Original Article

Utilisation of the Labour Care Guide: Experiences of Health Workers in the Southern Part of Nigeria – A Qualitative Study

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Abstract

Background: The World Health Organisation (WHO) Labour Care Guide (LCG) is a standardised tool designed to enhance the quality of maternal care by systematically monitoring labour progression, maternal and fetal well-being, and supportive care. We sought to explore the views of Obstetricians on awareness, utilisation, challenges, experiences and potential modifications of the LCG implementation among healthcare providers in Nigeria's South-South and South-East zones. **Methodology:** The study employed qualitative methods, conducting interviews with 11 physicians from nine states: Ebonyi, Enugu, Abia, Anambra, Imo, Akwa Ibom, Cross River, Rivers, and Bayelsa. **Result:** Findings revealed that while LCG is recognised as a valuable tool for improving maternal care, its implementation remains limited, with full adoption observed only in Ebonyi State. Most respondents were aware of the LCG but awaited directives on usage from higher authorities. Barriers to adoption included insufficient training, resistance to transitioning from the traditional partograph, and resource limitations. Despite these challenges, non-users expressed optimism about future adoption, though no definitive timeline was provided. **Conclusion:** While the LCG holds significant potential to improve labour management and maternal outcomes, addressing these barriers is crucial to its successful and widespread adoption.

Keywords: Labour Care Guide, Partograph, Women, Monitoring

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INTRODUCTION

The World Health Organisation (WHO) recommends respectful maternity care.[1] Respectful maternity care upholds dignity, confidentiality, privacy, and freedom from harm and mistreatment during labour.[1] All of these are embedded in the Labour Care Guide (LCG), which was developed following a series of studies and modifications with the aim of making childbirth a more tolerable experience, ultimately achieving the goal of a healthy baby and a satisfied mother. [2.] The guide enables birth attendants to offer labouring women individualised, woman-centred and evidence-based care during labour and childbirth. [2] It emphasises respectful maternal care during childbirth. [1,3,4]

The partograph has been the most common labour monitoring tool worldwide until the development of LCG, a revised version of the WHO partograph that focuses on timely clinical interventions.[4,5] There have been evolutionary changes in labour management with the aim of preventing maternal and perinatal morbidity

and mortality. [5] Despite this, there are still high rates of maternal and perinatal morbidity and mortality in some facilities due to sub-optimal monitoring at the health facility level. [5] Partograph has been in use for the past 40 years and has been changed to LCG based on the available evidence from the 2018 document. [5] The essence is to reduce medicalisation of labour as much as possible, so as to allow the more evidence-based natural process to occur.

Some of the modifications made to the WHO LCG are: defining the active phase of labour as 5cm of cervical dilation; clarifying the duration of the first and second stages of labour; de-emphasising cervical dilatation of 1cm per hour; and emphasising women-centred, evidence-based care. [5] This would improve labour experience and childbirth for women and their babies. [5] The aim of developing this next-generation partograph called the Labour Care Guide (LCG) by WHO is to continuously remind health professionals to offer supportive care throughout labour and childbirth, to continuously observe labour for early identification of complications, to define reference thresholds for abnormal labour and to reduce over-diagnosis and under-diagnosis of abnormal labour, avoiding unnecessary intervention and promoting audits as well as improving labour care. [5-8]

It has been reported that there is a rising incidence of Caesarean section worldwide, most of which are said to be medically not necessary. [2] The World Health Organisation's LCG, as a tool, has been postulated to reduce the rising incidence of unnecessary CS if used effectively and implemented in all labour ward facilities. [2,9-11]

The LCG was introduced by the WHO in December, 2020, to replace the partograph. [3,8] Since then, some centres have adopted it to replace the traditional partograph, while some are yet to fully implement its use. The Society of Gynaecology and Obstetrics of Nigeria (SOGON) adopted it in November, 2021, at its annual conference at Markudi, Benue State. This demonstrates growing interest among healthcare institutions in various countries in implementing, adopting, or adapting the document to improve women's overall experience and quality of care during labour and delivery. [8] This was well demonstrated by SOGON.

A study that employed focus group discussions was conducted in six countries. This study involved doctors, midwives, and nurses and was based on labour outcomes and levels of satisfaction with the use of LCG. LCG was strongly recommended because it was feasible and acceptable for ensuring women-centred care. [9]

Some of the benefits of labour management with LCG include prevention of maternal death, stillbirths and newborn deaths.[6] Maternal and perinatal mortality rates have been very high in developing countries. The effort over the past 20 years has been widespread support for skilled birth attendants to improve care so as to prevent preventable deaths. This has led to increasing hospital delivery, yet mortality is still very high. The next step was to develop an effective tool to help achieve the goal of zero maternal and perinatal deaths [6,7,] the promise the WHO LCG has for Obstetricians. Our objectives were to determine the level of awareness of the LCG in tertiary health facilities, ascertain its implementation in tertiary health facilities' labour management, and explore the drivers and barriers to its implementation.

METHODOLOGY

This study utilised a descriptive research design with a fully qualitative approach. Key Informant Interviews (KII) were conducted virtually with obstetricians from nine states in Nigeria: Ebonyi, Enugu, Abia, Anambra, Imo, Akwa Ibom, Cross River, Rivers, and Bayelsa. Participants were Heads of Departments (HODs) of Obstetrics and Gynaecology from the tertiary hospitals. Each interview lasted between 5 and 10 minutes. The participants were asked what they know about LCG and whether it is currently in use at their facilities. They were asked about their personal experience with the LCG and how it compares with the partograph in terms of effectiveness. Questions about the challenges in using LCG and the barriers to implementing LCG were asked. They were also asked whether there has been any departmental training on the use of LCG and whether there are plans to strengthen and expand its use across their various states. The interview continued until saturation was reached, and a total of 11 participants were interviewed. The interviews were recorded and transcribed using an online transcription tool (Otter Meeting agent), and the transcripts were then carefully edited to correct errors and inconsistencies. The final transcripts were systematically analysed in alignment with the study's five objectives. Data collection, transcription, and analysis lasted for one month, from 1st to 31st of October,2024.

Data were analysed using thematic analysis to identify themes that emerged. The analysis was done manually. The transcripts were assembled, and themes were extracted. The extracted themes constitute the study's findings and discussion. The stages of analysis involved familiarisation with the data, generation of codes until saturation was reached, searching, reviewing and naming themes and finally generating a report.

RESULTS

Knowledge

All the respondents had detailed knowledge of the WHO LCG. The majority said it was an instrument recently developed by WHO and approved by SOGON and the Federal Ministry of Health. They were aware that its use begins during the active phase of labour and extends into the postpartum period. Some of the respondents, in their words, said: 'The most important thing is that it has come to replace the partograph that requires a lot of drawing and all that'.
'It is just a modified way of monitoring labour, a new thing and it is from WHO'.
'LCG is a new innovation and tool, recently introduced and adopted for the monitoring of labour. It is specifically made to ensure that women receive the best care'. KII8
'We were using partograph until the WHO came up with this modification, which they call labour care guide, making it simpler. The federal ministry of health has given more detail on how the woman and other parameters should be monitored and assessed during labour'. KII 1: 'LCG is a tool for monitoring the progress of labour'. KII 7

Usage

Only one centre has commenced full implementation of the LCG in labour management, while another has just completed a trial run. Others have adopted it as a tool for labour monitoring but have yet to commence implementation. In their own words - 'Our centre recently adopted it to replace the popular partograph'. KII 1 'We are not using it; I have never used it, but I read it on paper'.KII 9 'We are not using it because many people are not comfortable using it; we have not been trained. People are more trained on partograph'. KII 5 'In our centre, we have LCG and partograph in the folder of any booked patient; the reason is for those that are conversant with LCG to feel free to use it, but I have come to understand that most people, both junior and senior, are still using partograph'. KII 2

Experience

This generated a mixed response with conflicting experiences. 'The experience has been exciting and captures everything, and as a doctor you are never in a tight corner to see the action line because here you have a more relaxed atmosphere using the labour care guide because it ensures that baby and mother are okay. It gives you more time, and people say the experience is better. LCG encourages the patients to have companionship during labour; there is less medicalisation, and LCG gives the woman a longer time to be able to deliver'. KII 1. 'LCG requires a lot of writing, and you have to be detailed while writing, and every time you write, you need to correlate it with what you are seeing'. KII 1 'Staff have been trained, but people are still learning how to use it and become comfortable with it'. KII 2

Challenges

The majority of the respondents said that it is not easy to change from the old method of partograph to a new method of LCG, as they were already used to partograph, while others had varied opinions as shown below in their words; 'We wanted it to kick start immediately after the training on LCG, many people were finding it difficult to adopt the new innovation, until it was made compulsory by one of our top professors this week'. KII 2 'I have noticed that some people still have small hitches; some doctors do not follow it accordingly'. KII 1 'A lot of filling of additional information is required in the LCG'. KII 1 'Apart from the departmental training and meetings with the doctors, the nurses have not been trained on the use of LCG '. KII 1'It is a matter of policy, and you cannot be the only person that will be using it in your centre; you need to use partograph because everybody is conversant with it and can take over the management of a labour from you'. KII 3

Suggestion for Modification

A few respondents suggested the inclusion of a special segment to document the induction of labour in the LCG. Some suggested measures for enforcing its use, such as a protocol, as they await a standing order to commence its use. A respondent had this to say: 'The Prof. told us that centres can modify a little to suit what they want, so there are some areas we are trying to modify, but we have not done that. In that first column where the items were written in red, the nurses are asking if they can write anything there, but we are saying that the nurses should not write, except the doctor'. KII 1

DISCUSSION

Distinct themes, each reflecting key insights and perspectives shared by the study participants, were evident in this survey. By focusing on these themes, a comprehensive analysis highlighting the diverse experiences and viewpoints related to the implementation and use of the LCG is provided. Each theme was supported by specific statements and examples from the participants, allowing for a deeper understanding of their experiences, challenges, and successes. The thematic structure facilitated a focused exploration of various aspects of the LCG, including awareness, training, barriers to implementation, and perceived benefits.

Through this thematic discussion, we identified patterns and trends in participants' responses, highlighting common challenges and areas for improvement while also acknowledging the successes some facilities have achieved in adopting the LCG. This comprehensive examination will ultimately contribute to a better understanding of the current landscape of labour care practices and provide valuable recommendations for enhancing the use of the LCG in the future.

The majority of respondents were aware that the World Health Organisation (WHO) introduced the LCG as a standardised tool for monitoring labour progression and ensuring that adequate services and attention are provided to both the mother and the fetus during childbirth. This finding differs from a study conducted in Enugu, which reported poor knowledge and awareness of the LCG. Possibly because the participants in Enugu were a mixed audience comprising all cadres of health workers, whereas this study involved only the Heads of Departments (HODs) of Obstetrics and Gynaecology, who are the highest cadre of health professionals who care for women in labour. [12] The HODs understood that the LCG plays a crucial role in improving the overall quality of maternal care by facilitating a more organised, structured, and evidence-based approach to labour management. By guiding healthcare providers through continuous assessments of maternal and fetal well-being, labour progress, and supportive care, the LCG helps to ensure that no critical stages of labour are overlooked and that appropriate interventions are made promptly.[1.] Participants in another study had a negative perception of the LCG, as it emphasised impediments to its use, including time-consuming processes, insufficient manpower, insufficient knowledge, and a lack of training. The negative perception was associated with poor knowledge of LCG.[12]

Respondents also recognised that the LCG aligned with global standards for providing respectful and individualised care, contributing to better outcomes for mothers and babies. By promoting a more systematic approach to labour, the LCG ensures that care is not only reactive but also proactive, enabling timely adjustments and interventions when necessary. [3] This structured monitoring approach is seen as a significant advancement in maternal health, especially in settings where the traditional partograph has been the primary tool for labour tracking. The LCG's emphasis on a holistic and patient-centred approach is recognised as an important step in enhancing the quality of childbirth experiences and improving maternal and neonatal outcomes. [2] This finding is similar to a multi-country study where practitioners described the LCG as supporting precise and meticulous monitoring during labour, encouraging critical thinking in labour management, and improving the provision of woman-centred care. [9]

A tertiary hospital in Ebonyi State was said to have fully commenced the use of the LCG. This finding emerged from discussions with the obstetrician who participated in the study. According to the respondents, all doctors and midwives involved in caring for women in labour have received training in using the LCG. This further supports the multi-country findings that implementing the LCG needs to be accompanied by training and supportive supervision, and by strategies to promote an enabling environment (including updated policies on supportive care interventions and ensuring essential equipment is available).[9]

Additionally, the LCG is now routinely included in the medical records of all antenatal care (ANC) patients who have accessed ANC services at these facilities, as well as those who come to these facilities for delivery. This ensures that the LCG is readily available and integrated into their care process, supporting its effective use. The findings further emphasised that the LCG is feasible and acceptable to use across different clinical settings and can promote woman-centred care, though some design improvements would benefit usability.[9] Some factors identified by respondents as responsible for the non-implementation of the labour care guide are: **l**ack of strong enforcement by hospital authorities, as the LCG is not part of their unit or departmental protocols; difficulty adjusting to the abandonment of the partograph; **i**nsufficient number of trained personnel; and increased documentation requirements.

Most non-users expressed optimism about adopting the LCG in the near future, signalling a positive attitude toward its potential benefits for labour management and maternal care. However, despite this optimism, none of them could provide a specific date or timeline for when they would start using the LCG at their facilities. This uncertainty suggests that, while there is general interest and willingness to incorporate the guide into their practice, several key barriers remain to be addressed before full implementation can occur. One major obstacle is the lack of comprehensive training. Many healthcare workers are not yet fully trained in using the LCG, which creates hesitation and reluctance to adopt the tool. Without adequate training programs to equip staff with the knowledge and skills needed to use the guide confidently, implementation is likely to remain delayed. There is also the challenge of keeping up with retraining, as some staff may need periodic updates on best practices or adjustments to the LCG. Additionally, the absence of clear directives from hospital authorities and health policymakers further contributes to the delay in adoption. In many cases, healthcare workers are awaiting explicit orders or guidelines from higher authorities before they feel comfortable moving forward with implementation. The lack of strong enforcement policies and formal mandates results in the LCG being

viewed as optional rather than an essential part of labour management, leading to inconsistent or sporadic use. Another challenge is resistance to change among healthcare workers accustomed to using the traditional partograph. Many physicians and midwives have relied on the partograph for years and may be hesitant to abandon a familiar tool in favour of the more detailed and comprehensive LCG. This resistance to change is compounded by the perception that the LCG involves significantly more writing and documentation than the partograph, which could be viewed as burdensome by staff already dealing with heavy workloads.

One of the most significant observations is that the use of the LCG ensures that patients are never left unattended. It facilitates consistent and thorough monitoring at every stage of labour, with regular, close check-ups to assess both the mothers' and the fetus's well-being. This steady and proactive approach allows healthcare providers to promptly address issues, leading to higher-quality care and improved maternal and fetal outcomes. The findings of this study are similar to those reported in the multi-country studies, which emphasised that the LCG is feasible and acceptable to use across different clinical settings and can promote woman-centred care, though some design improvements would benefit usability. [9]

CONCLUSION

In conclusion, the study highlights both the potential benefits and challenges of implementing the WHO LCG in healthcare facilities across Nigeria's South-South and South-East zones. While there is widespread awareness of the LCG, with physicians and healthcare providers recognising its value in improving maternal and fetal monitoring during labour, the adoption of the tool remains limited to a few states, with Ebonyi being the only state that has fully commenced its use. Key barriers identified include a lack of strong enforcement by hospital authorities, resistance to abandoning the familiar partograph, insufficient personnel training, and the perception that the LCG entails more detailed and time-consuming documentation.

These challenges suggest that without significant policy enforcement, continued training efforts, and a shift in mindset among healthcare providers, the adoption of the LCG may remain slow. Despite these obstacles, there is optimism among non-users that the LCG will eventually be adopted, although no specific implementation timeline has been provided. Physicians in states where the LCG has been introduced report positive experiences, particularly in ensuring that labouring women receive consistent, close monitoring throughout labour. To enhance the adoption and effective use of the LCG, several recommendations have been proposed: continuous training and retraining of hospital staff, stronger enforcement of policies mandating LCG use, WHO-led monitoring and evaluation, and initiatives such as incentives for successful implementation and public awareness campaigns.

Additionally, integrating the LCG into digital health records could help reduce the burden of documentation and facilitate smoother transitions between caregivers. Overall, while the LCG has the potential to significantly improve labour management and maternal outcomes, successful implementation will depend on addressing the identified barriers and fostering a supportive environment for change.

REFERENCES

1. Bohren MA, TunÃ§alp Ã Miller S. Transforming intrapartum care: Respectful maternity care. Best Practice &Research Clinical obstetrics and Gynaecology. 2020; 67:113-126.
2. Fawole AO, Hunyinbo KI, Adekanle DA. Knowledge and utilization of the partograph among obstetric care givers in south west Nigeria. Afr J Reprod Health. 2008;12(1):22-29.
3. Lavender T, Cuthbert A, Smyth RM. Effect of partograph use on outcomes for women in spontaneous labour at term and their babies. Cochrane Database Syst Rev. 2018;8(8):CD005461. doi:10.1002/14651858.CD005461.pub5.
4. Yadav A, Baghel J, Davile M, Prakash A. An Analysis of the Barriers in Implementation of Labour Care Guide in India and Possible Measures to Combat Them. J Obstet Gynaecol India. 2023;73(Suppl 2):330-332.
5. Nnagbo JE, Agu PU, Eze MI, Ugwu GO, Adiri CO, Odoh GU et al. Introducing the World Health Organisation Labour Care Guide in Nigeria: Knowledge, Perceptions, and Impediments by Doctors and Nurses at 3-Tier Hospitals in Enugu, Nigeria. Niger J Basic Clin Sci.2024
6. Oladapo OT, Daniel OJ, Olatunji AO. Knowledge and use of the partograph among healthcare personnel at the peripheral maternity centres in Nigeria. J Obstet Gynaecol. 2006;26(6):538-41. doi: 10.1080/01443610600811243. PMID: 17000501.
7. Opiah MM, Ofi AB, Essien EJ, Monjok E. Knowledge and utilisation of the partograph among midwives in the Niger Delta Region of Nigeria. Afr J Reprod Health. 2012;16(1):125-132
8. Vogel JP, Pingray V, Althabe F, Gibbons L, Berrueta M, Puja Y et al. Implementing the WHO Labour Care Guide to reduce the use of Caesarean section in four hospitals in India: protocol and statistical analysis plan for a pragmatic, stepped-wedge, cluster-randomised pilot trial. Reprod Health 2023; 18:20.

9. Vogel JP, Comrie-Thomson L, Pingray V, Gadama L, Galadanci H, Goudar S et al. Usability, acceptability, and feasibility of the World Health Organisation Labour Care Guide: A mixed-methods, multicountry evaluation. Birth. 2021;48(1):66-75.
10. World Health Organisation (WHO). WHO Labour Care Guide: User's Manual. Geneva: WHO. 2020
11. World Health Organisation (WHO). Implementation challenges of the WHO Labour Care Guide: A policy brief. Geneva: WHO.2021
12. Nnagbo J, Agu PU, Eze MI, Ugwu GO, Adiri CO, Odoh GU et al. Introducing the World Health Organisation Labour Care Guide in Nigeria: Knowledge, Perceptions, and Impediments by Doctors and Nurses at 3-Tier Hospitals in Enugu, Nigeria. Nigerian Journal of Basic and Clinical Sciences. 2024; 21(3): 24-25.