greece, Finland, Sweden, South Africa, Botswana, Nigeria, Australia, Brazil, Thailand, Mexico, Guatemala, Chile and Iran). Hospital routines and facilities varied considerably in different settings; for example, epidural analgesia was not routinely available in seven of the trials.

Continuous support was defined slightly differently in different trials but mainly women were accompanied at least during the active stages of labour. The companions in different trials varied: sometimes labour companions (or doulas) provided support while in other trials a female relative or husband was present throughout labour.

Continuous support versus usual care: maternal outcomes

- The mean length of labour was reduced for women supported in labour by approximately 35 minutes (MD –0.58 hrs, 95% CI –0.85 to –0.31; 12 trials, 5366 women).
- The rate of operative deliveries was reduced if they were supported during labour. The rate of caesarean section was reduced by more than 20% (RR 0.78, 95% CI 0.67 to 0.91; 22 trials, 15,175 women) and there was a modest reduction in the number of women undergoing instrumental vaginal birth (RR 0.90, 95% CI 0.85 to 0.96; 19 trials, 14,118 women), so that the overall number of women with spontaneous vaginal births was increased (RR 1.08, 95% CI 1.04 to 1.12; 19 trials, 14,119 women).
- There was a slight reduction in other interventions in labour in the supported group. The use of regional analgesia was reduced by approximately 7% (RR 0.93, 95% CI 0.88 to 0.99; nine trials, 11,444 women) and the number of women requiring other analgesia was also reduced (RR 0.90, 95% CI 0.84 to 0.96; 14 trials, 12,283 women).
- There was no significant difference between groups in the requirement of synthetic oxytocin during labour. Overall, more than a third of women in both groups received oxytocin (RR 0.97, 95% CI 0.91 to 1.04; 15 trials, 12,620 women), although there was considerable variation between trials.
- Only two trials reported on postpartum depression and results suggested that continuous support was associated with lower rates of depression. The two trials were carried out in very different settings and outcomes were measured in different ways, and while the direction of the effect was the same, the size of the effect was very different so results were not pooled.
- More than half of the women in both groups had perineal trauma and there was no significant difference between groups (RR 0.97, 95% CI 0.92 to 1.01).
- Women were much less likely to report negative feelings about their childbirth experience if they received continuous support (RR 0.69, 95% CI 0.59 to 0.79; 11 trials, 11,133 women).

Continuous support versus usual care: infant outcomes

- Infants whose mothers had been supported were less likely to have an Apgar score < 7 at five minutes (RR 0.69, 95% CI 0.50 to 0.95; 13 trials, 12,515 infants).
- There were no clear differences in the number of babies admitted for special care or having prolonged hospital stays (RR 0.97, 95% CI 0.76 to 1.25, and RR 0.83, 95% CI 0.42 to 1.65 respectively).
Continuous support did not seem to affect the number of babies being breastfed at 1–2 months postpartum, although this outcome was only reported in three trials (RR 1.01, 95% CI 0.94 to 1.09).

Further information and considerations related to this recommendation can be found in the WHO guidelines, available at: http://apps.who.int/iris/bitstream/handle/10665/112826/WHO_RHR_14.15_eng...

Implementation considerations

- The successful introduction of this recommendation into national programmes and health-care services depends on well-planned and participatory consensus-driven processes of adaptation and implementation. The adaptation and implementation processes may include the development or revision of existing national guidelines or protocols based on this recommendation.
- The recommendation should be adapted into a locally appropriate document that can meet the specific needs of each country and health service. Any changes should be made in an explicit and transparent manner.
- A set of interventions should be established to ensure that an enabling environment is created for the use of the recommendations (including, for example, the availability of augmentation agents and monitoring capacity), and that the behaviour of the healthcare practitioner changes towards the use of this evidence-based practice.
- In this process, the role of local professional societies is important and an all-inclusive and participatory process should be encouraged.

Research implications

The GDG did not identify further research priorities on this topic.

Related Links

WHO recommendations for augmentation of labour (2014) –full document and evidence tables

Supporting systematic review:


References


Citation


Published on RHL (https://extranet.who.int/rhl)

Home > WHO recommendation on continuous companionship during labour