Editorial

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WHO Next Generation Partograph-Labor Care Guide (LCG)

Greetings!

How much are we aware of it, and moreover, how much are we ready to accept the change from the WHO's old partogram to the WHO's new LCG!

Nevertheless, this is not new, but almost 7 years have been passed since it was introduced by the WHO in 2018. The World Health Organization (WHO) has been at the forefront of improving maternal and neonatal care, with the partograph being a cornerstone of intrapartum monitoring for decades. However, in 2018, recognizing its drawbacks, WHO introduced the Labor Care Guide (LCG), a next-generation partograph designed to manage labor in a more comprehensive, patient-oriented, and individualized way.[1] This transition from the traditional partograph to LCG marks a paradigm shift, but the question remains: How much are we aware of it, and how prepared are we to accept this change?

The traditional partograph was developed to provide a structured visual representation of labor progress, helping in timely decision-making. However, its rigid parameters, such as the action line, often led to unnecessary interventions or failure to detect maternal and fetal well-being comprehensively. Recognizing these gaps, WHO introduced the LCG as an improved version after undergoing a large multicentric study, with the central idea of respectful maternity care.

For a thorough overview of both the first and second stages of labor and delivery, this LCG appears to be a more useful tool, with additional cautions to monitor and prevent caesarean deliveries, to avoid needless oxytocin augmentation, and to make a correct diagnosis of protracted labor. Its strong quality improvement features are fostered by the incorporation of recent World Health Organization suggestions for a pleasant delivery experience in terms of intrapartum care.[2]

Overall, the modifications made to the LCG as compared to previous partograph designs are: Firstly, the active first stage of labor begins with a cervical dilatation of 5 cm (as opposed to 4 cm in old WHO partogram) and, evidence-based time restrictions at each cm of cervical dilatation during active first stage of labor in place of the 1 cm/hour "alert" line and "action" line. Secondly, it no longer records the intensity of uterine contractions due to subjective variations; it is as clinically challenging to measure and standardize. Thirdly, in addition to having a section for monitoring the second stage of labor, it also incorporates a section for evaluating and encouraging the use of supportive interventions to improve the overall experience of childbirth. Additionally, the provider must record any response that deviates from predicted observations of any labor parameter.[3]

Implications

Starting the active phase at 5 cm might produce better results. However, this leaves a sizable portion of women outside the labor ward in the latent period (less than <5 cm) who still require some kind of observation. The WHO LCG manual acknowledges the WHO recommendation from 2015, though it doesn't provide a clear updated approach to monitor women throughout the latent phase.[4] It is therefore technically necessary to find an appropriate location and a way to monitor a woman who is in pain and has a cervix that is 3 to 4 cm dilated. The new layout for maternity units should be standard wards for women who are not in labor, a labor ward with accommodation for labor companions, and a connecting space or room adjoining the labor ward for women in the latent phase. Because their labor can quickly shift into the active phase in the next few hours, women who are in the latent phase

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can also be admitted to the labor units. Reports state that in order to reap the anticipated benefits of this WHO LCG, national regulations regarding the actual layout of maternity wards, medical supplies and devices, and standard intrapartum care protocols must be updated. Setting up the labor companion of choice, a tried-and-true, healthful labor support technique, might be difficult in some circumstances. However, cultural presumptions about the ideal labor partner and practical methods for monitoring women during the latent phase must be addressed by local professional groups and legislators in order to prove this intervention to be effective. The existing partogram is stronger, but it shouldn't be completely and suddenly altered.

As the second stage of labor was not included in the WHO modified partograph design, there was a need to monitor the health of the mother and their unborn baby during the second stage of labor. This stage is an essential period because of the mother's expulsive attempts and increasing uterine activity; neglecting this stage could have adverse consequences. The LCG has addressed this drawback, as it advocates for a stronger emphasis on mothers' and babies' health during the second stage. [5]

Awareness: Are We Informed Enough?

Despite WHO's efforts in disseminating knowledge about LCG, its implementation remains varied across different healthcare settings.[6] Lack of widespread training, reluctance to move away from familiar practices, and gaps in integration into existing health systems have slowed down its adoption. Many frontline obstetric care providers are still more comfortable with the conventional partograph, mainly due to habit and limited exposure to the new system.

Acceptance and Readiness: The Challenges Ahead

Training & Capacity Building

The success of LCG depends on adequate training. Healthcare providers, especially in resource-limited settings, require continuous medical education and hands-on experience to transition effectively. WHO and national health systems must focus on capacity-building programs to ensure a smooth shift.

Resistance to Change

Many clinicians are reluctant to abandon well-established practices. The partograph, despite its flaws, is deeply ingrained in obstetric training. Accepting LCG requires a mindset shift—understanding that a more comprehensive tool can improve decision-making and patient outcomes.

Integration into Health Systems

A major barrier is the integration of LCG into routine clinical practice and digital health records. Countries that have digitalized their healthcare documentation need to adapt their systems to accommodate LCG, which requires policy-level decisions and investment in health informatics.

The LCG has been developed through an abundance of studies, knowledge synthesis, discussion, field experiments, and modifications. Further research on its application and effects on labor care and outcomes, including women's treatment experiences, is desperately needed. This explanation of the basic ideas that guided the creation of the new instrument intends to reassure healthcare professionals, using which will enhance rather than diminish the goals of the original partograph. The delivery of compassionate and evidence-based intrapartum care has changed significantly during the past 50 years. We sincerely hope that the LCG has taken note of these changes and will support best practices that provide all women and their newborns and families, the kind of high-quality, considerate, and respectful care they so desperately need.

Keeping this view in mind, at the end of this journal, we've incorporated an online survey of the knowledge and practices prevalent among obstetricians here, which not only helps us to acquaint ourselves with but also to share our thoughts and advice ahead!

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