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Readiness for transition from partograph to who labour care guide: A narrative review

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Abstract

Background: Introduced by World Health Organization (WHO) in 2020, the Labour Care Guide (LCG) is an evidence-based successor to the conventional partograph that combines systematic maternal and fetal monitoring with woman-centered intrapartum care. Its successful implementation depends on both clinical validity and health-worker readiness.

Purpose: To synthesize evidence on the transition from the conventional partograph to the WHO LCG, determinants of health-worker readiness, and their relevance to independent midwifery practice in Indonesia, particularly Aceh.

Method: A narrative literature review synthesized literature on LCG development and implementation, limitations of the conventional partograph, health-worker readiness, and factors influencing adoption of new clinical tools. Literature was thematically synthesized around the rationale for LCG transition, implementation evidence, readiness determinants, and the Indonesian and Acehnese context.

Results: The conventional partograph has limitations due to rigid assumptions about labour progression and inconsistent use. Evidence supports the LCG's feasibility and potential clinical value, including reduced unnecessary obstetric interventions. Implementation depends on provider readiness, including knowledge, attitudes, resources, training, and organizational support, while evidence among independently practicing midwives remains limited.

Conclusion: Successful transition depends on provider knowledge, attitudes, training, resources, supervision, and organizational support. Evidence on LCG readiness among independent midwives in Indonesia and Aceh remains limited, highlighting the need for context-specific research.

Keywords : Intrapartum Care; Labour Care Guide; Midwives; Partograph; Readiness for Change.

INTRODUCTION

Over the past two decades, global maternal health policy has pursued two parallel goals: increasing access to skilled birth attendance and reducing unnecessary medical intervention during physiological labour. Although facility-based childbirth has increased substantially worldwide, this improvement has occurred alongside a continuing rise in obstetric interventions, particularly caesarean section. Global caesarean section rates have increased substantially and are projected to continue rising if current trends persist. Similar patterns have been observed in Indonesia, where caesarean

delivery represents a substantial proportion of births and regional variation remains considerable. These developments have stimulated renewed attention to the ways in which labour is monitored and clinical decisions are made during childbirth (Betran et al., 2021; Ministry of Health of the Republic of Indonesia, 2023; Yunitawati et al., 2024)

One of the principal instruments used to monitor labour progress has traditionally been the partograph. For more than four decades, the conventional partograph has been widely used to monitor cervical dilatation, fetal condition, maternal

condition, and labour progress. Its alert and action lines were historically based on Friedman's labour curve. However, subsequent evidence has demonstrated substantial physiological variability in labour progression, raising concerns that rigid thresholds may classify some normal labours as abnormal and potentially contribute to unnecessary interventions (Demissie et al., 2025; Ghulaxe et al., 2022).

The World Health Organization (WHO) introduced the Labour Care Guide in 2020 as an updated approach to intrapartum monitoring. The LCG maintains systematic assessment of fetal and maternal conditions while introducing more flexible interpretation of labour progress. Importantly, the tool also incorporates indicators of the woman's experience of care, including hydration, mobility, pain relief, and birth companionship. Consequently, the LCG represents not merely a revised monitoring chart but a practical instrument for integrating clinical surveillance with woman-centered care (World Health Organization, 2018, 2020).

Nevertheless, the introduction of an evidence-based clinical innovation does not automatically lead to its routine adoption. Implementation science emphasizes that successful implementation depends on the readiness of individuals and organizations to accept, use, and sustain a new practice. In the context of labour monitoring, readiness may involve knowledge of the new tool, positive attitudes toward changing established practices, and availability of the material and organizational resources required for implementation (Weiner, 2009; Shea et al., 2014).

This issue is particularly important in decentralized maternity-care systems. In Indonesia, independent midwifery practices (Praktik Mandiri Bidan/PMB) represent an important component of community-based maternal and reproductive health services. Midwives working independently may have less direct clinical supervision and variable access to continuing professional development and institutional resources than providers working in hospitals. Consequently, implementation strategies developed primarily in hospital settings cannot necessarily be transferred directly to PMB settings.

Aceh provides an important context in which to examine this issue. The province has experienced substantial maternal health challenges and a relatively high caesarean section burden. The

literature reviewed in this article indicates that routine intrapartum monitoring in Aceh continues to rely on the conventional national partograph, while empirical evidence regarding LCG adoption in independent midwifery practice remains scarce (Aceh Provincial Health Office, 2023; Ministry of Health of the Republic of Indonesia, 2023; Vogel et al., 2021).

Therefore, this narrative review synthesizes evidence regarding three interconnected issues: the rationale for transitioning from the conventional partograph to the WHO LCG, the determinants of health-worker readiness to adopt labour-monitoring innovations, and the relevance of these determinants to independent midwifery practice in Indonesia, particularly Aceh.

RESEARCH METHOD

This article used a narrative literature review approach. The review synthesized literature addressing the transition from the conventional partograph to the WHO Labour Care Guide, evidence concerning LCG implementation, determinants of health-worker readiness to adopt clinical innovations, and the specific context of independent midwifery practice.

The literature was organized thematically into four domains: (1) limitations of the conventional partograph; (2) design and emerging clinical evidence concerning the WHO LCG; (3) determinants of health-worker readiness, including knowledge, attitude, resource availability, and individual characteristics; and (4) the Indonesian and Acehese context of independent midwifery practice.

The synthesis was conducted narratively by comparing findings across international studies, implementation-science literature, WHO guidance, and literature concerning maternal and intrapartum care. Particular attention was given to studies conducted in low- and middle-income countries and to evidence involving midwives and community-based maternity services.

Because this article is a narrative review rather than a systematic review, it does not claim to provide a comprehensive systematic search or quantitative meta-analysis. The purpose was instead to integrate the available evidence conceptually and identify gaps requiring further empirical investigation.

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RESEARCH RESULTS

The literature synthesis produced four interconnected findings: the limitations of the conventional partograph, the emerging evidence and design of the WHO Labour Care Guide, the multidimensional determinants of health-worker readiness, and the specific implementation gap in independent midwifery practice in Aceh.

The conventional partograph was originally developed as a visual tool for identifying abnormal labour progression at an early stage. Historically, its use was associated with improvements in recognition of prolonged labour and obstetric complications. However, the clinical assumptions underlying its alert and action lines have increasingly been questioned (Ghulaxe et al., 2022; Demissie et al., 2025).

Evidence summarized in the source literature indicates that the traditional Friedman cervical-dilatation curve does not adequately represent the natural variability of labour among women with spontaneous labour and reassuring maternal and fetal outcomes. Consequently, rigid interpretation of labour progression may result in some physiologically normal labours being classified as abnormally slow (Ghulaxe et al., 2022; Demissie et al., 2025).

A second limitation concerns implementation. Studies conducted in low- and middle-income countries have reported inconsistent completion and utilization of the partograph. Inadequate training, insufficient knowledge, unfavourable attitudes, limited clinical leadership, and weak supervision have repeatedly been identified as barriers to appropriate use. Thus, the limitations of the partograph are not exclusively related to its clinical design but also to the capacity of health workers and health systems to use it consistently.

The WHO Labour Care Guide was introduced in 2020 as a practical tool accompanying WHO recommendations for intrapartum care and positive childbirth experiences. The LCG retains important clinical observations, including fetal heart rate, cervical dilatation, maternal vital signs, and other indicators of labour progress. At the same time, it provides a more flexible approach to interpreting cervical dilatation and incorporates elements of the woman's experience during labour (World Health Organization, 2018, 2020).

The integration of woman-centered indicators is one of the distinguishing features of the LCG. Hydration, mobility, pain relief, and birth companionship are documented alongside clinical observations. These elements reflect the importance of addressing women's expectations and experiences during intrapartum care, including respectful communication, emotional support, involvement in decision-making, and the provision of supportive care (Ahmed et al., 2023). This design moves intrapartum monitoring beyond a purely biomedical approach and supports the concept of positive childbirth experience (World Health Organization, 2018, 2020).

Evidence concerning LCG implementation has expanded since its introduction. A pragmatic stepped-wedge cluster-randomized pilot trial in four hospitals in India demonstrated that LCG implementation was feasible in busy public hospitals and was associated with a reduction in caesarean section compared with routine care, without evidence of worsening maternal or neonatal outcomes (Vogel et al., 2024).

Evidence from Uganda also provides support for LCG use in midwife-led community health facilities. An ambispective cohort study reported that the modified LCG detected more cases of prolonged and obstructed labour than the conventional partograph in the participating facilities. In addition, implementation research has been designed to examine context-specific barriers and facilitators before wider implementation (Mugenyi et al., 2024; Mugenyi et al., 2025).

WHO's implementation approach further emphasizes that LCG adoption should be viewed as a quality-improvement process rather than a one-time training intervention. Situational analysis, capacity building, implementation support, and iterative improvement are important components of successful transition (World Health Organization, 2025).

Despite these encouraging findings, the available evidence remains geographically concentrated. Most implementation studies have been undertaken in hospitals or formal health facilities in South Asia and sub-Saharan Africa. Evidence concerning decentralized, independently practicing midwives remains considerably more limited (Demissie et al., 2025; Vogel et al., 2024; Mugenyi et al., 2024).

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DISCUSSION

Knowledge is a fundamental component of readiness for adopting a new clinical tool. Health workers need to understand not only how to complete a monitoring form but also the clinical principles underlying the tool, the interpretation of findings, and the actions required when thresholds are reached (Weiner, 2009; Shea et al., 2014).

Studies of conventional partograph utilization have demonstrated that inadequate knowledge is associated with poor utilization. Training and exposure to the tool are important factors supporting routine use. This issue is particularly relevant to the transition toward the LCG because the tool introduces substantial changes in the interpretation of labour progression and adds indicators related to women's experience of care. Familiarity with the conventional partograph therefore cannot automatically be assumed to represent adequate knowledge of the LCG (Ghulaxe et al., 2022).

Midwives who completed their foundational education many years before the introduction of the LCG may have developed clinical routines based on older concepts of labour progression. Consequently, transition programs should assess existing knowledge rather than assume that experienced providers are automatically prepared for the new approach.

Knowledge alone is insufficient to guarantee adoption. A provider may understand a new clinical tool but remain reluctant to change a familiar practice. Attitudinal readiness refers to the extent to which providers perceive a proposed change as useful, necessary, acceptable, and feasible (Weiner, 2009; Olavesen et al., 2025).

Evidence reviewed in the source article demonstrates that negative attitudes can contribute to poor utilization of clinical monitoring tools even when providers possess adequate knowledge. More recent evidence among midwives and public health nurses similarly suggests an association between attitudes toward evidence-based interventions and individual readiness to change (Olavesen et al., 2025).

This is particularly important in the transition from the partograph to the LCG. The conventional partograph has been used for decades and may be perceived by experienced midwives as familiar and reliable. In contrast, the LCG requires providers to

interpret labour progression more flexibly and incorporate woman-centered indicators into routine documentation (Ghulaxe et al., 2022; World Health Organization, 2020).

Therefore, implementation strategies should not frame LCG adoption simply as replacing one form with another. The transition represents a change in clinical thinking and practice. Training should consequently include opportunities for discussion, demonstration, simulation, mentoring, and reflection on the clinical rationale for the change. (World Health Organization, 2025).

Even highly knowledgeable and motivated providers may be unable to sustain a new clinical practice when resources are inadequate. Resource availability includes access to appropriate LCG forms or digital tools, updated guidelines, training materials, supervisory support, and institutional or professional policy support (Shea et al., 2014; Weiner, 2009; World Health Organization, 2025).

This issue is especially relevant to PMB settings. In hospitals, implementation can often be coordinated through centralized management structures. Independent midwives, however, may operate with greater autonomy and variable access to formal supervision and continuing professional development. Consequently, the implementation of LCG in PMB settings may require collaboration between professional organizations, health offices, educational institutions, and midwifery practices. Without adequate organizational support, training may produce short-term knowledge gains without sustained changes in documentation and clinical decision-making.

Age, educational background, length of clinical experience, and previous training may influence readiness to change. However, these characteristics should not be interpreted as determinants in isolation (Abore et al., 2022; Awol et al., 2020; Olavesen et al., 2025). Longer-serving midwives may have extensive clinical experience that facilitates recognition of labour abnormalities, but they may also have stronger attachment to established tools and routines. Conversely, younger or recently trained providers may have greater exposure to updated clinical frameworks but less practical experience.

Thus, individual characteristics are more appropriately considered moderating variables that may strengthen or weaken the relationship between

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knowledge, attitude, resources, and readiness. Independent midwifery practice occupies an important position within Indonesia's maternal health system. Community-based midwives frequently provide antenatal, reproductive, and maternity services and therefore have an important role in determining how labour is monitored and when women are referred to higher-level facilities.

However, the structural characteristics of PMB services mean that implementation cannot simply reproduce hospital-based strategies. PMB midwives may have different levels of access to training, supervision, equipment, clinical governance, and referral networks. This difference is important because the majority of available LCG implementation evidence comes from hospitals or formal health facilities. The evidence may therefore not adequately represent the realities of independent midwives working in community settings.

Aceh provides a particularly relevant setting for investigating LCG readiness (Diba et al., 2019). The source literature indicates that caesarean section rates in the province exceed the national proportion and that maternal health challenges remain

important. At the same time, preliminary observations reported in the manuscript indicate continued reliance on the national partograph format in independent midwifery and referral settings.

The key issue is therefore not simply whether the LCG is clinically superior to the conventional partograph. The more immediate implementation question is: Are midwives working independently ready to use the LCG, and what factors determine that readiness?. The literature reviewed indicates that knowledge, attitude, and resource availability provide a theoretically coherent framework for addressing this question. Individual characteristics such as age, education, experience, and prior training can be incorporated as potential moderators (Shea et al., 2014; Olavesen et al., 2025). This creates an important research opportunity. A context-specific study among PMB midwives in Aceh could measure LCG knowledge, attitudes toward the transition, availability of implementation resources, and overall readiness. Such research could subsequently inform training design, professional development, supervision, and policy before large-scale implementation.

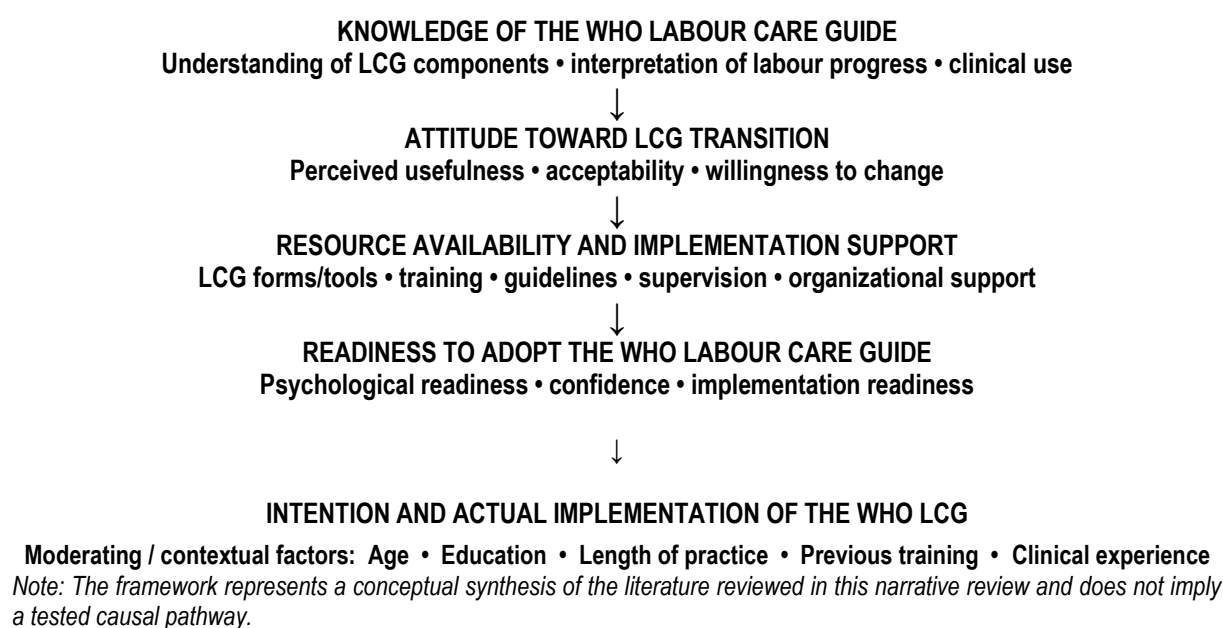


Figure 1. Conceptual framework synthesized from the literature for readiness to adopt the WHO Labour Care Guide in independent midwifery practice

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Figure 1 presents a conceptual framework synthesized from the literature reviewed in this narrative review. The framework proposes that knowledge, attitudes, and availability of implementation resources are important domains associated with midwives' readiness to adopt the WHO Labour Care Guide. Individual and contextual characteristics, including age, educational background, length of practice, previous training, and clinical experience, may influence these relationships. Readiness is expected to contribute to intention and subsequent implementation of the LCG in independent midwifery practice (Shea et al., 2014; Weiner, 2009; Olavesen et al., 2025).

CONCLUSION

The WHO Labour Care Guide represents an important development in intrapartum monitoring, combining systematic assessment of maternal and fetal conditions with woman-centered indicators of the childbirth experience. Emerging international evidence indicates that implementation is feasible and may contribute to more appropriate labour management and reductions in unnecessary obstetric intervention.

However, successful transition from the conventional partograph to the LCG depends on more than the availability of a new clinical tool. Health-worker readiness is a critical implementation condition. Knowledge, attitude, and resource availability emerge as central domains, while age, educational background, length of service, and previous training may influence readiness.

The current evidence base is dominated by hospital-based studies from South Asia and sub-Saharan Africa. Evidence concerning independently practicing midwives in decentralized community settings remains limited, particularly in Indonesia and Aceh. This represents a significant research gap. Empirical assessment of LCG readiness among PMB midwives in Aceh is therefore warranted as a foundation for context-specific training, implementation planning, and policy development.

SUGGESTION

Future research should develop and validate a context-specific instrument for measuring LCG readiness among independent midwives. The instrument should assess knowledge, attitudes,

perceived resource availability, and behavioral or implementation readiness, while considering age, education, length of practice, and previous training as potential moderating factors.

Implementation studies should subsequently evaluate whether targeted training, simulation, mentoring, supervision, and resource support can improve readiness and sustained use of the LCG in PMB settings. For health authorities and professional organizations, LCG implementation should be approached as a structured quality-improvement process rather than as a simple replacement of the existing partograph form. Contextual assessment, capacity building, supervision, and continuous evaluation should accompany the transition.

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