

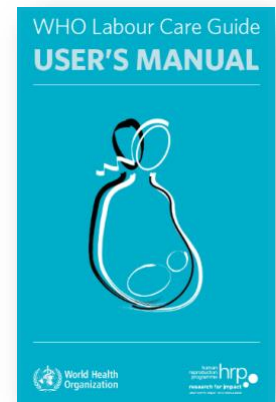
KEY POINTS FOR CONSIDERING ADOPTION OF THE WHO LABOUR CARE GUIDE: POLICY BRIEF

BACKGROUND

More than one-third of maternal deaths (1), an estimated 42.3% of stillbirths (2), and 11.6% of neonatal deaths (3) result from complications during labour and childbirth. The majority of these deaths occur in low-resource settings and are largely preventable through timely interventions (4). With appropriate management and avoidance of unnecessary interventions, complications can be minimized. Monitoring of maternal and fetal well-being and labour progress, and early identification and management of complications, are critical for preventing adverse birth outcomes. Across the continuum of care, improving the quality of care at the time of childbirth and the period immediately after birth has been identified as the strategy having the greatest potential impact on the reduction of stillbirths and maternal and newborn deaths (5).

To improve the quality of care during labour and childbirth, facilitate effective implementation of the World Health Organization (WHO) [recommendations: Intrapartum care for a positive childbirth experience](#) (6), published in 2018, and promote a shift towards improving the experience of childbirth, WHO developed the [WHO Labour Care Guide](#) (LCG) (see Annex 1) and an accompanying [WHO labour care guide: user's manual](#) (7). The WHO LCG is a tool to facilitate implementation of quality, evidence-based, woman-centred care for a positive childbirth experience within the context of a broader, rights-based approach (7).

The goal of this policy brief is to provide maternal and newborn health stakeholders and decision-makers with an overview of the WHO LCG and its guiding principles, key advantages of making the shift from the WHO partograph to the WHO LCG, and what is required to ensure an enabling environment that will facilitate a sustainable introduction of the WHO LCG.



Key points for adoption of the WHO Labour Care Guide (LCG)

- Overview and guiding principles of the WHO LCG
- Advantages of making the shift to using the WHO LCG
- Training and enabling environment

OVERVIEW OF THE WHO LCG

The WHO LCG incorporates the evidence-based 2018 recommendations on intrapartum care for the definitions of latent and active phases of labour, labour duration, and supportive care interventions; and has alert values that should trigger additional assessment and, if indicated, clinical interventions. The WHO LCG (see Annex 1) has seven sections, which were adapted from the previous partograph design (see Annex 2: Similarities and differences in the modified WHO partograph and the WHO LCG). The sections for care during the active phase of the first stage of labour and the second stage of labour are as follows:

Section 1. Identifying information and labour characteristics at admission:

For documentation of the woman's name; known obstetric, medical and social risk factors, and labour admission characteristics that could have an impact on outcomes and should be considered when planning for care and managing labour.

Section 2. Supportive care: For documentation of interventions that optimise quality of care and improve women's comfort, maternal and perinatal outcomes, and the experience of care. These include labour companionship, pharmacological and non-pharmacological pain relief, oral fluid, and maternal posture (i.e. encouraging mobility and maternal choice of labour/childbirth position).

Section 3. Well-being of the baby: For documentation of parameters to monitor the well-being of the baby: baseline fetal heart rate (FHR) and decelerations in FHR, amniotic fluid, fetal position, moulding of the fetal head, and development of caput succedaneum. Careful review of these parameters and comparison to alert signs helps providers make decisions about labour management based on how the fetus is tolerating labour and if there are potential signs of obstructed labour (e.g. caput+++/moulding+++).

Section 4. Well-being of the woman: For documentation of parameters to monitor the well-being of the woman: pulse, blood pressure, temperature, and urine. Careful review of these parameters and comparison to alert signs helps providers make decisions about labour management based on how the woman is tolerating labour and if there are deviations from normality.

Section 5. Labour progress: For documentation of intermittent monitoring of labour progression parameters—frequency and duration of contractions, cervical dilatation, and descent of the baby's head. Careful review of these parameters and comparison to alert signs helps providers make decisions about labour management based on whether labour is progressing normally or not.

Section 6. Medication: For documentation of all types of medication used during labour: name of the medication (e.g. oxytocin) and dose, name of IV fluids and perfusion rate. This ensures continuity of care between providers and prevents medication errors.

Section 7. Shared decision-making: For documentation of the plan of care, based on findings during monitoring and continuous communication with/consent from the woman and her companion. The provider developing the plan of care must place their initials under it. This ensures continuity of care between providers and accountability by the provider for the agreed upon plan of care.

Objectives of the WHO LCG:

- Guide skilled health personnel to offer woman-centred, supportive care throughout labour and childbirth to ensure a positive childbirth experience for women, newborns, and families;
- Guide the monitoring and documentation of the well-being of women and babies and the progress of labour and childbirth;
- Assist skilled health personnel to promptly identify emerging labour complications by providing reference thresholds for labour observations that are intended to trigger reflection and specific action(s) if an abnormal observation is identified;
- Guide shared decision-making by health care providers, the woman, and her family throughout labour and childbirth;
- Assist skilled personnel in preventing unnecessary use of interventions in labour by promoting supportive care and providing reference thresholds for labour observations;
- Ensure accountability for and continuity of care by including areas where assessment and the plan of care are written; and
- Support audits and quality improvement of labour care.

GUIDING PRINCIPLES OF THE WHO LCG

Quality-of-care initiatives include the experiences of receiving care as a fundamental aspect of overall quality of care (8). This is particularly important given that disrespectful and undignified care is prevalent in many facility settings globally and affects women's choice to not give birth in a facility (9). The 2018 recommendations for intrapartum care elevate the concept of experience of care as a critical aspect of ensuring high-quality labour and childbirth care and improved woman-centred outcomes, and not just complementary to provision of routine clinical practices. The WHO LCG expands the focus of labour monitoring to individualizing care and ensuring that a positive childbirth experience for the woman, the newborn, and her family are at the forefront of labour and childbirth care at all times by:

- Including non-clinical practices: Section 2 of the LCG, supportive care, aims to encourage the consistent practice of respectful maternity care through the continuous provision and monitoring of supportive care.
- Promoting shared decision-making: Section 7 of the LCG, shared decision-making, aims to facilitate continuous communication with the woman and her companion and the consistent recording of all assessments and plans agreed. Shared decision-making is the process of applying person-centred communication, deliberation, and decision-making to ensure a woman receives the best, individualized care. To enable shared decision-making, WHO recommends effective communication between maternity health care providers and women in labour, using simple and culturally appropriate language. Clear explanations of procedures and their purpose, findings of physical examinations and their implications, and care options should be explained to the woman and her companion, and the subsequent course of action agreed on and documented.



Figure 1: Labour support

Source: HMS/Laerdal. Prolonged and Obstructed Labour

Ensuring that skilled personnel practise according to evidence-based standards is important since it affects the quality and cost of care that women and newborns receive and facilitates optimal maternal and newborn outcomes. Although there is a wealth of clear guidance for evidence-based maternity care, there remains a widespread and continuing underuse of beneficial practices and overuse of harmful or ineffective practices. The WHO LCG:

- Provides a tool to effectively implement the WHO 2018 evidence-based recommendations for intrapartum care for a positive experience; it also includes reference threshold values for labour observations that define normal, expected ranges for the different parameters.
- Promotes application of the Assess→Record→Check→Plan process at each assessment throughout labour: **Assess** (assess the well-being of woman and her baby and progress of labour)→**Record** (document labour observations)→**Check** with “alert” values (compare labour observations with reference values in the “Alert” column)→**Plan** (decide whether and what interventions are required, in consultation with the woman, and document accordingly).
- Encourages skilled personnel to think critically, avoid unnecessary interventions and act on warning signs by recording and comparing observations against these references. The decision to intervene in the course of labour is primarily based on observation of a deviation from expected observations, thus ensuring that:
 - No intervention is implemented without a clear medical indication, and
 - Only interventions that serve an immediate purpose and are proven to be beneficial are promoted.

ADVANTAGES OF THE WHO LCG

The modified partograph (or partogram), formerly recommended by the WHO, is the most common labour monitoring tool used during the active phase of labour. If the partograph is currently in use, replacing the partograph with the WHO LCG will require considerable health systems commitments to ensure an enabling environment and its consistent use. Maternal and newborn health stakeholders and decision-makers must therefore understand the LCG's advantages over use of the WHO modified partograph, and that its use should support implementation of the new WHO intrapartum care recommendations and lead to better experiences of care and outcomes.



Figure 2: Assessment in Labour

Source: HMS/Laerdal. Prolonged and Obstructed Labour

The chief advantages of the WHO LCG over the WHO modified partograph are as follows (10):

- 1. Improved respectful care during labour and childbirth:** Every woman in labour has individual expectations, wishes, needs, and fears influenced by familial experiences and local cultural norms and values. A systematic review (11) found that what mattered most to women was a positive labour and childbirth experience during which they are able to retain a sense of personal achievement and control in decision-making. The WHO LCG seeks to improve the experience of care during labour and childbirth in the following ways:
 - The capacity for women to enact what matters to them is enhanced by using a person-centred care approach.
 - Providing and documenting non-clinical intrapartum practices (i.e. labour companionship, pain relief, maternal position, oral fluid intake) should ensure women's comfort and well-being during labour and childbirth and thus their experience of care and improved outcomes.
 - The inclusion of shared decision-making, whether findings are normal or not, should ensure that 1) women and their companions' informational needs are met, thus reducing uncertainty and fear; and 2) women and their companions are involved in decisions about care, thus empowering women and helping them maintain a sense of control.
- 2. Improved labour support and care leading to improved outcomes:** The partograph does not document non-clinical intrapartum practices that are essential components of care that should complement any necessary clinical interventions to optimize the quality of care provided to the woman and her family. The inclusion of non-clinical intrapartum practices on the WHO LCG not only improve a woman's experience of care but are also important for improving labour progress.
- 3. More accurate assessment of fetal well-being:** The partograph only includes assessment of the fetal heart rate; the WHO LCG requires additional assessment and documentation of presence/absence of decelerations. The identification of decelerations is important because there are specific interventions for each type of deceleration that can improve fetal outcome; without this information, the fetus' status could deteriorate rapidly and result in poor peripartum outcomes.
- 4. More accurate assessment of labour progress:**
 - In the last decade, the validity of the most important components of the partograph's cervicograph, the "alert" and "action" lines, have been called into question as the findings of several studies suggest that normal labour can indeed be slower than the limits on which these lines are based (5).

Because the threshold of 1 cm/h is suboptimal for identifying women at risk of adverse birth outcome, the risk of false positive findings could lead to unnecessary labour interventions that might be potentially harmful.

- The partograph only includes assessment of moulding of the fetal head; the WHO LCG requires additional assessment and documentation of caput. Marked caput can be a sign of cephalopelvic disproportion and is an important part of assessing poor progress in labour.
5. **Timelier, evidence-based interventions:** Unlike the partograph, the WHO LCG has reference threshold values for labour observations that define normal, expected ranges for the different parameters. If an abnormal observation is identified, providers are triggered to reflect and then undertake a specific action(s). Understanding normal values should reduce unnecessary interventions; while triggers should ensure timely action when there is an abnormal finding, including for non-clinical interventions.
 6. **Documentation of care during the second stage:** Unlike the partograph, the WHO LCG has a section for the second stage. This is important because continued monitoring of the woman, fetus, and labour progress are often not monitored during the second stage. The inclusion of the second stage ensures that ongoing non-clinical interventions are provided and complications are identified and managed in a timely manner.
 7. **Greater accountability:** Providers using the partograph are not required to document their actions or sign their initials after conducting assessments. Providers using the WHO LCG are required to 1) signal or highlight any observation that is inconsistent with good quality care, well-being, or normal labour progress; 2) write the plan of care developed with the woman and her companion; and 3) initial the column with assessment findings and the plan of care. Initializing the document is important for two reasons: to create accountability and to tag certain actions or data records with the indexical information of who did or observed what and when that action was taken/when that observation was made. When providers feel accountable they are likely to exert greater effort resulting in performance enhancements and outcomes.

TRAINING AND ENABLING ENVIRONMENT

A 2017 realist review by Bedwell et al. (12) showed that, to use a partograph effectively, providers need additional supports: essential equipment, clear policies on correct partograph use, effective supervision, regular refresher training, and monitoring and auditing of the partograph in practice, including completion, decision-making, referral, and outcomes. When a decision is made to introduce the WHO LCG to replace the labour monitoring tool currently being used, effective implementation of the LCG will require the same health systems inputs to ensure an enabling environment.

- Skilled personnel who piloted the LCG identified several challenges to using the LCG, including (13,14):
 - Staff responsible for completing the LCG, particularly at primary facilities and in rural areas, may not have the skills required to make certain assessments (e.g. assessing caput, moulding, fetal position, fetal heart decelerations/accelerations);
 - Perception that the LCG is time-consuming;
 - Insufficient numbers of staff;
 - Heavy workloads and time pressures;
 - Standard protocols for labour care that do not reflect standards in the LCG;
 - Inability to accommodate labour companions without additional space, privacy measures, or updated facility policies; and
 - Lack of essential equipment and medical supplies.

- Skilled personnel commented that implementing the LCG should be accompanied by (13,14):
 - The necessary initial and ongoing training and supportive supervision;
 - Strategies to promote an enabling environment for providers to use the LCG efficiently, e.g. ensuring that essential equipment, medical supplies, and adequate staff are available; updates of facility protocols and policies on effective intrapartum interventions; infrastructure updates to accommodate a companion and ensure privacy;
 - Increasing knowledge of current WHO labour care recommendations across a range of stakeholders, including health staff working outside the labour ward, health policymakers, and women’s families and communities.

IMPLEMENTATION CONSIDERATIONS

Effective implementation of the WHO LCG will require implementation of the 2018 intrapartum care recommendations; the WHO LCG is a tool that facilitates application of the new intrapartum care recommendations. Introduction will require leadership and the engagement of key actors across the health system; additional financial resources to fund reorganization of care and redistribution of health care resources in settings with shortages of skilled maternity care providers; training and support of providers; and monitoring introduction and women’s experience of care (see Figure 4).

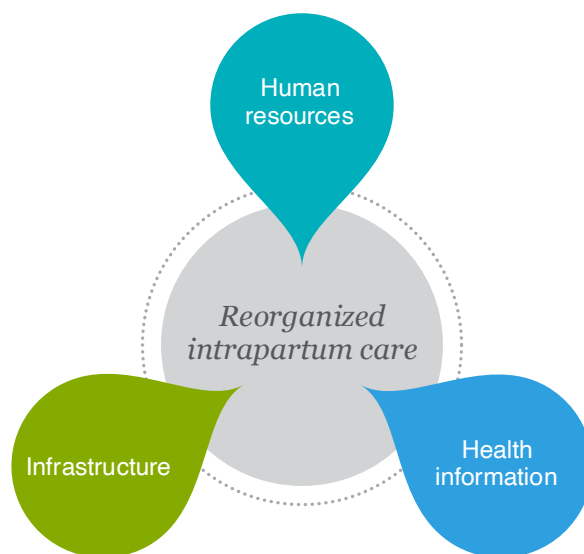


Figure 4. Anticipated impact on organization of care
Source: WHO intrapartum care guideline [slide deck](#)

Successful, sustained implementation will require:

1. Adequate human resources with the necessary expertise and skills to:
 - Correctly assess women and babies for all parameters included in the WHO LCG;
 - Correctly complete the WHO LCG, interpret findings on the WHO LCG, share decision-making with women and their companions, and develop an appropriate plan of care;
 - Coach and mentor providers newly trained to use the WHO LCG and provide structured, constructive feedback on completed WHO LCGs to help users improve their skills;

- Maintain or establish a monitoring system based on the LCG to:
 - Monitor use of the WHO LCG (correct use, completeness) and appropriate use of interventions;
 - Monitor effects of implementing the WHO LCG (health outcomes, e.g. mortality, intrapartum complications, proportion of women with a labour companion of choice, the caesarean birth rate);
 - Monitor women’s experience of care during labour and childbirth.
2. Infrastructure updates to support recommended practices, e.g. physical space for labour companions, comfortable waiting rooms for women in early labour.
 3. Adequate equipment, supplies, and medicines to support implementation of the recommendations.
 4. A health information management system designed to document and monitor recommended practices.

The following resources will assist countries to take introduction of the WHO LCG to scale and optimize the quality of essential intrapartum care with the ultimate goal of improving maternal, fetal, and newborn outcomes at a national and local level:

- Annexes 2, 3, and 5 in the WHO LCG [User’s Manual](#);
- The upcoming WHO Intrapartum Care Implementation Toolkits that aim to: 1) assist policy makers, maternity services administrators, programme managers, and providers to adopt WHO’s intrapartum care recommendations at the health system or service level and effectively implement these recommendations in routine clinical practice in health facilities (**country-level toolkit**); 2) help/support facilities to take a more systematic approach to implementation, considering wide range of potential barriers and enablers to implementing guideline recommendations and matching choice of intervention approach to identified barriers and enablers (**facility-level toolkit**).

CONCLUSION

Introduction of the WHO LCG will facilitate effective implementation of the 2018 *WHO recommendations: Intrapartum care for a positive childbirth experience* and promote a shift towards improving the experience of childbirth, thus improving quality of care during labour and childbirth and maternal and newborn outcomes for all pregnant women.

ANNEX 1: WHO LABOUR CARE GUIDE

WHO LABOUR CARE GUIDE

Name _____ Parity _____ Labour onset _____ Active labour diagnosis [Date _____]
 Ruptured membranes [Date _____ Time _____] Risk factors _____

		Time	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
		Hours															
		ALERT	ACTIVE FIRST STAGE												SECOND STAGE		
SUPPORTIVE CARE	Companion	N															
	Pain relief	N															
	Oral fluid	N															
	Posture	SP															
BABY	Baseline FHR	<110, ≥160															
	FHR deceleration	L															
	Amniotic fluid	M+++ , B															
	Fetal position	P, T															
	Caput	+++															
	Moulding	+++															
WOMAN	Pulse	<60, ≥120															
	Systolic BP	<80, ≥140															
	Diastolic BP	≥90															
	Temperature °C	<35,0, ≥37,5															
	Urine	P++, A++															
	Contractions per 10 min	≤2, >5															
	Duration of contractions	<20, >60															
LABOUR PROGRESS	Cervix [Plot X]	10															
		9	≥ 2h														
		8	≥ 2.5h														
		7	≥ 3h														
		6	≥ 5h														
	Descent [Plot O]	5	≥ 6h														
		5															
		4															
		3															
		2															
MEDICATION	Oxytocin (U/L, drops/min)																
	Medicine																
	IV fluids																
SHARED DECISION-MAKING	ASSESSMENT																
	PLAN																
INITIALS																	

In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.

INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERT' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN. IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE.
 Abbreviations: Y – Yes, N – No, D – Declined, U – Unknown, SP – Supine, MO – Mobile, E – Early, L – Late, V – Variable, I – Intact, C – Clear, M – Meconium, B – Blood, A – Anterior, P – Posterior, T – Transverse, P+ – Protein, A+ – Acetone

ANNEX 2: SIMILARITIES AND DIFFERENCES BETWEEN THE PARTOGRAPH AND THE WHO LCG

Similarities:		
<ul style="list-style-type: none"> • Documentation of the woman's name and parity • Plotting of the progress of labour in terms of women's cervical dilatation and descent of the fetal presenting part, against time • Regular documentation of important clinical parameters describing the well-being of the woman and baby • Documentation of oxytocin, drugs, and IV fluids 		
Differences		
Parameter	Modified WHO partograph	WHO Labour Care Guide
Woman's gravidity	✓	⊘
Date and time of admission	✓	⊘
Date active first stage of labour diagnosed	⊘	✓
Time of ruptured membranes	✓	✓
Type of labour onset (spontaneous or induced)	⊘	✓
Medical and social risk factors	⊘	✓
Supportive care interventions (labour companionship, pain relief, oral fluid intake, and maternal position)	⊘	✓
Fetal heart rate (FHR)	✓*	✓**
Presence of early, late, or variable decelerations	⊘	✓
Amniotic fluid characteristics	✓	✓
Fetal position	⊘	✓
Caput	⊘	✓
Moulding	✓	✓
Woman's pulse and blood pressure (BP)	✓*	✓**
Woman's temperature	✓	✓
Urine volume	✓	⊘
Proteinuria and acetonuria	✓	✓
Duration and frequency of uterine contractions	✓	✓
Strength of contractions	✓	⊘

Differences:		
Parameter	Modified WHO partograph	WHO Labour Care Guide
Definition of active phase	Starting from 4 cm of cervical dilatation	Starting from 5 cm of cervical dilatation
Definition of “satisfactory” labour progress	Fixed 1 cm/hour time limit (“alert” and “action” lines)	Evidence-based time limits at each centimetre***
Cervical dilatation	✓	✓
Descent of the fetal head	✓	✓
Values for “normal”	“Alert” and “action” lines for cervical dilatation; thick lines to identify parameters for normal FHR	“Reference threshold” values*** are listed for non-clinical and clinical parameters
Second stage section	⊙	✓ (all parameters except cervical dilatation)
Time when pushing begins	⊙	✓
Identification of deviations from expected observations	No explicit way to document deviations from expected observations of any labour parameter, other than cervical dilatation to the right of “alert” and action lines and FHR 180 bpm or faster/100 bpm or slower	Requires circling any observations meeting the criteria in the “alert” column
Assessment of findings	⊙	✓
Plan of care	⊙	✓
Provider’s initials	⊙	✓
<p><i>*Values are plotted on a graph</i> <i>**Values are written in the appropriate cell</i> <i>***Reference threshold values for labour observations define normal, expected ranges for the different parameters. They are intended to trigger reflection and specific action(s) if an abnormal observation is identified.</i></p>		

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