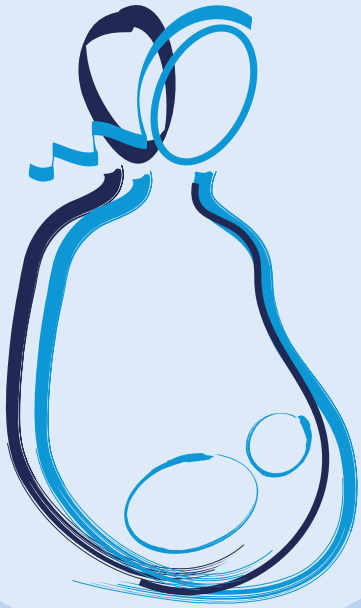
WHO labour care guide

Implementation resource package



World Health Organization

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Abbreviations

ANC	Antenatal Care
FHR	Fetal Heart Rate
IPC	Intrapartum Care
LCG	Labour Care Guide
LCG-SAQT	Labour care guide situation analysis assessment quick tool
LMIC	Low- and middle-income countries
M&E	Monitoring and Evaluation
PDSA	Plan-Do-Study/Learn-Act cycle of quality improvement
PNC	Postnatal Care
QoC	Quality-of-Care
RHIS	Routine health information system
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
RMPC	Respectful maternity and perinatal care
WHO	World Health Organization

Executive summary

The WHO Labour Care Guide replaces the WHO modified partograph to incorporate the latest evidence to promote shared decision-making for women-centred supportive care, with a special emphasis on ensuring safety, avoiding unnecessary interventions. Health professionals use of the WHO Labour Care Guide will be a major action towards the effective implementation of the WHO Intrapartum care recommendations.

WHO Labour Care Guide promotes respectful maternity care for a positive childbirth experience for every woman and newborn. Supportive care is emphasised, specifically: labour companionship, women's mobility, birth position, use of oral fluids and use of pain relief.

Rapid scale-up of the LCG is an important global priority to improve quality of care during labour and childbirth. High fidelity labour care guide implementation will contribute to ending preventable maternal and newborn mortality and stillbirth – for Every Woman and Newborn to survive and thrive.

This document brings together a package of resources including details on why, by whom, when and how the LCG can be sustainably implemented across diverse contexts. This package is a resource for uptake of some WHO intrapartum care recommendations and complements the *WHO Toolkit for implementation of the WHO intrapartum care and immediate postnatal care recommendations in health-care facilities.* The LCG is a key component of evidence-based IPC, essential newborn care, postnatal care and the recording & reporting. Its implementation is critical and must be maintained comprehensively.

1. Introduction

Preventable maternal deaths, stillbirths and newborn deaths remain high *(1)*. Every two minutes in the world, a woman dies during pregnancy, childbirth or postpartum - an estimated 287,000 women each year. Alongside these women, an estimated 1.9 million babies are stillborn and 2.3 million newborns die in their first month of life, representing nearly half (47%) of all under-5 deaths worldwide *(2, 3)*. Many more women and newborns experience life-threatening complications and suffer the consequences of severe maternal and neonatal morbidity and disability which impacts their long-term health and well-being *(4, 5, 6)*. The greatest burden of these deaths and loss of health and well-being are in low-and middle-income countries (LMIC), highest in sub-Saharan Africa and Central and South Asia *(2, 3, 7)*.

Labour and childbirth carry the greatest risk for the woman, fetus and newborn and the major contributor to mortality and morbidity across the continuum of care. Implementing essential interventions is critical to decreasing high levels of maternal and newborn mortality and morbidity worldwide, it is not enough *(8)*. More than half of maternal deaths and more than 60% of neonatal deaths are due to poor quality-of-care (QoC) *(9, 10)*. WHO envisions a future in which "*Every pregnant woman and newborn receives high-quality care throughout pregnancy, childbirth and the postnatal period*" *(11)*.

High quality healthcare services are defined by WHO as effective, safe, timely, and people-centred providing respectful and dignified care, clear communication and information, emotional and psychological support, within a supportive environment for patients and their families. Globally many partners are striving to achieve equitable access to such high-quality healthcare services for all women and newborns, regardless of their location, socioeconomic status, or other demographic factors. In 2016, WHO launched a framework for improving Quality of Care(QoC) in health-care facilities which includes two dimensions of quality: provision of care and experience of care *(11)*. These dimensions include domains of quality linked to standards, statements, and measures across the continuum of care: antenatal, intrapartum and postnatal *(12)*.

In 2018, WHO published new recommendations on intrapartum care (IPC) for a positive childbirth experience *(13)*. The IPC guidelines provide updated evidence for the use of labour interventions to improve the health and well-being of women and their babies, replacing the previous standard of care. Evidence-based, effective practices highlighted are supportive interventions including labour companionship and pain relief. The WHO IPC guidelines published new definitions for duration of first and second stages of labour with guidance on the timing and use of interventions.

The WHO Labour Care Guide (LCG) incorporates this latest evidence-based care and has become the IPC tool, replacing the previous WHO partograph *(14)*. Importantly, the LCG has a person-centred focus across the seven-sections, expanding the focus of labour monitoring and actions to towards promoting a positive childbirth experience for every woman and baby. Specifically, the supportive care in the LCG includes labour companionship, women's mobility, birth position and pain relief. The LCG was developed collaboratively with maternity care providers and found to be feasible and acceptable across diverse settings *(15, 16)*. A detailed WHO LCG User's guide was published in 2020 *(17)*. The successful implementation of LCG is an important global priority to ensure high quality care during labour and childbirth for mothers and babies and contribute to ending preventable mortality and morbidity. Evidence based standarized intrapartum care is to save many newborns and also prevent both physical and mental disabilities of various levels.

This document brings together the package of WHO LCG implementation resources and includes details on why to implement the LCG, what is the purpose, for whom, when and how to use this LCG implementation resource package.

LCG guidance development methodology:

The development of this implementation package for the LCG followed a structured, multi-disciplinary approach. Experts in obstetrics, midwifery and public health, including professionals with experience in piloting LCG implementation, contributed to the process. Input was provided by representatives from WHO headquarters, regional offices and country teams, ensuring that diverse perspectives and healthcare contexts were considered.

The package development was guided by a comprehensive review of existing WHO guidelines and resources on labour care and maternal and newborn health quality standards. Key documents reviewed included the WHO Labour Care Guide: User's Manual (2020) and Standards for Improving Quality of Maternal and Newborn Care in Health Facilities (2016). A participatory action approach was adopted using Acceleration Grant funding and piloted in Bangladesh, Burkina Faso, Ethiopia, Ghana, India, Mozambique, and Pakistan. Country teams played an important role in refining the package and contextualizing LCG implementation strategies to local health care settings.

The package incorporated feedback from WHO country offices. This was followed by the discussion with experts from WHO regions, including doctors and midwives during a virtual expert group meeting. The draft was finalized with the contributions from all experts. The declarations of interests from all external contributors were collected, assessed and managed as per WHO policy.

2. Why implement the WHO Labour Care Guide?

The overall aim of LCG implementation is to improve the quality, safety, and effectiveness of maternal and newborn care during labour and childbirth, and ultimately improve health outcomes for women and their babies.

The WHO LCG was created to facilitate the effective implementation of the latest evidence synthesis in the 2018 WHO intrapartum care recommendations and ultimately to:

1. **Improve the quality of maternal and newborn care** by promoting the use of evidence-based interventions and best practices. This includes ensuring that women receive appropriate care during labour and childbirth, such as monitoring vital signs and fetal status, providing pain relief, and using appropriate interventions to manage complications.
2. **Promote the rights and preferences of women and their families** during labour and childbirth. This involves respecting women's choices and preferences for care, providing clear and accurate information about their care options, and ensuring that the decision-making process is shared with women throughout the labour and childbirth process.
3. **Improve the overall experience of care for women and their families** during labour and childbirth. This includes promoting respectful and compassionate care, addressing cultural and social norms that may impact care, and providing emotional support and counselling as needed.

The LCG incorporates respectful care associated practices during labour and childbirth and its implementation may require a shift in provider`s perspective rather than simply adopting a different format from the previous WHO partograph. It is a person-centred clinical decision support tool to help healthcare providers in early identification of clinical conditions that may challenge the safety of both mother and baby and jointly establish a shared decision-making with the mother. Additionally, it enhances the accountability of service providers and families while supporting women in achieving a positive childbirth experience.

Implementation of the LCG is to:

- Guide monitoring and documentation of the well-being of women and newborn and the progress of labour.
- Enable health personnel strengthen supportive care during labour to ensure a positive childbirth experience for women.
- Assist health professionals promptly identify emerging labour complications, to trigger rapid action(s).
- Prevent unnecessary medical interventions in labour.
- Promote shared-decision making between health-professionals and women.
- Support continuous intrapartum quality improvement including audit.

3. What is the purpose of WHO LCG implementation package?

This comprehensive set of technical resources is designed to support implementation and scale up LCG use at national, sub-national and facility levels. This implementation package provides practical guidance and tools for diverse health systems and contexts. Using the concept of a five-level maturity model, it outlines specific actions from planning to sustainable LCG implementation. This resources package includes educational materials as well as and monitoring and evaluation tools. This package forms part of the WHO Intrapartum Care Recommendations Adaptation Toolkit *(18)*.

4. Whom is the LCG implementation resource package for?

The resources of this LCG implementation package are designed for health facilities at all levels of service. The target audience are a range of country stakeholders responsible for enabling high quality management of labour and childbirth in public and private sectors (Table 1).

Country leadership support is critical to endorse LCG implementation as a priority at the highest level.

Sustainable LCG implementation will be best achieved by the whole healthcare team working together: midwives, nurses, doctors, facility chiefs and programme managers. Engaging all stakeholders and providing them with the necessary tools and resources will clarify the implementation steps and improve the chance of success.

Table 1: LCG implementation package: target audience

Organisations	Maternal and newborn health services stakeholders	How this WHO Labour Care Guide implementation package contributes
Ministries of health policymakers	Leaders and technical officers at national, regional and sub-regional levels	Provides a national and sub-national implementation approach framework adapted for LCG, showing actions to co-ordinate the process linking to quality improvement processes
Healthcare managers in public and private health sector	Involved in the planning and management of maternal and newborn health services at health-care facilities	Links facility implementation to sub-national and national approach, to ensure adequate resources to implement the LCG linking to quality improvement processes
Healthcare professionals in public and private health sector	Midwives, nurses, medical doctors, obstetricians, and other skilled health personnel working on labour and delivery wards	Links frontline implementation in health-care facilities with subnational and national efforts to implement latest evidence-based standards of care. Provides tools to strengthen the knowledge, skills and attitudes for improving quality-of-care
Professional associations - national and sub-national	Midwives, obstetricians, paediatricians, family physicians and General practitioners and other skilled health personnel	Provides technical guidance tools to support health professional practice
WHO regional and county offices, UNFPA, UNICEF and other agencies working in maternal & newborn health and well-being	Medical / Technical officers, National Professional Officers and regional advisors technically supporting maternal and newborn Health	Provides a common implementation platform to enable wide collaboration with all partners to ensure effective policy advocacy for successful implementation
Implementing partners including non-governmental organizations (NGOs)	Maternal and newborn health specialists	Provides technical guidance tools to support countries deliver high quality maternal and newborn care
Researchers and academics	Researchers focused on generating evidence for maternal and newborn care and reducing stillbirth	Provides a common framework to generate priority evidence regarding learning questions to improve LCG implementation
Donor agencies	Interested in improving maternal and newborn health and reducing stillbirth	Provides a common implementation framework to support implementation and scale up

5. What is the most effective way to use the LCG implementation package?

To use these resources effectively, it is important to familiarize yourself with the content of the package and the rationale for each action. This will help to implement the LCG in your specific context. Each chapter describes one action of the implementation approach building towards maturity step by step.

6. When to use the LCG Implementation resource package?

These resources are designed to support countries at all stages of implementation. You can track your progress towards sustainability using five-levels each with a specific focus (Figure1):

- **Level 1: Creating awareness, adapting & adopting the LCG**
  Stakeholders consider LCG implementation and focus on preparing for implementation including raising awareness among health care professionals and policymakers, assessing the existing quality of maternal and newborn care in all health facilities where deliveries are taking place, including private health-care facilities, identifying resource gaps and adapting the LCG for the local context.
- **Level 2: Implementing transformative practices & the optimal use of the LCG**
  A training program for healthcare professional and master trainers is developed to ensure that all frontline providers are equipped with the skills to use the LCG effectively, enabling safe and high quality care for women and newborns during labour and childbirth. The transformative practices; consistent documentation, person centered care, informed decision making, use of digital technology supports to enhance quality, efficient and women centered care. Shift from previous WHO standard partograph to structured holistic approach with LCG in public and private health-care facilities can ensure evidence based, positive child birth experience.
- **Level 3: Consolidating and sustaining the use of the LCG & transformative practices**
  The use of the LCG is consolidated and continuously strengthened to ensure effective implementation and long term sustainability. To transform IPC practices, on going efforts to improve the quality-of-care during labour and childbirth in both public and private health-care facilities, in line with the latest IPC guidelines are essential. The LCG supports this process.
- **Level 4: Sustaining the use of the LCG & implementing additional measures to improve the Quality of intrapartum Care**
  Intrapartum care recommendations in addition to the LCG are implemented for a positive birth experience for all women and newborns.
- **Level 5: Continuous improvement of quality of implementation, consolidate previous achievements, and develop innovative solutions to further improve quality-of-care**
  The achievements of steps 1-4 consolidated, and innovative solutions are developed to further improve the QoC. This includes the integration of the LCG into pre-service and in-service education and ongoing support for healthcare professionals to enhance skill, continuous M&E of care practices, and the adoption of new technologies and approaches.

Figure 1: LCG Implementation five maturity levels – description and main focus

	Level 1	Level 2	Level 3	Level 4	Level 5
Description	**Create awareness, adapt & adopt the LCG**	**Implement transformative practices & optimal LCG use**	**Consolidate and sustain LCG use & transformative practices**	**Sustain LCG use & implement additional measures to improve the quality of LCG use**	**Continuously improve quality-of-care**
Activities	Prepare for LCG implementation phase wise in all health setting where maternity services are provided. Understand the local context and adapt the LCG to the country specific needs across public and private health-care facilities with maternity care. It can be started in one of the future training site and plan, expand further with the leadership of government	LCG implementation to replace the WHO standard partograph, including LCG user training. Transformative practices; Standarized, evidence based labour monitoring and documentation using LCG, respectful maternity care by involving women in shared decision making, involving family, strengthening competencies of service providers, support data collection for improvement of QoC	Consolidate the LCG use. Prepare for the implementation of wider intrapartum care and support service providers to sustain new transformational practices. Using LCG data for audit, review & response to promote evidence based practices, early detection of complication and timely management. Facility based reviews of labor outcomes to identify the gaps and best practices	Sustain LCG use. Implement the full set of intrapartum care recommendations for a positive birth experience by maintaining leadership support, organising refresher courses, mobilising resources etc Use LCG data for policy advocacy Ensure equity and accessibility of LCG in all births including private sector	Continuous improvement of quality of LCG use by continuous monitoring and supervision to ensure correct use of LCB during intrapartum care. Consolidate and review previous achievements in IPC using LCG and develop innovative solutions to further improve quality implementation of LCG, improving quality-of-care. Multisectoral collaboration and policy support

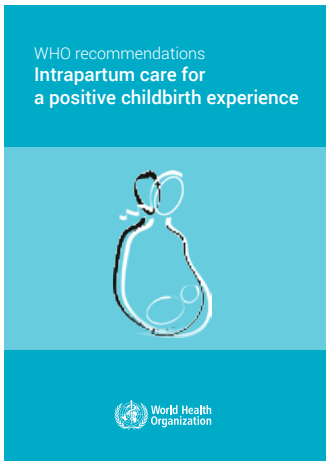
7. How to link LCG implementation to improving quality of care

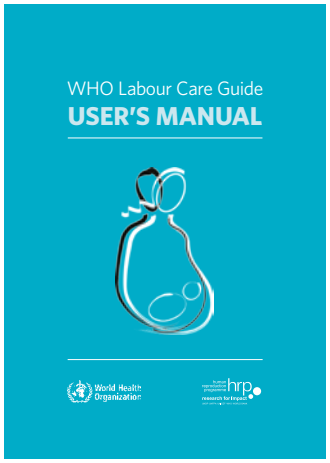
In 2016, WHO launched the *Standards for improving quality of maternal and newborn care in health-care facilities (12)*. This guidance aligns to two dimensions of quality in the quality of care framework: provision of care and experience of care *(11)*. The dimensions relate to eight quality domains with linked to standards, statements, and measures across the continuum of care: antenatal, intrapartum and postnatal. To operationalise these standards of care, an innovative

WHO recommends a seven-action implementation approach based on synthesis of evidence, best practice and experience *(12)*. Within this guidance the partograph has now been replaced with the LCG.

This LCG implementation resource package is based on the QoC seven-action implementation approach (Figure 2), linking to advancing to higher levels of maturity. The actions applied to implement LCG are:

- **Action 1: Establish leadership** support to prioritize national implementation of Labour Care Guide (LCG). Under the leadership of the Ministry of Health, secure national -level commitment to LCG implementation. Establish an interprofessional LCG steering committee or working group, linked to existing maternal and newborn health technical working groups. Ensure coordination of the LCG implementation process, including defining the approach and identifying the need for technical assistance.
- **Action 2: Conduct situation analysis** of intrapartum care in public and private health-care facilities. Assess the country context to identify implementation priorities, opportunities for improvement and potential barriers to the effective adaptation of the LCG.
- **Action 3: Take ownership and create implementation roadmap:** Develop an implementation roadmap by adapting the LCG implementation maturity model, including with timelines for pilot testing and rollout. Select implementation strategies appropriate to the country context such as integrating the LCG into pre-service and in-service education, conducting workshops & webinars for advocacy and master trainers`capacity building, providing incentives and restructuring the health care environment, etc.) to prioritise the use of LCB during intrapartum care.
- **Action 4: Ensure essential infrastructure to get started.** Standardize national policies on intrapartum care to integrate LCG implementation into health care policies, guidelines and standard of practices. Adapt the WHO LCG to the national context, allocate budget for supplies and infrastructural improvements and develop necessary resources including training manuals and monitoring and evaluation systems.
- **Action 5: Build capability and implement LCG. Provide** training and initiate Plan-Do-Study/Learn-Act quality improvement cycles to ensure effective implementation.
- **Action 6: Continuously monitor and evaluate** implementation. Assess the implementation process to identify opportunities for strengthening LCG use and ensuring high quality intrapartum care across public and private health-care facilities.
- **Action 7: Refine strategies for scale up and** sustainability. Ensure the long term institutionalization of LCG use for all births by refining implementation strategies and strengthening sustainability measures.





LCG is a comprehensive decision-making tool including multiple interventions/ practices organised into seven sections:

Section 1: Identification
Section 2: Supportive care
Section 3: Baby
Section 4: Woman
Section 5: Labour progress
Section 6: Medication
Section 7: Shared decision making.

The frameworks illustrating LCG implementation actions (Figure 2) presents the seven LCG actions arranged around the central Plan-Do-Study/Learn-Act cycle, emphasising that multiple cycles will be required for each action. Depending on the country context and specific needs, each cycle may involve different implementation packages- ranging from individual to multi-faceted or complex interventions alongside other strategies to achieve the desired implementation goals.

At the health facility level, the *Toolkit for implementation of the WHO intrapartum care and immediate postnatal care recommendations in health-care facilities* presents detailed sub-actions within the PLAN action of the PDSA - cycle. These include preparing for implementation, defining and behaviours that need to change understanding the determinants of current practice and enablers for desired change, identify potential solutions and implement strategies, monitor and evaluate *(18)*.

8. How to use the LCG implementation approach?

Overall, implementing LCG using a quality improvement approach supports progress towards implementation maturity. By following the seven-action approach and working collaboratively as a team, healthcare providers and administrators can effectively implement the LCG and improve the quality of intrapartum care.

The following section provides a detail description of each of the seven recommended actions in the WHO LCG implementation approach to support sustainable LCG use.

LCG action 1. Establish support for planning & implementation, leadership structure, and functions

Action 1 summary

- Country leadership support of the Ministry of Health is critical to endorse LCG implementation as a priority at the highest level.
- Establish a national LCG implementation steering committee or working group linked within existing national maternal and newborn technical working group structures.

The first action lays the foundation towards the long-term goal of full implementation.

Leadership of the Ministry of Health

- Establish high-level support to prioritise LCG implementation as a national priority. Engage key stakeholders under the leadership of the country national maternal and newborn health program officer and other senior health officials within the Ministry of Health or its equivalent.
- Conduct high-level stakeholder consultations to raise awareness across all levels of the health system and seek guidance for collaborative LCG implementation. Secure commitments for sustained support and coordination (Annex 1).

National LCG Steering Committee or Working Group

- Strengthen LCG implementation by providing in depth discussions and guidance with in the national maternal and newborn health technical working group or an equivalent body.
- Facilitate the establishment of a national interprofessional LCG steering committee or designated appropriate individuals to provide leadership. This group plays a critical role in building a strong foundation for long-term LCG implementation (maturity level 5 in Figure 1) and is responsible for setting implementation tasks and milestones. The steering/ working group should be linked to other relevant national structures such as maternal and newborn quality improvement committees and similar technical working group.
- Identify key interprofessional stakeholders to ensure a broad range of technical expertise for effective alignment and dissemination of LCG related activities. Based on country context, representatives should include midwives, obstetrician and gynaecologists, paediatricians, general practitioners or family physicians, nurses and health systems experts.
- Consider balancing effective top-down strategies with soft influence approaches based on the context when selecting the group. Flexibility may be required to accommodate the commitments of key stakeholders within their busy schedules. Ensure representation from both the public and private health sectors.
- Define the LCG steering or working group`s membership, structure, roles, and responsibilities as well as its coordinating mechanism, decision-making processes, reporting channels and monitoring and evaluation framework to track LCG implementation progress.
- Outline these functions Terms of Reference (TOR) for the LCG steering or working group (Annex 1)

Interprofessional Leadership is vital for LCG implementation

- Brief local leaders and advocates to familiarize themselves with the LCG.
- Build a team with intrapartum experience from multiple disciplines (midwifery, obstetrics, nursing) to become master LCG trainers.

The structure and function of the LCG steering or working group should be adopted your context, considering:

- effective implementation strategies relevant to the setting;
- interprofessional representation;
- inclusion of both public and private health sectors;
- representation of women, families, and the community;
- engagement of development partners; and
- availability of key stakeholders - dedicated staff or seconded from key organizations.

List of resources for LCG action 1:

- LCG steering committee or working group Terms of Reference (TOR) (Annex 1).

LCG action 2. Understand the implementation context and conduct situation analysis

Action 2 summary

- Successful LCG implementation depends on considering potential implementation environment, including enablers and barriers in the country context.
- Conduct a situational analysis to understand existing intrapartum care practices.

The second action of the LCG implementation requires an understanding of the context of intrapartum care practices, resource constraints, health system structures and access to facility care, particularly for marginalised groups.

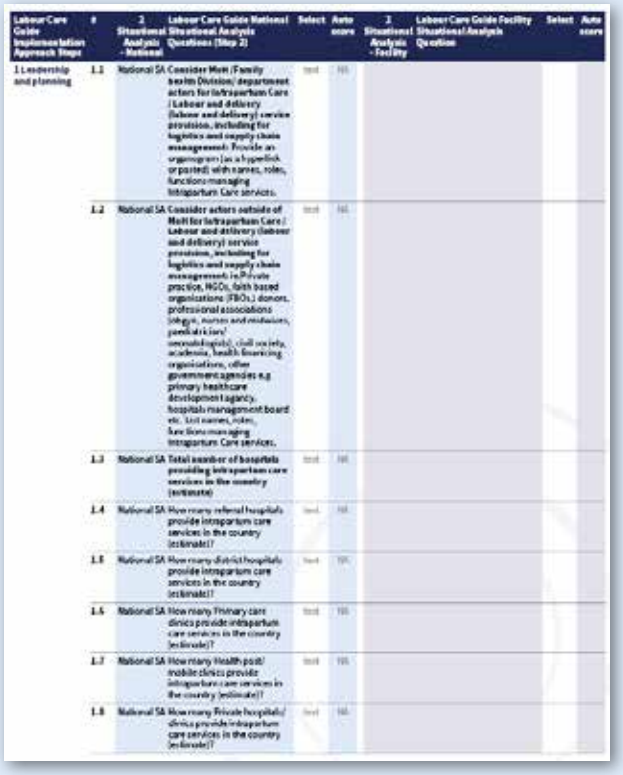
Use the LCG situational analysis quick tool (LCG-SAQT) in Annex 2 to assess the implementation landscape. The LCG-SAQT is structured around the seven actions of the implementation approach to facilitate discussions primarily at the national level. However it can also be used at sub-national level if implementation is conducted at that scale. It is designed for two key user`s group: national or subnational stakeholders and health facilities. It can be used during national steering committee or working group meetings as well.

The tool includes an auto-scoring feature for 30 of the 50 questions, providing a quantitative measure of the enabling environment for LCG implementation. If helps identify which LCG practices and interventions to prioritize and guides decision-making for national, sub-national, facility level implementation.

Engaging professional societies in the situation analysis process is essential, as it provides an opportunity to familiarise key advocates among service providers with the LCG.

List of resources for LCG action 2:

- LCG Situational Analysis Quick Tool (Annex 2).



LCG action 3. Take ownership and create an implementation plan

Action 3 summary

- Design a context – specific LCG implementation plan.
- Keep the end goal of sustainable implementation (maturity level 5) in sight.
- Set realistic timelines to reach the milestone of each level.

Implementation plan

In this action, the steering group (action 1) facilitates using the situational assessment findings (action 2) to develop an implementation plan and is owned and contextualized for your health system. Continuous representation from service providers – including midwives, nurses, obstetrician-gynaecologists, paediatrician, general or family practitioners is essential to integrate LCG into routine practice. The implementation plan should consider all administrative levels: national, sub-national, and health facility (Figure 1).

The LCG benefits women, newborns and prevents stillbirths; therefore, broader collaboration must be planned. This includes the Ministry of Health, UN agencies (UNFPA, WHO, UNICEF), civil society groups, parents' organizations, professional associations for midwives, nurses and doctors. Consider strategies to leverage support, identify opportunities for LCG implementation and collaboratively address the gaps identified in action 2.

Include specific tasks and subtasks with timelines, and budgets in implementation plan. The implementation actions should follow cycles of PDSA rather a simple linear approach. The choice of implementation strategies should be based on the specific needs of the health system and the clinical practices that are being targeted. Select appropriate strategies for each section of the LCG. If more detailed implementation guidance is required, refer to the WHO *Toolkit for implementation of the WHO intrapartum care and immediate postnatal care recommendations in health-care facilities (18).*

Consider LCG adaptation

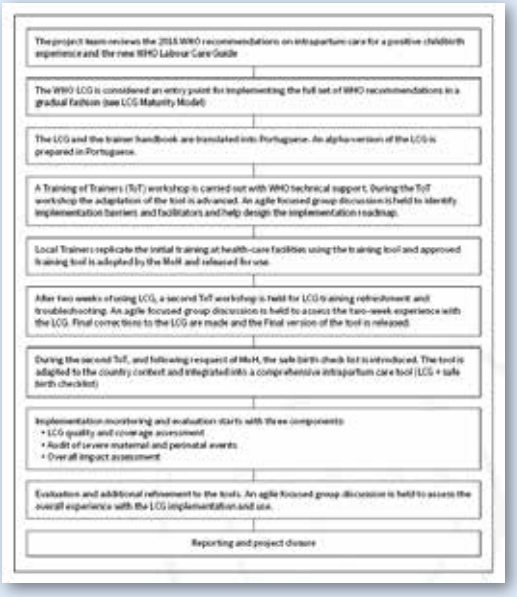
When developing your implementation plan, assess whether any local adaptations of the LCG are needed (see box below). Standardized national policies on intrapartum care are essential for effective LCG adaptation making it imperative to include plans for policy standardization.

Include routine data plans

Discuss within the steering group how routine health information systems (RHIS) data can support LCG implementation. Ensure that your implementation plan incorporates any necessary adaptations to align with system revision timelines.

List of resources for LCG action 3:

- Country example of LCG roadmap (Annex 3).



Process to adapt the Labour Care Guide (adapted from WHO LCG User's manual Annex 2 *(17)*)

- **Critically review the LCG** and decide whether local adaptation is necessary. For example, ensure the abbreviations required for in the LCG are meaningful in the local context. If needed translate the LCG, user manual and other educational materials.
- **Aim for quality care**: Strive for the highest quality of care; do not remove components of the LCG solely because they may be challenging to implement. The LCG is based on evidence designed to to optimise outcomes for women and newborns, so it is essential to retain effective interventions and practices, even if immediate implementation is difficult. Include all components in your adopted tool and prioritise their implementation systematically.
- Any adaptations of the LCG should be made with caution to ensure that no effective interventions are excluded. Efforts should focus on aligning national standards and guidelines with the LCG, guided by the LCG implementation steering group.
- **Involve experts and end-users:** Arrange stakeholder consultations to discuss any necessary contextual adaptations including language translation and integration into standardised individual patient case notes. National or local experts should review the LCG to ensure alignment with relevant national standards and guidelines. Involvement from health care providers working in maternity-care settings, local leaders and administrators is essential to support effective adaptation and implementation.
- **Keep it concise:** Keep the LCG focused on labour monitoring and avoid adding excessive new variables. The LCG is not intended to replace a medical record. Adding too many items increases the risk of duplicate documentation. Only include additional variables if they are essential for labour and child care. When incorporating new variables or parameters, consider:
  - Is it relevant for labour monitoring?
  - Is it evidence based?
  - Is it feasible to collect it in different setting?
  - Is it already included in the medical record?
  - Would it be more appropriate in the medical record?
- **Align with existing records:** Adapt relevant sections of standardised medical records to monitor and document latent phase, third stage of labour and newborn details as appropriate. Minimize duplication between the LCG and standardised medical records to ensure efficient and streamlined documentation.
- **Pilot the adapted LCG:** Before rolling out of an adapted LCG, conduct a pilot in clinical settings and gather feedback from end-users. This process helps ensure successful adoption.
- **Review relevant policies and associated procedures**. Ensure they support an enabling environment for effective LCG implementation.

LCG action 4. Ensure essential infrastructure and resources to get started

Action 4 summary

- Develop action plans based on the findings of LCG situation analysis and prioritise the activities.
- Focus on available resources, infra structure and adequate, appropriate service providers.

Use the findings of your situational analysis conducted earlier (action 2) to prioritize actions across all sections of the LCG and ensure costed budget plans are prepared. A summary of resources/ infrastructure to consider is shown in Table 2 and Annex 4.

In many settings these resources will already be available for intrapartum care. However, in others, additional investments may be needed to build or renovate health-care facilities to support LCG implementation.

Adequate staffing with competent motivated health workers is critical for the successful implementation of the LCG. Frontline health workers using the LCG may initially need extra supportive supervision to enable all the skills, knowledge and attitudes embedded in the guide. Peer-to-peer support can be strengthened by using the LCG to facilitate interprofessional transfer of care for women between labour and delivery ward shifts.

Table 2: LCG essential infrastructure and resources by section for costing

LCG section	Examples of essential resources needed in sufficient quantities at all times	Examples of context specific responsible departments for costed budget plans
LCG section 1 Identifying information	Supply of printed LCG for every facility birth. LCG user guide for every labour and delivery ward. Posters and job-aids	Logistics
LCG section 2 Supportive care	**Companionship:** Basic accommodation with privacy for companions (chair, space, access to toilet)	Infrastructure and logistics
	Pain relief: Supplies of pharmacological and non-pharmacological pain relief methods	Logistics
	Oral fluid: drinking water and food	
	Mobility: with access to clean and accessible bathrooms	Infrastructure and logistics
LCG section 3 Assess baby	**Fetal heart rate monitoring** Functioning fetal doppler heart rate monitors and, or stethoscope – one for each midwife on duty in labour and delivery	Logistics
	Amniotic fluid/ caput/ moulding Room: examination beds with clean linens, privacy curtains Hand washing: clean water supply, soap, nail brush, clean towels Waste bucket for soiled linens Equipment: sterile speculum, gloves, light source	Logistics
LCG section 4 Assess woman	**Vital signs:** Thermometer, stethoscope, blood pressure machine	Logistics
	Urine: dipsticks for protein and acetone	Logistics
LCG section 5 Labour progress	Uterine contractions: Wall clock with second hand. Sterile delivery kits	Logistics
LCG section 6 Medication and commodities	Supplies for augmentation medications and family planning for PPFP including ART as per national guidelines	Logistics
LCG section 7 Shared decision-making	Private physical space to enable effective communication between women and health workers	Infrastructure

LCG section	Examples of essential resources needed in sufficient quantities at all times	Examples of context specific responsible departments for costed budget plans
Cross-cutting	**Training:** e.g., courses, manuals, videos, or webinars	Pre-service, in-service curriculum
	Monitoring and evaluation: e.g., updating standardised registers/ case notes, electronic RHIS systems	Information systems

Developing training resources and job-aids

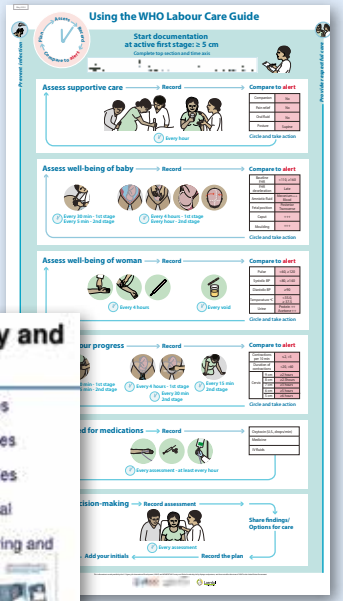
The LCG steering group can guide optimizing training materials for your specific implementation context. The materials should be learner-centred to help health workers and facility managers develop the knowledge, skills and attitudes for LCG implementation. This implementation resource package includes materials that have been used in diverse contexts that can be adapted. Consider developing/ adapting:

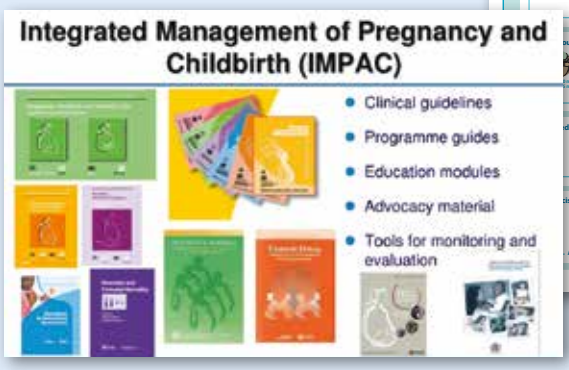
- **WHO LCG orientation Meeting guides:** to introduce the LCG at national/ sub- national/ facility levels for orientation and implementation planning. These guides could include the meeting objectives, expected outcomes, and agenda. (Annex 5)
- **WHO LCG action plan –** developed to facilitate use of the LCG as a decision-making tool. Introduced during training to support transfer of LCG into the health facility labour and delivery ward. (Annex 6)
- **WHO LCG Training materials: Developed** for facilitators and participants covering all learning domains: knowledge, skills and attitudes. Ensure these materials support participatory learning methods and provide the detailed guidance on recommended LCG practices and processes. Include both didactic and practical components. Ideally training should be interprofessional, fostering teamwork between the health workers caring for women and newborns during labour and birth (e.g., midwives, doctors, nurses). (Annex 7)
- **Job aids**: Quick-reference guides for health workers to implement specific sections of the LCG e.g. cervical dilatation assessment models.

Ensure the resources developed meet the need of health workers in your health system. Pilot the draft resources alongside the LCG before implementation. Select a range of facilities at all levels providing care for women and babies during childbirth. Gather feedback from end-users to refine your strategies and resources.

List of resources for LCG action 4:

- Basic equipment and supplies for intrapartum care from WHO LCG user's guide (Annex 4).
- LCG sensitisation meeting guides (Annex 5).
- LCG Action plan / decision-making support (Annex 6).
- LCG Training package (facilitator's guide, agenda, slide-deck, clinical case scenarios, attendance logs, and evaluation forms). https://www.jhpiego.org/momentum-country-and-global-leadership/
- IMPAC tool.





LCG action 5. Build capability and commence implementation

Action 5 summary

- Plan and provide orientation workshop to introduce the LCG.
- Provide post training follow-up including onsite supervision, coaching and mentoring.
- Implement PDSA cycles based on the identified gaps during follow-up supervision, onsite coaching and mentoring. Link with ongoing QI process in the service site.

This is the action to operationalize your plans to build LCG capability of the health workforce. Action 5 uses the infrastructure and resources developed in action 4, based on the plans in action 3 from the situational analysis is action 2, all under the leadership of the steering group in action 1.

Build capability of LCG implementers for sustainable practice using learner-centred strategies and methods including education and supportive supervision. Mentoring can be provided in person and/or remotely by more experienced healthcare providers within the team. The mentoring program should be designed to address specific challenges or gaps in knowledge, skills and attitudes identified during the training or during clinical practice.

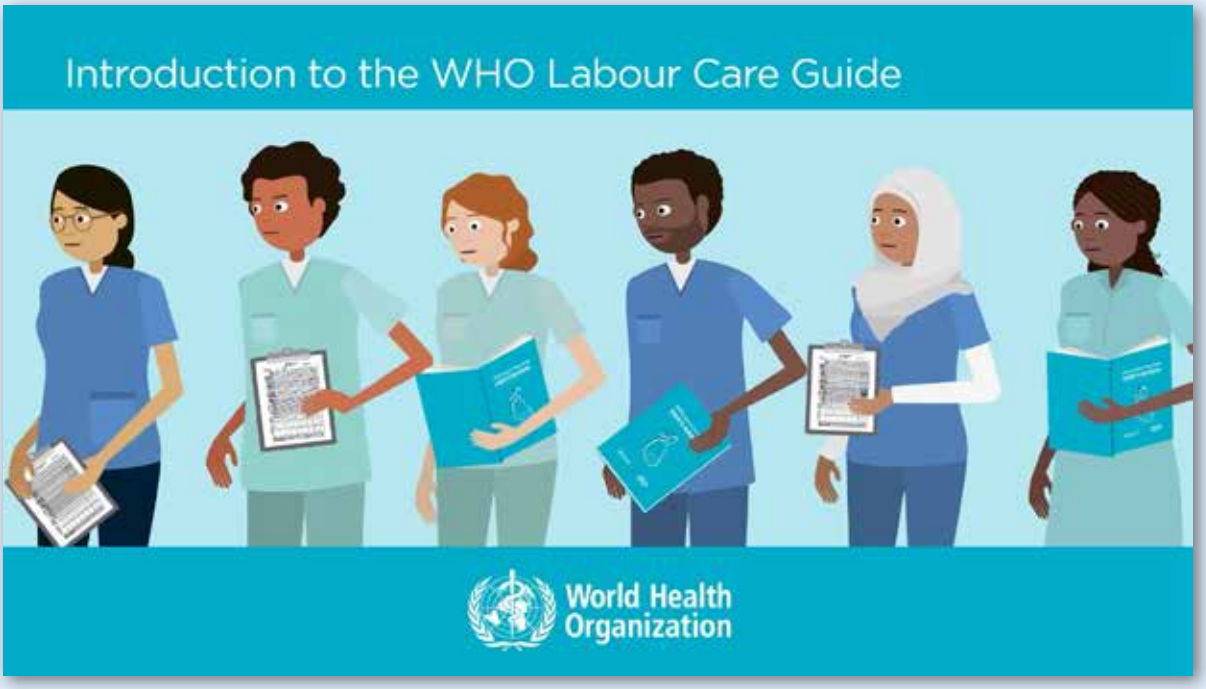
LCG learner-centred education

- Orientation workshops for health managers and health professionals.
- Initial training, low-dose high-frequency refresher training, focused on practice.
- Allow time for skill acquisition for all learners to attain high quality practice.
- Supportive supervision during training and implementation with structured feedback
- Onsite coaching and Mentoring.

Remember implementation will likely take multiple PDSA cycles and see action 5 linking to “DO” in PDSA.

List of resources for LCG action 5:

- Introduction to the LCG video



LCG action 6. Continuously measure quality-of-care and outcomes

Action 6 summary

- As part of the "Study" phase in the PDSA cycle, prepare a PDSA monitoring template for the planned quality improvement (QI) project.
- Populate the template with progress and outcome indicator values.
- Analyse findings against the planned QI goal/target, interpret changes and document key learnings to inform next steps.

The focus of action 6 of the implementation process is to ensure that monitoring the LCG process and its outcomes for women and newborns is fully integrated in your approach.

Evaluating LCG implementation is important to determine whether strategies are achieving the intended outcomes or and to identify areas for improvement -aligning with the "LEARN" phase in PDSA. Data use is a key component of quality improvement and LCG implementation contributes to these efforts.

Leverage LCG implementation as an opportunity to strengthen the quality and use of routine core indicators for women and newborns (Table 3) to track progress at health facility, sub-national and national levels *(19, 20)*.

To evaluate LCG implementation and its impact on maternal and new born health care quality at the facility level, indicators were selected based on priorities established by the WHO Monitoring and Evaluation Technical Advisory Group (MoNITOR) and global discussion on QoC measurement. These indicators were designed to align with international best practices while ensuring adaptability to different health care systems, facilitating effective monitoring and continuous quality improvement.

Table 3: Indicators for assessing the LCG implementation and the quality of MNH care (health facility level)

Type of indicator	Indicator	Definition	Computation (e.g. numerator [N]/denominator [D])	Possible disaggregations(s)	Purpose
Output/ Process	LCG use	Proportion of women giving birth in the health facility for whom the LCG was completed	N: Number of women for whom the LCG was completed D: Number of women giving birth in the health facility	-	Assess LCG implementation
	Fetal heart monitoring on admission	Proportion of women whose baby's fetal heart rate was documented on admission to the labour ward	N: Number of women who had their baby's fetal heart rate documented on admission in labour in the health facility D: Number of women giving birth in the health facility	-	Assess QoC
	Blood pressure monitoring on admission	Proportion of women who gave birth in the health facility whose blood pressure was measured on admission to the labour ward	N: Number of women who had their blood pressure documented on admission in labour in the health facility D: Number of women giving birth in the health facility	-	Assess QoC
	Companion of choice during labour and/ or childbirth	Proportion of women who wanted and had a companion of choice during labour and/or childbirth	N: Number of women giving birth in the health facility who wanted and had a companion of choice during labour and/or childbirth D: Number of women giving birth in the health facility who wanted a companion of choice during labour and/or childbirth	Stage 1 Stage 2 with suggested further disaggregation by vaginal births and caesarean section	Assess QoC
	Caesarean Section Rate	Proportion of births in the health facility by caesarean section	N: Number of women giving birth in the health facility with a C-section D: Number of women giving birth in the health facility	Robson classification	Assess QoC

Type of indicator	Indicator	Definition	Computation (e.g. numerator [N]/denominator [D])	Possible disaggregations(s)	Purpose
Outcome	Institutional stillbirths	Number or proportion of babies born in a health facility with no signs of life (born after 28 weeks of gestation or weighing at least 1000 g)	Number of stillbirths in the health facility *If calculating this indicator as a proportion:* N: Number of stillbirths in facilities D: Total number of births in facility (live births and fresh & macerated stillbirths)	Antepartum/ intrapartum. Before/ after admission	Assess QoC

Assessing the completeness of the LCG can be done on a routine basis by the sub-national teams (eg. District teams) responsible for the (supportive) supervision or by mentors. A sample of LCGs can be selected and reviewed for completeness. In addition of LCG completeness, the teams should also assess the quality of the completed LCGs and provide feedback with the health facility team to support continuous improvement.

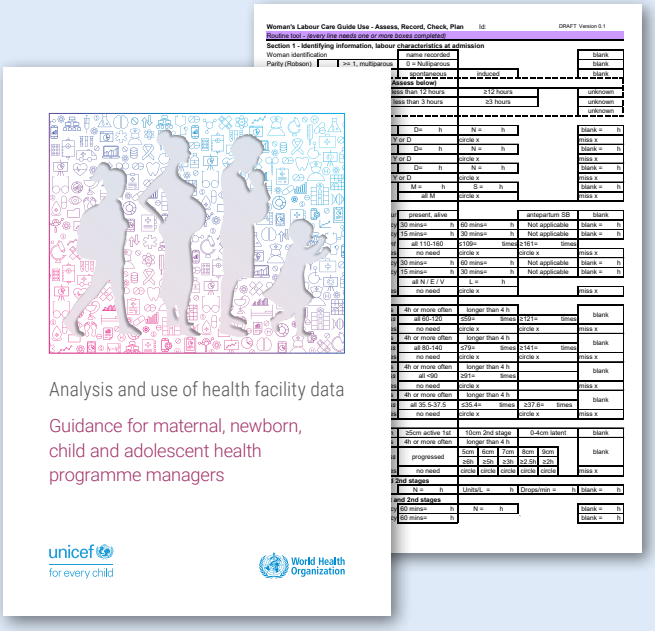
You may also consider using clinical audit processes to assess wheather LCG documentation aligns with the standards outlined in the LCG user's guide. This can help provide to feedback to health workers, highlighting areas of good practice and identify opportunities for improvement. This implementation resource package includes an LCG audit tool Annex 8 including an example of a completed version.

Display and share your LCG indicators and quality measures on childbirth QoC dashboards and with the community using your health facility to drive continuous improvement.

Engaging in discussion and linkages with Maternal and Perinatal Death Survillance and Response (MPDSR) review mechanism can help strengthen the quality of intrapartum care, depending upon the level of health facility.

List of resources for LCG action 6:

- LCG clinical audit tool for routine use Annex 8
- WHO, UNICEF, Analysis and use of health facility data. Guidance for maternal, newborn, child and adolescent health programme managers, 2023



LCG action 7. Refine strategies for sustainable scale up

Action 7 summary

- Develop sustainable scale up strategies, based on the experience on action 2 to action 6.
- Include PDSA cycles in strategies to continue improvement in quality of services provided during intrapartum care.

The seventh action in the implementation approach is action for scale up to ensure every woman and baby benefits from the care practices outlined in the LCG. The steering group determine when to scale up using refined strategies from actions 2 to 6 learning. This ensures that the implementation approach is adaptable to diverse contexts. By following this approach, LCG implementation can effectively expand to other facilities and sub-national areas, promoting wider adoption and impact.

Remember implementation is often a non-linear process, requiring ongoing PDSA cycles as you implement the LCG in individual facilities and scaled towards universal coverage. The highest level of implementation is continuous improvement of quality of LCG use. This means consolidating previous achievements while also developing innovative solutions to further enhance quality implementation to improve quality-of-care. Use r data from action 6 to support health workers in providing high quality care, including through ongoing educational activities. Consider listing key learning questions and conducting implementation research within your specific context or in collaboration with other LCG implementers to share insights. Together we can learn how to scale-up more effectively, ensuring that every mother and baby benefits from a positive childbirth experience, strengthened by LCG implementation.

The section below provides a detailed explanation of how these seven actions of implementation align with a maturity model.

Action 1: Establish leadership

Action 2: Conduct situation analysis

Action 3: Take ownership and create implementation roadmap

Action 4: Ensure essential infrastructure to get started

Action 5: Build capability and implement

Action 6: Continuously monitor and evaluate

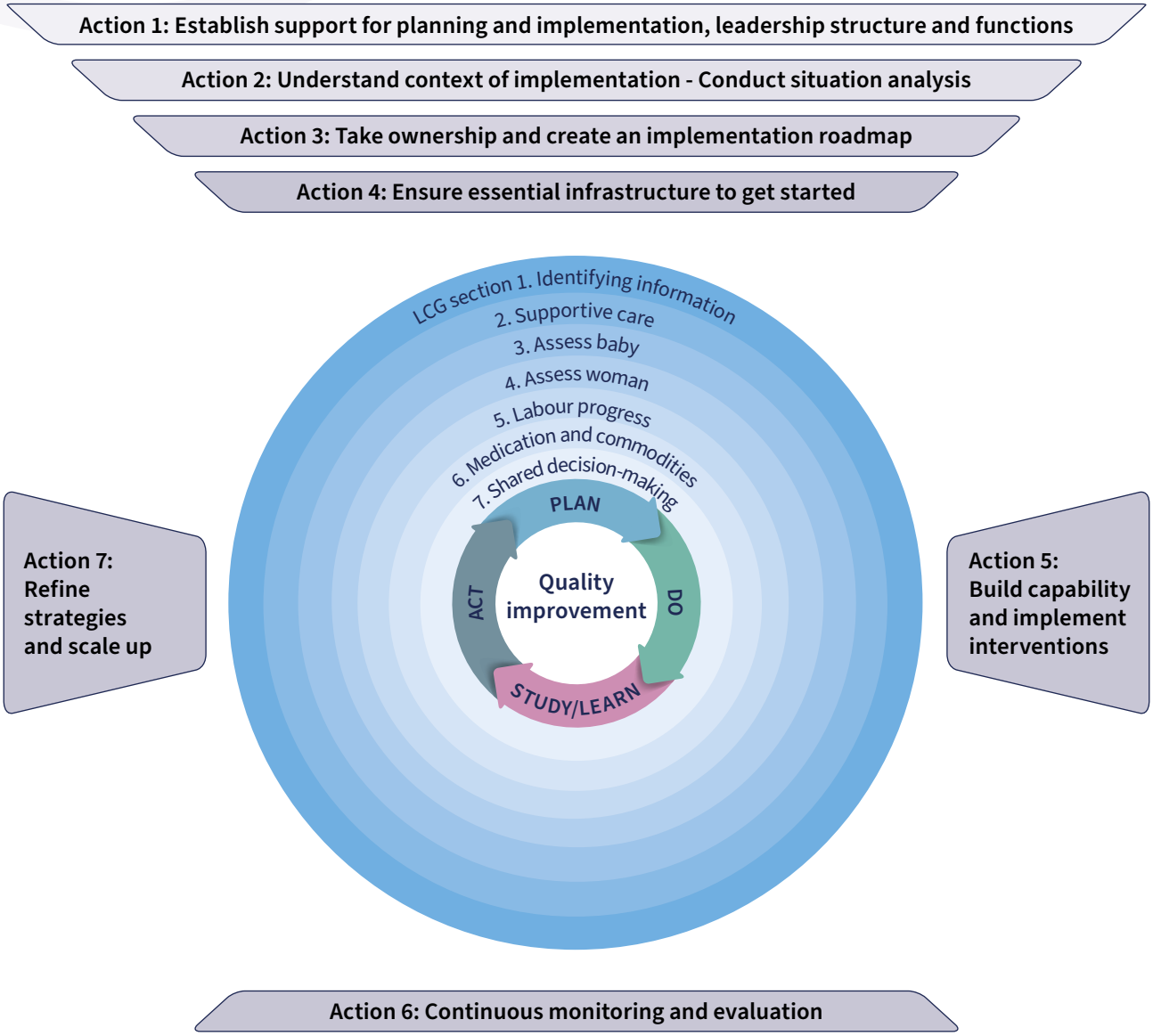
Action 7: Refine strategies for scale up

9. Summary - Sustainable LCG implementation to improve QoC

This implementation resource package outlines key actions to support sustainable implementation and progress maturity (Figure 1).

Actions 1, 2 and 3 correlate with maturity level 1, adding action 4 takes you to level 2, adding action 5, 6 and 7 to level 3 and then improving the quality of implementation to Level 4 and Level 5 (Figure 3).

Figure 2: LCG implementation actions for quality improvement

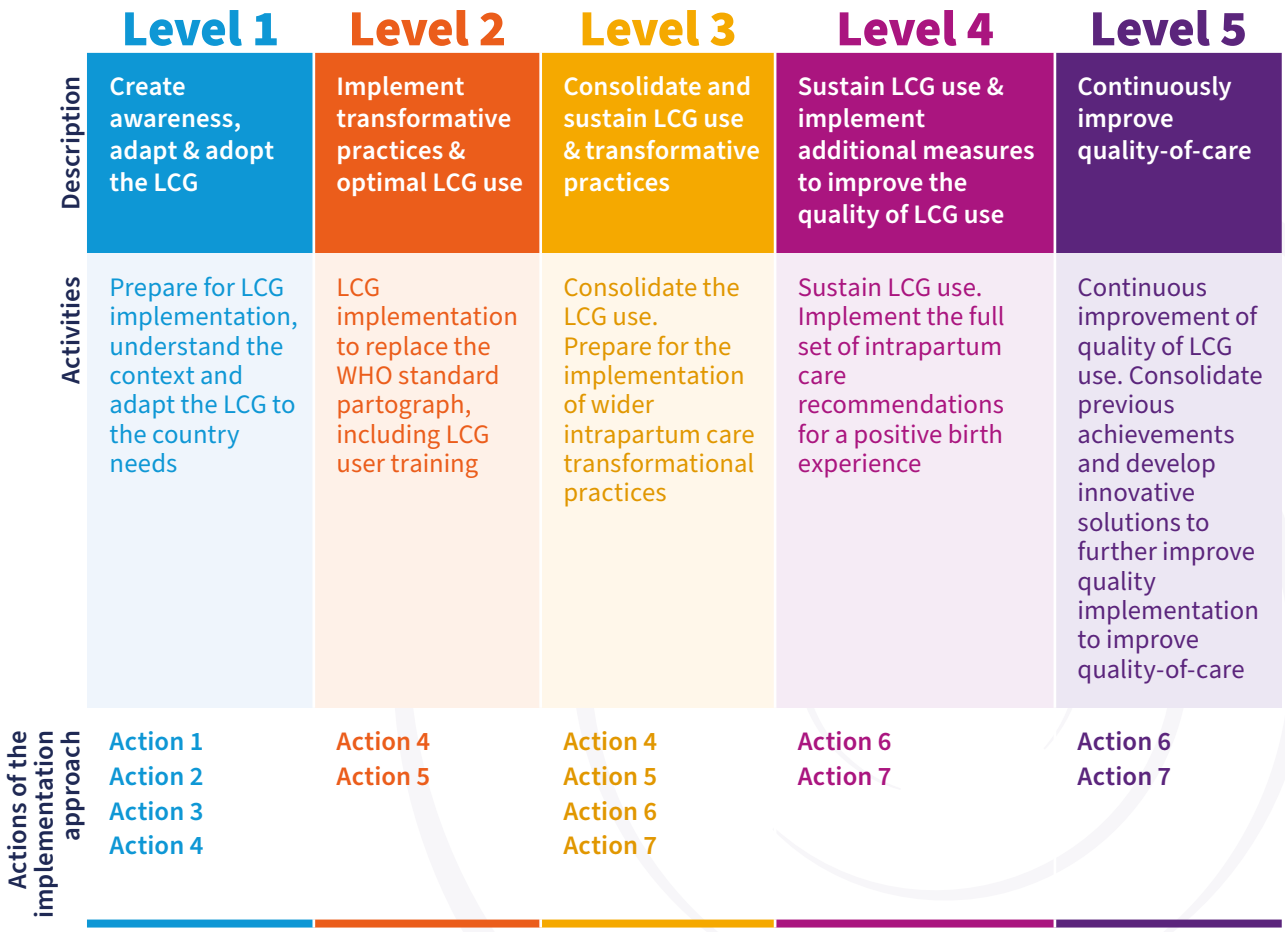


At the centre of the LCG implementation framework are quality improvement cycles, involving continuous repetitions of four linked actions: Plan-Do-Study/Learn-Act (PDSA):

- **PLAN:** Identify the specific intervention/ practice/ section in the LCG that will be implemented; consider the associated barriers/ enablers and identify strategies for implementation. Set clear goals and objectives for the process and plan to monitor its implementation.
- **DO:** Implement the identified specific intervention/ practice/ section in the LCG intervention you identified. Collect data during implementation, including information on challenges or barriers/ enablers you encountered.
- **STUDY / LEARN**: evaluate the process and result of LCG implementation including any data you collected. Ask the following questions: Is the LCG implementation going as planned? Is LCG implementation achieving the desired results for women and newborns? Identify any changes to your LCG implementation plans and identify any new strategies to enable implementation.
- **ACT:** Continue to implement using what is learned and continue the cycle of improvement for the specific intervention/ practice/ section you identified. Begin a PDSA cycle for the next intervention.

Using the PDSA cycles enables strategies to implement the LCG more effectively to be identified and applied. Remember that implementation processes are not linear, so it is likely you will need to facilitate actions concurrently as well as loop back and repeat actions when contextual circumstances change over time.

Figure 3: LCG Implementation five maturity levels with corresponding LCG implementation action approach



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Annexes

Annex 1: Generic WHO LCG Steering Committee/ Working Group Terms of Reference

Objectives

Support implementation of the LCG – intrapartum recommendations adaptation tool kit and enhance the QoC during child birth at country level.

Formation of the committee/ working Group

The committee or working group can be established based on the country`s needs.

Chair: The Manager responsible for leading overall program planning in Reproductive, maternal, newborn, child and adolescent health (RMNCAH).

Member secretary; National program officers (Ministry of Health) responsible for maternal and newborn health and a member of national maternal and newborn technical working group.

Members: Other relevant programme managers from the Ministry of health involved in QoC improvement processes, and newborn health. Representatives from United Nations partners in reproductive health; stakeholders, bilateral donors, international nongovernmental organizations (INGOs)and NGOs working in maternal health.

Professional representation: Representatives from professional societies: midwives, nurses, obstetricians and gyaecologists family physician and general practitioners, GPs etc.

Secretariate: WHO Country Office.

ToR

The committee/working group will: Advocate for and facilitate the national implementation of LCG to ensure the adoption of WHO intrapartum care recommendations.

Conduct stakeholder consultations at national and subnational level.

Establish a coordinating mechanism that defines decision- making processes and reporting channels.

Support the conduct of a situation analysis to assess existing intrapartum care practices using WHO LCG-SAQT.

Develop a context specific LCG implementation plan, including monitoring and evaluation framework, with regular process reviews.

Provide guidance in developing training resources (for both facilitators & participants) and job aids to support the use of LCG as a decision making tool.

Coordinate and communicate with higher authorities regarding the status of LCG implementation and provide recommendations for its improved use.

Collaborate with the planning team to scale up LCG implementation nationally, incorporating lessons learnt.

Annex 2: WHO LCG situational analysis quick tool

Labour Care Guide Implementation Approach Steps	#	2 Situational Analysis - National	Labour Care Guide National Situational Analysis Questions (Step 2)	Select	Auto score	2 Situational Analysis - Facility	Labour Care Guide Facility Situational Analysis Question	Select	Auto score
1 Leadership and planning	**1.1**	National SA	**Consider MoH /Family health Division/ department actors for Intrapartum Care / Labour and delivery (labour and delivery) service provision, including for logistics and supply chain management:** Provide an organogram (as a hyperlink or pasted) with names, roles, functions managing Intrapartum Care services.	text	NA				
	1.2	National SA	**Consider actors outside of MoH for Intrapartum Care / Labour and delivery (labour and delivery) service provision, including for logistics and supply chain management:** ie.Private practice, NGOs, faith based organisations (FBOs,) donors, professional associations (obgyn, nurses and midwives, paediatrician/ neonatologists), civil society, academia, health finanicing organisations, other government agencies e.g primary healthcare development agancy, hospitals management board etc. List names, roles, functions managing Intrapartum Care services.	text	NA				
	1.3	National SA	**Total number of hospitals providing intrapartum care services in the country (estimate)**	text	NA				
	1.4	National SA	How many referral hospitals provide intrapartum care services in the country (estimate)?	text	NA				
	1.5	National SA	How many district hospitals provide intrapartum care services in the country (estimate)?	text	NA				
	1.6	National SA	How many Primary care clinics provide intrapartum care services in the country (estimate)?	text	NA				
	1.7	National SA	How many Health post/ mobile clinics provide intrapartum care services in the country (estimate)?	text	NA				
	1.8	National SA	How many Private hospitals/ clinics provide intrapartum care services in the country (estimate)?	text	NA				
	1.9	National SA	**Desbribe any research conducted on women's and/ or health care providers experiences during labour and childbirth in this country.** List recommendations that include LCG content	text	NA				

Labour Care Guide Implementation Approach Steps	#	2 Situational Analysis - National	Labour Care Guide National Situational Analysis Questions (Step 2)	Select	Auto score	2 Situational Analysis - Facility	Labour Care Guide Facility Situational Analysis Question	Select	Auto score
3 Ownership and roadmap	**3.1**	National SA	**National policy or strategy** supporting WHO LCG already?	Choose	0	Facility SA	**National policy or strategy** supporting WHO LCG already?	Choose	0
4 Infrastructure/ resouces human and physical	**4.1**	National SA	**LCG S3 Doppler handheld instrument** for fetal heart rate monitoring typically available?	Choose	0	Facility SA	**LCG S3 Doppler handheld instrument** for fetal heart rate monitoring typically available?	Choose	0
	4.2	National SA	**LCG S3 Supplies for doppler (gel, etc)** typically available?	Choose	0	Facility SA	**LCG S3 Supplies for doppler (gel, etc)** typically available?	Choose	0
	4.3	National SA	**LCG S3 Pinard Stethoscope** for fetal heart rate monitoring typically available?	Choose	0	Facility SA	**LCG S3 Pinard Stethoscope** for fetal heart rate monitoring typically available?	Choose	0
	4.4	National SA	**LCG S4 Equipment for blood pressure measurement** typically available?	Choose	0	Facility SA	**LCG S4 Equipment for blood pressure measurement** typically available?	Choose	0
	4.5	National SA	**Health personnel** typically available for routine childbirth care 24 hours a day in all facilities?	Choose	0	Facility SA	**Health personnel** typically available for routine childbirth care 24 hours a day in all facilities?	Choose	0
	4.6	National SA	**Health personnel (typically) available to do caesarean section 24 hours a day?**	Choose	0	Facility SA	**Health personnel (typically) available to do caesarean section 24 hours a day?**	Choose	0
5 Build capability & implement	**5.1**	National SA	**WHO LCG guidelines in labour and delivery wards** - are they already available?	Choose	0	Facility SA	**WHO LCG guidelines in labour and delivery wards** - are they already available?	Choose	0
	5.2	National SA	**Training manuals for WHO LCG** - are they already available?	Choose	0	Facility SA	**Training manuals for WHO LCG** - are they already available?	Choose	0
	5.3	National SA	**Pre-service training midwives -** are WHO LCG guidelines already part of the national curriculum?	Choose	0	Facility SA	**Pre-service training midwives -** are WHO LCG guidelines already part of the national curriculum?	Choose	0
	5.4	National SA	**Pre-service training - medical doctors - a**re WHO LCG guidelines already part of the national curriculum?	Choose	0	Facility SA	**Pre-service training - medical doctors - a**re WHO LCG guidelines already part of the national curriculum?	Choose	0
	5.5	National SA	**In-service WHO LCG training programme** and database of health professionals trained?	Choose	0	Facility SA	**In-service WHO LCG training programme** and database of health professionals trained?	Choose	0
	5.6	National SA	**LCG S1 The WHO LCG** is typically charted for every woman in labour	Choose	0	Facility SA	**LCG S1 The WHO LCG** is typically charted for every woman in labour	Choose	0
	5.7	National SA	**A labour monitoring tool (e.g WHO modified partograph)** is currently typically charted already for every woman in labour	Choose	0	Facility SA	**A labour monitoring tool (e.g WHO modified partograph)** is currently typically charted already for every woman in labour	Choose	0
	5.8	National SA	**LCG S1 When a labour monitoring tool** (e.g WHO modified partograph) are used, typically **all health care professsionals** (e.g. midwives and doctors) typically indicate their findings on the tool?	Choose	0	Facility SA	**LCG S1 When a labour monitoring tool** (e.g WHO modified partograph) are used, typically **all health care professsionals** (e.g. midwives and doctors) typically indicate their findings on the tool?	Choose	0
	5.9	National SA	**LCG S2 A companion of choice is typically** permitted for all women throughout labour and childbirth	Choose	0	Facility SA	**LCG S2 A companion of choice is typically** permitted for all women throughout labour and childbirth	Choose	0
	5.10	National SA	**LCG S2 What percentage of women who wanted and had a companion** supporting them during childbirth typically in health facilities typically?	Choose	0	Facility SA	**LCG S2 What percentage of women who wanted and had a companion** supporting them during childbirth typically in health facilities typically?	Choose	0

Labour Care Guide Implementation Approach Steps	#	2 Situational Analysis - National	Labour Care Guide National Situational Analysis Questions (Step 2)	Select	Auto score	2 Situational Analysis - Facility	Labour Care Guide Facility Situational Analysis Question	Select	Auto score
	5.11	National SA	**LCG S2 Mobility and an upright position** during labour is typically encouraged	Choose	0	Facility SA	**LCG S2 Mobility and an upright position** during labour is typically encouraged	Choose	0
	5.12	National SA	**LCG S2 Birth position of the individual woman's choice**, including upright positions is typically encouraged	Choose	0	Facility SA	**LCG S2 Birth position of the individual woman's choice**, including upright positions is typically encouraged	Choose	0
	5.13	National SA	**LCG S2 Oral food and fluids** are typically allowed for women in labour	Choose	0	Facility SA	**LCG S2 Oral food and fluids** are typically allowed for women in labour	Choose	0
	5.14	National SA	**LCG S3 Fetal Heart rate** typically taken every 30 minutes in 1st stage of labour	Choose	0	Facility SA	**LCG S3 Fetal Heart rate** typically taken every 30 minutes in 1st stage of labour	Choose	0
	5.15	National SA	**LCG S3 Fetal Heart rate** typically taken every 5 minutes in 2nd stage of labour	Choose	0	Facility SA	**LCG S3 Fetal Heart rate** typically taken every 5 minutes in 2nd stage of labour	Choose	0
	5.16	National SA	**LCG S4 Woman's observations** typically taken every 60 minutes in 1st stage of labour	Choose	0	Facility SA	**LCG S4 Woman's observations** typically taken every 60 minutes in 1st stage of labour	Choose	0
	5.17	National SA	**LCG S5 Active phase of labour** is typically defined as 5cm and monitoring tools are started	Choose	0	Facility SA	**LCG S5 Active phase of labour** is typically defined as 5cm and monitoring tools are started	Choose	0
	5.18	National SA	**LCG S6 Augmentation** - what proportion of labours are typically augmented?	text	NA	Facility SA	**LCG S6 Augmentation** - what proportion of labours are typically augmented?	text	NA
	5.19	National SA	**LCG S7 What percentage of women typically participate in decision-making** regarding the care provided to them during labour and delivery room admission to discharge?	Choose	0	Facility SA	**LCG S7 What percentage of women typically participate in decision-making** regarding the care provided to them during labour and delivery room admission to discharge?	Choose	0
	5.20	National SA	**Quality improvement mechanisms** are typically ongoing for labour and delivery performance?	Choose	0	Facility SA	**Quality improvement mechanisms** are typically ongoing for labour and delivery performance?	Choose	0
6 Continuous M&E in RHIS	**6.1**	National SA	**How are labour and delivery services documentation** (e.g. paper based registers/ individual medical records) costs financed? Including all government and stakeholder funding and if National Health Accounts information/report is available please provide.	text	NA	Facility SA	**How are labour and delivery services documentation** (e.g. paper based registers/ individual medical records) costs financed? Including all government and stakeholder funding and if National Health Accounts information/report is available please provide.	text	NA
	6.2	National SA	Are **digital systems** typically used at health facility level for routine health information system data for care and outcomes of labour and chilbirth service delivery?	text	NA	Facility SA	Are **digital systems** typically used at health facility level for routine health information system data for care and outcomes of labour and chilbirth service delivery?	text	NA
	6.3	National SA	**Are labour monitoring tools coverage indicators** captured in national Routine Health Information Systems (RHIS) (e.g. what percentage of births were monitored using a standard monitoring tool (e.g. WHO partograph/ LCG))	Choose	0	Facility SA	Are **labour monitoring tools coverage indicators** captured in national Routine Health Information Systems (RHIS) (e.g. what percentage of births were monitored using a standard monitoring tool (e.g. WHO partograph/ LCG))	Choose	0

Labour Care Guide Implementation Approach Steps	#	2 Situational Analysis - National	Labour Care Guide National Situational Analysis Questions (Step 2)	Select	Auto score	2 Situational Analysis - Facility	Labour Care Guide Facility Situational Analysis Question	Select	Auto score
	6.4	National SA	**Neonatal resuscitation at birth** indicator (Bag-mask-ventilation) is captured in national Routine Health Information Systems (RHIS) (e.g. what percentage of live births and stillbirths received bag-mask-ventilation after birth)	Choose	0	Facility SA	Neonatal resuscitation at birth indicator (Bag-mask-ventilation) is captured in national Routine Health Information Systems (RHIS) (e.g. what percentage of live births and stillbirths received bag-mask-ventilation after birth)	Choose	0
	6.5	National SA	**Strong feedback loops for Routine Health Information Systems (RHIS) indicator measurement** between sub-national level and health facilities.	Choose	0	Facility SA	**Strong feedback loops for RHIS indicator measurement** between sub-national level and health facilities -	Choose	0
	6.6	National SA	National total births/ deliveries per year (estiimate)	text	NA	Facility SA	National total births/ deliveries per year (estiimate)	text	NA
	6.7	National SA	National population caesarean section rate (%)	text	NA	Facility SA	National population caesarean section rate (%)	text	NA
	6.8	National SA	Proportion of health facilities actively conducting maternal and perinatal death surveillance and response	Choose	0	Facility SA	Proportion of health facilities actively conducting maternal and perinatal death surveillance and response	Choose	0
	6.9	National SA	Institutional Maternal Mortality Ratio (MMR)/ 100,000 livebirths tracked in RHIS	Choose	0	Facility SA	Institutional Maternal Mortality Ratio (MMR)/ 100,000 livebirths tracked in RHIS	Choose	0
	6.10	National SA	Institutional Neonatal mortality rate/ 1000 live births tracked in RHIS	Choose	0	Facility SA	Institutional Neonatal mortality rate/ 1000 live births tracked in RHIS	Choose	0
	6.11	National SA	Institutional Stillbirth rate/ 1000 total births tracked in RHIS	Choose	0	Facility SA	Institutional Stillbirth rate/ 1000 total births tracked in RHIS	Choose	0
	6.12	National SA	Institutional Antepartum Stillbirth rate / 1000 total births tracked in RHIS	Choose	0	Facility SA	Institutional Antepartum Stillbirth rate / 1000 total births tracked in RHIS	Choose	0
	6.13	National SA	Institutional Intrapartum Stillbirth rate / 1000 total births tracked in RHIS	Choose	0	Facility SA	Institutional Intrapartum Stillbirth rate / 1000 total births tracked in RHIS	Choose	0
	6.14	National SA	In-facility Stillbirth rate / 1000 total births tracked in RHIS	Choose	0		In-facility Stillbirth rate / 1000 total births tracked in RHIS	Choose	0
	6.15	National SA	Intrapartum stillbirth rate and very early neonatal death rate (proportion of births that results in intrapartum or very ealry neonatal death within 24 hours)/ 1000 total births tracked in RHIS	Choose	0	Facility SA	Intrapartum stillbirth rate and very early neonatal death rate (proportion of births that results in intrapartum or very ealry neonatal death within 24 hours)/ 1000 total births tracked in RHIS	Choose	0
7 Refine strategies and scale up	**7.1**	National SA	Over what time frame do you hope to scale up LCG implementation?	text	NA	Facility SA	Major causes of neonatal mortality and % neonatal mortality by cause	text	NA
		National SA			**0**	**Facility SA**			**0**
		Max			**37**	**Max**			**37**
		National SA			**0%**	**Facility SA**			**0%**

Annex 3: Country example of WHO LCG Implementation roadmap – to reach maturity level 2-3

The project team reviews the 2018 WHO recommendations on intrapartum care for a positive childbirth experience and the new WHO Labour Care Guide.

The WHO LCG is considered an entry point for implementing the full set of WHO recommendations in a gradual fashion (see LCG Maturity Model).

The LCG and the trainer handbook are translated into Portuguese. An alpha-version of the LCG is prepared in Portuguese.

A Training of Trainers (ToT) workshop is carried out with WHO technical support. During the ToT workshop the adaptation of the tool is advanced. An agile focused group discussion is held to identify implementation barriers and facilitators and help design the implementation roadmap.

Local Trainers replicate the initial training at health-care facilities using the training tool and approved training tool is adopted by the MoH and released for use.

After two weeks of using LCG, a second ToT workshop is held for LCG training refreshment and troubleshooting. An agile focused group discussion is held to assess the two-week experience with the LCG. Final corrections to the LCG are made and the Final version of the tool is released.

During the second ToT, and following resquest of MoH, the safe birth check list is introduced. The tool is adapted to the country context and integrated into a comprehensive intrapartum care tool (LCG + safe birth checklist).

Implementation monitoring and evaluation starts with three components:
- LCG quality and coverage assessment
- Audit of severe maternal and perinatal events
- Overall impact assessment.

Evaluation and additional refinement to the tools. An agile focused group discussion is held to assess the overall experience with the LCG implementation and use.

Reporting and project closure.

Annex 4: Basic equipment and supplies for intrapartum care

Health facilities require basic essential equipment and supplies for routine care and detection of complications in the area of the maternity unit for labour and childbirth which should be available in sufficient quantities at all times.

Warm and clean room

1. Sufficient examination tables or beds with clean linens
2. Light source
3. Heat source
4. Clean and accessible bathrooms for the use of women in labour
5. Curtains if there are more than one bed

Equipment

1. Sphygmomanometer or other blood pressure machine
2. Stethoscope
3. Body Thermometer
4. Fetal stethoscope or Doppler

Hand washing

1. Clean water supply
2. Soap
3. Nail brush or stick
4. Clean towels
5. Alcohol-based hand rub

Medication

1. Bag of IV fluids
2. Oxytocin
3. Injectable Magnesium Sulphate
4. Antibiotics
5. Antiretrovirals
6. Antihypertensives
7. Analgesics
8. Anesthetics

Waste

1. Buckets for soiled pads and swabs
2. Receptacle for soiled linens
3. Container for sharp disposals

Sterilization

1. Instrument sterilizer
2. Jar for forceps
3. Vacuum extractor

Miscellaneous

1. Printed LCG
2. Wall clock
3. Torch with extra batteries and bulb
4. Log book
5. Medical records
6. Informed consent forms
7. Refrigerator
8. Basic accommodation facility for companions (chairs, space to change clothes, access to toilets)
9. Private physical space for the women and her companion
10. Power supply
11. Food and drinking water

Supplies and commodities

1. Gloves
2. Urinary catheters
3. Syringes with needles
4. Sterilized blade and scissors
5. IV tubing
6. Suture material for tear or episiotomy repair
7. Antiseptic solutions (Iodophors or chlorhexidine
8. Sprit (70%alcohol)
9. Swabs
10. Bleach (Chlorine based compound)
11. Impregnated bed nets
12. Urine dipsticks
13. Clamps
14. Oxygen cylinder/concentrator
15. IUCD, IMPLANTS for post partum family planning

From WHO LCG users guide, Annex 2. 1. World Health Organization. WHO labour care guide: user's manual 2020. https://iris.who.int/bitstream/handle/10665/337693/9789240017566-eng.pdf

Annex 5: WHO LCG sensitisation meeting guides

Objectives

To sensitise the Healthcare managers in public and private health sector as well as master trainers to support implementation of LCG as a decision making tool in labor care facility.

- Advocate for the use of the LCG by health providers to improve quality of intrapartum care
- Educate health providers on importance of using the LCG and document their experiences
- Orient and develop master trainers to cascade LCG trainings
- Provide orientation on supportive supervision, coaching and mentoring

Agenda

Session 1:

- Welcome, setting the stage
- WHO Intrapartum care recommendations
- WHO LCG, user`s manual
- WHO LCB implementation package

Session 2:

- WHO LCB and its comparison with WHO Partograph
- Supervision and monitoring mechanisms, including mentoring & coaching
- LCG implementation plan and its application in the local setting, expected risks and mitigation plans
- Strengthening implementation using the PDSA cycle

Annex 6: WHO LCG action plan

The aim of the WHO LCG action plan is to emphasize the LCG as a decision-making support tool. This begins during educational activities (e.g., initial training and low-dose-high-frequency refresher training) and also to support the transfer of learning to drive behaviour change in the labour and delivery ward. The action plan can be used within learner materials, or as a wall poster.

May 2024

Using the WHO Labour Care Guide

Assess – Record – Compare to alert – Plan

Prevent infection

Provide respectful care

Start documentation at active first stage: 5 cm

Complete top section and time axis

Assess supportive care → Record → Compare to alert

Companion	No
Pain relief	No
Oral fluid	No
Posture	Supine

Every hour

Circle and take action

Assess well-being of baby → Record → Compare to alert

Every 30 min - 1st stage
Every 5 min - 2nd stage

Every 4 hours - 1st stage
Every hour - 2nd stage

Baseline FHR	<110, ≥160
FHR deceleration	Late
Amniotic fluid	Meconium+++ Blood
Fetal position	Posterior Transverse
Caput	+++
Moulding	+++

Circle and take action

Assess well-being of woman → Record → Compare to alert

Every 4 hours

Every void

Pulse	<60, ≥120
Systolic BP	<80, ≥140
Diastolic BP	≥90
Temperature °C	<35.0, ≥ 37.5
Urine	Protein ++ Acetone ++

Circle and take action

Assess labour progress → Record → Compare to alert

Every 30 min - 1st stage
Every 15 min - 2nd stage

Every 4 hours - 1st stage
Every 30 min 2nd stage

Every 15 min 2nd stage

Contractions per 10 min		≤2, >5
Duration of contractions		<20, >60
Cervix	9 cm	≥2 hours
	8 cm	≥2.5hours
	7 cm	≥3 hours
	6 cm	≥5 hours
	5 cm	≥6 hours

Circle and take action

Assess need for medications → Record

Every assessment - at least every hour

Oxytocin (U/L, drops/min)
Medicine
IV fluids

Shared decision-making → Record assessment

Every assessment

Share findings/ Options for care

Record the plan

Add your initials

This information is made possible by the U.S. Agency for International Development (USAID) and MOMENTUM Country and Global Leadership, led by Jhpiego and partners, and does not reflect the views of USAID or the United States Government.

Annex 7: LCG training

WHO LCG training package is adaptable for training at national, sub-national & facility level.

Aims of the training

- To promote the use of the WHO LCG as the new labour-monitoring tool in routine clinical practice
- To ensure all participants are clinically competent in the use, documentation, and interpretation of the WHO LCG

Objectives of the training

On completion of the Initial LCG Training Workshop, participants will be able to:

- Use the WHO LCG as a routine labour-monitoring tool in clinical practice for all births
- Prospectively and accurately document clinical findings on a WHO LCG
- Make sound clinical decisions based on the interpretation of the WHO LCG, involving clients
- Implement best-practice supportive care principles into routine clinical practice

Target audience

Multi-professional team of skilled birth attendants: doctors, midwives, nurses and other health cadres delivering intrapartum care to women and newborns.

Training duration

2-day duration comprising of five sessions based on a participatory methodology to engage trainees and improve their knowledge and skills through group work, plenary discussions and learning by doing.

Material for training master trainers and participants (links to be added)

- WHO LCG Users' manual
- WHO LCG blank copies (A3 format)
- Labour Care Guide (LCG) Learning Resource Package developed by Momentum Country and Global leadership
- Cards and pens
- Anonymized intrapartum individual case: all participants are encouraged *to bring a set of ten anonymized intrapartum individual case notes* of women cared for in their hospital that will be used for case study practice. For data protection, please ensure all identifiers (Name, Address, Hospital number etc) are removed.

Sessions

Introduction to WHO LCG	This session assesses existing pre-training knowledge on intrapartum care and allows the participants to deepen their knowledge and understanding about WHO LCG.
Practice with evolving case	This session allows participants to get acquainted with each section of the LCG and with the distinct abbreviations used to fill in the LCG. The objectives of the session are: • To practice prospective completion of the LCG with an evolving clinical case. • To work collaboratively as a team to address any challenges or questions that arise.
Practice with real cases	This session trains participants to complete the LCG from real anonymized case scenarios. It also allows them to identify the missing information from existing partographs that are needed to adequately complete the LCG. The aims of the session are: • To practice additional LCG completion with clinical scenarios. • To discuss each case with the support of a small group of peers. Following the completion from real scenarios, participants will be able to: • Complete the LCG and apply their knowledge to a diverse range of real clinical scenarios. • Seek feedback and discuss any concerns they have with LCG completion. • Assist peers with LCG completion.
LCG implementation	This session encourages participants to discuss the perceived barriers and facilitators in implementation of LCG in their settings and consider the next actions to promote LCG implementation. The objectives of the session are: • To reflect on individual experiences, to then identify any facilitators and challenges to LCG implementation. • To identify solutions to any LCG implementation barriers identified. • To discuss next actions for LCG implementation.

Annex 8: WHO LCG Clinical Audit tool for routine use

(Ref- MCGL-WHO-LCG-LRP-Audit tool)

Woman's Labour Care Guide Use - Assess, Record, Check, Plan Id: DRAFT Version 0.1

Routine tool - *(every line needs one or more boxes completed)*

Section 1 - Identifying information, labour characteristics at admission					
Woman identification		name recorded			blank
Parity (Robson)	>= 1, multiparous	0 = Nulliparous			blank
Labour Onset		spontaneous	induced		blank
Length LCG completed (use for Record/ Assess below)					
Active first stage total	hours	less than 12 hours	≥12 hours		unknown
Second stage total	hours	less than 3 hours	≥3 hours		unknown
First and second total	hours				unknown
Section 2 - Supportive Care recorded					
Companion *Record*	Y = h	D= h	N = h		blank = h
Check - alert thresholds	all Y or D		circle x		miss x
Pain relief *Record*	Y = h	D= h	N = h		blank = h
Check - alert thresholds	all Y or D		circle x		miss x
Oral fluid *Record*	Y = h	D= h	N = h		blank = h
Check - alert thresholds	all Y or D		circle x		miss x
Posture *Record*		M = h	S = h		blank = h
Check - alert thresholds		all M	circle x		miss x
Section 3 - Baby					
FHR *Record*	start active labour	present, alive		antepartum SB	blank
FHR 1st stg *Record*	frequency	30 mins= h	60 mins= h	Not applicable	blank = h
FHR 2nd stg *Record*	frequency	15 mins= h	30 mins= h	Not applicable	blank = h
	assessment	all 110-160	≤109= times	≥161= times	
Check - alert threshold circles		no need	circle x	circle x	miss x
Decel 1st stg *Record*	frequency	30 mins= h	60 mins= h	Not applicable	blank = h
Decel 2nd stg *Record*	frequency	15 mins= h	30 mins= h	Not applicable	blank = h
	assess	all N / E / V	L = h		
Check - alert threshold circles		no need	circle x		miss x
Section 4 - Woman					
Pulse *Record*	freq = times	4h or more often	longer than 4 h		blank
	assess	all 60-120	≤59= times	≥121= times	
Check - alert threshold circles		no need	circle x	circle x	miss x
SBP *Record*	freq = times	4h or more often	longer than 4 h		blank
	Assess	all 80-140	≤79= times	≥141= times	
Check - alert threshold circles		no need	circle x	circle x	miss x
DBP *Record*	freq = times	4h or more often	longer than 4 h		blank
	Assess	all <90	≥91= times		
Check - alert threshold circles		no need	circle x		miss x
Temp *Record*	freq = times	4h or more often	longer than 4 h		blank
	assess	all 35.5-37.5	≤35.4= times	≥37.6= times	
Check - alert threshold circles		no need	circle x	circle x	miss x
Section 5 - Labour progress					
LCG started	cervix = cm	≥5cm active 1st	10cm 2nd stage	0-4cm latent	blank
Cervix *Record*	freq = times	4h or more often	longer than 4 h		blank
	Assess	progressed	5cm ≥6h / 6cm ≥5h / 7cm ≥3h / 8cm ≥2.5h / 9cm ≥2h		blank
Check - alert threshold circles		no need	circle / circle / circle / circle / circle		miss x
Section 6 - Medication recorded - 1st and 2nd stages					
Oxytocin augmentation *record*		N = h	Units/L = h	Drops/min = h	blank = h
Section 7 - Shared Decision making - 1st and 2nd stages					
Asessment *Record*	frequency	60 mins= h	N = h		blank = h
Initials *Record*	frequency	60 mins= h			blank = h

Example of completed LCG form for review

Woman's Labour Care Guide Use - Assess, Record, Check, Plan Id: 54321 Version 0.1 /5

Audit tool - (every line needs one or more boxes completed)

Section 1 - Identifying information, labour characteristics at admission

Woman identification		name recorded				blank
Parity (Robson)	2 >= 1, multiparous	0 = Nulliparous				blank
Labour Onset		spontaneous	induced			blank
Active Labour diagnosis	: h 6 / 7 / 20		time blank	date blank		blank
Ruptured membranes	05:00 h 6/7 /20		time blank	date blank		blank
Risk Factors						
Age	y	20-34y	≤19y	≥35y	recorded / risk missed	unknown
Gestation	weeks	37-40 weeks	≤36w	≥41w	recorded / risk missed	unknown
Obstetric conditions		recorded "none"	= Previous SB		recorded	unknown
			= Anaemia		recorded	unknown
			=		recorded	unknown
			=		recorded	unknown

Length LCG completed (use for Record/ Assess below)

Active first stage total	8 hours	less than 12 hours	≥12 hours	unknown
Second stage total	1 hours	less than 3 hours	≥3 hours	unknown
First and second total	9 hours			unknown

Section 2 - Supportive Care recorded

Companion *Record*	Y = 7 h	D= 0 h	N = 2 h		blank = h
Check - alert thresholds	all Y or D		circle x 2		miss x
Pain relief *Record*	Y = 7 h	D= 0 h	N = 2 h		blank = h
Check - alert thresholds	all Y or D		circle x 2		miss x
Oral fluid *Record*	Y = 7 h	D= 2 h	N = h		blank = h
Check - alert thresholds	all Y or D		circle x		miss x
Posture *Record*		M = 5 h	S = 4 h		blank = h
Check - alert thresholds		all M	circle x 4		miss x

Section 3 - Baby

FHR *Record*	start active labour	present, alive		antepartum SB	blank
FHR 1st stg *Record*	frequency	30 mins= 8 h	60 mins= h	Not applicable	blank = h
FHR 2nd stg *Record*	frequency	15 mins= 1 h	30 mins= h	Not applicable	blank = h
	assessment	all 110-160	≤109= times	≥161= times	
	Check - alert threshold circles	no need	circle x	circle x	miss x
Decel 1st stg *Record*	frequency	30 mins= 8 h	60 mins= h	Not applicable	blank = h
Decel 2nd stg *Record*	frequency	15 mins= 1 h	30 mins= h	Not applicable	blank = h
	assess	all N / E / V	L = h		
	Check - alert threshold circles	no need	circle x		miss x
Amniotic fluid *Record*	freq = 2 times	4h or more often	longer than 4 h		blank
	Assess	I /C /M+ /M++	B = times	M+++ = times	
	Check - alert threshold circles	no need	circle x	circle x	miss x
Position *Record*	freq = 2 times	4h or more often	longer than 4 h		blank
	Assess	A	P = times	T = times	
	Check - alert threshold circles	no need	circle x	circle x	miss x
Caput *Record*	freq = 2 times	4h or more often	longer than 4 h		blank
	Assess	0 / + / ++	+++ = times		
	Check - alert threshold circles	no need	circle x		miss x
Moulding *Record*	freq = 2 times	4h or more often	longer than 4 h		blank
	Assess	0 / + / ++	+++ = times		
	Check - alert threshold circles	no need	circle x		miss x

Section 4 - Woman						
Pulse *Record*	freq = 2 times	4h or more often	longer than 4 h			blank
	assess	all 60-120	≤59= times	≥121= times		
	Check - alert threshold circles	no need	circle x	circle x		miss x
SBP *Record*	freq = 2 times	4h or more often	longer than 4 h			blank
	Assess	all 80-140	≤79= times	≥141= times		
	Check - alert threshold circles	no need	circle x	circle x		miss x
DBP *Record*	freq = 2 times	4h or more often	longer than 4 h			blank
	Assess	all <90	≥91= times			
	Check - alert threshold circles	no need	circle x			miss x
Temp *Record*	freq = 2 times	4h or more often	longer than 4 h			blank
	assess	all 35.5-37.5	≤35.4= times	≥37.6= times		
	Check - alert threshold circles	no need	circle x	circle x		miss x
Urine *Record*	freq = 2 times	4h or more often	longer than 4 h			blank
	Assess	P neg/ P +	P++	P+++	P++++	unknown
	Check - alert threshold circles	no need	circle x	circle x	circle x	miss x
	Assess	A neg/ A +	A++	A+++	A++++	unknown
	Check - alert threshold circles	no need	circle x	circle x	circle x	miss x
Section 5 - Labour progress						
Contractions 1st stage *record*	frequency	30 mins= 8 h	60 mins= h			blank = h
Contractions 2nd stage *record*	frequency	15 mins= 1 h	30 mins= h			blank = h
	Assess	all 3-5	≤2 = times	≥6 times		
	Check - alert threshold circles	no need	circle x	circle x		miss x
Duration contractions 1st stg	frequency	30 mins= 8 h	60 mins= h			blank = h
Duration contractions 2nd stg	frequency	15 mins= 1 h	30 mins= h			blank = h
	Assess	all 20-60	≤19= times	≥61= times		
	Check - alert threshold circles	no need	circle x	circle x		miss x
LCG started	cervix = 5 cm	≥5cm active 1st	10cm 2nd stage	0-4cm latent		blank
Cervix *Record*	freq = 3 times	4h or more often	longer than 4 h			blank
	Assess	progressed	5cm / ≥6h	6cm / ≥5h	7cm / ≥3h	8cm / ≥2.5h	9cm / ≥2h
	Check - alert threshold circles	no need	circle	circle	circle	circle	circle	miss x
Descent *Record*	freq = 3 times	4h or more often	longer than 4 h			blank
Section 6 - Medication recorded - 1st and 2nd stages						
Oxytocin augmentation *record*		N = 9 h	Units/L = h	Drops/min = h		blank = h
Medicine *Record*		N = 9 h	medicine recorded = h			blank = h
IV fluids *Record*		N = 9 h	Y = h			blank = h
Section 7 - Shared Decision making - 1st and 2nd stages						
Asessment *Record*	frequency	60 mins= 9 h	N = h			blank = h
Plan *Record*	frequency	60 mins= 9 h	N = h			blank = h
Initials *Record*	frequency	60 mins= 9 h				blank = h

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