GUIDELINE FOR ATTENDANCE AT A PHYSIOLOGICAL (EXPECTANT) THIRD STAGE OF LABOUR

BACKGROUND
Uterotonics are not always available for active management of the third stage of labour in many developing countries. The accessibility or the supply of uterotonics may be sporadic due to interruptions in the supply chain or their cost may prohibit their purchase by the woman and her family [1, 2]. In some countries women may choose not to have prophylactic uterotonics during the third stage of labour. The midwife must know how to provide safe care to prevent postpartum haemorrhage in the absence of uterotonic drugs during the third stage.

The purpose of this guideline is to clarify the effective attendance at the third stage of labour in situations in which there is an absence of uterotonic drugs or when the woman requests a physiological third stage.

This guideline reflects the best available evidence, drawn from the scientific literature and expert opinion in attendance at the third stage when uterotonics are not available or not given following maternal request [3-9].

GUIDELINE
In a physiological or expectant third stage of Labour, immediately following the birth and while awaiting delivery of the placenta the midwife:

- Hands the baby to the mother to hold, encouraging skin to skin contact; both are kept warm, dry and covered
- Encourages the woman to adopt a position comfortable for her but preferably upright to aid observation of blood loss and descent of the placenta
- Observes both the mother’s and baby’s vital signs and well-being
- Encourages breastfeeding when the baby is ready to feed
- Observes for excessive vaginal blood loss

It is important that the mother and baby are kept together immediately following the birth and for up to two hours after the birth, in a calm environment. Uninterrupted mother-baby contact during this time enhances the mother’s natural oxytocin production supporting breastfeeding and uterine contraction [10].

Umbilical cord management
The cord is left alone until either:

- It has stopped pulsating or until the placenta has been delivered at which point the cord is then clamped or tied and cut
- If the baby requires resuscitation there are some indications that it may be beneficial to leave the cord intact during resuscitative efforts [11-13]
In the case where blood gasses or cord blood is a legal requirement, the cord should only be clamped and not cut to obtain such a specimen.

**Physiological signs of placental separation**
The midwife visually observes for the following signs:
- The woman may become uncomfortable, experience contractions or feel that she wants to change position. She may also indicate heaviness in the vagina and a desire to bear down
- A change in the size, shape and position of the uterus; this can usually be seen, and palpating the uterus should be avoided
- A “gush” of blood
- The cord lengthens at the vaginal introitus

As a guideline it can be expected that the majority of placentas will be birthed within forty minutes and the vast majority within an hour.

**Facilitating the delivery of the placenta**
Upon observation of the signs of placental separation the midwife:
- Encourages the women into an upright position, e.g., standing, sitting on toilet or birthing stool
- Notes the placenta will either be expelled spontaneously or the woman may push or bear down with contractions to birth the placenta (which should only be encouraged after signs of separation have been noted). She may gently ‘lift’ the placenta out by easing gently on the cord IF the cord insertion can be seen at the vagina
- Catches the placenta in cupped hands or a bowl. If the membranes are slow to deliver the midwife can assist by holding the placenta in two hands and gently turning it until the membranes are twisted, then exerting gentle tension (not traction) to complete the delivery. Alternatively, the midwife can grasp the membranes gently and ease them from the vagina by an up and down motion of the hand

**Controlled cord traction is contraindicated in the absence of uterotonic drugs or prior to signs of separation of the placenta as this can cause partial placental separation, a ruptured cord, excessive bleeding, and/or uterine inversion.**

**Immediately following the birth of the placenta**
The midwife:
- Observes and estimates blood loss
- Palpates the uterine fundus to confirm that the uterus is well contracted (the uterus will be found in the area around the naval and should feel firm to the touch)
- Examines the placenta for completeness
- Continues to observe mother’s and baby’s vital signs and well-being

**The first two hours after the birth of the placenta**
The midwife:
- Observes and estimates blood loss
- Teaches the woman how to check her blood loss and the firmness of her own uterus
- Palpates for a contracted uterus on a regular basis
- Encourages mother/baby attachment by skin to skin and breastfeeding
Maintains a warm, calm environment for mother and baby. The mother’s innate physiological capacities are important in protecting her from postpartum haemorrhage. The preceding recommendations facilitate those mechanisms by acknowledging the essential nature of the hormonal feedback mechanisms in the prevention of haemorrhage.

**Adopted at Durban Council meeting, 2011**

_Due for next review 2017_

**REFERENCES**


