



Provision of routine intrapartum care in the absence of pregnancy complications

This statement has been developed and reviewed by the Women's Health Committee and approved by the RANZCOG Board and Council.

A list of Women's Health Committee Members can be found in [Appendix A](#).

Disclosure statements have been received from all members of this committee.

Disclaimer This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: March 2010
Current: July 2017
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Objectives: To provide advice on the intrapartum care of healthy women during childbirth.

Outcomes: To improve the delivery of routine intrapartum care, resulting in improved maternal and fetal outcomes.

Target audience: All health practitioners providing intrapartum care and patients.

Evidence: A literature search was undertaken to identify systematic reviews of randomised controlled trials relating to the routine intrapartum care of women in labour at term.

Values: The evidence was reviewed by the Women's Health Committee (RANZCOG), and applied to local factors relating to Australia and New Zealand.

Validation: This statement was compared with WHO and SOGC guidance on this topic.

Background: This statement was first developed by Women's Health Committee in March 2010 and most recently reviewed in July 2017.

Funding: The development and review of this statement was funded by RANZCOG.

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1. Patient Summary

Irrespective of the setting for labour and birth or level of care, the aims of intrapartum care are to achieve a healthy mother and baby with the minimal possible intervention that is compatible with safety and a fulfilling birth experience.

2. Summary of recommendations

Recommendation 1	Grade and reference
Where on-site services cannot be provided, women should be informed of the limitations of services available and the implications for intrapartum and postpartum care. Antenatal transfer to a centre with more comprehensive services should be considered.	Consensus-based recommendation
Recommendation 2	Grade and reference
In circumstances where transfer may be necessary, formal systems must be in place to ensure the safe and timely transfer of women and/or their babies who require specialist treatment. These arrangements should be collaborative and hold the safety of mother and baby as paramount.	Consensus-based recommendation
Recommendation 3	Grade and reference
All transfers should be documented for future review. Such information is valuable for planning and resourcing improvements of those units requiring transfer capability.	Consensus-based recommendation
Recommendation 4	Grade and reference
Each unit should have a prescribed regimen for taking, recording and notifying observations in labour such as pulse rate, blood pressure, respiratory rate, temperature, contraction duration/frequency, abdominal palpation findings, vaginal examination findings, presence/colour of the amniotic fluid and fetal heart rate.	Consensus-based recommendations
Recommendation 5	Grade and reference
Women should be encouraged to ambulate freely according to comfort, where it does not compromise maternal and fetal observations in labour.	Consensus-based recommendations ²
Recommendation 6	Grade and reference
Women should be informed prospectively of the obstetric analgesia and anaesthesia services offered by an institution.	Consensus-based recommendations

Recommendation 7	Grade and reference
All women should give birth in a position where they can rapidly access treatment in the event of sudden unexpected complications such as maternal collapse or shoulder dystocia.	Consensus-based recommendation
Recommendation 8	Grade and reference
Birth in water can be performed in centres where staff are trained in performing water births, and where recourse to a non water birth can occur rapidly and safely should the situation dictate.	Consensus-based recommendation
Recommendation 9	Grade and reference
"Active" management of the third stage of labour includes oxytocic administration followed by assisted delivery of the placenta and is recommended for all women. There should be no urgency to cut the umbilical cord and this can be done in an appropriate time frame.	Consensus-based recommendation
Recommendation 10	Grade and reference
Skin to skin contact should be facilitated providing there are no maternal or neonatal complications. The term healthy infant should be placed naked on the mother's bare skin and both covered with a warm blanket.	Consensus-based recommendation
Recommendation 11	Grade and reference
Debriefing opportunities should be provided following an adverse outcome or experience that did not meet the expectations of the woman or her partner.	Consensus-based recommendation
Recommendation 12	Grade and reference
Perinatal outcomes and obstetric intervention must be subject to regular multi-disciplinary clinical practice audit, supported by robust, systematic data collection systems. Where there has been transfer between birthing units or models of care, this must be flagged in the data collection system and subject to clinical audit by both the referring and receiving clinical teams.	Consensus-based recommendation

3. Discussion and Recommendations

3.1 What are the service requirements for the provision of intrapartum care?

Women in labour should have timely access to obstetric, midwifery, neonatal paediatric, anaesthetic, operating theatre and resuscitation services in labour and for at least several hours after birth. Further requirements include: access to intensive care specialist consultation, haematology and blood bank services (including specialist haematological consultation) and policy documents detailing methods of accessing emergency assistance.

Even among women without pregnancy complications, women in labour and their babies can rapidly develop complications where timely access to these services may be life-saving. For this reason, birth centres are ideally placed within (or immediately adjacent to) an appropriately resourced 24-hour obstetric facility.

Where, by virtue of remote location, such on-site services cannot be provided, women should be informed of the limitations of services available and the implications for intrapartum and postpartum care. Antenatal transfer to a centre with more comprehensive services may be considered.

In circumstances where transfer may be necessary, formal systems must be in place to ensure the safe and timely transfer of women and/or their babies who require specialist treatment. These arrangements should be collaborative and hold the safety of mother and baby as paramount.

All transfers should be documented for future review. Such information is valuable for planning and resourcing improvements of those units requiring transfer capability. Amongst women selected for low obstetric risk, approximately 25% will develop peripartum complications necessitating transfer to an obstetrician led service.¹

Recommendation 1	Grade and reference
Where on-site services cannot be provided, women should be informed of the limitations of services available and the implications for intrapartum and postpartum care. Antenatal transfer to a centre with more comprehensive services should be considered.	Consensus-based recommendation
Recommendation 2	Grade and reference
In circumstances where transfer may be necessary, formal systems must be in place to ensure the safe and timely transfer of women and/or their babies who require specialist treatment. These arrangements should be collaborative and hold the safety of mother and baby as paramount.	Consensus-based recommendation
Recommendation 3	Grade and reference
All transfers should be documented for future review. Such information is valuable for planning and resourcing improvements of those units requiring transfer capability.	Consensus-based recommendation

3.2 What are the requirements for admission of women to the delivery suite?

3.2.1 Clinical Assessment

All members of the clinical team (midwives and medical practitioners) should be notified of the admission of a woman in labour at an agreed time.

The woman should be assessed with a careful history and examination taking particular care to note:

1. History: Gestational age (check ultrasound dates), Past History (Obstetric, Gynaecological, Medical & Surgical), Medications, Pregnancy Complications, Investigation Results (Ultrasounds, GBS status, and routine antenatal investigations).
2. Clinical Examination: General and abdominal examination. A vaginal examination is indicated for women admitted in apparent labour unless there are contraindications. This should be done within 4 hours of admission to diagnose and assess the progress of labour.

3.3 What are the recommendations for routine care throughout labour?

Care for women is optimised where there is 1 to 1 midwifery support in labour in collaborative service.

3.3.1 Communication and support

The team responsible for the care of the woman in labour should be given an opportunity to introduce themselves, explain procedures as clearly as possible, and actively involve the woman and her support person in management decisions in labour.

In birthing units where it is common for an obstetrician to manage women in labour 'off-site', the birthing unit should provide facilities for the obstetrician to view intrapartum electronic fetal monitoring.

3.3.2 Maternal observations

Each unit should have a prescribed regimen for taking, recording and notifying observations in labour such as pulse rate, blood pressure, respiratory rate, temperature, contraction duration/frequency/intensity, abdominal palpation findings, vaginal examination findings, the presence/colour of the amniotic fluid and fetal heart rate.

The World Health Organisation (WHO) recommends that such information be graphically displayed on a partograph to facilitate review of a woman's progress in labour. Standards exist for such a document and are available from WHO Integrated Management of Pregnancy and Childbirth [Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice](#).

In addition, key recommendations of the UK Confidential Enquiries into Maternal Mortality (Saving Mothers Lives, 2011) highlight the importance of recognising the sick mother, and recommend routine use of an obstetric early warning chart to assist in timely recognition, treatment and referral of women who may develop a critical illness during labour or post-partum.

Recommendation 4	Grade and reference
Each unit should have a prescribed regimen for taking, recording and notifying observations in labour such as pulse rate, blood pressure, respiratory rate, temperature, contraction duration/frequency/, abdominal palpation findings, vaginal examination findings, presence/colour of the amniotic fluid and fetal heart rate.	Consensus-based recommendations

3.3.3 Fetal Surveillance

See [RANZCOG Fetal Surveillance Clinical Guideline - Third Edition](#)

3.3.4 Activity

A Cochrane review assessing the impact of the mothers' position during the first stage of labour was published in October 2013. It showed that the first stage of labour may be approximately one hour and twenty minutes shorter for women who are upright or walk around.²

Although better quality studies are required to validate these results for all women in labour (not just low risk women), it is recommended that wherever possible, women should be encouraged and supported to use upright and mobile positions of their choice during the first stage of labour.

Women should be encouraged to ambulate freely according to comfort, where it does not compromise maternal and fetal observations in labour.

Recommendation 5	Grade and reference
Women should be encouraged to ambulate freely according to comfort, where it does not compromise maternal and fetal observations in labour.	Consensus-based recommendations ²

3.3.5 Analgesia in labour

See Position Statement on the [Provision-of-Obstetric-Anaesthesia-and-Analgesia-Services-\(WPI-14\)](#)

Women should be informed prospectively of the obstetric anaesthesia and analgesia services offered by an institution. Where such facilities are limited, women should be informed and offered transfer antenatally to a centre with more comprehensive services.

Pharmacological and non-pharmacological methods of pain relief should be both available and offered to women in labour.

Where epidural analgesia is being employed:

- Consideration should be given to fluid loading.
- Particular attention should be made to bladder care with prompt insertion of a urinary catheter.
- Continuous electronic fetal monitoring should be instituted as per the RANZCOG Intrapartum Fetal Surveillance Guideline.

Recommendation 6	Grade and reference
Women should be informed prospectively of the obstetric anaesthesia and analgesia services offered by an institution. Where such facilities are limited, women should be informed and offered transfer antenatally to a centre with more comprehensive services.	Consensus-based recommendations

3.3.6 Fluids and oral intake

There is some data to suggest that inadequate hydration may increase the length of labour and the need for oxytocin augmentation in labour. However, women should be encouraged to only have clear fluids and light diet in the active phase of labour to minimise the small risk of aspiration pneumonitis. Intravenous fluid replacement may be necessary in women unable to tolerate sufficient oral intake, and is recommended for volume loading prior to epidural anaesthesia. Oral medications can be given as usual in labour, although absorption may be impaired in established labour and another route may need to be considered (eg for anticonvulsants).

3.3.7 Antibiotics

Indications for antibiotic administration in labour:

- For prevention of early onset Group B Streptococcus (GBS) infection (see C-Obs 19 Screening and Treatment for Group B Streptococcus).
- For women at risk of chorioamnionitis or where other bacterial infection is suspected – E.g. fever ≥ 38 on one occasion or ≥ 37.5 on two occasions.
- For women with cardiac lesions susceptible to infective endocarditis.

3.3.8 Amniotomy (ARM)

Indication

1. Induction of Labour

Women not in labour or in “early/spurious labour” may elect to have an ARM performed. This should be done in the knowledge that this may be inducing rather than augmenting labour.

2. Augmentation of Labour

Routine amniotomy in labour has both benefits and adverse consequences. In considering amniotomy for the augmentation of labour, the following should be noted:

- i. Evidence that routine ARM shortens labour is largely lacking (Cochrane review 2009).
- ii. The risk of infection increases following rupture of the membranes, whether by amniotomy or following spontaneous rupture of the membranes.
- iii. ARM provides useful information on fetal wellbeing (liquor volume and colour). The presence of scant amniotic fluid or meconium staining of liquor at ARM enables identification of a fetus that would benefit from Continuous Electronic Fetal Monitoring (CEFM) when this may not otherwise be known.

Relative Contraindications to Amniotomy

1. Hepatitis B, Hepatitis C, HSV and HIV infection in order to minimise the hazards to the fetus of ascending infection.
2. Presenting part high and mobile.

3.3.9 Progress in Labour

Principles

The purpose of labour augmentation with a syntocinon infusion is to increase the rate of progress in labour when it is considered slower than normal progress. However, assessment of the cause for abnormally slow progress is critical, particularly in parous women, or in those with a uterine scar. It is important that obstruction, for example due to cephalo-pelvic disproportion, is considered in this setting.

Frequency of cervical examinations in labour

Most trials examining frequency of cervical assessments - including those involving assessment of active management of labour - have included 2 hourly cervical assessments. This enables dystocia to be diagnosed and corrected early, but needs to be weighed against the added maternal discomfort of more frequent examinations and the potential for introducing infection. A compromise position is the common practice of 4 hourly examinations in the first stage of labour.

Where full dilatation is not apparent clinically 2 hours after a woman is 9cm dilated, a further vaginal examination is beneficial to confirm full dilatation or allow the diagnosis of 'failure to progress' if full dilatation has not occurred.

Reassessment should occur after 2 hours in the second stage of labour in a primigravida and 1 hour in a multigravida.

Definition of Failure to Progress

1st Stage – before "Established Labour"

No upper limit to the length of the "Latent Phase" of labour can be defined. It is not uncommon for labour to "stop and start" with multiple episodes of early/spurious labour before labour is finally established. Nevertheless, recurrent or prolonged episodes of spurious labour, may contribute to a legitimate decision to induce labour in some women.

1st Stage – in "Established Labour" (defined above).

Primigravida

The 10th centile for progress of cervical dilatation in labour is 0.9 cm/hour in a primigravida.

The threshold at which slow cervical dilatation merits a recommendation for oxytocin infusion is therefore appropriately:

- i. Individualised with an informed discussion between the woman and her carer.
- ii. Will commonly be at 1 cm/hr for most women in spontaneous labour but may be as high as 1 cm/2 hrs in women prioritising low intervention.

Multigravida

The 10th centile for progress of cervical dilatation in labour is 1.2 cm/hour in a multigravida.³

Augmentation of labour in the multigravida labour should proceed only after careful assessment and then with caution as it carries the particular risk of uterine rupture which is exceedingly uncommon in the primigravida.

2nd Stage

Progress is judged solely in terms of cervical dilatation and head descent in the 1st stage of labour. Progress in second stage includes flexion, rotation and descent of the head. Normal second stage for a primigravida is up to 2 hours and up to 1 hour for a multigravida. When these times are exceeded, assessment should occur by a medical practitioner with the view to correcting dystocia or **effecting** birth.

3.4 What are the recommendations for routine birth?

3.4.1 Positioning

Preparation for spontaneous birth should take into account the woman's , preference for positioning.

See College Statement [Warm Water Immersion in Labour and Birth \(C-Obs 24\)](#)

Recommendation 7	Grade and reference
All women should give birth in a position where they can rapidly access treatment in the event of sudden unexpected complications such as maternal collapse or shoulder dystocia.	Consensus-based recommendation
Recommendation 8	Grade and reference
Birth in water can be performed in centres where staff are trained in performing water births, and where recourse to a non water birth can occur rapidly and safely should the situation dictate.	Consensus-based recommendation

3.4.2 The Accoucheur

The role of the accoucheur at birth is to minimise maternal perineal trauma, prevent fetal injury and provide initial support of the newborn. The accoucheur should control the fetal head at crowning (to avoid precipitous expulsion) and support the perineum to reduce perineal tears.

A Cochrane review has found the application of warm compresses during the second stage of labour to have a significant effect on reducing perineal tears.¹ The intervention involves holding the compress on the perineum continuously during and between contractions.

3.4.3 Episiotomy

There is no benefit to 'routine' episiotomy. Episiotomy should be considered where there is:

A high likelihood of severe laceration;

1. Soft tissue dystocia;
2. A requirement to accelerate the birth of a compromised fetus;
3. A need to facilitate operative vaginal birth;
4. A history of Female Genital Mutilation (FGM).

3.4.4 Third Stage of Labour

"Active" management of the third stage of labour includes oxytocic administration followed by assisted birth of the placenta and is recommended for all women. "Expectant" or "physiological" management cannot be recommended on the basis of evidence and is associated with approximately a two-fold increase in the incidence of postpartum haemorrhage and an increased risk of blood transfusion when compared with active management. A poorly contracted uterus poses an increased risk of the potentially fatal complication of uterine inversion. Women should be informed of the reasons for this recommendation prior to labour.

Recommendation 9	Grade and reference
<p>“Active” management of the third stage of labour includes oxytocic administration followed by assisted delivery of the placenta and is recommended for all women. There should be no urgency to cut the umbilical cord and this can be done in an appropriate time frame.</p>	<p>Consensus-based recommendation</p>

3.4.5 Oxytocic administration

Prophylactic oxytocin decreases both PPH greater than 500ml and the need for therapeutic uterotonics.⁴ Caution must be exercised if there is the possibility of an undiagnosed second twin (i.e. no ultrasound in pregnancy) and hence the uterus should be palpated prior to the administration of an oxytocin agent.

A number of oxytocic regimens have been used and each has its advocates. The most popular regimens are oxytocin 5 or 10 units (intramuscularly or intravenously) OR Syntometrine 1ml intramuscularly (ergometrine 0.5 mg + oxytocin 5 units).

Ergometrine commonly produces nausea and vomiting and may lead to raised blood pressure. Care should be taken in women with hypertension or heart disease. When intramuscular ergometrine is used, side effects have, in general, been found to be mild. There is no evidence to suggest that prophylactic oxytocin increases the risk of a retained placenta.⁴

3.4.6 Assisted delivery of the placenta

It is absolutely essential to ensure the uterus is well contracted and the placenta separated before controlled cord traction is applied.

3.4.7 Immediate versus delayed cord clamping

In preterm infants, delayed cord clamping is associated with a reduced risk of requiring transfusion, infection, necrotising enterocolitis and intraventricular haemorrhage².

In term infants, delayed cord clamping is associated with an increased haematocrit and reduced iron deficiency at 3-6 months of age. These benefits are achieved at the expense of an increase in early polycythemia and jaundice. At present, there is no clear evidence to guide practitioners regarding delayed cord clamping in term infants, but infants most likely to benefit are those where maternal iron stores are low, or in infants who will be exclusively breast fed without iron supplementation.

Approximately 75% of available placental blood for transfusion is achieved in the first minute after birth, and the transfer of blood from placenta to newborn is facilitated by the infant being held below the level of the insitu placenta. If the infant is held between 10 cm above to 10 cm below the level of the placenta, transfusion is complete within 3 minutes. If the infant is held 40 cm below the placenta, transfusion time is shortened to 1 minute.

3.5 What are the recommendations for routine newborn care?

At birth, the neonate should be immediately assessed as to the need for resuscitation. Skin to skin contact should be facilitated providing there are no maternal nor neonatal complications. The term healthy infant should be placed naked on the mother’s bare chest or abdomen and both covered with a warm blanket. Skin to skin contact improves thermal regulation in the neonate, and facilitates mother infant attachment. Skin to skin contact has been demonstrated to improve rates, and duration of, breast feeding. Nevertheless, it is important that the infant remains under close observation by both the mother and maternity care

providers during this time, particularly given that newborns are frequently placed prone on the mother during this critical period of neonatal transition.

Apgar scores should be completed at 1 and 5 minutes of age.

Regular observations of the neonate should continue during the early neonatal period including:

- Neonatal respiration, PR, colour, tone and reflex irritability;
- Observing for any evidence of respiratory distress (grunting, nasal flaring, intercostal retraction, tachypnoea, cyanosis).

Following a Vacuum – Assisted Birth, additional neonatal observations may be recommended.

Intramuscular vitamin K administration is recommended, and in some centres, Hepatitis B vaccination.

Recommendation 10	Grade and reference
<p>Skin to skin contact should be facilitated providing there are no maternal or neonatal complications. The term healthy infant should be placed naked on the mother’s bare skin and both covered with a warm blanket.</p> <p>There should be no urgency to cut the umbilical cord and this can be done in an appropriate time frame.</p>	<p>Consensus-based recommendation</p>

3.6 What are the recommendations for routine early postpartum care?

All women should be cared for in the early postpartum period by caregivers experienced in the management of the early puerperium and its complications. This applies also to women being cared for in a “recovery area” after an operative procedure and to women who have been admitted to an area of high dependency or intensive care.

Regular maternal observations should include:

- Pulse rate, blood pressure and temperature;
- Palpation of the uterine fundus to exclude atony;
- Inspection of the perineum to exclude excessive postpartum blood loss or development of vulval haematoma.

Complications such as haemodynamic instability, excessive PV blood loss or evidence of expanding haematoma necessitate immediate notification of the responsible obstetrician.

3.7 What is the value of debriefing following labour and birth?

Events surrounding the labour and birth have the potential to have an impact on a woman’s long term emotional well-being. Debriefing includes a variety of post-birth discussions that provide women an opportunity to talk about their birth expectations and experience. Debriefing opportunities should be provided following an adverse outcome or experience that did not meet the expectations of the woman or her partner.

Additionally, staff should be given the opportunity to debrief following an adverse event. This may occur individually or as part of the multidisciplinary team involved with the woman’s care. Not only is debriefing an

effective tool for promoting learning, reflection and system change, it may also help to identify vulnerable team members who need further support after an adverse event.

3.8 What is the importance of clinical practice audits?

Perinatal outcomes and obstetric intervention must be subject to regular multi-disciplinary clinical practice audit, supported by robust, systematic data collection systems. Where there has been transfer between birthing units or models of care, this must be flagged in the data collection system and subject to clinical audit by both the referring and receiving clinical teams.

Recommendation 12	Grade and reference
Perinatal outcomes and obstetric intervention must be subject to regular multi-disciplinary clinical practice audit, supported by robust, systematic data collection systems. Where there has been transfer between birthing units or models of care, this must be flagged in the data collection system and subject to clinical audit by both the referring and receiving clinical teams.	Consensus-based recommendation

4. References

1. Aasheim V NA, Lukasse M, Reinar LM. Perineal techniques during the second stage of labour for reducing perineal trauma. *Cochrane Database of Systematic Reviews*. 2011(12).
2. Fogarty M, Osborn D, Askie L, Seidler A, Hunter K, Lui K, et al. Delayed Versus Early Umbilical Cord Clamping for Preterm Infants: A Systematic Review and Meta-Analysis. *American journal of obstetrics and gynecology*. 2017;17:31439-4.

5. Other suggested reading

World Health Organisation (WHO) Care in normal birth: A practical guide. Report of a technical working party. 1996 Geneva: Publication no WHO/FRH/MSN/96.24. King Edward Memorial Hospital (KEMH) Obstetric Clinical Care Unit: Management of normal labour. 2002.

Stern C, Permezel M, Petterson C, Lawson J, Eggers T, Kloss M. The Royal Women's Hospital Family Birth Centre: The first ten years reviewed. *Aust NZ J Obstet Gynaecol* 1992; 32: 291-5.

Institute for Clinical Systems Improvement (ISCI) Health Care Guideline: Prevention, diagnosis and treatment of failure to progress in obstetrical labor. 2003.

Society of Obstetricians and Gynaecologists (SOGC) Policy Statement Number 89: Attendance at Labour and delivery guidelines for obstetrical care. 2000.

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Pregnancy, childbirth, postpartum and newborn care - A guide for essential practice. World Health Organization, Department of Making Pregnancy Safer. 2006. Available at:
http://www.who.int/maternal_child_adolescent/documents/imca-essential-practice-guide/en/

6. Links to other related College Statements

[RANZCOG Intrapartum Fetal Surveillance Clinical Guideline - Third Edition](#)

[Instrumental Vaginal Delivery \(C-Obs 16\)](#)

[Maternal Group B Streptococcus \(GBS\) in pregnancy: screening and management](#)

[Warm Water Immersion in Labour \(C-Obs 24\)](#)

[Joint RANZCOG/ANZCA/RACGP/ACRRM Position statement on the provision of Obstetric Anaesthesia and Analgesia Services \(WPI 14\)](#)

[Consent and provision of information to patients in Australia regarding proposed treatment \(C-Gen 02\)](#)

[Evidence-based Medicine, Obstetrics and Gynaecology \(C-Gen 15\)](#)

7. Patient information

A range of RANZCOG Patient Information Pamphlets can be ordered via the [RANZCOG website](#)

Appendices

Appendix A Women's Health Committee Membership

Name	Position on Committee
Professor Yee Leung	Chair
Dr Joseph Sgroi	Deputy Chair, Gynaecology
Associate Professor Janet Vaughan	Deputy Chair, Obstetrics
Associate Professor Ian Pettigrew	EAC Representative
Dr Tal Jacobson	Member
Dr Ian Page	Member
Dr John Regan	Member
Dr Craig Skidmore	Member
Associate Professor Lisa Hui	Member
Dr Bernadette White	Member
Dr Scott White	Member
Associate Professor Kirsten Black	Member
Dr Greg Fox	College Medical Officer
Dr Marilyn Clarke	Chair of the ATSI WHC
Dr Martin Byrne	GPOAC Representative
Ms Catherine Whitby	Community Representative
Ms Sherryn Elworthy	Midwifery Representative
Dr Amelia Ryan	Trainee Representative

Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in March 2010 and was reviewed over a few months in 2014. The Women's Health Committee carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.
- Structured clinical questions were developed and agreed upon.
- An updated literature search to answer the clinical questions was undertaken.
- At the June 2014 teleconference, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part iii). The RANZCOG Board approved this statement at their meeting on 1 August 2014. At the March 2015 face-to-face meeting, minor amendments were made to items 2.3.1 and 2.3.2.

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women's Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women's Health Committee members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines.⁵ Where no robust evidence was available but there was sufficient consensus within the Women’s Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

Recommendation category		Description
Evidence-based	A	Body of evidence can be trusted to guide practice
	B	Body of evidence can be trusted to guide practice in most situations
	C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
	D	The body of evidence is weak and the recommendation must be applied with caution
Consensus-based		Recommendation based on clinical opinion and expertise as insufficient evidence available
Good Practice Note		Practical advice and information based on clinical opinion and expertise

Appendix C Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.