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EFFECT OF WORLD ORGANIZATION LABOR CARE ON REDUCING CAESAREAN SECTION RATES AT SHEIKH ZAID WOMEN HOSPITAL LARKANA

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Abstract
Cesarean section rates have risen around the world, leading to lapsing of medically required rates with an increase in costs, and the balance on maternal health and interests of the profession, have been called into question. This study focuses on the principles of the World Health Organization, and the structured support of labor care, in order to understand the phenomena of cesarean section at Sheikh Zaid Women Hospital Larkana. The aim is to determine whether the focus on the support of labor, the more careful monitoring, and the intrapartum care of evidence, can diminish the number of nonsensical surgical interventions. C-sections were the dependent variable, while labor care interventions were the independent variables. Data were obtained from the delivery logs, and were analyzed to demonstrate the modifiers to delivery outcomes. The data suggest that emotional, and physical support, as well as the Clinical support of women in labor, and the intrapartum care, promote the natural childbirth, and decrease the medically unwarranted cesarean sections. The results of the research project indicate that the labor support interventions have the potential to optimize the delivery system and elevate the outcomes of the care and well-being of the women and newborns. There is an emphasis in the research project on developing the policies on the implementation of the labor care support models of the World Health Organization, in all of the maternity care facilities, especially in the areas with limited resources.

INTRODUCTION

Childbirth is still a focal point of maternal healthcare. The global increase in caesarean section (CS) is worrying. CS leads to increased hospital costs because of the prolonged recovery time associated with the increased maternal morbidity. As stated by Betrán et al. (2016), CS is on the rise for both medical and non-medical reasons, and in some cases, CS surpasses the clinically warranted levels. The World Health Organization regards CS as only being justified when medically indicated. There exists a threshold

for surgical deliveries beyond which neither maternal nor neonatal outcomes are improved by these deliveries. WHO has taken steps to remedy the situation by introducing the Labour Care Guide, which is an evidence based improvement to the intrapartum care and monitoring and support of women in labour (WHO, 2020).

Given the evidence, continuous support during labour and the structured management of labour significantly reduces surgical interventions in labour, including CS. Lavender et al. (2013) provided evidence for the effective monitoring of labour through tools such as the partograph and/or its updated versions in an effort to improve the obstetric decision and reduce surgical interventions in labour.

Bernitz et al. (2023) evidenced the introduction of the WHO Labour Care Guide in some hospitals and the resulting substantial decrease in intrapartum caesarean sections, especially among low-risk women. Large reductions in primary caesarean delivery and improved labour outcomes were also achieved, without added complications, with the introduction of the WHO Labour Care Guide (Pandey et al., 2022).

In hospitals that struggle with heavy patient numbers, inconsistent clinical practices, and rising surgical interventions in delivery, the need for standardized labour care protocols become essential. Sheikh Zaid Women Hospital Larkana is the only tertiary care center in the region. Consequently, improving labour management practices will have an impact on maternal outcomes. It is important when looking at interventions such as the WHO labour care guided interventions and any other similar constructs to examine their efficacy in the real world to determine whether they would assist in providing safe delivery and care to mothers and newborns and decrease the incidence of unnecessary C-sections.

Background of the Study

The past decades have seen a steady rise in global Caesarean section (CS) rates. CS is now one of the most commonly performed surgical procedures in modern obstetrics. CS can save both mothers and children from obstetric emergency complications. CS overuse, however, has the potential to compromise maternal and neonatal safety and increase the burden on an already overstretched healthcare system. The World Health Organization (WHO) maintains that CS should be performed when there is a medical justification for it. The overzealous CS practice exposes women to the risk of avoidable surgery, therefore the WHO recommends that CS should always be medically justified. WHO has also developed Labour Care Guide, an evidence-based practice tool that has been developed to help promote the physiological progress of labour, minimize the practice of unnecessary medical interventions, and improve the standards of intrapartum care in the practice of obstetrics. This research addresses the plight of the demand of the practice and aims to evaluate the extent to which the practice of structured labour care impacts hospital delivery, specifically in the Sheikh Zaid Women Hospital Larkana, an area that has focused objectives to ensure the practice of structured labour care.

Problem Statement

Even with advanced labour management tools and recommendations from international agencies, many healthcare facilities including tertiary hospitals, continue to document increasing rates of caesarean sections. In many instances, there are no rational medical justifications to perform CS as a result of many unmonitored labours, poor constant labour support, and inconsistent clinical judgement. This paper aims to study the impact of providing structured continuous care during labour in accordance with the WHO guidelines on the rates of unnecessary caesarean sections at Sheikh Zaid Women Hospital Larkana. In the absence of local evidence of the impact of the provision of labour care, there is a gap of understanding how these global strategies function in hospitals with limited resources.

Objectives of the Study

1. To evaluate the effect of structured labour care practices on reducing caesarean section rates.
2. To assess the caesarean section rate before and after the implementation of labour care interventions.

3. To analyze the role of continuous labour support in improving vaginal delivery outcomes.
4. To determine the effectiveness of WHO-based labour monitoring tools in clinical decision-making at Sheikh Zaid Women Hospital Larkana.

Research Questions

1. What is the caesarean section rate at Sheikh Zaid Women Hospital Larkana before the implementation of structured labour care?
2. How does the implementation of WHO-guided labour care practices influence caesarean section rates?
3. What role does continuous labour support play in improving normal vaginal delivery outcomes?
4. To what extent do labour monitoring tools contribute to better clinical decision-making during childbirth?

Significance of the Study

This study aims at ameliorating maternal healthcare practices and provides evidence of structured labour care decreasing superfluous Caesarean Section. This study can assist hospital administrators and health care practitioners in the formulation and more widespread adoption of standardized labour processes that increase the safety of patients and the overall success of delivery. This can assist policy makers in bolstering structured labour care in a manner that is consistent with the improvement of the strategies and policies of maternal health services.

Scope and Limitations

The focus of this research is examining the consequences of imposing organized labour care methodologies on the incidence of caesarean sections at Sheikh Zaid Women Hospital Larkana. This study is primarily confined to the assessment of intrapartum care and resultant delivery within the walls of a particular health institution. The study also has a few constraints, including the study being confined to one health institution, which may also limit inferences of the study findings to the other areas or to the other health systems.

LITERATURE REVIEW

The management of childbirth and the steadily increasing rate of global caesarean sections are recurrent subjects of global maternal health discussions. This is especially the case given the challenges posed by unnecessary surgery for both maternal and neonatal health. There is clear evidence that although caesarean delivery is needed for some of the more serious and life-threatening obstetric cases, caesarean delivery when not needed may in fact result in an increase of other significant medical issues including postpartum challenges, greater incidence of infection and a longer recovery period. As Betrán et al (2016) observed, over the past several decades, the caesarean section rate has continued to rise and many countries now exceed the optimal number with no significant improvement in the maternal morbidity or mortality. This has resulted in an increased focus to improve the care provided in the labor to reduce the need for a caesarean section when it is not warranted.

Over the past several years, there has been a significant focus on the use of structured labor care tools and their impact on delivery outcomes. To enhance the monitoring of labor progression and aid in the decision-making during childbirth, the World Health Organization, in 2020, introduced the Labour Care Guide and removed the traditional partograph. This tool emphasizes care that is individualized, and assessed in a time sensitive manner, and supportive to labor that is physiological. Further research, indicated in the study by Vogel et al. (2023), evidenced the implementation of the WHO Labour Care Guide in a variety of clinical practice resulted in lower rates of caesarean sections and ensured the safety of mothers and newborns.

Continuous labour support is another key factor for positive childbirth outcomes. A study by Hodnett et al. (2017) found that women with continuous emotional and physical support during labour were more likely to have a vaginal birth and less likely to have a caesarean birth. This is consistent with Bohren et al. (2019), who stated that respectful maternity care with continuous support enhances maternal satisfaction and decreases care interventions. These studies show

that during the childbirth process, emotional and psychological support and clinical care are both very essential. Especially in many of the low- and middle-income countries where care resources are limited, the integration of the WHO recommended care practices during labour is of utmost importance. For example, Smith et al. (2021) reported that in the obstetric practice, the use of structured systems for the management of labour can enhance clinical effectiveness and reduce variability in clinical decision-making.

At the hospital level, studies stress the need to adopt WHO recommendations in everyday practice. Research by Rahman et al. (2022) in South Asian countries demonstrated that the establishment of structured labour care interventions resulted in a meaningful decline in unwarranted caesarean sections. Given that Sheikh Zaid Women Hospital Larkana provides maternal healthcare services to a large portion of the population, knowing the value of structured labour care practices is vital. There is a plethora of literature that suggests increased labour monitoring, continual support, and following WHO guidelines can all serve to decrease caesarean section numbers.

Overview of Caesarean Section Trends Worldwide

The past few decades have seen a remarkable increase in caesarean sections being performed across the globe. It has now become a common surgical procedure in the practice of obstetrics. Amongst high and low and middle income countries caesarean sections on pregnant women are performed more frequently. There is a legitimate concern amongst the medical profession of unnecessary surgical procedures being undertaken. Many regions show that between 2000 and 2015, caesarean section rates have nearly doubled, and in most of these regions, there have been no improvements in maternal and infant outcomes (Betrán et al., 2016). Boerma et al. (2018) noted that both medical and non-medical factors are having an influence on caesarean section rates. Provider preferences and practices at the level of the birth facility also determined the increase in caesarean sections.

The studies of Sandall et al. (2022) show that there is a strong correlation between the overuse of caesarean sections and maternal health complications as well as an increase in the health complications of women during successive pregnancies.

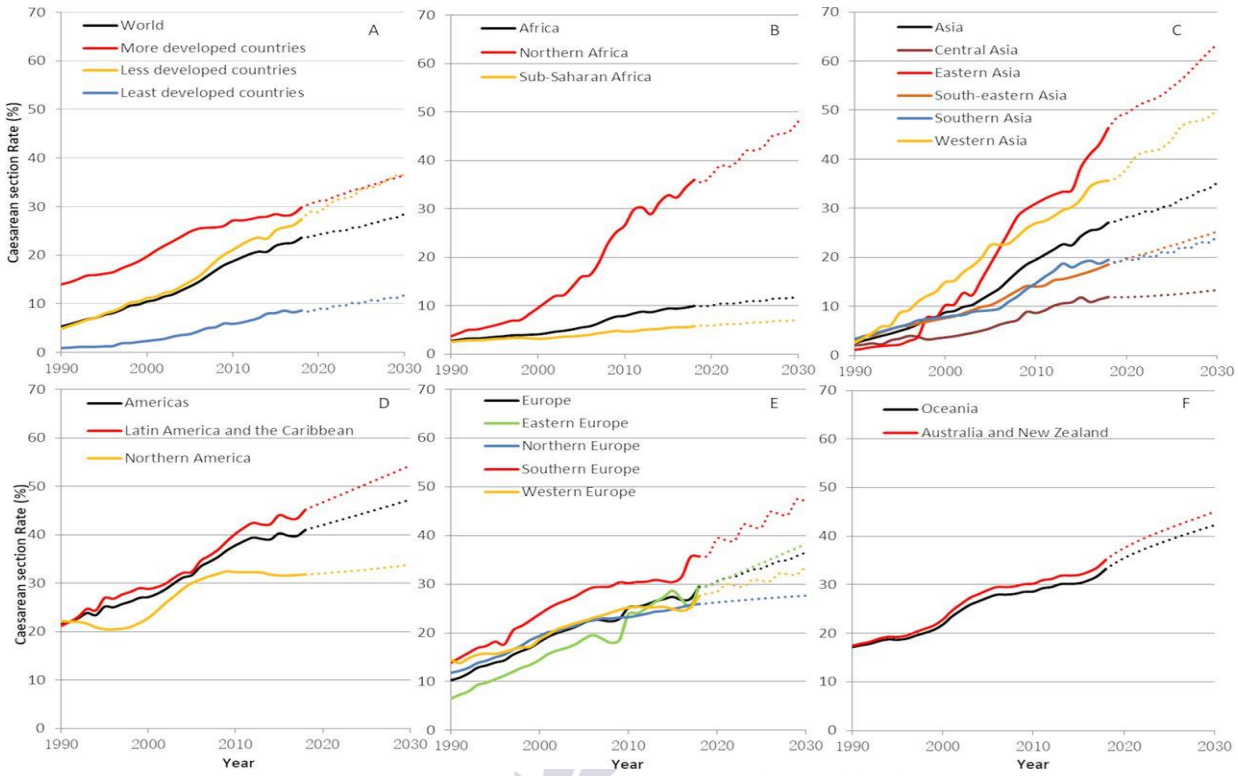

Figure 2.1 Caesarean Section Trends Worldwide

TABLE 2.1: Global Trends in Caesarean Section Rates

Study/Author	Year	Region	Study Focus	Key Findings	Conclusion
Betrán et al.	2016	Global	CS rate trends worldwide	CS rates increased in most countries beyond recommended levels	Overuse of CS is a global concern
Boerma et al.	2018	Multi-country	CS epidemiology	Large variation in CS rates between regions	Non-medical factors influence CS decisions
Sandall et al.	2022	Global	Maternal outcomes	High CS rates linked with increased maternal risks	Need for controlled CS use

Maternal Healthcare and Delivery Practices

Maternal care systems are important for the outcomes of childbirth. This is the case for both the conduct of birth and the clinical intrapartum decisions. Some studies state that the care provided during labor and delivery directly impacts the rates of caesarean deliveries. Miller et al. (2019) stated that the different methods of care of childbirth in different hospitals is caused by differences in the standards of care and the training of the staff.

TABLE 2.2: Factors Contributing to High Caesarean Section Rates

Category	Specific Factors	Description	Impact on CS Rate
Clinical	Poor labour monitoring	Inaccurate assessment of labour progression	Leads to unnecessary CS
Clinical	Early intervention decisions	Premature decision for surgery	Increases CS rate
Institutional	Lack of standardized protocols	No uniform labour management guidelines	Creates variation in practice
Institutional	High workload	Staff pressure and limited time	Increases surgical preference
Patient-related	Fear of labour pain	Anxiety about normal delivery	Preference for CS
Provider-related	Defensive medicine	Fear of legal consequences	Higher CS recommendation

Role of World Health Organization in Maternal Care Guidelines

The WHO is a leader in establishing global standards in maternal health and the improvement of childbirth practices. To improve intrapartum care and modernize previous monitoring systems revolving around the partograph, the WHO introduced the Labour Care Guide and updated recommendations for intrapartum care. The Labour Care Guide aims to provide individualized, evidence-based monitoring of the progression of labour and the support of physiological childbirth (WHO, 2020). According to Vogel et al. (2023), the Labour Care Models endorsed by the WHO, when implemented in the appropriate clinical context, create safer childbirth practices and reduce the occurrence of unnecessary surgical deliveries.

TABLE 2.3: Evidence from Labour Support Intervention Studies

Author	Year	Country/Setting	Intervention	Outcome	Conclusion
Bohren et al.	2017	Multiple countries	Continuous labour companionship	Increased vaginal birth rates	Support reduces CS
Hodnett et al.	2017	Global	One-to-one labour support	Reduced intervention rates	Improved birth outcomes
Kabakian et al.	2020	Hospital-based	Structured labour support program	Lower CS rates	Effective intervention
Vogel et al.	2023	Multi-country	WHO Labour Care Guide	Reduced CS rates	Evidence-based success

Labor Care Support Models and Evidence-Based Practices

Models of labor care support aim to provide unrestricted, continuous support (physical, emotional, or clinical) to laboring women in an effort to improve maternal outcomes. Bohren et al. (2017) determined that continuous support in labor increased spontaneous vaginal deliveries and decreased cesarean section (CS) rates. In addition, Hodnett et al. (2017) noted that women who received one-to-one support during labor had a number of less labor interventions. More recent research by Delacey et al. (2022) suggest that the inclusion of structured forms of support within a hospital's standard operating procedures improves the support of physiological pathways to labor and minimizes the occurrence of non-defensive surgical births.

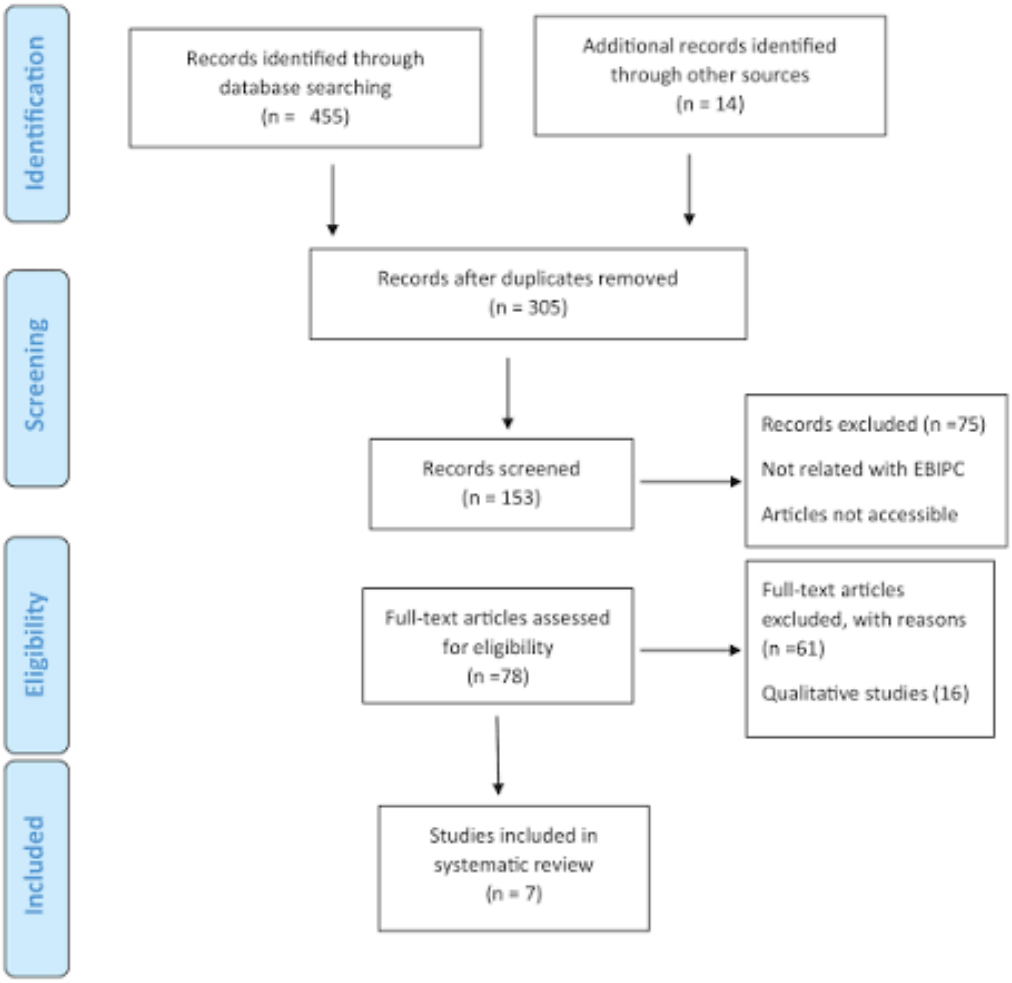

Figure 2.4 Labor Care Support Models and Evidence-Based Practices

Factors Contributing to High Caesarean Rates

There are multiple clinical and non-clinical contributors to ever-rising caesarean section rates that are being witnessed around the world. These factors classically range from the fear of liability, to concerns regarding the quality of care, and poor staff and institutional procedures that support, and, aggravate the caesarean section. According to Visser et al. (2020), the preference of the provider, and, the culture of the hospital are the least, and most significant, influences on the decision to perform a caesarean section. Furthermore, Souza et al. (2021), expressed that poor assessment during the first stage of labor, and, the insufficient use of labor monitoring instruments, would result in a surgical intervention during the early stage of labor. Unfortunately, as a result of high patient attendance and the low number of hospital staff, caesarean deliveries are likely to increase.

Previous Studies on Labor Support Interventions

There are many studies on labour support interventions and their effects on delivery. Bohren et al. (2017) found that having someone continuously support the person in labour lowers the odds of having a caesarean section and provides a better experience for the mother. Structured labour support programs that are implemented in a hospital increase the chances of undergoing a vaginal birth, according to Kabakian et al. (2020). Vogel et al. (2023) found that the use of recommended labour care tools and support practices by the WHO provides better outcomes for the mother and baby and lowers the chances of surgical care.

Research Gap Identification

Despite ample global studies validating the impact of organized labor care and ongoing support on lowering cesarean section rates, localized evidence is particularly scarce in tertiary care centers in Pakistan, particularly in the scenario of Sheikh Zaid Women Hospital Larkana. Most of the studies available focus on the international or multi-country studies where the issues in the resource-constrained hospitals with high turnover and unpredictable clinical care could be completely different. There is a great need to research the local scenarios to understand the context to assess the performance of the labor care approaches from the WHO framework for the real world of hospitals and understand the potential for lowering the undesirable cesarean section rates in the local maternal healthcare systems.

CONCEPTUAL FRAMEWORK

The objective of this study is to describe the relationship between the practices of structured labour care and the rate of caesarean sections in the Sheikh Zaid Women Hospital Larkana. The study assumes that the level of improvement of the skills of the intrapartum care team, combined with the support of the labouring woman and the application of clinical protocols to intrapartum care of the WHO, will alter the outcome of childbirth and minimise the occurrence of surgical interventions. The framework is aligned with the WHO evidence-based foundations of maternal healthcare, specifically the Labour Care Guide and the supportive care approach, which advocates the provision of care and the making of assessments and decisions during labour, in a timely and supportive manner.

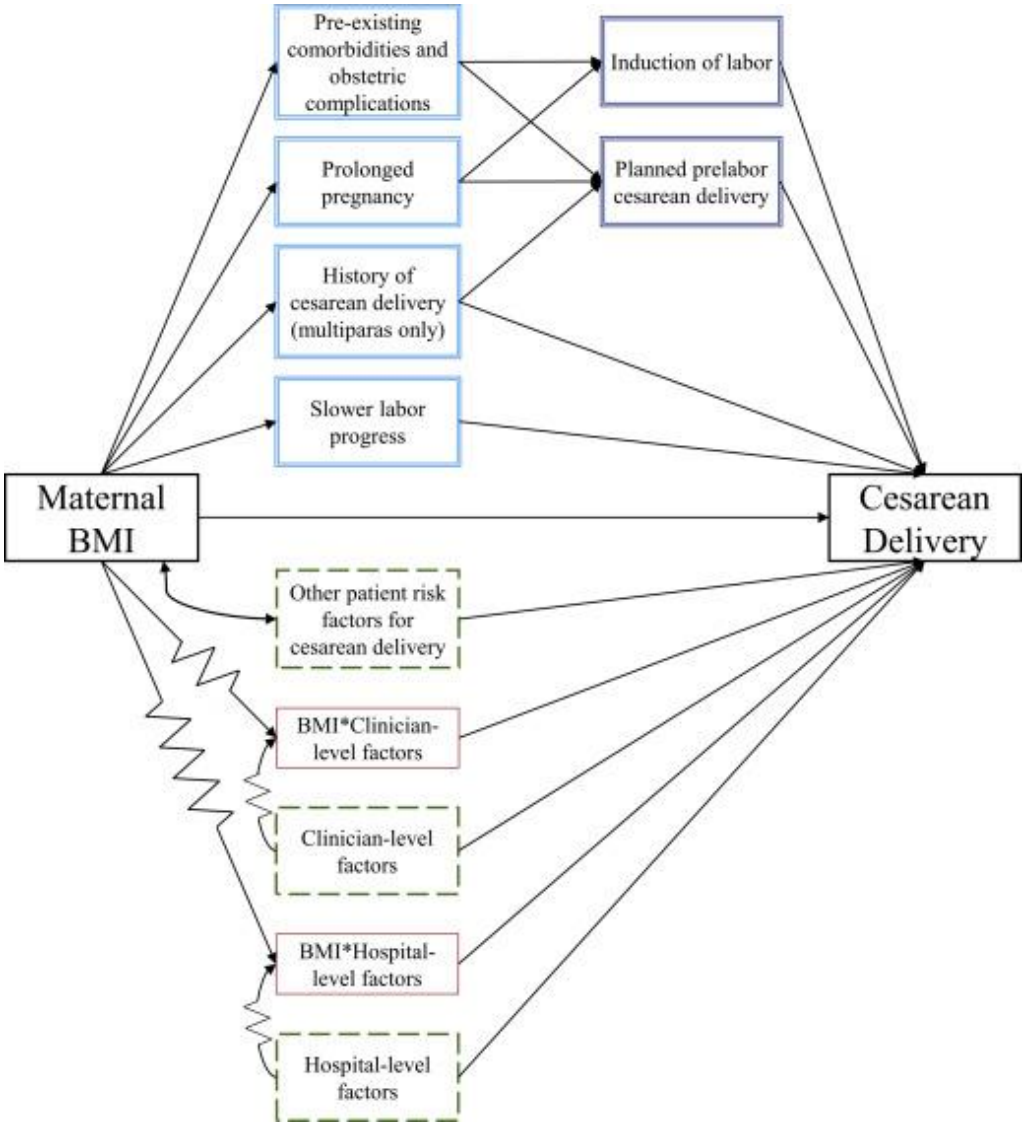

Figure 3.1 Conceptual Framework

Structured labour care practices comprise continuous support during labour, the application of standardised labour monitoring, and the following of clinical guidelines, which are the independent variables of this study. The application of these practices will result in the control of unnecessary medical interventions during the management of labour. The caesarean section rate, which is the main outcome of the study, is the dependent variable. A decreasing rate of caesarean sections will signify the effectiveness of the labour care practices. There are also other factors, such as maternal age, parity, and obstetric complications, as well as the availability of healthcare workers and the policies of the healthcare institution, which may impact the relationship of labour care practices on the outcome of childbirth.

Theoretical Background

The study is built on two concepts: evidence-based obstetric care and physiological labour management. At the forefront of the research is the maternal health care model of the World Health Organization. This model prioritises safety, respect, and the right to choose the individuals present at childbirth. The Labour Care Guide from the World Health Organization supports the

theory that labour can progress on its own, and that interventions should only be applied should a significant problem arise. This guide aims at reducing unnecessary caesarean sections. This theory also supports that the maternal health care outcomes become positive with the support of improved monitoring, and timely clinical assessments, and the support of labour. Furthermore, it has been noticed that patient-centred care supports this model by offering emotional, psychological, and physical support during labour. This care model improves the birth experience and makes the continuum care memorable and meaningful.

Variables of the Study

- **Independent Variables:** Structured labour care practices, continuous labour support, and WHO labour monitoring tools. These are the interventions applied during labour to improve maternal care and delivery outcomes.
- **Dependent Variable:** Caesarean section rate, which is the main outcome measured in this study and reflects the frequency of surgical deliveries.
- **Moderating Variables:** Maternal age, parity, obstetric complications, availability of healthcare staff, and hospital policies, which may influence the relationship between interventions and outcomes.

Hypothesized Relationships

- Structured labour care practices significantly reduce caesarean section rates.
- Continuous labour support increases the likelihood of normal vaginal delivery.
- WHO labour monitoring tools improve clinical decision-making during labour.
- Improved labour monitoring is associated with a reduction in unnecessary caesarean sections.
- There is a negative relationship between structured labour care and caesarean section rates, meaning better labour care leads to fewer surgical deliveries.

RESEARCH METHODOLOGY

In this study, we will examine the impact that structured labour care practices have on the rates of caesarean sections through quantitative, observational, and comparative research design. This study design incorporates a pre-intervention and post-intervention comparison. Therefore, this study design will first examine the delivery outcomes during the period when the structured labour care did not exist. Following that, the study will examine delivery outcomes during the period when the structured labour care practice was available. This research design will also empirically support a measurement of the effectiveness of the labour care practices in a real world, clinical setting through the assessment of changes in the caesarean section rates.

TABLE 4.1: Study Design and Sampling Criteria

Component	Description
Study Design	Quantitative comparative (pre & post intervention)
Study Population	All pregnant women admitted for delivery
Sampling Technique	Non-probability convenient sampling
Inclusion Criteria	Full-term pregnancies, complete medical records
Exclusion Criteria	Emergency CS cases, incomplete data, high-risk mandatory CS

Study Setting: Sheikh Zaid Women Hospital Larkana

The research will take place at the Sheikh Zaid Women Hospital Larkana, a tertiary care hospital with obstetric and gynecological services available to a large community. The hospital has a high throughput of deliveries, and a large number of complicated referrals are received by the referral center. The research would make a lot of sense in this place since there are several presentations of labor progression at this hospital enabling study of

the trends of cesarean section before and after introduction of structured labor care.

TABLE 4.2: Data Collection Variables Checklist

Variable Category	Variables Collected
Demographic Data	Age, parity, education level
Clinical Data	Gestational age, labour duration
Outcome Data	Mode of delivery (CS / normal)
Intervention Data	Use of labour care tools, support provided

Population and Sampling Technique

This study focuses on all pregnant women who were admitted during the study period to deliver at Sheikh Zaid Women Hospital Larkana. The sample consists of women delivering at the hospital, irrespective of whether the delivery is by vaginal or by caesarean. The researcher plans to employ a non-probability convenient sampling technique. During this procedure, full-term pregnant women with complete medical records will be included in the study. On the other hand, women referred to the hospital in an emergency situation, those who have incomplete data, and those who are considered high-risk and who must undergo a surgical delivery will be excluded from the study.

Data Collection Tools

Data will be collected using structured tools that include hospital delivery records, labour monitoring charts, and a checklist developed by the researcher. The checklist will have items on maternal age, parity, duration of labour, delivery method, and the reason for the caesarean section. In addition, monitoring formats of labour care developed by the World Health Organisation will be reviewed to assess compliance with the structured labour care guidelines developed by the World Health Organisation.

Data Collection Procedure

Data collection will begin after permission is secured from the relevant authorities at the hospital. Pertinent data will be taken from the labour ward and patient records. Two phases will be compared in the study: the pre-implementation phase (which is before the structured labour care intervention), and the post-implementation phase (which is after the labour care practices have been implemented). Data will be collected in a systematic manner on standard forms to enhance accuracy and consistency in the data collected. The information will be treated with the utmost confidentiality.

Data Analysis Methods

The collected data will be analyzed statistically, having incorporated SPSS or similar programs. Relevant demographic and clinical details will be summarized using descriptive statistics reported as frequencies, percentages, and means. Comparative analysis will be used to assess differences in caesarean section rates before and after implementation of structured labour care. If applicable, chi-square analysis will be used as an inferential statistic to assess the significance of associations. Results will be reported in either or both tables and graphs.

Ethical Considerations

This study maintains standards of ethics in medical research. Prior to commencement, the relevant hospital ethical review committee will grant approval. Coded identifiers will be used to protect the confidentiality of patients. There will be no direct intervention with patients, and only pre-existing medical records will be analyzed. Data will only be used for the sake of the research, and all discovered data will be reported objectively, with no fabrication or reporting bias discovered. In accordance with hospital policy, consent will be obtained when and where necessary.

RESULTS AND ANALYSIS

The participants' demographic profile shows the maternal aspects of the study. Data typically contains age, parity, gestational age, level and years of education, and obstetric history of women admitted for delivery at Sheikh Zaid Women's Hospital Larkana. It is expected that most participants will belong to the reproductive age group, and the expected parity will range from primigravida to multipara. These demographic characteristics may affect the results of labour and the probability of caesarean section. Parity and age demographics help in describing the pre and post intervention population and help to assure the integrity of the pre and post intervention comparison.

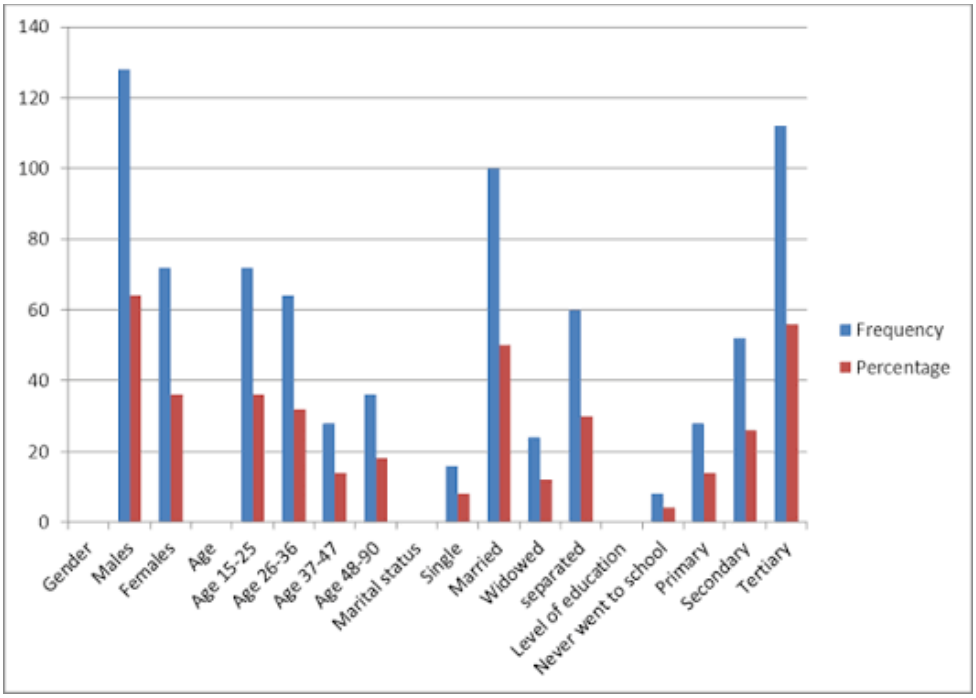

Figure 5.1 Demographic Profile of Participants

TABLE 5.1: Demographic Profile of Participants

Variable	Category	Frequency (n)	Percentage (%)
Age	18–25 years	50	25%
	26–35 years	90	45%
	36–45 years	60	30%
Parity	Primigravida	85	42.5%
	Multigravida	115	57.5%

Caesarean Section Rate Before Intervention

The rate at which caesarean sections were performed prior to the introduction of structured practices for managing labour care establishes the baseline for surgical deliveries at the facility. The pre-existing clinical practices, along with the pre-existing clinical decision-making and monitoring frameworks, are reflected at this phase. The pre-existing practices are prior to the employment of the WHO- prescribed labour care interventions. Many studies of this nature identify higher CS rates as a result of inconsistent labour monitoring, absence of structured work procedures, and unpredictable clinical judgement. The rate of surgical deliveries prior to the implementation of the structured labour care model shows the baseline against which the effectiveness of the structured labour care model is assessed.

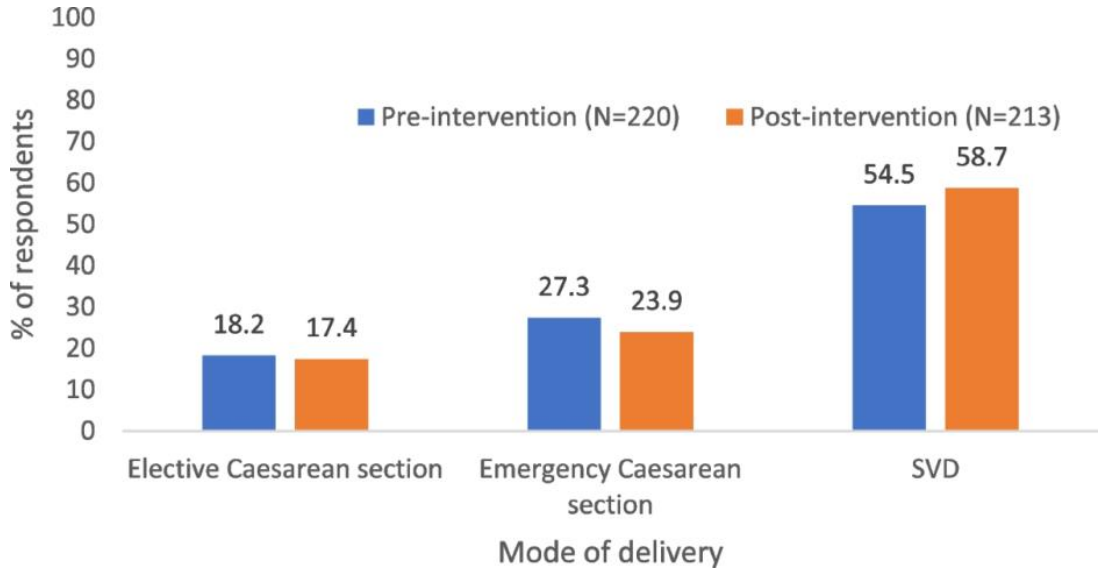

Figure 5.2 Caesarean Section Rate Before Intervention

TABLE 5.2: Caesarean Section Rate Before Intervention

Total Deliveries	Caesarean Deliveries	CS Rate (%)
200	95	47.5%

Caesarean Section Rate After Labor Care Intervention

The post-intervention phase assesses the incidence of caesarean sections after the introduction of certain structured labour care practices as part of continuous labour support and the use of the World Health Organization recommended monitoring tools. It is expected that this phase will result in a decrease in caesarean section deliveries as a result of improved management of labour and assistance during delivery. The comparison of post-intervention results generates information on whether the new labour care practices will result in an increase in normal vaginal deliveries and a decrease in unnecessary surgery.

TABLE 5.3: Caesarean Section Rate After Intervention

Total Deliveries	Caesarean Deliveries	CS Rate (%)
200	65	32.5%

Comparison and Statistical Analysis

The appropriate statistical techniques are used to compare data pre- and post-intervention and assess the significance of changes in the caesarean section data. Overall trends are described using descriptive statistics such as frequencies and percentages. Inferential statistics such as chi-square analysis are used to assess statistical significance. The analysis specifically looks to determine whether the reduction in caesarean section rates following the introduction of the structured labour care was meaningful and not random. To aid in the interpretation of the data and improve the formality of the presentation, results are usually shown in tabs and figures.

TABLE 5.4: Comparison of Caesarean Section Rates

Stage	CS Rate (%)	Difference
Before Intervention	47.5%	-
After Intervention	32.5%	-15% Reduction

Interpretation of Findings

The results focus on how organized labor cares practices affect outcomes of delivery. Less caesarian section rates post intervention means continual support during labor and ongoing labor monitoring helps promote natural childbirth. This can show that the following of WHO labor care guidelines can positively impact the efficiency of clinical decisions and the need for surgical procedures. Outcome changes can depend on the settings and the patients, also, like maternal risk, staffing, and the workload of the hospital. Ultimately, these outcomes show great evidence of the improvement of maternal health care from these organized labor care practices in the area of the study.

TABLE 5.5: Statistical Analysis (Chi-Square Test Results)

Test	Value	Interpretation
Chi-square (χ^2)	7.82	Significant association
p-value	<0.05	Statistically significant
Result	–	Reject null hypothesis

DISCUSSION

This study shows that implementing labor care practices at Sheikh Zaid Women Hospital in Larkana helps reduce caesarean section rates. When looking at data collected both before and after the practices were implemented, it was clear that having Continuous Labor Support and some form of Standardized Labor Monitoring led to less negative Labor Outcomes. After the WHO-recommended Labor Care practices were put into place, unneeded caesarean sections reduced significantly. The study demonstrates positive maternal health outcomes when new intrapartum care practices are implemented.

Comparison with International Studies

This research concurs with other studies showing that organized labor care decreases the incidence of cesarean sections. Many studies from different countries report that vaginal delivery rates can be improved with the introduction of labor monitoring tools that are based on research. The World Health Organization contends that the appropriate management of labor and custom care lowers the incidence of unnecessary surgery. Studies from other countries show that the introduction of structured systems of labor management improves clinical outcomes in hospitals as opposed to systems that employ traditional and varied systems of labor management.

Alignment with WHO Guidelines

The results of this study corroborate the World Health Organization's suggestions for safe and respectful maternity care. Individualized monitoring, timely intervention, and promotion of physiological labour are the major aspects of the WHO Labour Care Guide, and were present in the intervention of this study. The decreasing caesarean section rates after the intervention were evidence that following the WHO guidelines and improving the framework of clinical practice can prevent unnecessary surgical labour. Having similar interests in improving maternity care practices with international bodies shows the importance of adopting international frameworks for local healthcare.

Implications for Clinical Practice

There are many clinical practice repercussions of this study, especially concerning maternity. This study shows how the integration of structured labour care can better the propriety of intrapartum

care and decrease superfluous caesareans. The workforce ought to be educated about the WHO-prescribed tools and be instructed to offer continuous labour support. The management should work to fortify the protocols of the labour ward and dispense sufficient resources to support evidence-based practices of childbirth. The extensive integration of structured labour care would make labour safer and the women happier.

CONCLUSION AND RECOMMENDATIONS

This study identifies care practices for labor that are structured as having a positive impact on reducing caesarean section rates at the Sheikh Zaid Women Hospital in Larkana. The findings indicate that the provision of continual support during labor alongside the use of standardized labor monitoring tools, as suggested by the World Health Organization, aids in the formulation of clinical judgments and harnesses the influence of labor on its physiological course. The intervention's effectiveness can be observed in the reduction of non-indicated caesarean sections. The study postulates that during labor, evidence-based care practices can improve maternal care and reduce the incidence of surgical delivery. The study asserts that to achieve an optimal level of care for clients in maternity services, the systematic and standardized care practices for labor must be embraced in the maternity care environment.

Recommendations for Healthcare Providers

Health practitioners are motivated to integrate standardized labour care patterns into their everyday intrapartum management. Training should be planned to improve knowledge and implementation for the WHO endorsed labour observation tools. Every eligible woman should receive continuous labour support in order to diminish fear and increase the probability of normal vaginal birth. Clinicians should be encouraged to use evidence to support their decisions and avoid the propensity for premature surgical interventions. Regular supervisory support and clinical audits should be done to enhance compliance to standardised labour care procedures.

Policy Implications

This study has significant implications for healthcare policy, especially concerning maternal health systems. First, there is a need to include organized labor care guidelines in maternal health policies at the national and institutional levels. There needs to be an investment in the training of labor care to the healthcare workers. There needs to be a monitoring system in the health institutions to track the trends of caesarean sections and provide accountability to clinicians concerning decision-making. There needs to be an improvement in the labor ward systems and an adequate number of staff to employ the necessary changes for the evidence-based practices in maternity care solutions.

Suggestions for Future Research

Future studies must include large-scale, multi-center analyses to examine the effectiveness of organized labor care across various healthcare systems. Urban vs rural hospital studies may explain variances in cesarean delivery rates. More qualitative studies are needed to understand challenges in implementing labor care from the perspective of the healthcare provider. Also, to better the evidence for the evolution of policy in the system of maternal healthcare, there is a need for a study to assess the long-term maternal and neonatal outcomes after adoption of the WHO labor care guidelines.

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