

Changing Expectations in Labour Care: The Emergence and Significance of Successive Labour Monitoring Guidelines

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ABSTRACT

Labour care today aims to achieve more than a healthy mother and baby. It also seeks to provide a positive childbirth experience through respectful, individualised and evidence-informed care. As expectations of labour care have changed, successive labour monitoring guidelines have emerged in response to these changing expectations.

Labour monitoring is usually taught as a series of guidelines. It is seldom taught as the progression of clinical thinking behind them. Current recommendations describe what to do, but understanding why successive guidelines emerged provides the context in which they should be interpreted and applied.

This narrative review examines the emergence of successive labour monitoring guidelines through the changing expectations of labour care. Rather than presenting a chronological history, it explores why each guideline emerged, the evidence supporting it, its limitations, and the shift in expectations that led to the next stage in the evolution of labour monitoring. Earlier guidelines are not viewed as obsolete, but as appropriate responses to the priorities and understanding of their time.

The review provides clinicians with a practical framework for interpreting labour monitoring guidelines and applying them with informed clinical judgement while maintaining focus on the woman and her childbirth experience.

Keywords: Labour monitoring; Partogram; Clinical judgement; Evidence-based medicine; Labour Care Guide; Artificial intelligence

1. INTRODUCTION

Labour-monitoring tools can only be understood in the context of what each generation expected labour care to achieve. Every era of obstetric practice has approached the surveillance of labour with a different implicit question in mind, and the tools that era produced were built to answer

that question. Read this way, the history of labour monitoring is not simply a sequence of inventions. It is a sequence of answers to a changing question.

Expectations, as used here, means the prevailing priorities that clinicians, women, health systems, and policymakers held for

what labour care should achieve at a given time.

Existing accounts largely describe the development or performance of individual labour-monitoring tools. This review instead examines the transitions between them, using changing expectations of labour care as an interpretive framework to explain why successive approaches emerged and why older approaches continue to retain value in particular settings.

This is a narrative review, not a systematic review. Publications were selected on a clear basis: each marked a new instrument, overturned a prevailing assumption, or changed the stated aims of intrapartum care. The purpose was to trace and interpret these turning points in the history of labour monitoring, not to catalogue every publication addressing it.

At its origin, that question was survival: could the mother and baby be delivered safely by the hands available. As obstetric care moved into institutions and involved successive shifts of different attendants, the question changed to one of reproducibility: could progress be recorded in a form that any attendant, not only the one who had examined the woman, could understand. As caseloads grew and services were delivered across large public health systems, the question changed again to one of standardisation: could a system tell any attendant, in any setting, when to act. As outcomes improved and attention turned to the quality of the experience itself, the question changed once more to one of individualisation: was this woman treated as a person, with her preferences and her dignity respected, and not merely as a set of measurements. Most recently, as monitoring has come to draw on more data than any clinician can hold in mind at once, from continuous fetal heart-rate traces to ultrasound-derived measurements of fetal head position, the question has become one of complexity: can the growing volume and richness of intrapartum data be managed without overwhelming clinical judgement or displacing the woman from the centre of her

own care. These questions did not retire one another; each has continued to be asked, however unevenly, in different rooms on the same day.

This review follows that progression, not chronologically for its own sake, but as a way of showing why each stage of labour monitoring emerged when it did, what evidence supported it, what its limitations were, and what shift in expectations carried practice to the next stage. None of the approaches discussed below should be regarded as obsolete. Each was an appropriate response to the priorities and understanding of its time, and each may still offer value when applied in the context for which it was suited.

Clinical judgement has remained central throughout this history. What has changed is the scaffolding around it, the guidelines through which that judgement is directed toward a clinical diagnosis. Each new guideline redesigned the scaffold; none replaced the judgement it was built to support. FIGO has called for the Labour Care Guide to become the universal standard of labour monitoring, replacing the classical partograph.^[1] In practice, however, the classical partograph remains in widespread use, and the newer guide is still at an early stage of adoption in many settings. European health systems illustrate this pattern clearly. The United Kingdom's National Institute for Health and Care Excellence, for instance, maintains its own national intrapartum care guideline,^[2] illustrating how robust, well-established national systems can coexist with gradual, still-evolving adoption of the WHO guide.

2. CLINICAL JUDGEMENT BEFORE STANDARDISATION

For most of the history of childbirth, the surveillance of labour depended entirely on the clinical judgement of the attendant present. The experienced midwife or obstetrician built, through years of practice, an internalised sense of what a labour progressing well should feel like: the character of a contraction under the

palpating hand, the sense of a cervix that was ready to yield against one that was not, the subtle change in a labouring woman's behaviour that preceded difficulty. This judgement integrated many observations at once into a single clinical impression, and in skilled hands it was often accurate well before any single measurable sign had declared itself.

What this era expected of labour care was, in essence, competent presence: a trusted individual whose accumulated experience stood in for any formal system of measurement or record. This expectation was met, when it was met, by the quality of the individual attendant rather than by any tool. Its value lay in its sensitivity to the individual woman in front of the clinician; a good attendant read each labour on its own terms. Its limitation lay in everything that made it private. Judgement of this kind could not easily be communicated at a change of shift, could not be standardised between different attendants, could not be audited once an outcome had occurred, and could not be scaled to the many women who laboured without access to an experienced attendant. As childbirth moved from the home into institutions, and as a single woman's labour came to be observed by several different attendants across a single admission, this reliance on private, unrecorded judgement became increasingly difficult to sustain. The expectation of labour care was about to change, from trust in an individual to the ability to reproduce a shared observation.

This move was not simply imposed on women. Many expected childbirth to be painless and safe: anaesthesia offered relief that home birth could not, and physicians were trusted as the most qualified attendants available. That trust ran ahead of the evidence. Florence Nightingale's own midwifery ward at King's College Hospital, opened in 1862, closed just five years later after nine of one hundred and twenty-five women delivered there died of puerperal fever in a single year; Nightingale herself concluded that a woman was safer giving

birth at home than in most lying-in hospitals of her day.^[3] Only once antiseptics matured did institutions begin to deliver the safety long expected, aided in Britain by wartime displacement. Measurable improvement in maternal outcome did not arrive until the 1940s: for most of this period, the expectation of safety preceded the evidence for it.

3. THE NEED FOR REPRODUCIBILITY

By the mid-twentieth century, as childbirth moved into hospitals, both society and the labouring woman herself expected something simple: that someone could say, with some objectivity, whether her labour was progressing normally. That expectation could not yet be met. No reproducible, shared measure existed for what an experienced attendant judged, by touch, to be normal progress; the judgement lived in the attendant's hands and could not be verified by anyone else. Emanuel Friedman's answer to this gap arrived almost by accident. In 1954, as a young obstetric resident, he was asked by the anaesthesiologist Virginia Apgar to record cervical dilatation through a night on call, to study the effect of caudal anaesthesia on labour. By morning, his hourly measurements had traced a consistent sigmoid curve.^[4] Friedman's graphic analysis of labor supplied what the expectation required: a description of what normal labour looked like, set out as a latent phase of slow cervical change followed by an active phase in which the cervix was expected to dilate at a minimum of approximately one centimetre per hour.

Friedman's own purpose, however, was closer to research than prescription: to characterise normal labour and study how interventions altered it, not to fix a threshold for clinical decision-making. It was only as the tool spread into practice that later clinicians repurposed his descriptive curve into a prescriptive one, applying it as a standard against which every labouring woman would be measured. This is the first

instance of a pattern that recurs throughout this history: a finding answers the question it was built to answer; its later use can drift beyond that purpose.

4. THE NEED FOR STANDARDISED DECISION-MAKING

The expectation Philpott and Castle answered, in the peripheral clinics surrounding Harare Hospital, was a narrow one: a shared threshold that any midwife could apply, so that the decision to transfer a labouring woman for surgical care no longer depended on which attendant happened to be present. In 1972, they superimposed two lines on the cervicograph to meet it. The alert line, drawn at the minimum acceptable rate of one centimetre per hour, marked the point at which heightened vigilance and preparation for transfer became appropriate. The action line, drawn a fixed interval to its right, marked the point at which intervention was required.^[5] For the first time, the graph prescribed a response, not merely described one, in a form any trained attendant could apply without reproducing an experienced specialist's judgement.

By the 1980s, the expectation had grown beyond any single hospital or health system. Maternal death from poorly managed labour was understood to be a problem of global scale, and women everywhere, not only those within reach of a clinician like Philpott, were expected to have access to the same basic protection. The World Health Organization's Safe Motherhood Initiative, launched in 1987, was the institutional response. Between 1990 and 1991, the WHO tested the partograph in a multicentre trial across South East Asia involving over 35,000 women, and found that its systematic use reduced prolonged labour from 6.4 to 3.4 per cent, the need for augmentation from 20.7 to 9.1 per cent, emergency caesarean section from 9.9 to 8.3 per cent, and intrapartum stillbirth from 0.5 to 0.3 per cent.^[6] On this evidence, the WHO recommended the partograph for use in every labour ward, and many national health

systems subsequently embedded a version of it directly into routine intrapartum documentation, specifying not only how progress should be plotted but when referral or intervention was mandatory. This was a substantial achievement: a single, auditable, teachable standard of care, validated at a scale no single hospital's experience could have demonstrated.

A subsequent Cochrane systematic review was more circumspect, concluding that the evidence remains insufficient to be certain of the effect of routine partograph use, or of which design performs best,^[7] a caution that foreshadows the reassessment of the underlying assumptions described in the next section.

That same strength, however, contained the seed of the next shift. A standard applied uniformly to every woman necessarily disregards the differences between them. The one-centimetre-per-hour threshold, derived from a specific population under specific conditions, was treated as a universal law of labour rather than as a population average with a wide range of normal variation around it. Applied rigidly, it could convert physiological slow labour into a diagnosis of abnormal labour, and diagnosis into intervention that had not been strictly necessary. As the evidence matured, and attention turned to what labour care was for beyond avoiding the worst outcomes, this rigidity became harder to defend, and expectations began to shift again.

5. THE NEED FOR INDIVIDUALISED LABOUR CARE

The turning point in the evidence came from the Consortium on Safe Labor, whose large contemporary cohort, reported by Zhang and colleagues in 2010, re-examined the trajectory of cervical dilatation in women with normal outcomes and found that progress before five to six centimetres was considerably slower than Friedman's curve had suggested, without this slower progress being associated with any adverse consequence.^[8] The one-centimetre-per-hour rule was not, it turned out, a

physiological law. It was a feature of the population and conditions in which it had first been measured, not a universal norm, applied for decades as though it were.

The same reassessment occurred independently in the United States. The American College of Obstetricians and Gynecologists reached a parallel conclusion in 2014, recommending that the diagnosis of labour dystocia be revisited in light of evidence that contemporary labour progresses more slowly than historically taught,^[9] a position it has since maintained and updated.^[10]

This evidence, together with a broader reconsideration of what labour care should achieve, informed the World Health Organization's 2018 recommendations on intrapartum care for a positive childbirth experience.^[11] These recommendations explicitly rejected the rigid application of a single threshold and, for the first time at the level of global policy, placed the woman's experience of her own labour, her dignity, the presence of a companion of her choice, and her participation in decisions about her care, alongside clinical safety as a co-equal aim of intrapartum monitoring.

The WHO Labour Care Guide, published in 2020, translated this philosophy into practice.^[12] In place of a single alert line applied to every woman, it introduced reference thresholds for cervical dilatation that vary with the stage of labour, and it recorded supportive care and shared decision-making as formal elements of the labour record, documented with the same seriousness as cervical dilatation itself. The expectation this instrument answered was individualisation: that a woman's care should respond to her particular labour and her particular preferences, not merely to a population average.

The expectation of individualised care extended beyond how labour was monitored to where birth itself should take place, and this expectation did not originate with the Labour Care Guide. In England, advocacy from groups such as the National Childbirth Trust, and the statistician Marjorie Tew's

direct challenge to the assumption that hospital birth was inherently safer, led to the 1993 Changing Childbirth report and a national commitment to choice of birth setting, a quarter of a century before the WHO's 2018 recommendations.^[13] Data from the Birthplace in England study show that delay in labour progress is the single largest reason women planning a home birth are transferred to an obstetric unit, accounting for around a third of such transfers, more than twice the rate of any other cause.^[2] Since this figure reflects diagnoses of delay made under the threshold-based standards described in Section 4, individualised approaches to assessing progress, such as those introduced in the Labour Care Guide, would be expected to reduce the share of transfers driven by rigid threshold breaches, though this has not yet been directly measured. The Labour Care Guide did not create the expectation of individualised care in 2020; it gave a scattered movement a shared global voice.

This return to individualised assessment did not represent a rejection of the standardisation that preceded it. It represented standardisation maturing, informed by better evidence and a broader understanding of what good labour care requires, and reaching back toward the sensitivity to the individual woman that the earliest, unstandardised clinical judgement had always possessed, but now within a transparent, evidence-based, and teachable framework rather than as a private skill confined to the most experienced practitioner.

6. THE NEED TO MANAGE INCREASING COMPLEXITY

Alongside this philosophical shift, the volume and richness of data available during labour has grown substantially. Continuous electronic fetal monitoring generates a far denser record of fetal heart rate and uterine activity than intermittent auscultation, though interpretation remains subject to considerable inter-observer

variability. Intrapartum ultrasound now allows objective, reproducible measurement of fetal head station, position, and the angle of progression, addressing a source of subjectivity in the vaginal examination that no earlier tool had overcome.^[14] Wearable and wireless sensors are beginning to offer continuous, non-invasive monitoring of uterine activity and fetal wellbeing outside the constraints of a fixed monitor.^[20]

These newer modalities have, in turn, created the conditions for algorithmic decision support. Systems now exist that combine maternal characteristics with the dynamic trajectory of cervical dilatation to generate individualised predictions of labour outcome,^[21] and decision-support tools that integrate objective ultrasound measurements into models that stratify the risk of dystocic delivery.^[15,22] The expectation these tools respond to is the management of complexity: that no single clinician can hold every relevant data stream in mind simultaneously, and that a well-designed system might do for the twenty-first-century labour ward what the cervicograph once did for the twentieth, translating a mass of observation into something a clinician can act upon.

These concerns are not unique to obstetrics. Across medicine, the deployment of machine-learning tools has raised recurring questions of algorithmic bias, the difficulty of external validation across different populations, the opacity of model reasoning to the clinicians using it, and the absence of settled regulatory pathways for tools of this kind.^[16] Obstetric applications of artificial intelligence are only beginning to be evaluated against these same standards.^[17]

This stage of development carries its own characteristic risk, just as each preceding stage did. Where the rigid partograph risked converting a population threshold into a universal rule, an algorithmic system trained on data generated during the era of rigid thresholds risks inheriting and amplifying the same rigidity in a less visible form, and its recommendations are, by their nature, harder for a clinician to interrogate than a

printed line on a chart. Meeting the expectation of managing complexity without losing the individualisation so recently achieved, and without allowing a new form of opacity to displace clinical judgement, is the task that now defines this stage of labour monitoring's evolution.

7. LESSONS FOR CONTEMPORARY CLINICAL PRACTICE

Read as a sequence of responses to changing expectations rather than as a chronological catalogue of tools, this history offers a practical lesson for clinicians using any of these instruments today. Understanding why labour-monitoring guidelines evolved enables clinicians to exercise informed clinical judgement rather than apply recommendations mechanically. A clinician who understands that the one-centimetre-per-hour rule was a feature of one population, not a physiological law, is better equipped to recognise when a labour that falls outside it may nonetheless be safe. A clinician who understands why the alert and action lines were introduced is better placed to use them as intended, as prompts for vigilance and timely referral, rather than as automatic triggers for intervention. A clinician who understands what problem the Labour Care Guide was designed to solve is better placed to use its flexibility as it was intended, rather than mistaking flexibility for the absence of a standard.

None of the approaches described in this review should be regarded as redundant. Each addressed the realities and priorities of its time and continues to offer valuable insight when applied in the appropriate clinical context. Standardisation and individualisation can look like they pull in opposite directions. Read instead as good-faith responses to what each era understood of the woman's needs, neither approach is invalidated by the one that followed it. The rigid partograph remains a defensible instrument in a high-volume facility with limited staff and training time; it was, in its era, the best available tool for the standardisation that expectation required.

The individualised Labour Care Guide is expected to improve on this, in part by correcting caesarean sections driven by an over-rigid diagnosis of prolonged labour, since labour dystocia remains the most common indication for primary caesarean delivery.^[21] The task for the clinician is not to identify which single tool is correct, but to recognise which expectation of labour care that tool was built to answer, and whether that expectation still matches the woman and the setting in front of them.

The trial evidence for this expectation, however, is not yet settled. A single-centre randomised trial in India found a large reduction in caesarean rate with the Labour Care Guide, from 17.8% with the partograph to 1.5%.^[23] A larger, four-hospital cluster-randomised pilot trial, also in India, found a smaller crude reduction that did not reach statistical significance.^[25] An ambispective cohort study in rural Uganda found the opposite: the Labour Care Guide increased both the diagnosis of obstructed labour and the caesarean rate, by detecting genuine obstruction that the partograph had been missing.^[24] These findings are not simply in contradiction; they suggest that the Labour Care Guide's effect on intervention rates depends on the direction of the diagnostic error the partograph was making in a given setting, over-diagnosis of delay in some contexts, under-diagnosis of genuine obstruction in others.

This pattern of intertwining is not incidental; it is close to the central lesson. Needs, expectations, and the tools built to meet them do not arrive in sequence and retire in turn. Friedman's curve was repurposed into prescription decades after it was published as description. The partograph and the Labour Care Guide are recommended and used side by side today, not one after the other. England's turn toward individualised choice of birth setting predates the WHO framework that would later name the same expectation, by a generation. What looks, from a distance, like five discrete eras is, at close range,

several needs coexisting and evolving together, at different speeds, in different places, often within the same health system at the same time.

This task will only grow more important as artificial intelligence enters the labour ward. Emerging innovations are best evaluated against the underlying goals of labour care, not their technological novelty alone. A tool should be judged by whether it helps a clinician exercise better judgement on behalf of the individual woman in front of them, not by how much data it processes or how advanced its underlying method appears.

This review uses changing expectations of labour care as an interpretive framework rather than as a claim of historical causation. Other lenses, including resource availability, medicolegal liability, and technological capability, could illuminate the same history. This review focuses on the lens of changing expectations. The literature cited is predominantly English-language and drawn largely from high-income and a small number of low- and middle-income settings; it may not capture the full diversity of global practice.

Guidelines support clinical judgement; they do not replace it. That principle has held true at every stage of the history traced in this review, from the earliest cervicograph to the most recent guide, and there is no reason to expect it to hold any less true at the next stage still to come. The tools available to the labouring woman's attendant will keep changing, as they always have, in response to what each generation comes to expect of good labour care. What should not change is the discipline of asking, of any tool old or new, what expectation it was built to serve, and whether the woman at its centre is still being served by it.

The most recent instance of this pattern is unfolding as this review is being written, in the form of two 2025 publications from global professional and policy bodies.

8. FIGO'S 2025 POSITION: INTENTION AND IMPLEMENTATION

In 2025, FIGO's Committee on Childbirth and PPH issued a position statement on the use of the WHO Labour Care Guide versus the partograph.^[1] FIGO supports the WHO's intention that the LCG replace the partograph, on the basis of the evidence that informed the LCG's design. At the same time, FIGO anticipates that replacing a tool that has been in widespread use for more than half a century may provoke anxiety, apathy, uncertainty, and even opposition among labour care providers globally, an acknowledgement that this transition is a process still under way, not one already complete.

FIGO's own statement is candid about the scale of that process. It notes that heavy workloads in many labour wards make it challenging to consistently and accurately record all observations required by the LCG, a difficulty it states applies to the partograph as well. It observes that the physical layout of many labour wards does not support certain LCG components, such as companionship, and that poor staffing and limited equipment and medication supplies pose further barriers in many settings. Being a comparatively new tool, the LCG is not yet widely available, and many labour care providers remain unfamiliar with or untrained in its use. FIGO states that significant additional efforts, including medium- and long-term follow-up, will be required before implementation is complete.

In direct response to this gap, FIGO's seventh recommendation states that in settings where the LCG is unavailable or staff have not yet been trained in its use, the partograph should continue to be used for labour monitoring until conditions allow for its replacement. This is presented by FIGO as an implementation roadmap toward a declared destination, not as a claim that the partograph has already been superseded in practice.

WHO's own subsequent publications trace a parallel path. In October 2022, WHO published a policy brief setting out key points for countries considering adoption of the LCG.^[18] In September 2025, WHO published a further document, the WHO Labour Care Guide: Implementation Resource Package, built to help countries use the LCG to replace the partograph and to support policymakers, programme managers, trainers, and frontline providers in doing so.^[19]

Together, FIGO's 2025 position statement and WHO's 2025 implementation resource package mark the most recent stage in the WHO Labour Care Guide's development: from the 2018 recommendations that prompted its design, through its 2020 launch, a 2022 policy brief on adoption, to dedicated implementation guidance from both bodies in 2025.

CONCLUSION

Labour monitoring has evolved through successive tools, each built to answer the expectation of its era: survival, reproducibility, standardisation, individualisation, and now complexity. None of these tools has been rendered obsolete by the one that followed it; each retains value in the context for which it was suited. FIGO's and WHO's own 2025 publications confirm that this transition is still actively under way, not complete. Guidelines support clinical judgement; they do not replace it, and that principle is likely to hold at whatever stage of this history comes next.

Declaration

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