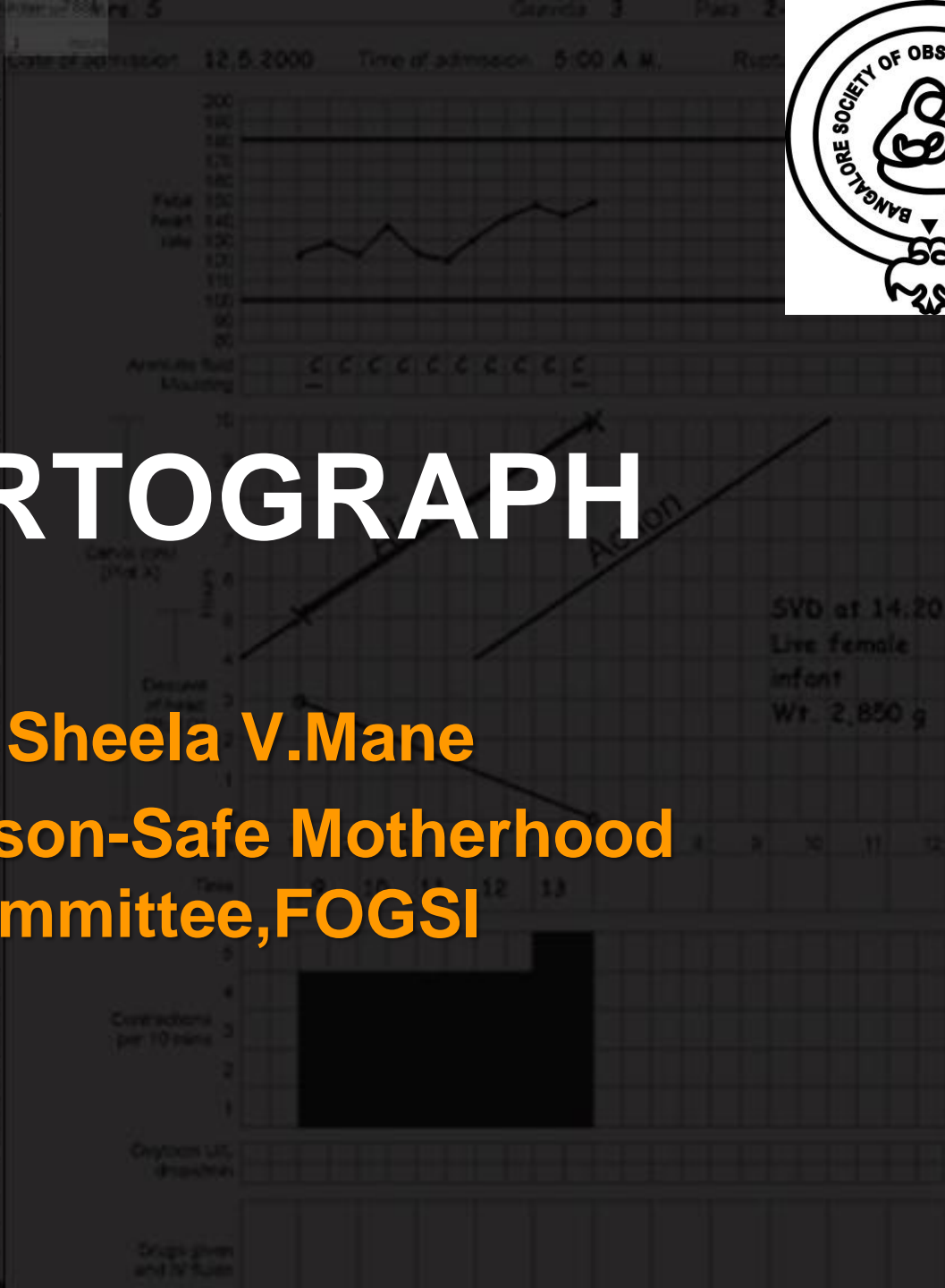




# PARTOGRAPH

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**Committee, FOGSI**



S A F E M O T H E R H O O D

# Preventing Prolonged Labour: a practical guide

## The Partograph Part II: User's Manual



MATERNAL HEALTH  
AND SAFE MOTHERHOOD PROGRAMME  
DIVISION OF FAMILY HEALTH  
WORLD HEALTH ORGANIZATION  
GENEVA

P r a c t i c a l G u i d e

# Maternal Mortality

- Half a million women lose their lives every year because of pregnancy
- Obstructed labour and ruptured uterus contribute upto 70% of maternal mortality
- Early detection of abnormal progress & prevention of prolonged labour can significantly reduce MM

## Objective of this EOC drill

- To teach the use of Partograph in the management of labour

*( Not to teach the principles and physiology of labour)*

# By the end of the program the participant should be able to:

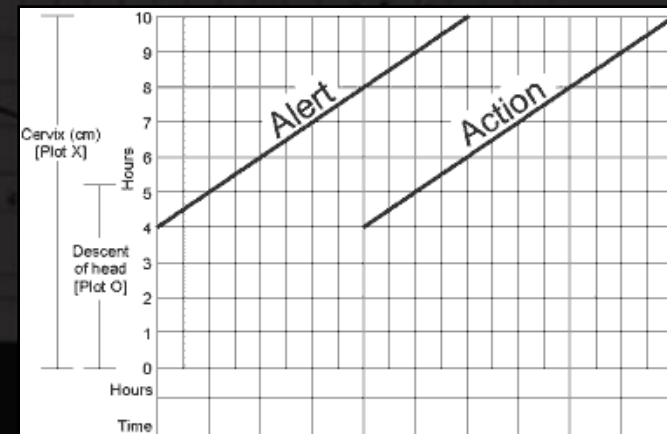
- Know when to start a Partograph
- Understand and complete all parts of the Partograph
- Describe all abnormalities in labour
- Know how to recognize prolonged labour on the Partograph
- Know when to transfer a woman in labour
- Have some knowledge of possible management options

# Partograph

- Graphic recording of the progress of labour
- Recording of salient conditions of the mother and fetus

## Uses

- To detect labour that is not progressing normally
- To indicate when augmentation of labour is appropriate
- To recognize CPD long before obstruction occurs



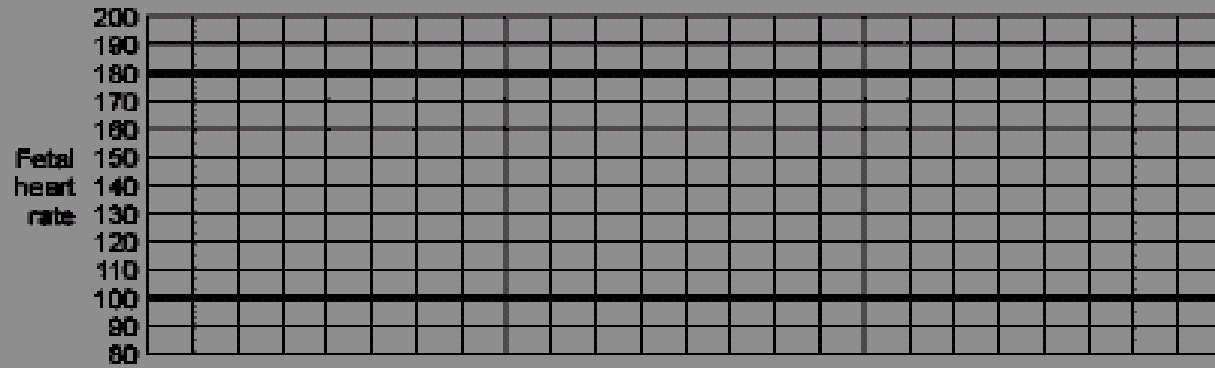
# Partograph

- Increases the quality of all observations on the mother and fetus in labour
- Serves as an “Early warning system”
- Assists in early decision on transfer, augmentation, termination of labour

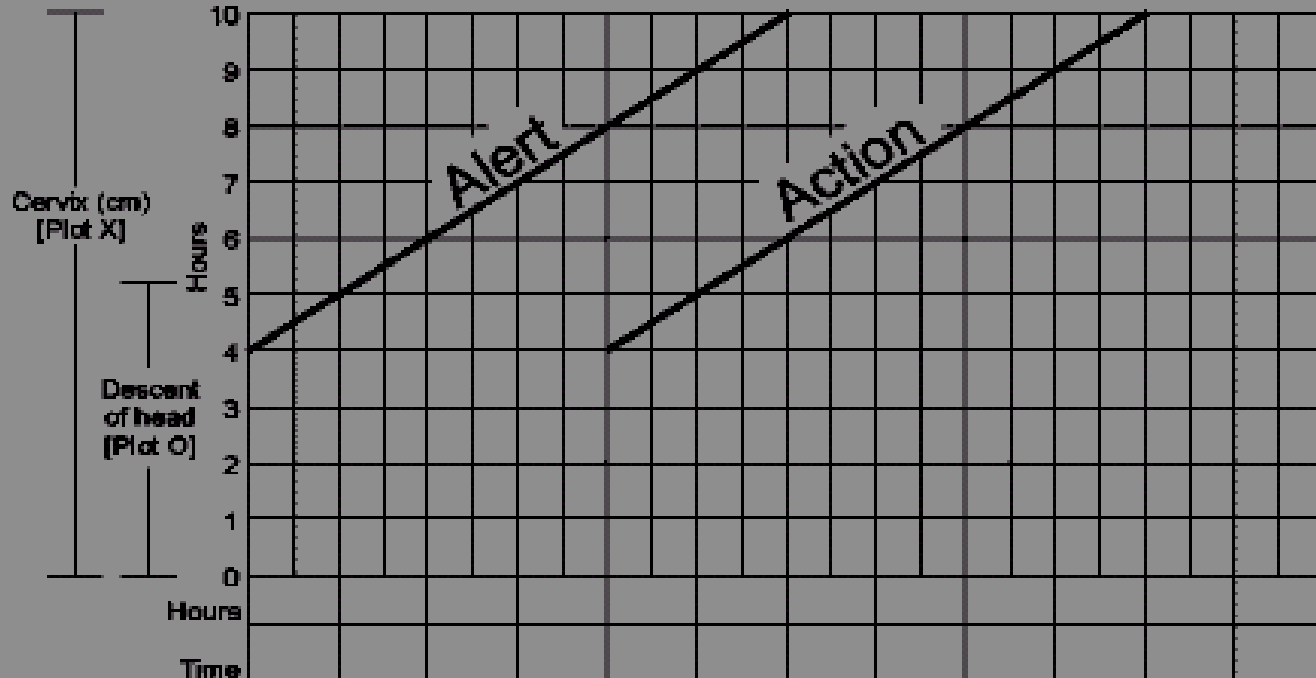
Name	Gravida	Para	Hospital number	
Date of admission	Time of admission		Ruptured membranes	hours
<p>Fetal heart rate</p> <p>Amniotic fluid Moulding</p> <p>Cervix (cm) [Plot X]</p> <p>Descent of head [Plot O]</p> <p>Hours</p> <p>Time</p> <p>Contractions per 10 mins</p> <p>Oxytocin U/L drops/min</p> <p>Drugs given and IV fluids</p> <p>Pulse ● and BP ▲▼</p> <p>Temp °C</p> <p>Urine { protein, acetone, volume</p>				
<p>Alert</p> <p>Action</p>				

Name \_\_\_\_\_ Gravida \_\_\_\_\_ Para \_\_\_\_\_ Hospital number \_\_\_\_\_

Date of admission \_\_\_\_\_ Time of admission \_\_\_\_\_ Ruptured membranes \_\_\_\_\_ hours \_\_\_\_\_



Amniotic fluid Moulding \_\_\_\_\_

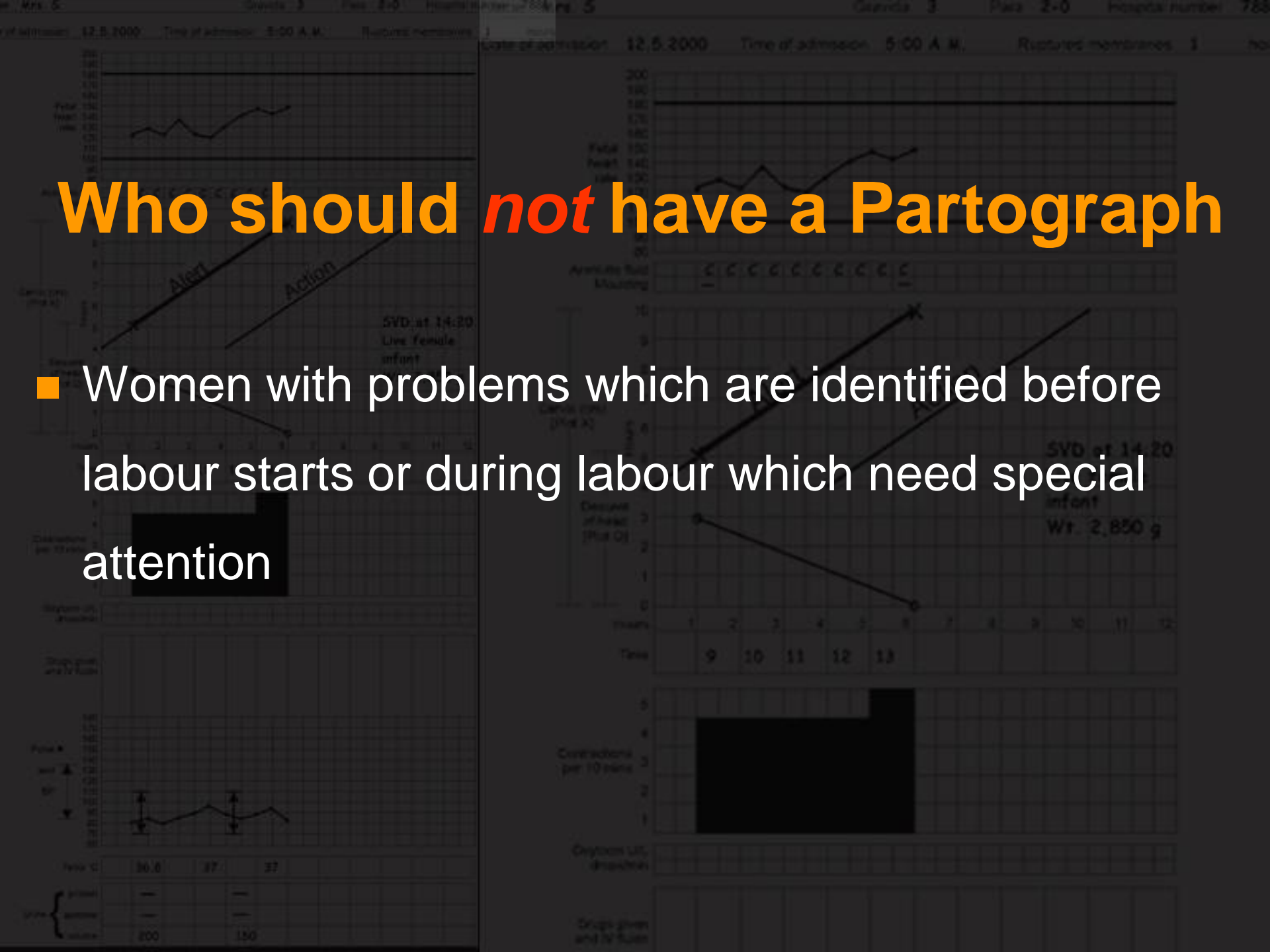






# Who should *not* have a Partograph

- Women with problems which are identified before labour starts or during labour which need special attention



# Observations charted on the Partograph

## The Progress of labour

Cervical dilatation

Descent of fetal head

Uterine contractions – duration, frequency

## Fetal condition

Fetal heart rate

Membranes and liquor

Moulding of the fetal skull

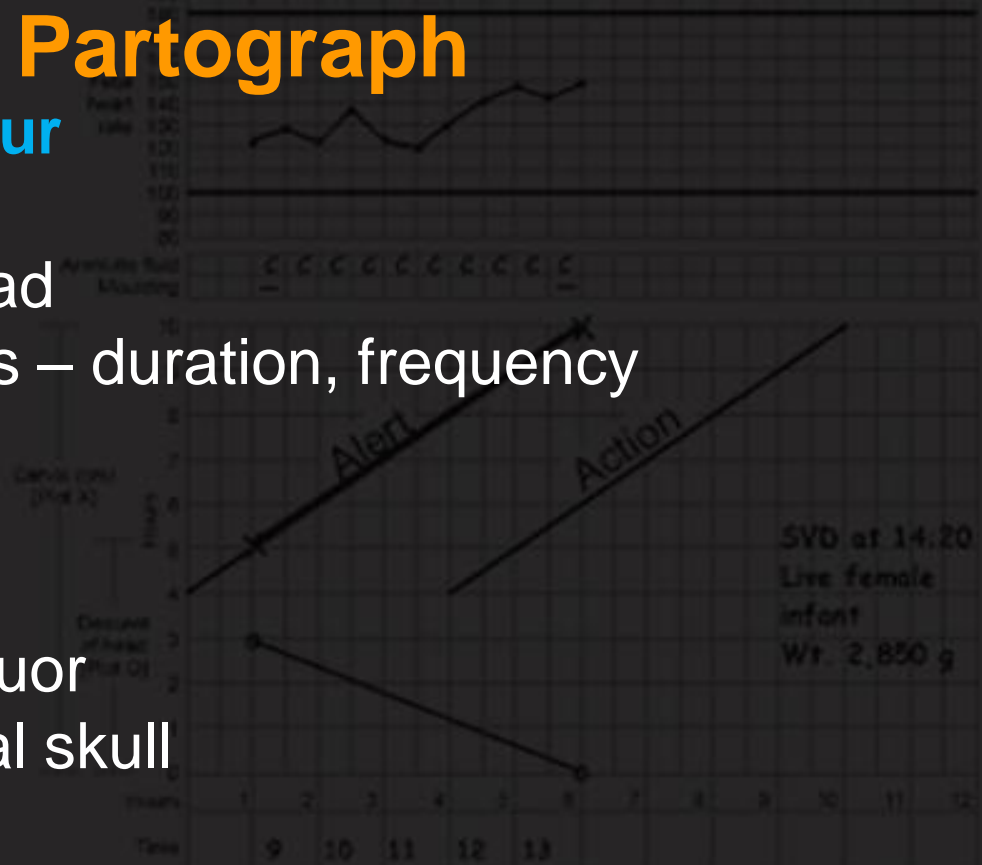
## Maternal condition

Pulse/ BP / Temp

Urine – volume, acetone, protein

Drugs & IV Fluids

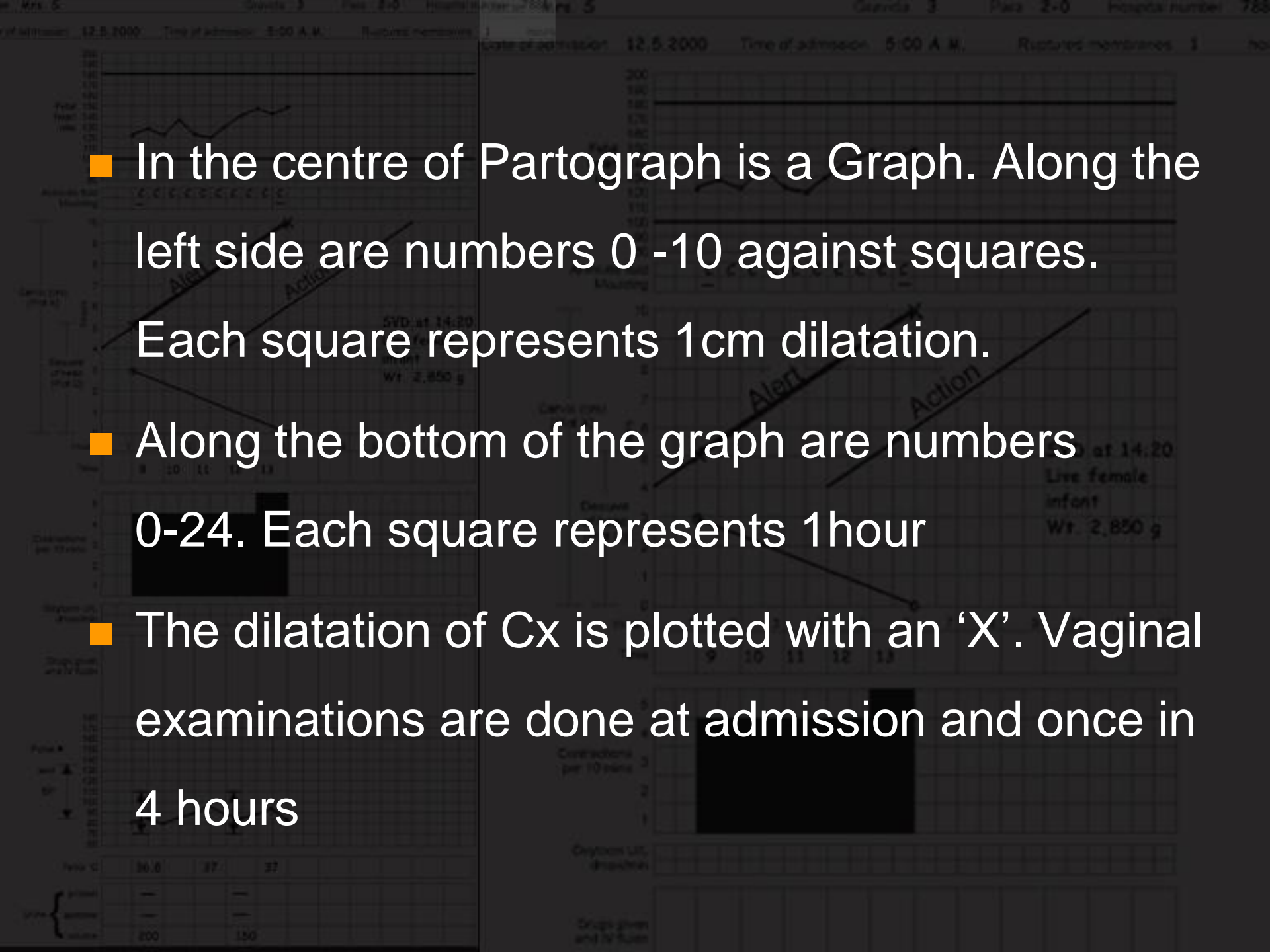
Oxytocin regime

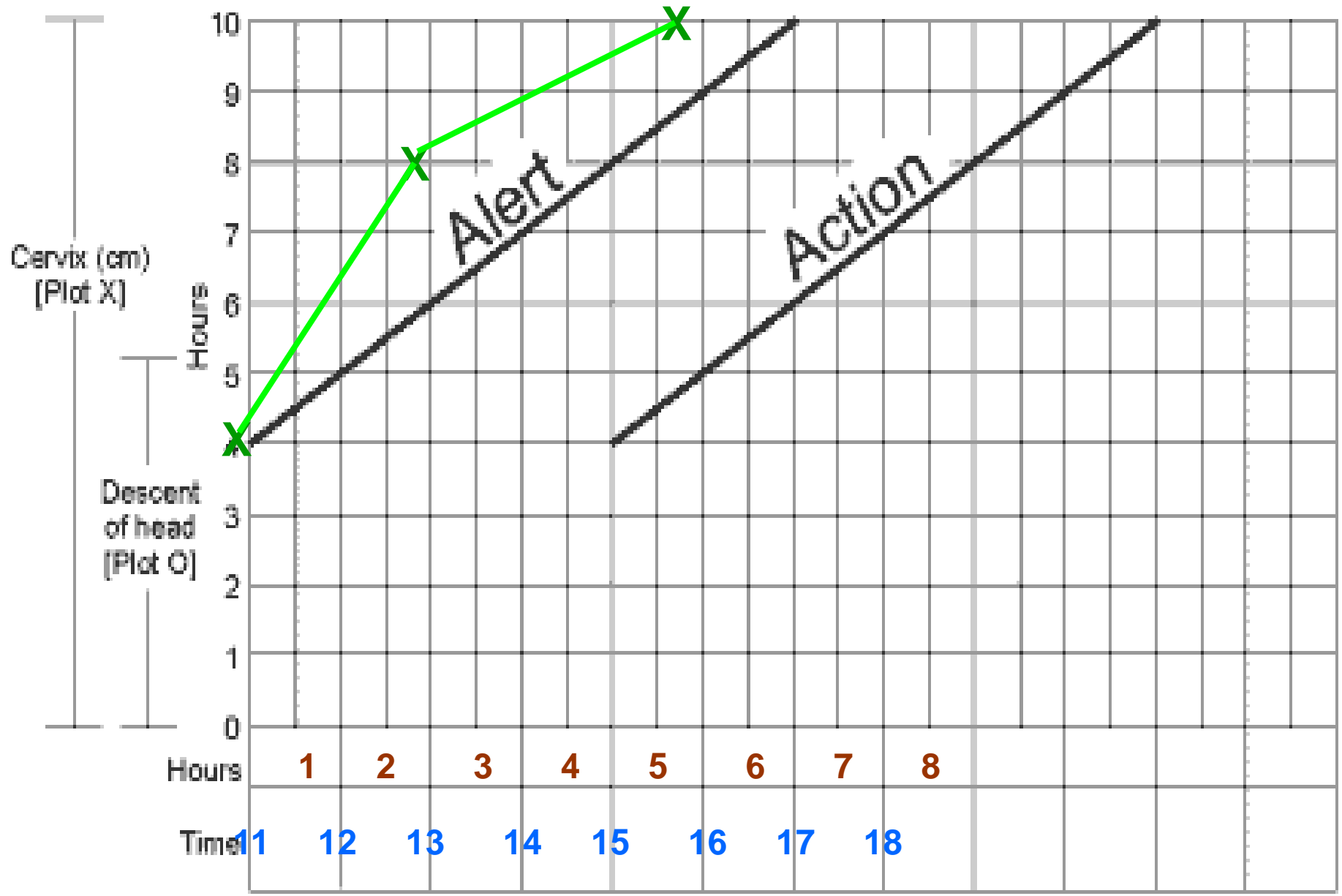


# Starting a Partograph

A partograph should be started only when a woman is in active phase of labour

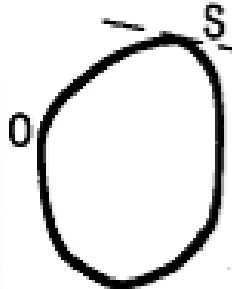
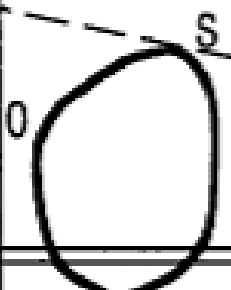
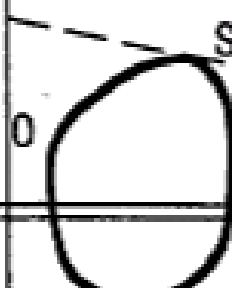
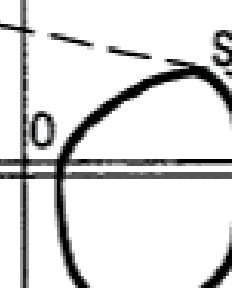
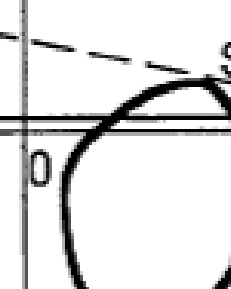
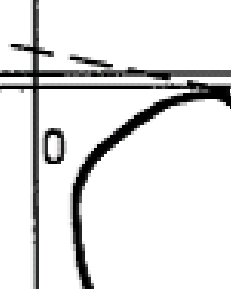
- Contractions must be 1 or more in 10mins, each lasting for 20secs or more
- Cervical dilatation must be 4cms or more

- 
- In the centre of Partograph is a Graph. Along the left side are numbers 0 -10 against squares. Each square represents 1cm dilatation.
  - Along the bottom of the graph are numbers 0-24. Each square represents 1 hour
  - The dilatation of Cx is plotted with an 'X'. Vaginal examinations are done at admission and once in 4 hours

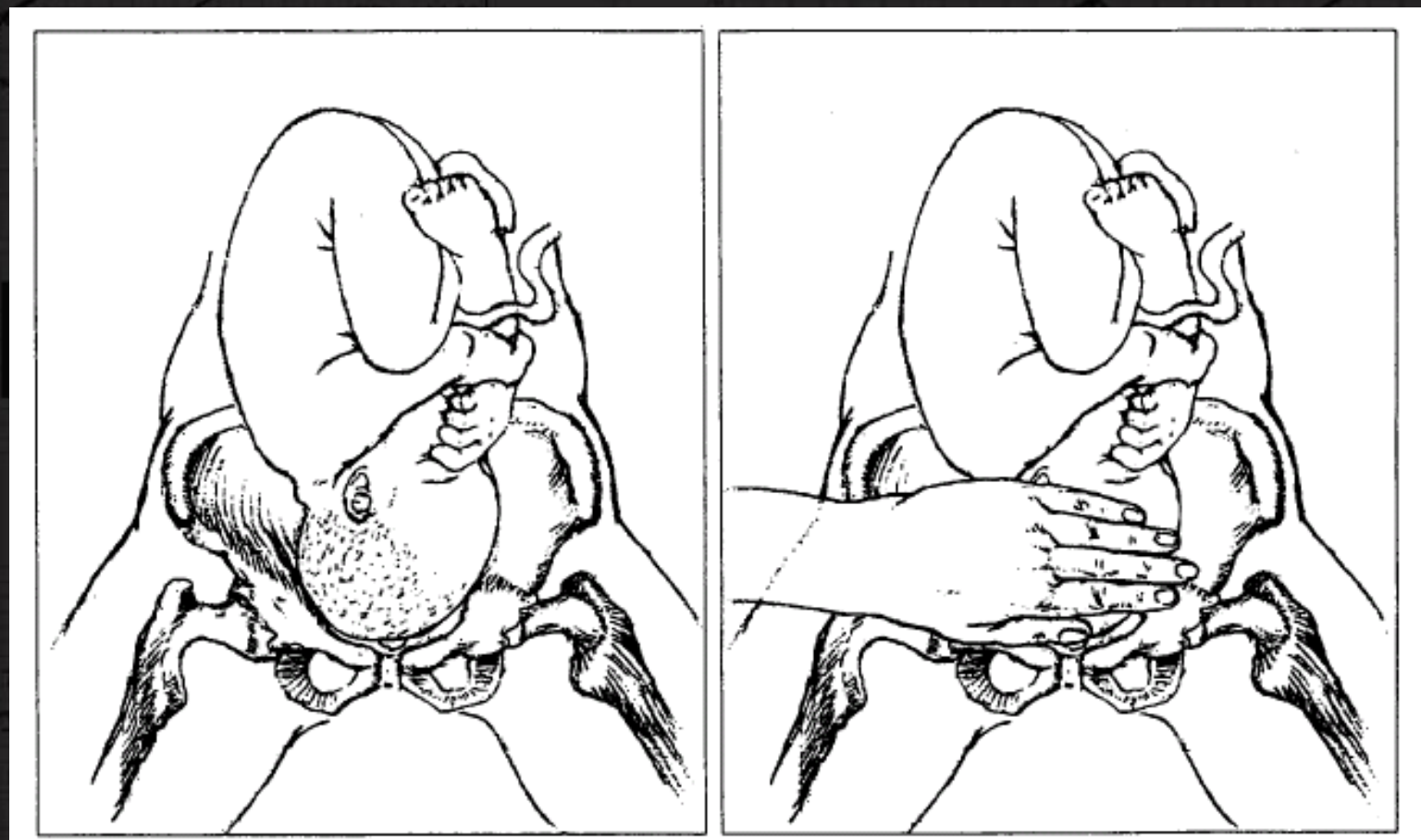


# Descent of fetal head

- It is measured in terms of fifths above the pelvic brim

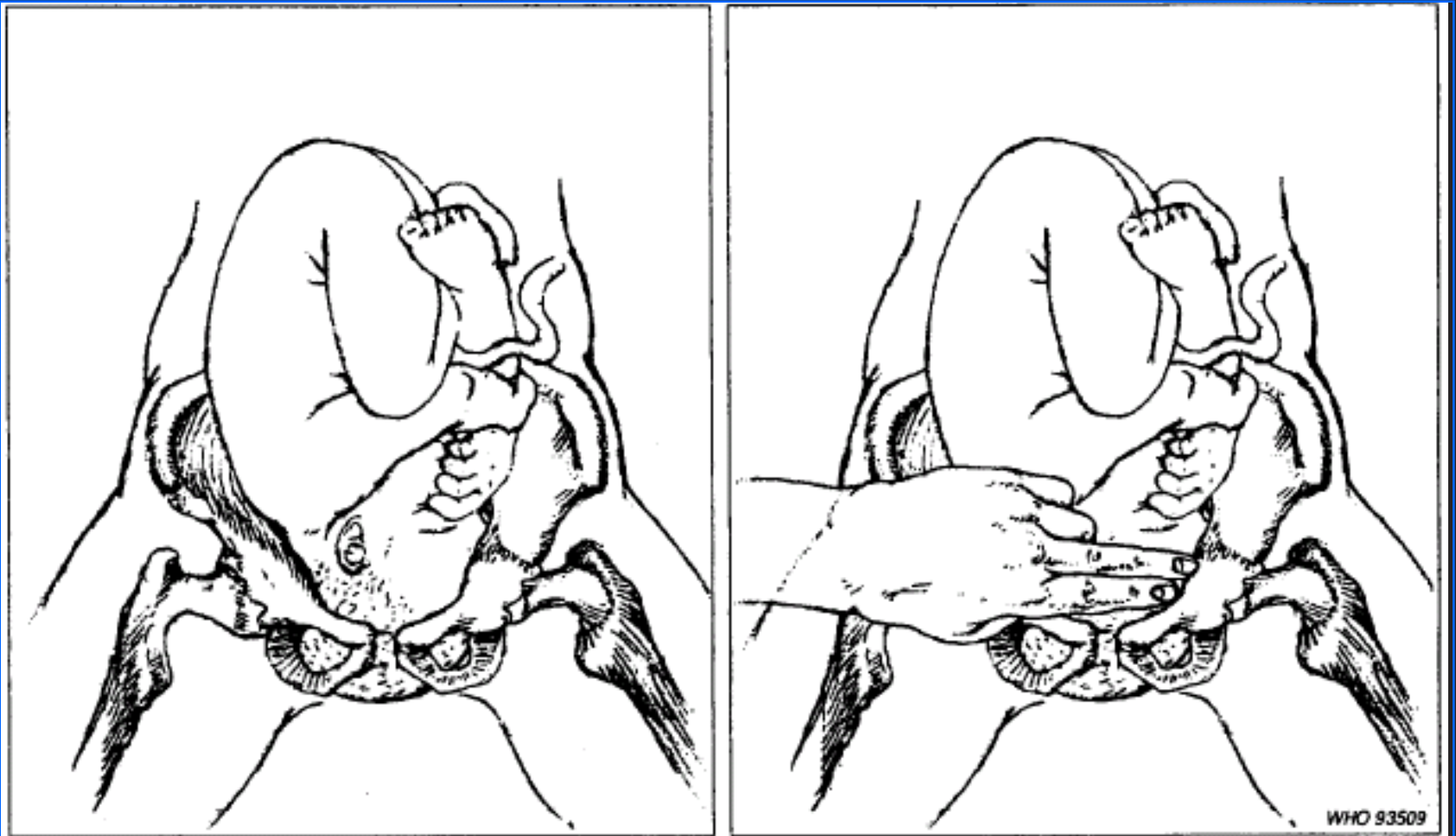
$5/5$	$4/5$	$3/5$	$2/5$	$1/5$	$0/5$
Abdomen					
					
Pelvic brim					
Pelvic Cavity					
Completely above	Sinciput High Occiput Easily felt	Sinciput Easily felt Occiput Felt	Sinciput Felt Occiput Just felt	Sinciput Felt Occiput Not felt	None of head palpable

The width of the 5 fingers is a guide to the expression in fifths of the head above the brim.  
A head that is mobile above the brim will accommodate the full width of 5 fingers

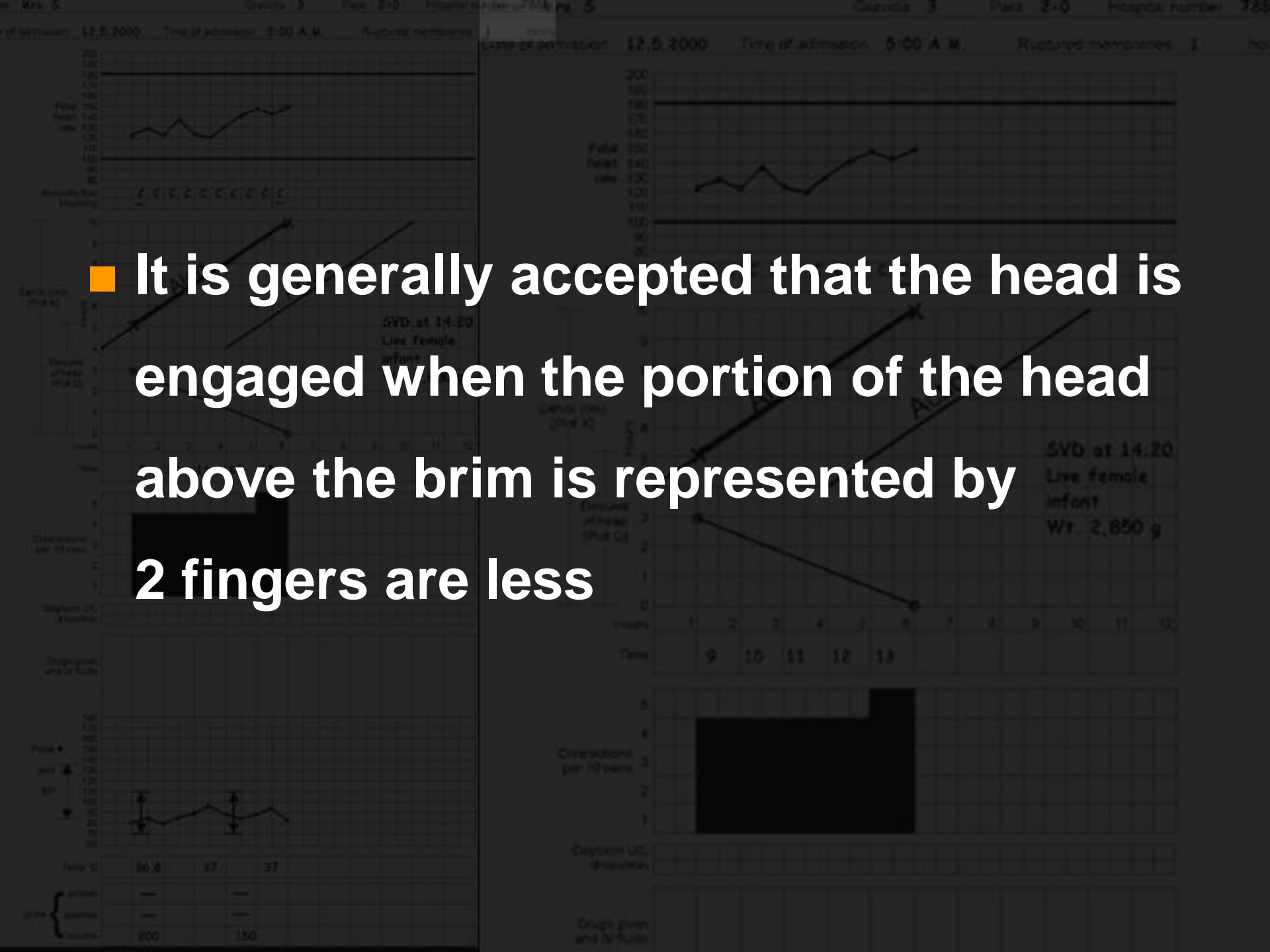




- As the head descends, the portion of the head remaining above the brim will be represented by fewer fingers

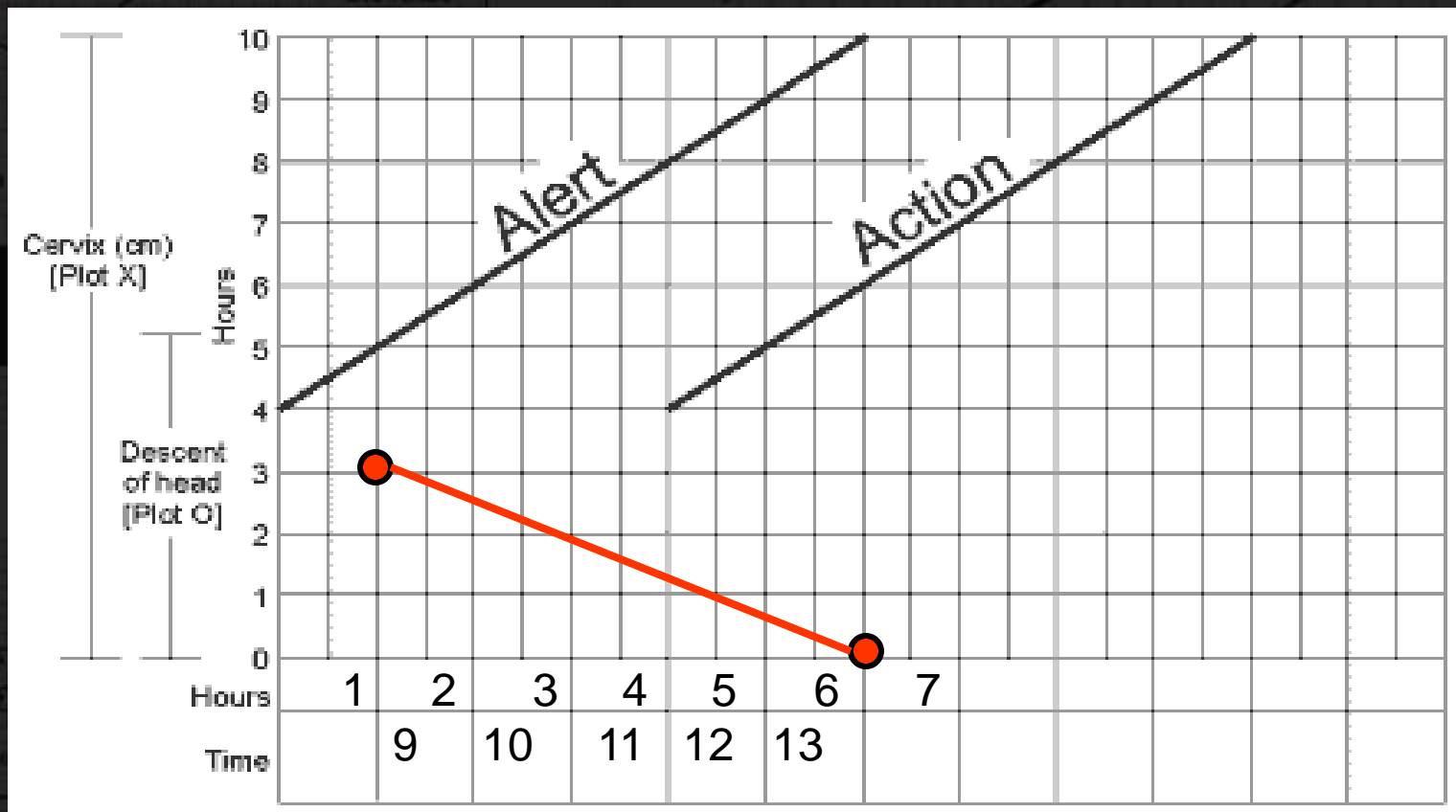


- It is generally accepted that the head is engaged when the portion of the head above the brim is represented by 2 fingers or less



# Plotting the Descent of the Head

- On the left hand side of the graph is the word “descent” with lines going from 5 – 0
- Descent is plotted with an “O” on the Partograph



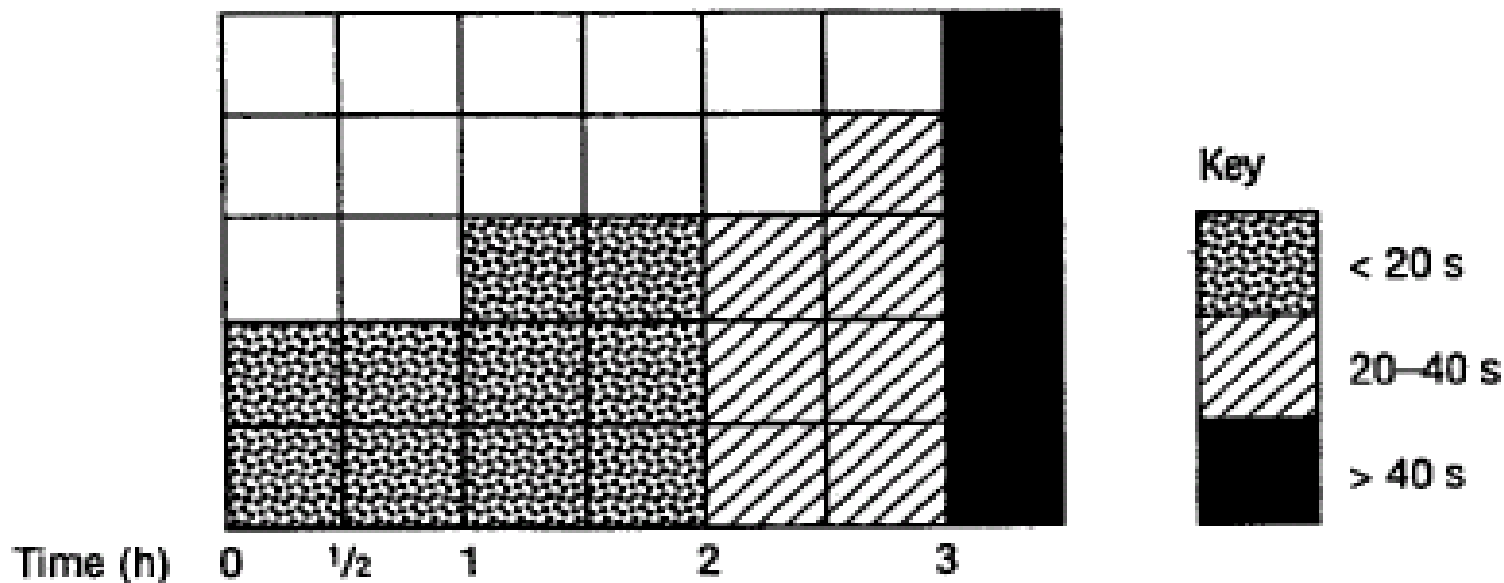
# Uterine Contractions

Observations are every half hour  
in active phase

- Frequency - Number of contractions in a 10 minutes period
- Duration – Measured in seconds from the time the contraction sets in to the time the contraction passes off

# Recording Uterine Contractions

On the Partograph below the time line, there are 5 blank squares going across the length of the graph. Each square represents 1 contraction





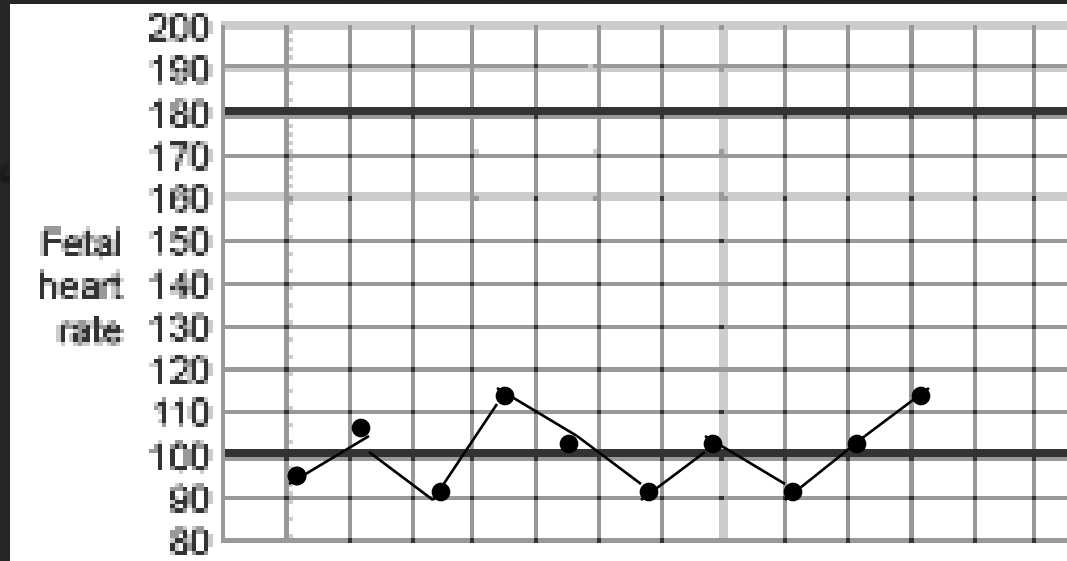
# Fetal Heart Rate

## Listen

- Patient in left lateral position
- Just after the contraction has passed its strongest phase
- For 1 full minute, if abnormal every 15mins
- If abnormal over 3 observations, take action

## Record

- At the top of the Partograph
- Every half hour



# Membranes & Liquor

**State of Liquor**      **Record**

**Membranes intact**

**I**

**Clear**

**C**

**Meconium**

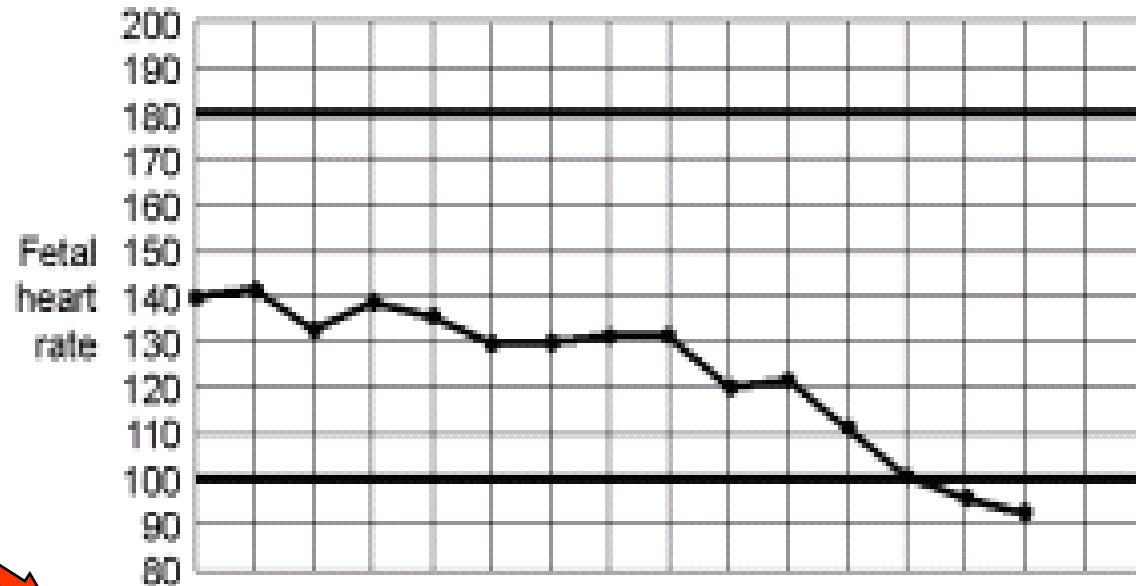
**M**

**Absent**

**A**

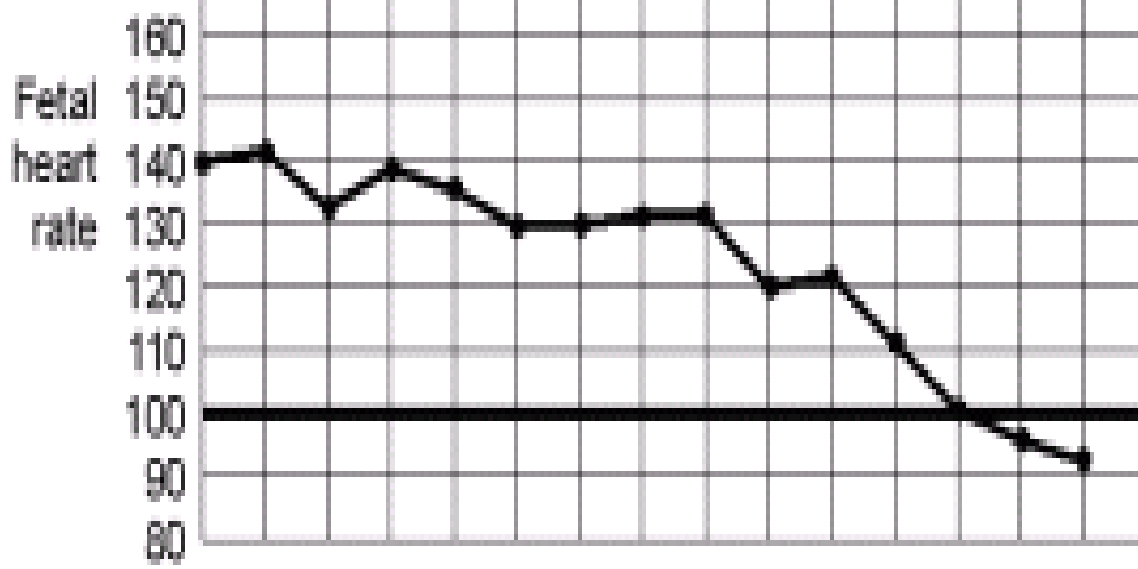
**Blood Stained**

**B**



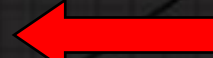
Amniotic fluid	C	C	C	C	C	C	C	C	B	B	B	M	M
Moulding	1+							2+				3+	





**Fetal condition**

Amniotic fluid	C	C	C	C	C	C	C	C	C	B	B	B	M	M
Moulding	1+								2+					3+



**State of Moulding**

**Record**

Bones are separated & sutures felt

O

Bones are just touching each other

1+

Bones are overlapping

2+

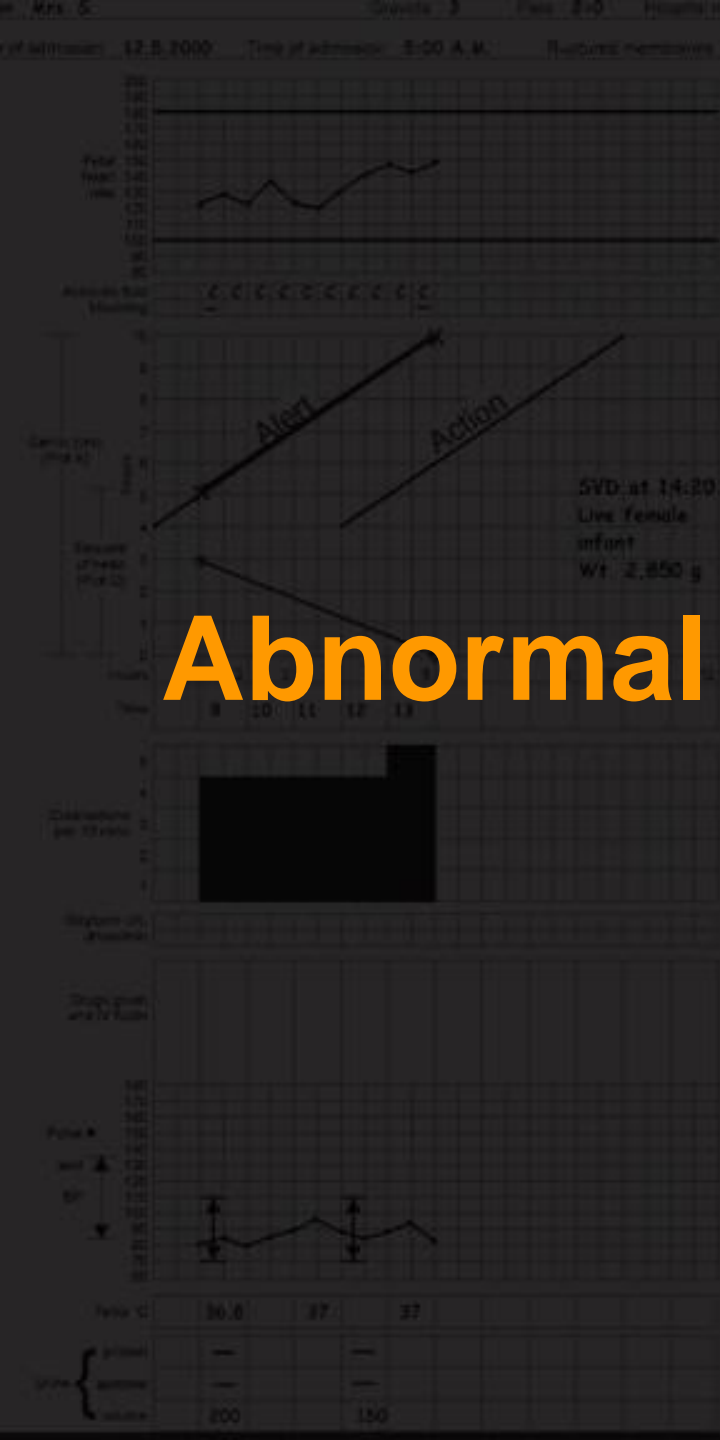
Bones are overlapping severely

3+



## Points to Remember

- When the woman comes in the active phase of labour, recording of cervical dilatation starts on the alert line
- When progress of labour is normal, plotting of cervical dilatation remains on the alert line or to the left of it



# Abnormal Progress of Labour

# Prolonged Active Phase

- In the active phase, plotting of cervical dilatation will remain on the left of or on the alert line
- If it moves to the right of the alert line, labour may be prolonged
- Transfer if facility for emergencies is not available
- Transfer allows adequate time for assessment for intervention when she reaches the action line



# At the Action Line

- It is 4 hours to the right of Alert line
- Assess the cause of slow progress and take action
- Action should be taken in a place with facility for dealing with obstetric emergencies is available

**Remember**

**WARNING**

*Transfer from hospital*

Reaching the action line means

**POSSIBLE DANGER**

*on further management*

*(usually by obstetrician or medical officer)*



# Management of Labour

## WHO Protocol



MATERNAL HEALTH  
AND SAFE MOTHERHOOD PROGRAMME  
DIVISION OF FAMILY HEALTH  
WORLD HEALTH ORGANIZATION  
GENEVA

# Normal Latent and Active Phases

*Latent phase is less than 8 hrs and active phase remains to the left of or on the alert line*

- Do not augment with oxytocin or intervene unless complications develop
- ARM may be done at any time in the active phase

# Between Alert and Action lines

## *In a Health Centre:*

- Transfer to hospital with facilities for Cesarean section, unless Cervix is almost fully dilated
- ARM may be performed if membranes are still intact and observe labour for a short period before transfer

## *In Hospital:*

- Perform ARM if membranes are intact and continue routine observations

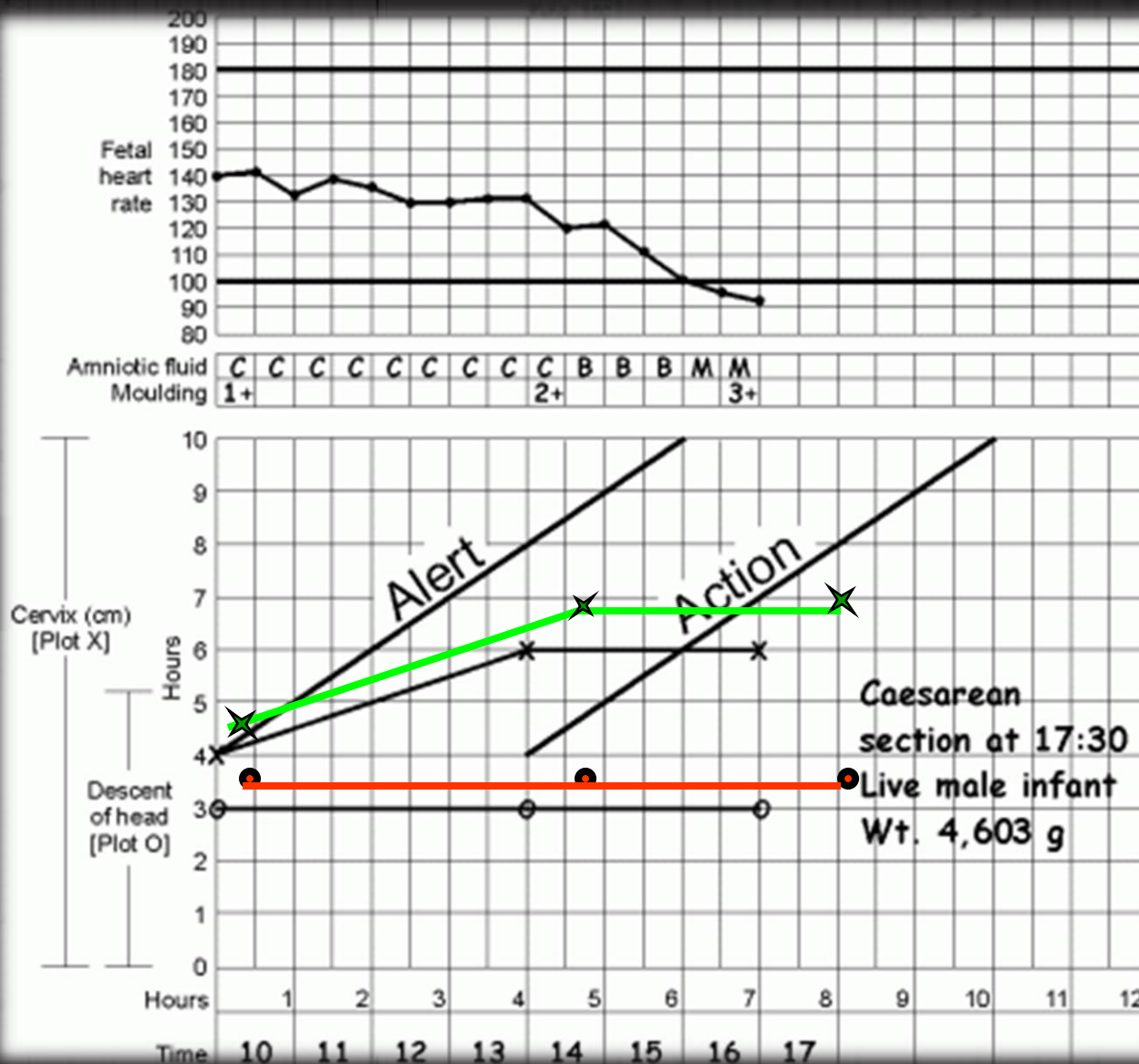
# At or Beyond Active Phase Action Line

- Full medical assessment
- Consider IV infusion/bladder catheterization/analgesia

## Options:

- Delivery if fetal distress or obstructed labour
- Oxytocin augmentation if no contraindication
- Supportive therapy (only if satisfactory progress is now established and dilatation could be anticipated at 1cm/hr or faster)

# Dilatation that reaches the Action Line





# CONTRIBUTORS

■ Dr Sheela V. Mane

■ Dr Susheela Rani

THANK YOU

