

1 **Suspected slow progress of active first stage of labour:** cervical dilatation < 2 cm in 4 h or <0.5-1 cm/h or above upper limit of P95th for given cervical dilatation.

2

<p>Maternal assessment</p> <ul style="list-style-type: none"> -Assess general condition: dehydration. -Perform maternal observations: pulse, blood pressure, temperature, urine output. -Palpate uterus: fetal presentation, position, engagement of the presenting part and descent, frequency, intensity and duration of contractions in 10 minutes. -Perform vaginal examination: asses membranes, liquor, bleeding, discharge, effacement, fetal presenting part, caput and moulding, position and descent, edematous cervix and cervix poorly applied to the presenting part. 	<p>Fetal assessment</p> <ul style="list-style-type: none"> -Asses fetal heart rate (FHR) using intermittent auscultation or cardiotocography if available.
<p>Initial management</p> <ul style="list-style-type: none"> -Provide adequate pain relief. -Ensure adequate hydration with IV fluids. Avoid oral fluids and food. -Encourage upright position and mobility. -Provide continuous companionship support. 	

3 Non-reassuring fetal heart rate ? OR thick meconium?

4 **Suspected fetal distress**

5 - Medical review for individualized plan of care and decision on mode of birth.
- Prepare for neonatal resuscitation.

6 **Identify probable cause**

7 Vertex or face presentation (mento anterior position)?

8 Are there signs of cephalopelvic disproportion/obstructed labour?*

9 **Malpresentation**

10 -Consider amniotomy if membranes intact.
-Regular routine maternal observations in labour.
-Repeat vaginal examination in 2h.

11 -Medical review for caesarean section.
-Consider vaginal birth for breech presentation.
-Prepare for neonatal resuscitation.

12 Is labour progress adequate?
2 cm in 4 h or below upper limit of P95th for cervical dilatation.

Link to normal 1st stage of labour algorithm

13 **Delay in progress of labour**

14 3 or 4 contractions in 10 minutes each lasting 40-60 sec?

15 Are there signs of cephalopelvic disproportion*/ obstructed labour**?

16 **Cephalopelvic disproportion / Obstructed labour**

17 **Inadequate uterine activity**

18 - Start oxytocin and adjust rate of infusion.
- Asses contractions, pulse and fetal heart rate every 30min.
- Review progress of labour.

19 Inadequate progress? <2 cm in 4 h or above upper limit of P95th for cervical dilatation.

20 -Medical review to consider caesarean section.
-Prepare for neonatal resuscitation.

Link to uterine hypoactivity algorithm

21 **Vaginal birth**

*Cephalopelvic disproportion is defined as secondary arrest of cervical dilatation and descent of presenting part in presence of good contractions.

**Obstructed labour is defined as secondary arrest of cervical dilatation and descent of presenting part with large caput, third degree moulding, cervix poorly applied to presenting part, oedematous cervix, ballooning of lower uterine segment, formation of retraction band, or maternal and fetal distress.

1

Suspected slow progress of second stage of labour:

More than 3 hours with or more than 2 hours without regional anaesthesia in nulliparous.
More than 2 hours with or more than 1 hour without regional anaesthesia in parous women.

2

<p>Maternal assessment</p> <ul style="list-style-type: none"> -Assess general condition: distress, anxious, pain. -Perform maternal observations: pulse, BP, temperature, urine output. -Palpate abdomen: palpate bladder. -Palpate uterus: fetal presentation, position, engagement of the presenting part and descent. frequency, intensity and duration of contractions in 10 minutes. -Perform vaginal examination: assess membranes, liquor, bleeding, discharge, effacement, foetal presenting part, position and descent. -Offer vaginal examination if progress is inadequate after 1 hour in nulliparous or 30 minutes in parous women. Confirm full dilatation. 	<p>Fetal assessment</p> <ul style="list-style-type: none"> -Asses fetal heart rate (FHR) using continuous auscultation or cardiotocography if available.
<p>Initial Management</p> <ul style="list-style-type: none"> -Explain the situation to the woman and companion. -Empty bladder if suspected full bladder. -Provide adequate pain relief. -Ensure adequate hydration with IV fluids. Avoid oral fluids and food. -Encourage upright position and mobility. -Provide continuous companionship support. 	



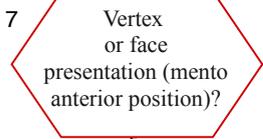
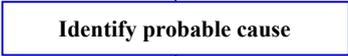
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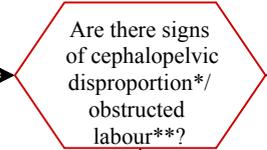
- Medical review for individualized plan of care and decision on mode of birth.
- Prepare for neonatal resuscitation.

6



Yes

8



Yes

9



No

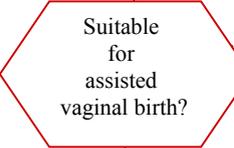
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11

-Medical review: consider assisted vaginal birth if suitable (presenting part below the spines, trained personnel available).

14



Yes

No

15



12



Yes

No

13



16

-Medical review to consider caesarean section.
-Prepare for neonatal resuscitation.

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**Obstructed labour is defined as secondary arrest of cervical dilatation and descent of presenting part with large caput, third degree moulding, cervix poorly applied to presenting part, oedematous cervix, ballooning of lower uterine segment, formation of retraction band, or maternal and fetal distress.