Labour Care Guide and Traditional Partograph: Comparative Analysis of Intrapartum Documentation in a Birth Center

Labour Care Guide e Partograma Tradicional: Análise Comparativa do Registro Intraparto em Centro de Parto Normal

Labour Care Guide y Partograma Tradicional: Análisis Comparativo del Registro Intraparto en un Centro de Parto

RESUMO

Objetivo: Analisar a documentação do trabalho de parto a partir da aplicação do Labour Care Guide, adaptado da Organização Mundial da Saúde, comparando-o ao partograma tradicional quanto ao registro dos eventos intraparto. **Método:** Estudo observacional, descritivo e transversal, realizado em um Centro de Parto Normal do Distrito Federal, com dez parturientes em trabalho de parto ativo, acompanhadas por meio do preenchimento simultâneo do Labour Care Guide e do partograma tradicional. A análise foi descritiva e comparativa, centrada na documentação produzida pelos instrumentos. **Resultados:** Ambos contemplaram parâmetros essenciais de acompanhamento; contudo, o Labour Care Guide integrou, com maior detalhamento, a vigilância materna e fetal, os fatores de risco intraparto e os aspectos da experiência da mulher. **Conclusão:** As diferenças concentram-se na estrutura do registro intraparto, sendo o Labour Care Guide mais abrangente na visibilidade documental do cuidado centrado na mulher.

DESCRITORES: Enfermagem obstétrica; Trabalho de parto; Avaliação de processos e resultados em cuidados de saúde.

ABSTRACT

Objetive: To analyze labor documentation using the Labor Care Guide, adapted from the World Health Organization, and compare it to the traditional partogram regarding the recording of intrapartum events. Method: An observational, descriptive, and cross-sectional study conducted at a Normal Birth Center in the Federal District, involving ten women in active labor, monitored through the simultaneous completion of the Labour Care Guide and the traditional partogram. The analysis was descriptive and comparative, focusing on the documentation produced by the instruments. Results: Both instruments covered essential monitoring parameters; however, the Labour Care Guide provided greater detail regarding maternal and fetal monitoring, intrapartum risk factors, and aspects of the woman's experience. Conclusion: The differences between th s lie in the structure of intrapartum documentation, with the Labour Care Guide offering a more comprehensive view of woman-centered care in the documentation.

DESCRIPTORS: Obstetric nursing; Labor; Evaluation of processes and outcomes in health care.

RESUMEN

Objetivo: Analizar documentos normativos e institucionales del Sistema Único de Salud (SUS) relacionados con la atención sanitaria de las personas trans embarazadas, identificando lagunas y contradicciones en la normativa vigente. **Método:** Estudio cualitativo, descriptivo-exploratorio, con análisis documental basado en el modelo READ, el análisis de contenido de Bardin y el análisis crítico del discurso de Fairclough. Se analizaron 27 documentos publicados entre 2009 y 2024. **Resultados:** Se observó una escasa presencia de referencias al embarazo trans en las normativas federales y un predominio de enfoques centrados en la transición de género, con ausencia de directrices para la atención prenatal y el parto. Se identificaron lagunas en la producción de datos desglosados por identidad de género, inconsistencias entre las directrices institucionales y las prácticas asistenciales, y deficiencias en la formación de los equipos de salud. **Conclusión:** Las normativas presentan limitaciones estructurales que comprometen la integralidad de la atención, lo que indica la necesidad de una revisión institucional, la cualificación profesional y la incorporación de directrices específicas para la salud reproductiva de las personas trans en el SUS.

DESCRIPTORES: Personas transgénero; Atención prenatal; Equidad en salud; Acceso a los servicios de salud; Política de salud

Cecília Silva Almeida
Nursing Resident in the Obstetric Nursing Residency Program at the Federal District School of Public Health (ESP/DF).
ORCID: https://orcid.org/0009-0008-2743-8711

Hygor Alessandro Firme Elias
Obstetric Nurse, Master of Nursing, Tutor of the Obstetric Nursing Residency Program at the Federal District School of Public Health - ESP/DF.
ORCID: https://orcid.org/0000-0002-4285-902X

Kelly da Silva Cavalcante Ribeiro
Obstetric Nurse, Master of Health Sciences, Coordinator of the Obstetric Nursing Residency Program at the Federal District School of Public Health (ESP/DF).
ORCID: https://orcid.org/0000-0001-9882-9455

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INTRODUCTION

Childbirth is a physiological process, yet critical for maternal and neonatal safety. Systematic

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monitoring is essential to identify deviations and inform care. The traditional partogram, based on Friedman's studies and refined by Philpott and Castle with warning and action lines, established the current model[1].

However, variability in labor progression has called into question rigid time and dilation limits[2]. Traditional models still focus on temporal progression, with little emphasis on maternal monitoring and the woman's experience.

In 2020, the WHO launched the *Labour Care Guide* (LCG), based on evidence and recommendations from 2018[3-4]. The LCG integrates maternal-fetal well-being, risk factors, and the birth experience, with individualized alerts. In Brazil, the lack of an official translation and routine use creates a gap in care. This study analyzed birth documentation using the LCG compared to the traditional partogram.

METHOD

This is an observational, descriptive, cross-sectional study with a mixed-methods approach (quantitative and qualitative) that compared the LCG with the traditional partogram regarding the structure, organization, completeness, and visibility of records of intrapartum clinical events.

The LCG was used in a version translated by the researcher, exclusively for observational recording, without interfering with the provision of care or decision-making.

The study was conducted at the São Sebastião Birth Center, a peri-hospital Normal Birth Center affiliated with the Federal District Health Secretariat (SES-DF). The sample included 10 parturients in active labor, with cervical dilation ≥5 cm and age ≥18– . Those outside the institutional criteria for low-risk delivery and those admitted in advanced labor or the expulsive stage were excluded.

Data collection involved the simultaneous and independent completion of the LCG and the partogram, based on clinical progress and care records. Fetal descent was assessed using the De Lee method via vaginal examination. Obstetric data were obtained from the prenatal record and the admission form.

Data analysis was conducted using previously defined comparative categories: (1) identification and obstetric information; (2) well-being of the parturient; (3) maternal monitoring; (4) fetal parameters; (5) labor progression; (6) assessment and interventions performed. A qualitative comparative analysis of the structure and organization of the records produced by the instruments was employed, limited to the documentary dimension, without evaluation of clinical outcomes or impact on decision-making.

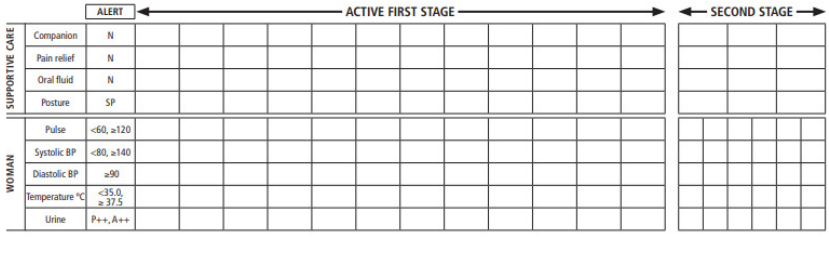
The study was approved by the Research Ethics Committee of the Foundation for Teaching and Research in Health Sciences (CAEE No. 87944925.8.0000.5553; opinion No. 7.916.752), in accordance with Resolution No. 466/2012 of the National Health Council.

RESULTS

Regarding the instruments analyzed, the identification domain showed equivalence in terms of basic data, differing in the recording of obstetric data, which were included only in the LCG.

Regarding maternal well-being and assessment, the parameters were recorded only in the LCG, since the partogram does not have specific fields. These included maternal position, pain relief strategies, and fluid intake, with warning criteria in six cases. Maternal clinical parameters were also recorded, with blood pressure changes in half of the cases. The organization of these components is shown in **Figure 1.**

Figure 1 - Maternal well-being and monitoring (LCG)



Source: WHO. LCG, 2020.

Regarding fetal vitality criteria, differences were observed in the form of recording, with no relevant clinical abnormalities. The LCG allowed for greater descriptive detail of fetal heart rate (FHR), with early decelerations recorded in three cases, while the traditional partogram was limited to the numerical value. Both recorded the appearance of the amniotic fluid; however, only the LCG allowed for its grading and association with warning criteria when meconium-stained. It also allowed for the recording of a variety of positions, as well as serosanguineous bulge and bone riding, both observed in a single case, enhancing the documentary visibility of these events (Figure 2).

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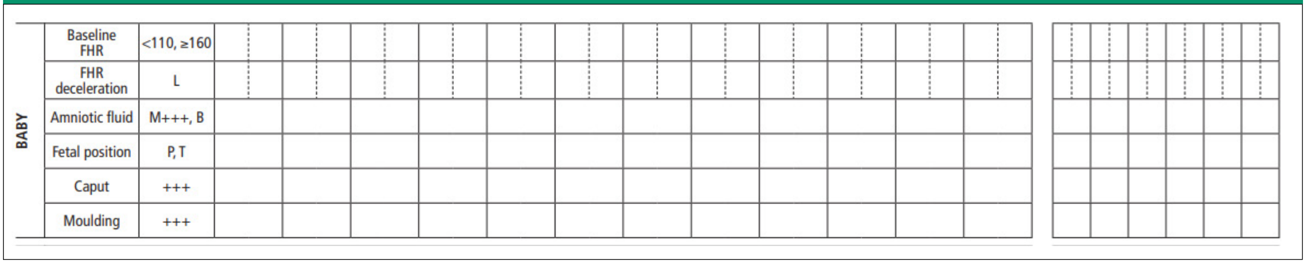
Figure 2 - Fetal parameters (LCG)

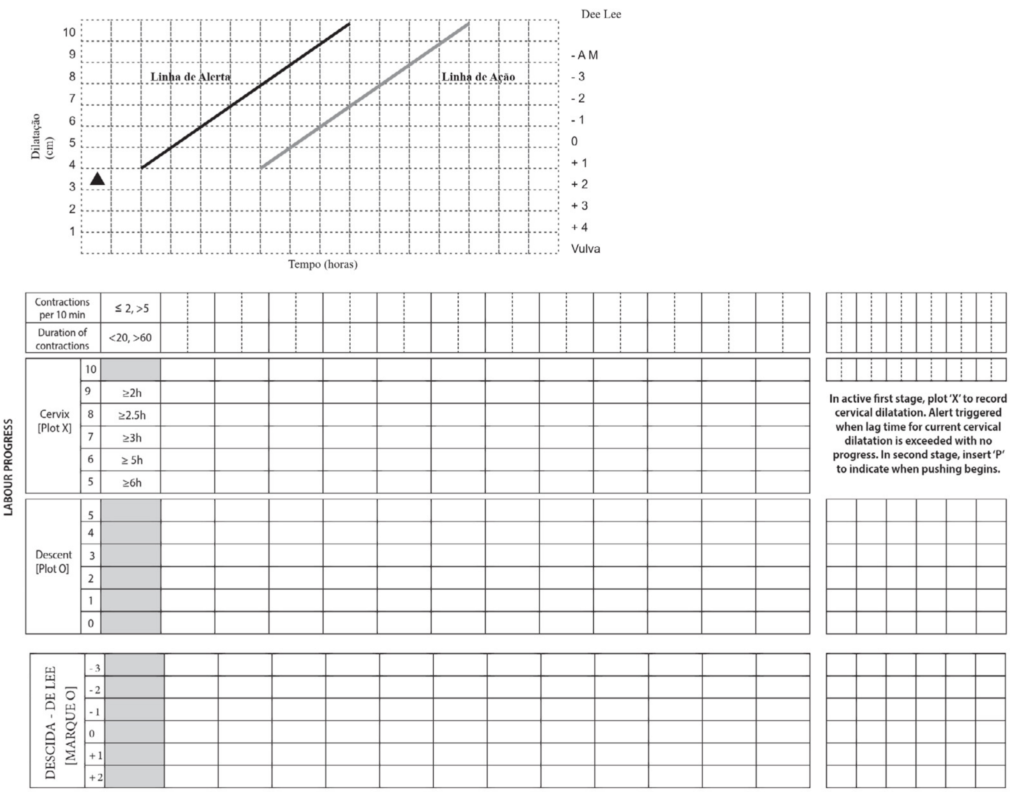


Source: WHO. LCG, 2020

Regarding labor progression, five cases of tachytocic progression were recorded. A difference in visualization was observed: the conventional partogram presents progression through a graphical representation with predefined alert and action lines, while the LCG organizes records in a descriptive manner structured by stages of labor. In both, no case exceeded the action curves.

The LCG allowed for greater detail regarding progression by organizing records by stages and adopting shorter assessment intervals, especially in monitoring FHR during the expulsive phase. In contrast, in the conventional partogram, records follow hourly intervals, with fewer notes and less descriptive detail. Fetal descent was assessed using the De Lee method, differing from the original LCG proposal but maintained in the corresponding field, preserving its recording logic. These differences are illustrated in

Figura 3 - Parâmetros de progressão de parto



Source: MS. Childbirth, abortion, and the postpartum period: humanized care for women, 2001, and WHO. LCG, 2020. Adapted by the authors, 2025.

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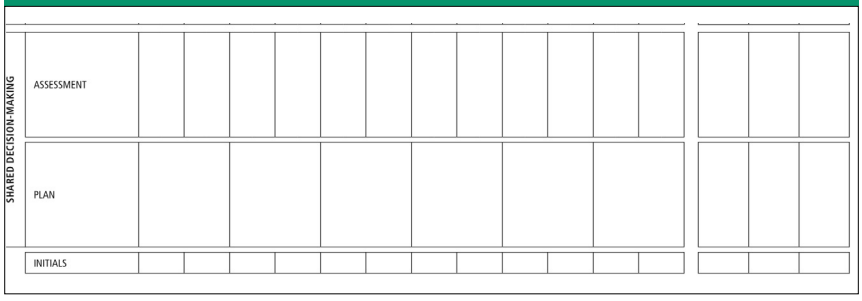
Regarding interventions, two cases of amniotomy and one of intrauterine resuscitation were recorded, with subsequent improvement in FHR, allowing for an integrated view of findings, interventions, and responses. Exercises during labor and delivery were recorded in three cases, and supportive measures in seven, including non-pharmacological methods for pain relief, encouragement of movement, and different positions during the expulsive stage—records exclusive to the LCG. These record fields are shown in Figure 4.

Figure 4—Assessment and Interventions



Source: WHO. LCG, 2020.

DISCUSSION

The findings highlight structural and functional differences between the LCG and the traditional partogram, particularly regarding the scope, organization, and visibility of intrapartum events. Although both include essential parameters, the LCG offers a more comprehensive record, centered on the woman and guided by clinical alerts.

In terms of identification, the data were equivalent; however, the LCG consolidates them into a single document, in open fields. Limitations were observed in both, with the absence of variables relevant to continuity of care and communication among professionals—a critical aspect for the safety of care [5-6]. Similarly, a study in Uganda [7] identified gaps also present in the partogram, indicating a need for contextual adaptations.

The mother's well-being parameters were recorded only in the LCG, demonstrating that alert situations remained undetected in the conventional record. This gap is significant, as guidelines from the WHO [3-4] and NICE [5] recognize physical and emotional well-being as an essential dimension of quality of care.

In maternal monitoring, hemodynamic parameters could only be recorded in the LCG. The incorporation of maternal risk factors, organized as a alert system, aligns with recommendations for continuous clinical surveillance [5-9] and ACOG guidelines [8-10-11]. The traditional partogram lacks structured fields for these records, which may limit the early identification of clinical deviations and delay interventions, in line with the literature that highlights the need for tools that integrate maternal and fetal monitoring in a systematic manner [6-12].

Regarding fetal vitality, differences were observed in the recording method. In the traditional partogram, FHR is recorded at hourly intervals, with limited characterization. The LCG aligns with auscultation recommendations for the first and second trimesters [5-13-14], considering accelerations, decelerations, and their relationship with uterine dynamics [5-10], which facilitates the early identification of hypoxia and the prevention of fetal acidosis [10].

Furthermore, the LCG allowed for the recording of specific fetal findings, with warning signs, that are absent in the conventional partogram. The integration of amniotic fluid into the overall clinical assessment, as recommended by guidelines [3-4-5-11], increases the visibility of events requiring an immediate response. Studies indicate that the quality of FHR and amniotic fluid recording is associated with the early detection of fetal distress and the reduction of adverse neonatal outcomes [15].

As labor progresses, differences in the organization of records reflect distinct monitoring approaches. The conventional partogram is based on graphical representation, while the LCG structures data by stages and with more frequent assessments. This model aligns with evidence that challenges the rigid limits of the Friedman model and acknowledges greater physiological variability in labor progression[2-16].

Interventions, on the other hand, were primarily related to supportive care and the well-being of the laboring woman, and were recorded exclusively in the LCG. They included non-pharmacological methods for pain relief, encouragement to change positions—including during the expulsive stage—as well as guidance on exercises during labor. This enhances the visibility of woman-centered care and is aligned with the recommendations of the WHO [3-4] and ACOG [8].

The presence of a support person, recorded exclusively in the LCG, demonstrated its ability to incorporate relational dimensions of care that are absent from the partogram. This aspect is relevant, as evidence indicates that continuous support during labor and delivery is associated with lower pain perception, greater maternal satisfaction, and better maternal and neonatal outcomes [17-18].

Regarding mobility, the adoption of non-supine positions and postural alternation is recommended due to their physiological benefits, such as

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improved labor progression, reduced pain, and fewer interventions [19-20]. The LCG allows for the recording of mobility and flags the supine position as an alert, a feature not present in the partogram, thereby enhancing the visibility of woman-centered care, especially in Normal Birth Centers [21].

Taken together, the findings corroborate international studies on the LCG, which highlight its documentary superiority over conventional partograms in integrating maternal and fetal monitoring, recording interventions, and incorporating the woman's perspective [8-12-22]. In the Brazilian context, where the instrument does not yet have an official translation or routine use, this study demonstrates its feasibility in a Normal Birth Center in the Federal District and its potential to improve intrapartum care documentation.

CONCLUSION

This study compared the documentation of labor using the LCG and the traditional partogram, showing that the main differences lie in the way clinical events, intrapartum risk factors, and aspects of the woman's experience are recorded. While the partogram focuses on the graphical representation of progression, the LCG broadens the scope by integrating maternal and fetal monitoring into an alert system and incorporating elements of woman-centered care.

Limitations include the small number of parturients, the single-site setting, and the documentary nature of the analysis. Future studies should investigate the applicability of the LCG in different contexts, its acceptability, and its impact on clinical practice and maternal-fetal safety.

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