Review Article

Implementing The 2018 Who Intrapartum Care Guidelines: A Narrative Review of Challenges and Opportunities

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Abstract

Background: Maternal and neonatal health remain a global priority, with efforts focused on reducing mortality and ensuring a positive childbirth experience. This review critically examines the 2018 WHO Intrapartum Care Guidelines (IPGs) and identified the challenges of its implementation. **Method:** The search was conducted on PubMed, Scopus, Web of Science, and Google Scholar to identify appropriate literature and involved the use of keywords: "WHO intrapartum guidelines", "Labour Care Guide (LCG)", and "positive childbirth experience", among others. Pertinent articles were reviewed, examined, and grouped according to specified themes. Findings were narratively synthesised, with attention to new evidence and relevance for global health equity. **Findings:** The guidelines offer 56 evidence-based recommendations for respectful, intervention-limited care during labour. Modifications included the extension of the active phase of labour to 5 cm and the replacement of the partograph with the LCG in order to facilitate close monitoring of labour. Recommendations included allowing companions in labour and delivery in a position convenient for the patient and the use of some pain relief techniques. Barriers to action are related to personnel, resources, and resistance, especially in underserved and over-medicalised settings. **Conclusion:** The 2018 WHO IPGs have greatly advanced the development of woman-centred intrapartum care. For effectiveness, the guidelines require reforms of systems, including infrastructure, improving human resources, and adaptation to the local context.

Keywords: Childbirth Experience, Evidence-Based Care, Intrapartum Care, Maternal Health, WHO Guidelines, Woman-Centred Care.

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BACKGROUND

Intrapartum care is regarded as the foundation for maternal and neonatal health, encompassing all attention provided to women and their babies during labour and childbirth [1]. The appropriate combination of clinical care, emotional support, and respect for the woman's autonomous right is essential during this critical time to enhance positive outcomes for both mother and baby [1]. One of the main drivers of maternal and neonatal mortality is intrapartum

complications, emphasising the need to focus on adequate intrapartum care [1]. Quality of care during childbirth has been highlighted by the World Health Organisation (WHO) as an essential component that could be improved to prevent unnecessary deaths and provide a more positive experience of childbearing for women and their families [1, 2]. WHO has been leading from the front in setting international health policy involving maternal and newborn care, but in the context of the unfolding story of childbirth, attention around delivery has had a strong emphasis on the reduction of maternal and newborn deaths [2, 3]. However, it is now recognised that good quality care is more than survival and includes the physical, emotional, and psychosocial health of women and their families [3].

This shift is embodied in the WHO 2018 guideline titled "Intrapartum Care for a Positive Childbirth Experience," which synthesises evidence-based intrapartum interventions to enhance labour and childbirth quality of care [1, 2]. These guidelines mirror a woman-centred, human rights approach that values women's experience of childbirth alongside clinical outcomes [1]. This patient-centric approach aligns with sustainable development goals (SDGs), such as SDG 3, which focuses on good health and well-being. As a result, they also underpin the global call to 'ensure healthy lives and promote well-being for all, at all ages', including that of respectful and personalised care, universal health coverage, and addressing inequity in healthcare access [3]. Recent evidence also confirms the importance of this holistic approach in improving maternal satisfaction and decreasing postpartum psychological morbidity [4, 5]. They are evidence-based, rights-affirming, and emphasise the importance of a woman-centred care to good clinical practice in maternal and newborn health [3]. The guidelines are designed to be adaptable across diverse healthcare delivery contexts, considering global disparities in resources and infrastructure [3]. WHO seeks to leverage these disparities by providing a global structure for context-specific implementation, focusing on respectful and individualised evidence-based care [1].

The WHO intrapartum care model consists of nine dimensions and reflects respectful care; emotional support, effective communication; pain relief strategies and continuum of care, with a focus on the physical, emotional, and psychological well-being of the mother and her baby [1, 2]. In addition to clinical measures, intrapartum care offers emotional and psychological support in enabling women to feel safe, respected, and confident in giving birth [3]. Studies have consistently reported that adoption of the WHO intrapartum care model has led to higher maternal satisfaction, lower levels of childbirth fear, and better breastfeeding outcomes [6, 7]. The recommendations also highlight the need to curb unjustified medicalisation like elective inductions and encourage care practices that align with women's preferences and evidence-based care [3, 8]. It has been shown that following these recommendations may result in a reduction in unnecessary Cesarean Sections (CSs) and an improvement in the experience of birth [9, 10].

However, the operationalisation of these recommendations is encountering several obstacles with variations in health facilities' infrastructure and shortage of well-trained personnel, resulting in non-compliance with these guidelines in some health facilities [11]. Challenges in adopting a patient-centred approach have been described in the literature, in terms of limited educational support and opposing cultural priorities [2, 12]. Addressing these barriers will require concerted efforts by governments, health service providers, and international agencies to guarantee that all women, regardless of socioeconomic status or location, have access to a high standard of intrapartum care [11]. Achievement of SDGs, including those related to maternal and child health, identified as a global priority, depends on the uptake of WHO recommendations for intrapartum care that can save lives while enhancing the health of communities. This paper critically discusses the 2018 WHO intrapartum directives, focusing on challenges and opportunities of implementation [13].

METHOD

This is a narrative critical review that aimed to coalesce findings in the literature on the use of the 2018 WHO Intrapartum Care Guidelines. The adopted narrative review design aims to facilitate a comprehensive and critical synthesis of the literature, commensurate with the task delineated by the guidelines as a 'paradigm shift' towards woman-centred, human-rights-based care. A multi-database search strategy was used to ensure that relevant literature had been meticulously and consistently identified. The main electronic databases used for literature review were PubMed, Scopus, Web of Science, and Google Scholar. The search was conducted using keywords such as 'WHO intrapartum guidelines', 'Labour Care Guide', 'positive childbirth experience', 'respectful maternity care', 'third stage of labour', and 'implementation challenges' or opportunities. The use of multiple bases and a large keyword strategy was necessary to maximise the retrieval of articles and reduce publication bias. Beyond academic databases, we searched grey literature and organisations' reports with a particular focus on publications by WHO, UNICEF, UNFPA, National Ministries of Health, and other international governmental and non-governmental organisations engaged in maternal newborn health, as well as non-governmental ones. This more expansive search approach was considered necessary to identify policy briefs and reports that are often not indexed in scholarly databases but are nonetheless highly relevant for global health recommendations and implementation. The selection criteria were peer-reviewed journal articles, WHO reports, and policy briefs, with English language publications only. Also, a limit was set on publication dates

(January 2018 to March 2025) and relevant studies, reviews, and reports specifically addressing the WHO intrapartum guidelines. Articles focusing exclusively on antenatal or postnatal care, and commentary/perspectives pieces lacking empirical evidence were excluded. Preliminary screening of articles was conducted considering titles and abstracts, followed by subsequent examination of the full text of selected articles. Pertinent articles were reviewed, examined, and grouped according to themes: evolution of WHO recommendations, evaluation of stages of labour, cross-cutting issues, challenges of implementation, policy, equity, and future direction. Findings were narratively synthesised, with attention to new evidence and relevance for global health equity.

Evolution of WHO's Intrapartum Care Recommendations

The 2018 WHO's intrapartum guideline represented a watershed by codifying 56 evidence-based recommendations for labour and delivery care, all directed toward a "positive childbirth experience [2]. The WHO model explicitly incorporated human rights and woman-centered principles, recognising that too often "women are not part of decision-making and are treated with contempt or even abuse" during childbirth [14, 15]. The recommendations specified that respectful care must be provided, and continuous support is ensured by a companion of the woman's choice, while effective communication is established, and strict freedom of movement is allowed [8,13]. One of the central tenets was to minimise unnecessary interventions such as outdated routine pelvimetry, shaving, enemas, and 1-cm/hour partograph alert lines, practices long used without solid evidence. Instead, WHO endorsed interventions known to improve outcomes (e.g., prophylactic uterotonics to prevent postpartum haemorrhage and use of analgesia in labour) and discouraged outdated routines such as liberal use of oxytocin or episiotomy [16, 17].

A key innovation was revising active labour definitions. Classical teaching (Friedman curve) held that active labour begins around 3–4 cm cervical os dilatation, but newer evidence (e.g., Shang et al.) showed that many women dilate more slowly. WHO aligned with this data shift: active labour is defined at ≥5 cm dilation (rather than 4cm); this change aims to avoid premature interventions during slow early labour [18]. WHO also launched the Labour Care Guide (LCG) in 2020, replacing the conventional paper partograph. The LCG adds a second stage monitoring column and an "alert" for labour onset while emphasising maternal comfort measures [19]. The International Federation of Gynaecology and Obstetrics and others tout the LCG as a new global standard that, when implemented with training, can reduce caesarean rates and unnecessary augmentation [14,20].

Beyond clinical protocols, the guidelines explicitly embed a paradigm shift from survival to thriving. The preamble notes that "beyond prevention of death implies woman-centred outcomes are also important," aligning with the SDG agenda of health and well-being [21]. A WHO commentary articulated the guiding principles to be that labour should be individualised and woman-centred, supporting normal physiological processes and respecting each woman's needs [16]. For example, continuous emotional support and free movement are recommended to promote calm and satisfaction, whereas unnecessary early amniotomy or continuous Caesarean section monitoring are discouraged due to potential harm [2, 22]. In short, the 2018 WHO guideline enshrines a holistic, rights-based model of intrapartum care. It emphasises respectful maternity care (RMC) as a fundamental right [2] and aligns with an evidence-supported move towards "humanised" childbirth as alluded to by ensuring companionship of choice, privacy, and no coercion.

Key domains of the WHO recommendations include every labour stage and cross-cutting issues. In the first stage of labour, the guideline addresses when to admit a woman (favouring admission in active labour) and how to monitor progress (discouraging a strict 1 cm/hour threshold [11]. It supports non-pharmacological and pharmacological pain relief, advising that women may have epidurals if they request them [2, 8] and encourages ambient support measures (massage, position change). In the second stage, WHO recommends allowing the woman to choose her birthing position and suggests perineal techniques to reduce tears. The guidelines also noted that routine episiotomy is not recommended [2]. For the third stage, WHO affirms active management of the placenta with prophylactic uterotonics for all deliveries (10 IU oxytocin IM/IV) [22], delayed cord clamping for all deliveries (except in fetal distress, abruptio placenta with live baby, Human Immunodeficiency Virus (HIV) infected mothers), and controlled cord traction [2]. Newborn care, such as immediate skin-to-skin and breastfeeding initiation, is also emphasised, though not detailed. Overall, the WHO intrapartum recommendations have evolved into a global model that blends evidence-based clinical rules with a high emphasis on respect, choice, and avoiding unnecessary interventions.

Critical appraisal of the core Recommendation

First Stage of Labour

Defining active phases of labour to be at cervical os dilatation of at least 5cm instead of 4 cm is a key WHO shift in active labour monitoring. This assertion is corroborated by empirical data from clinical trials, which indicated that women who are admitted during the active phase of labour (even at 4 cm) experience fewer medical interventions compared to those admitted during the latent phase,

without any subsequent adverse outcomes [23]. Raising the threshold to 5 cm may further decrease interventions by avoiding a cascade of diagnostics for slow dilation [3]. In practice, this change respects that "normal" labour curves vary greatly; some women take over 10 hours to reach 10 cm without harm [24]. This evidence-based relaxation of the old 1 cm/hour rule can reduce the rush to augmentation or caesarean [2]

However, critics worry that delaying action may risk dangers; A woman truly in slow labour (e.g., due to cephalopelvic disproportion) might benefit from an earlier augmentation. The WHO takes a cautious approach by explicitly reducing the emphasis on the use of the 1 cm/hr partograph alert line in its recommendations [24]. The LCG eliminates this inflexible threshold; however, certain clinicians have expressed concerns regarding the capability of all settings to adequately monitor labour progress in its absence. Moreover, WHO's endorsement of waiting until active labour before admission is conservative: a "research-context" recommendation advises delaying ward admission only in trials [25]. In other words, there is *insufficient high-certainty evidence* to universally encourage women to stay home in early labour. Indeed, a Cochrane-based RCT cited by WHO found that in low-risk nulliparous women, those who delayed hospital admission used fewer epidurals and oxytocin and had higher satisfaction [26]. But this was a single modest trial (209 women), so WHO prudently treats it as preliminary. In practice, many facilities still admit early-labour women to prevent isolation risks, and WHO emphasises that all women should have a health worker assessment upon presenting in labour [26]. Consequently, the WHO's prudent position illustrates the existing tension: postponing admissions has the potential to minimise "overmedicalisation"; however, such strategies must be counterbalanced with protective measures (such as waiting areas and means of effective transportation) to ensure that no woman requiring assistance is overlooked.

Similarly, the WHO guideline criticises the classic partograph's rigid "alert line" of 1 cm/hr as inaccurate [2]. This is well-supported by Friedman's original 1950s curve being challenged by modern data. The Labour Care Guide, which is currently endorsed by the WHO, substitutes this approach with signals activated by standard labour milestones (e.g., at 5 cm dilation) and promotes ongoing documentation during all stages of labour, inclusive of the second stage [27]. Proponents note that LCG implementation studies (though few) indicate lower rates of unnecessary Caesarean sections and labour augmentation. On the other hand, implementation of LCG or even simpler partographs faces barriers, especially in low-resource settings. WHO's own guideline notes that partographs are often filled out retroactively (to meet record-keeping demands) and can be confusing without training [27]. The LCG is therefore an effective training and supervision tool, although how to run it, with midwife shortages and busy patient loads, is an unanswered question. If staff cannot reliably update LCG, its theoretical benefits may not materialise. In short, the push to scrap the 1-cm rule and adopt the LCG is evidence-informed, but its impact hinges on real-world feasibility.

WHO explicitly discourages unnecessary interventions in early labour for low-risk women [2, 28]. Instead, it advised intermittent auscultation with Doppler or a stethoscope, which evidence shows is equally safe and avoids the cascade of interventions triggered by false alarms on CTG. It could be objected that not all settings have trustworthy alternative monitoring. In some busy hospitals, staff shortage may even complicate ad hoc auscultation. In addition, there remain anecdotal clinician fears that in the absence of CTG, some slight fetal heart rate (FHR) evidence of fetal distress may go undetected. That said, WHO's recommendation clearly reflects the balance of trial evidence (no improved outcomes with routine CTG, but increased caesarean deliveries [28]. The important equity note is that guidelines uniformly apply high-tech standards and low-tech options, recognising that in many places, continuous monitors simply do not exist. WHO also encourages non-medical support, such as freedom to ambulate, eat/drink, and keep a companion during labour [2]. These practices align with women's preferences and have modest support in the literature for reducing labour duration and anxiety. Evidence has shown that mobility in the first stage of labour is associated with shorter labour and fewer Caesarean deliveries [29]. This woman-centred approach is a major strength as it acknowledges that psychological state of the parturients affects their outcomes. However, some providers fear that totally unrestricted behaviour might lead to accidents. Therefore, it is imperative to explicitly review the guidelines to ensure safety; for example, ambulatory activities should occur under supervision, and the presence of a companion to assist where necessary is recommended.

Second Stage of labour

Considering the maternal pushing and position, WHO recommended that women be allowed to push spontaneously (rather than being directed) and to choose their birthing position [2]. The evidence summary in WHO notes that upright positions and mobility in the second stage shorten labour and reduce some interventions (caesarean, episiotomy) [30]. These findings support the WHO's push for a variety of positions. Moreover, allowing women to choose (including in an epidural) respects autonomy and can improve satisfaction [30].

Despite the inconclusive nature of the evidence on upright positioning, and while it is deemed unsuitable for obstetric use, it has been correlated with increased blood loss and perineal injury. Some experts believed that it might be traumatic and dangerous to women due to an unmitigated rise in the incidence of severe tears or haemorrhage [31, 32]. Thus, while offering women freedom of choice in positioning is laudable, guidelines

should stress skilled support during upright birth to manage any complications. On balance, the recommendation to encourage mobility and alternate positions is evidence-backed and aligns with midwifery models, but its real-world effect depends on facility design and staff acceptance.

Similarly, WHO strongly discourages routine episiotomy, permitting it only in the presence of a clear medical indication [21]. This reflects robust meta-analysis evidence that routine episiotomies do not improve outcomes and increase complications (pain, blood loss). In support, WHO recommends techniques like warm perineal compresses and manual support, which trials show reduce severe tears [20]. These interventions are low-cost and woman-friendly; this shift reduces iatrogenic injury and respects normal birth physiology. One possible downside is the risk of higher third/fourth-degree tears if providers are untrained in perineal support. Some obstetricians worry that restrictive episiotomy policies could inadvertently allow more severe spontaneous tears unless providers master perineal protection skills [31]. Additionally, while the guideline endorses birth plans and autonomy, emergencies can arise quickly. For example, if a foetal heart rate decelerates during pushing, a rapid episiotomy might expedite delivery; WHO's stance on restrictive use means providers must use good judgment.

Third Stage of Labour

The World Health Organisation has made a strong priority for the use of active management for the third stage of Labour (AMTSL), which consists of the administration of 10 IU oxytocin intramuscularly (IM) or intravenous (IV) after delivery, controlled cord traction, and uterine massage by bimanual palpation when required [17] These interventions remarkably decrease the likelihood of having postpartum haemorrhage (PPH), which is the most common cause of maternal mortality across the globe [16]. Delayed cord cutting (1 – 3 or more minutes after birth) has been shown to offer improved outcomes in neonatal iron count and a decrease in anaemia with no additional risk [18]. Immediate skin-to-skin and early breastfeeding in the first hour after delivery are key in the third-stage recommendations, which promote mother-infant attachment and neonatal survival [31]. However, barriers to implementation remain; in many low-resource settings, the implementation of AMTSL is challenging due to oxytocin unavailability, cold chain disruption, and inadequate provider training. Inappropriate use and overuse of uterotonics have also been documented, including repeated use [32]. Moreover, cultural beliefs and practices surrounding placenta delivery may dictate behaviour that is contrary to recommended guidelines, necessitating adaptation to and community acceptance of the WHO standard [17]. Notably, the evidence for AMTSL is compelling, yet WHO recognises shortcomings concerning the monitoring of its use and the importance for health systems to reach universal coverage [17].

Cross-Cutting Issues

The WHO recognises that most women want effective pain relief. It recommends offering pharmacological options (systemic opioids or epidural) where available, tailored to preference [17]. Epidurals are supported if requested, using low-concentration anaesthetics to maintain some mobility [18]. Although this respects maternal comfort, the worldwide availability of epidural services is shockingly unequal. Epidural analgesia is not an option in most low-resource settings due to the absence of anaesthetists. WHO's recommendation implicitly concedes this by presenting epidurals as "recommended, contingent on a woman's preference [17]. The guideline also highlights non-pharmacological methods (massage, breathing, warm showers), which are low-cost but variable in effectiveness [2, 15]. While advocating for a menu of options is ethically sound, one could argue that WHO might go further in suggesting alternative pain-relief technologies (e.g., nitrous oxide, which is used in some middle-income countries but not mentioned). In any event, pain management is largely a resource issue: guidelines can only say "offer this, if possible," but cannot change infrastructure.

A prevailing and prominent theme is the endorsement of midwife-led continuity of care. Midwifery models are increasingly recognised by the WHO and various organisations as efficacious methodologies for managing low-risk births. These models contribute to a reduction in the incidence of preterm births and infant mortality, likely to enhance satisfaction and decrease medical interventions, as evidenced by meta-analyses of midwife-led care [19]. Many nations face an acute shortage of trained midwives and legislation that does not support autonomous midwifery. Midwife-led birth centres do exist, but even then, they are more likely to cater mainly to the wealthier and urban population, while the poorer rural women are neglected. It appears best for low-risk women, thus necessitating appropriate risk screening. However, in practices with a weak referral system, over-reliance on midwives might lead to high-risk cases being left unattended. Nevertheless, fostering midwifery and continuity is broadly evidence-based, and the guidelines' strong emphasis on this (including encouraging birth plans and companion inclusion [24] is a positive equity-oriented stance. The 2018 WHO guideline failed to adequately cover digital health, but future-looking work acknowledges it.

Medicalisation and Intervention Use

WHO's intrapartum guidance pushes back against the overmedicalisation of birth. It underlines those routine interventions (induction, electronic foetal monitoring,

forceps/vacuum, episiotomy) should only be used for clear indications [2, 8]. These recommendations reflect evidence that many interventions hardly improve outcomes when used indiscriminately. However, some authorities have expressed the belief that withholding interventions might delay needed care, while others agreed that indiscriminate interventions (especially caesarean delivery) have potential risks [2]. Indeed, WHO's concern appears to be partly driven by the soaring caesarean delivery rates (>21% globally [13], up to 50% in some countries) that are unmatched by improved maternal/neonatal health. The guidelines and accompanying evidence call for "the use of fewer interventions" to improve care quality and equity [14, 19]. In support of this, the LCG emphasises patience in labour progress, in order to prevent unnecessary caesarean delivery [5; 16]. Relatedly, WHO updated its induction of labour guidance in 2022, reinforcing that induction should be limited to medical necessity [17]. In summary, the WHO's position is that medicine should be focused, and that the physiological process of giving birth should be left alone as far as possible.

Implementation Challenges and Barriers

Implementing WHO recommendations into routine practice could be challenging and complex. A rapid review of these recommendations in 2024 found that implementation barriers span multiple levels [22]. These include (i) health system factors such as. Workforce shortages, funding gaps, supply chain limitations; (ii) patient/population factors like cultural norms, health literacy, demand-side access; (iii) guideline-related factors such as complexity of recommendations, clarity and adaptability; (iv) organisational capacity leadership support, training programs, quality assurance; and (v) health professional practices like but not limited to clinical inertia, attitudes, skills, and inter-professional dynamic[22]. In intrapartum care, specifically in the low and middle-income settings, countries face additional hurdles as most of their labour wards lack enough midwives for optimal care as well as privacy for companions. They also lack basic equipment like blood pressure cuffs or fetoscopes, while their referral systems are often weak. Even in high-income settings, implementing new labour models requires additional training and retraining of staff and overcoming ingrained protocols.

Commonly cited barriers include limited training on the new tool, heavy clinical workloads, resistance from clinicians accustomed to the partograph, and insufficient space for continuous support or birth companions. For example, providers reported difficulty tracking all the new elements (alert columns, comfort measures) during busy shifts, and health facilities often had no budget or time for systematic LCG training. It has also been noted that "feasible measures" such as on-site mentoring, simplified algorithms, and stakeholder buy-in are needed to overcome these barriers [35]. In general, successful uptake will require integrated strategies including political commitment to prioritise quality intrapartum care, dedicated funding and staffing, and ongoing monitoring to ensure guidelines are followed as designed.

In low-resource settings, barriers include persistent midwife shortages, inadequately equipped facilities, and cultural norms. For example, continuous companionship recommended by WHO may be hard where labour rooms are crowded. Even simple ideas, such as allowing lighting of varying brightness or birthing in other positions, can be restricted by outdated hospital policies or space constraints. Getting staff to inhabit a 24-hour delivery centre can be challenging for many health systems in the LMICs. From a logistics perspective, implementation of the LCG requires a transition from an established partograph system, which may face resistance without ongoing training and support. Meanwhile, in high-resource settings, providers often exhibit scepticism and concerns about legal implications or incompatibility with the electronic health record. In some tertiary centres, labour is already highly medicalised (continuous monitoring, routine early epidurals, etc.), so adopting a more conservative approach can be counter cultural. However, wealthier systems often have more staffing and technology, so implementation bottlenecks are organisational (workflow redesign, digital charting) rather than resource scarcity.

Despite differences, a common finding is that WHO guidelines alone do not change practice. As one review noted, "implementation of guidelines is complex," requiring active engagement of all stakeholders [24]. Addressing these multifaceted challenges demands tailored strategies (training, audit and feedback, community education) to ensure that the intrapartum recommendations improve care rather than remain theoretical ideals [23; 24].

Strengths of the Guidelines

WHO's intrapartum guidelines bring several strengths; they are evidence-based and comprehensive, consolidating disparate recommendations into one model. The emphasis on positive childbirth experience and RMC represents a global best-practice consensus that elevates women's rights and satisfaction. By explicitly defining healthy pregnancy criteria and a standard care package, WHO provides a clear normative benchmark for countries to adapt. The introduction of the LCG as an updated partograph is innovative, as it integrates supportive care items that were previously neglected. Endorsement by professional bodies, such as FIGO, and early research, like the RCT [23], lend credibility and momentum to change. Moreover, WHO has developed implementation tools (e.g., online training modules, job aids, and a 2023 "Toolkit" for intrapartum recommendations [13] to facilitate rollout. In theory, these guidelines can significantly reduce unnecessary

interventions and improve equity by defining a universal standard [1, 2]. The partnership of a human-rights lens with clinical science is a notable policy strength, recognising that quality care goes beyond survival to encompass experience.

Limitations and Evidence Gaps

However, limitations remain; many intrapartum recommendations are graded as conditional due to low certainty evidence. For instance, systematic data are still accumulating on outcomes of delayed active labour diagnosis. As noted earlier, LCG's efficacy beyond single studies is yet to be proven. WHO acknowledges the need for prospective trials and for studying patient-reported outcomes [8]. Moreso, the guidelines may be too idealistic for some contexts; a fully staffed midwife-led model or continuous support, which may be unrealistic in crowded public hospitals without major system reforms. It is also obvious that certain controversial topics are yet to be fully settled; for instance, the WHO suggests maintaining intermittent fetal monitoring in normal labour, but some societies (e.g., ACOG, NICE) have differing stances on intermittent vs continuous monitoring. Likewise, the guidelines differ on many issues (e.g., timing of pushing, specific analgesia choices) from local protocols or future research. Another criticism is that the WHO document focuses on low-risk pregnancies and leaves out high-risk or preterm labour, and this may limit its applicability across all maternity services. Furthermore, while the emphasis on respectful care is notable, the guidelines provide insufficient detail regarding the enforcement of patients' rights and the establishment of accountability mechanisms. In practice, instances of disrespect and abuse during childbirth continue to be prevalent in numerous regions, highlighting a disparity between policy provisions and actual experiences that the guidelines alone fail to reconcile.

Implications for Policy, Systems, and Equity

Intrapartum guidance has broader implications for women; therefore, policymakers must incorporate these considerations into national protocols. For instance, the Ministry of Health of the Federal Republic of Nigeria has produced its own version of LCG that would be adopted in the three-tier levels of health facilities in Nigeria. [15, 35, 36] This necessitates the revision of training curricula, the enhancement of monitoring instruments, and the adaptation of staffing models. The need for many countries to invest in midwifery education and workforce expansion to attain the recommendations of the guidelines has been reiterated by global midwifery implementations. Systems must also adapt infrastructure (e.g., labour room design for companions, procurement of mobile fetal monitors). Equity is a cross-cutting concern, and if high-income hospitals adopt these recommendations faster, disparities could widen. Thus, donor agencies and governments should prioritise support for guideline implementation in the poorest regions. Conversely, these guidelines furnish health advocates with a mechanism to advocate for improved birthing care. Although this model is idealised and patient-focused, its effectiveness will continue to rely on strong policies and resources to implement recommendations.

CONCLUSION

The 2018 WHO guidelines on intrapartum care are highly significant for maternal health, comprehensive, evidence-based, built on the foundation of women's rights and born of dignity. The guidelines have appropriately redirected the emphasis worldwide from mere survival to supporting women and babies to "thrive" in the context of compassionate care, autonomy, and minimal intervention when needed. However, this critique has demonstrated that no guideline can do it all, and life-saving recommendations should be balanced between key, local, evidence-based, and equity considerations. Admission timing, technology use, and workforce limitations are gaps that require a shift in investment towards midwifery, and in culture, to imbibe respectful care with human rights, and then to narrow the gap that currently exists between global norms and local practice. The full realisation of WHO's esteemed vision for intrapartum care on a global scale will only be achieved through the continuation of these sustained advocacy efforts.

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