MODULE 6.10

MATERNAL, NEWBORN AND REPRODUCTIVE HEALTH

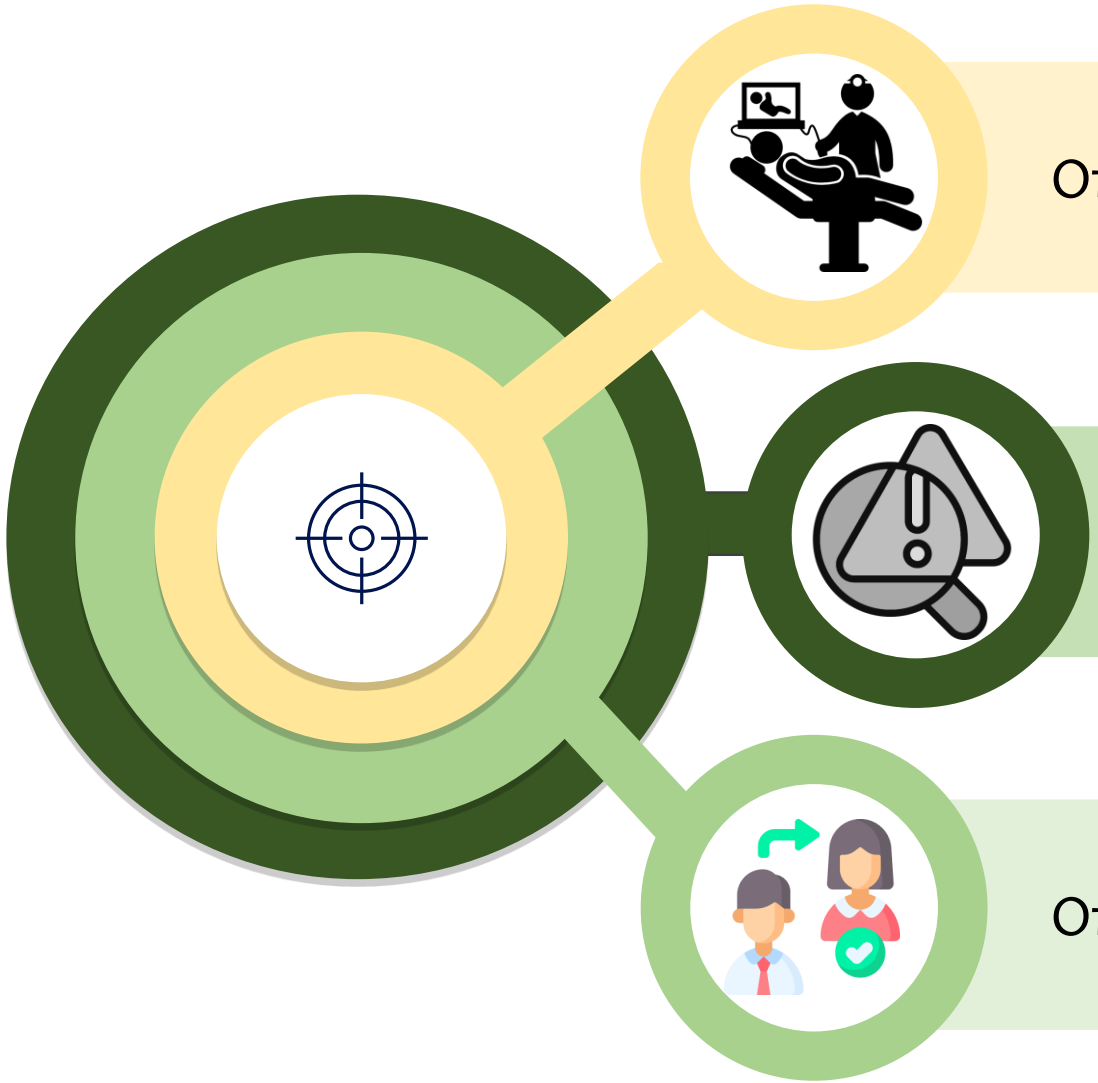
MODULE OVERVIEW OF MATERNAL, NEWBORN AND REPRODUCTIVE HEALTH

6.1	Antenatal Care
6.2	Basic Emergency Obstetric Care (BEmOC)
6.3	Normal Labour and Child Care
6.4	Hypertension in Pregnancy, Pre-Eclampsia/Eclampsia
6.5	Vaginal bleeding in Early Pregnancy
6.6	Vaginal bleeding in Late Pregnancy
6.7	Vaginal bleeding in Labour
6.8	Obstructed Labour
6.9	Respectful Maternity Care

MATERNAL AND NEWBORN CARE



LEARNING OBJECTIVES



Offer effective antenatal care services in PHCs

Seamless identification of dangers in obstetrics

Offer basic interventions and REFER ASAP

SESSION 6.11 ANTENATAL CARE

LEARNING OBJECTIVES

At the end of this session, participants should be able to:



- Understand the goals, concept, content, and components of Antenatal Care
- Take proper history and conduct proper physical examination for pregnant women
- Know and conduct routine screening for pregnant women
- Understand the components of birth preparedness and complication readiness and conduct birth preparedness sessions
- Identify high-risk pregnancies and refer, identify the danger signs and complications in pregnancy, manage and refer
- Advance in offering BEmONC services

INTRODUCTION



- Antenatal Care (ANC) is the care provided by trained health care workers to **pregnant women** and **adolescent girls** in order to ensure the **best** health conditions for both **mother** and **baby** during pregnancy.

- The components of ANC include ***risk identification*** and ***prevention and management of pregnancy-related or concurrent diseases*** (*W.H.O., 2016*).

MAIN PURPOSE OF ANTENATAL CARE (ANC)



The purpose of antenatal care is to ensure that pregnant women go through pregnancy in good health, ill health is detected and treated promptly, and at the end of the pregnancy, the woman delivers a live healthy baby safely

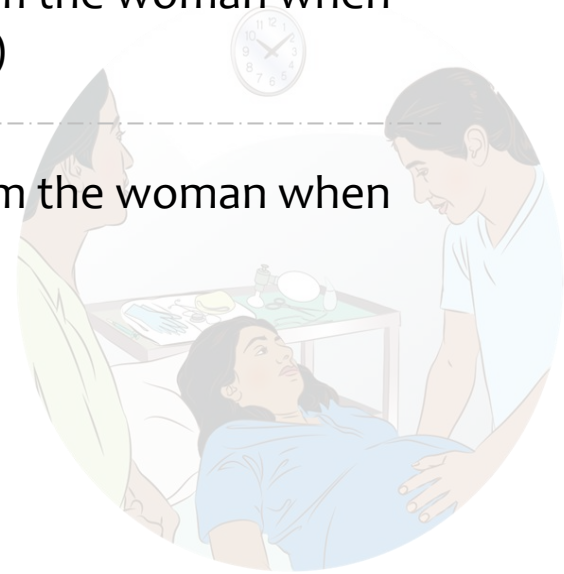
BENEFITS OF ANC



- ANC will provide the opportunity to monitor the health of the pregnant women
- Monitor the growth and development of the baby
- Identify and treat health problems in a mother
- Prevention for malaria and anaemia
- Educate the mother on proper nutrition and hygiene
- Help the pregnant woman to plan for the birth of the baby

ANTENATAL CARE SCHEDULE

Trimester	Number of visits	Comments
1 First Trimester	▪ First visit	▪ After two or three missed periods (up to 13 weeks
2 Second Trimester	▪ Second visit	▪ SBAs will conduct ANC and inform the woman when to return at 20 weeks (5 months)
	▪ Third visit	▪ SBAs will conduct ANC and inform the woman when to return at 26 weeks (6 months)
3 Third Trimester	▪ Fourth - eight visits	▪ SBAs will conduct ANC and inform the woman when to rerun at 30 weeks - Contact 5th – 34 weeks - Contact 6th – 36 weeks - Contact 7th – 38 weeks - Contact 8th – 40 weeks



Unscheduled ANC Visits

Unscheduled ANC Visits are made when



Complications occur

Follow-up referral is needed

Woman wants to see the provider

Provider changes frequency based on findings (history, exam, testing) or local policy

STEP-BY-STEP PROCESS OF ANC (1/2)









1

- Ask the following questions:
  - Last date of menstruation
  - Number of children the woman has and sex distribution
  - The average interval between each pregnancy
  - Any stillbirths, abortions, neonatal jaundice
  - Problems associated with previous pregnancies e.g. hypertension, bleeding
  - Type of family planning device used after delivery of each child
  - Eating pattern

2

- Calculating the expected date of delivery by using a chart wheel or manually (practical calculation should be done for EDD)

3

- Examination of mother

4

- Routine screening tests (MP- for malaria, PCV, VDRL- for syphilis, HBsAg and HCV)

STEP-BY-STEP PROCESS OF ANC (2/2)



5

- Giving routine drugs/immunization to pregnant women (Fersolate, folic acid, TT, IPT)



6

- Preparing mother for lactation by educating her on the care of the nipples, for example



7

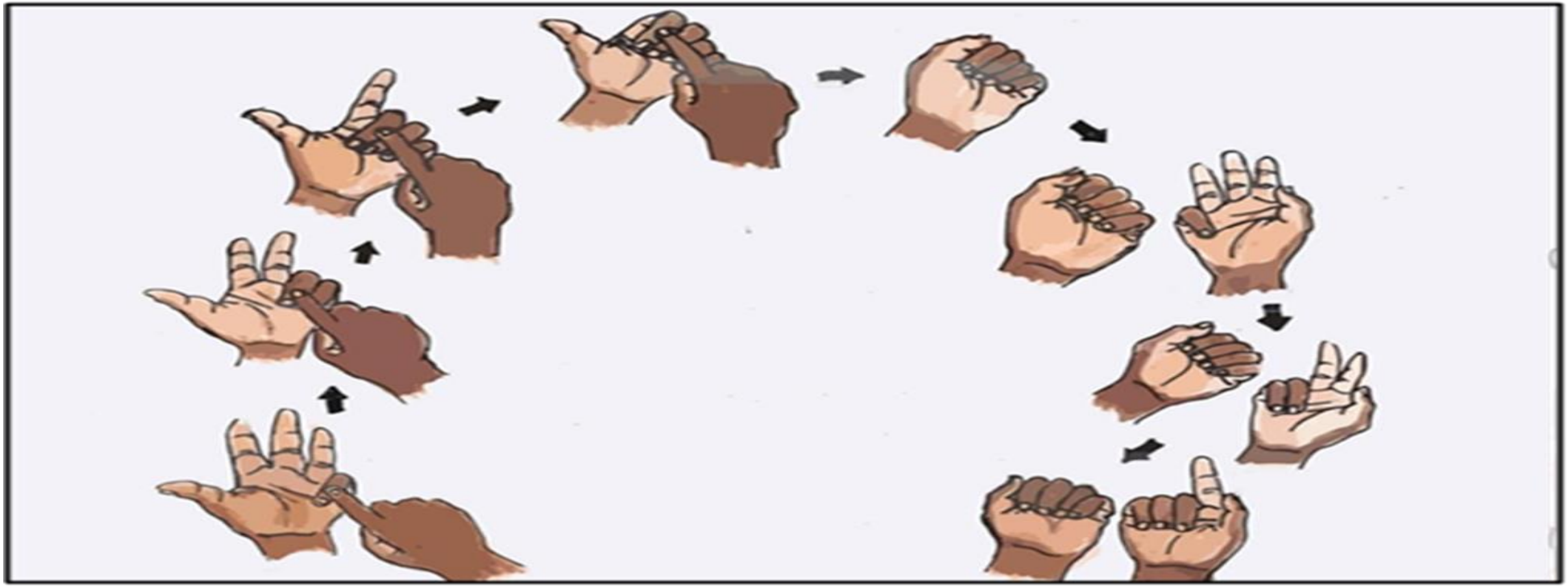
- Managing common complaints in pregnancy



8

- Discussing birth plans and education on pregnancy complications.

THE EIGHT ANC VISITS' COUNT



'SAY AND DO' DEMONSTRATION

Facilitator: Use your fingers to count out the eight visits.
Repeat the schedule several times, then ask participants to volunteer to repeat the schedule by counting out the visits using their hands.

KEY MESSAGES

Antenatal care is important for pregnant and adolescent women to achieve positive pregnancy outcomes

Having an effective transition to positive labour, childbirth and achieving positive motherhood.

Maintaining physical and sociocultural normality

SESSION 6.2: BASIC EMERGENCY OBSTETRIC CARE (BEMOC)

NORMAL LABOR AND CHILDBIRTH

BIRTH PREPAREDNESS AND COMPLICATION READINESS FOR THE WOMAN AND FAMILY



Educate the community about birth preparedness and complication readiness



Recognize danger signs



Offer first aid such as IV Access and fluids, supplemental O2 etc

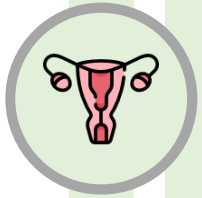


Plan route



Inform the Receiving Centre

DIAGNOSING LABOUR



- This is the commencement of the intermittent, rhythmic and painful uterine contractions and hardening of the uterus which progressively increases in strength and frequency.
- There is also marked progressive shortening (effacement) and dilation of the cervix which is different for the primiparous and multiparous woman:
  - In a primipara, the cervix will first efface then, dilate;
  - In a multipara, effacement and dilation occur simultaneously

The conditions below should not be considered as the start of labour (also known as "false labour")



- Repeated contractions without cervical effacement and dilatation.
- Repeated contractions that are not regular, abruptly start and stop of short duration and may not be painful

NB: DO NOT RUPTURE THE MEMBRANE OR COMMENCE OXYTOCIN

- Dilation of the cervix with no or few, irregular uterine contractions

STAGES OF LABOUR

There are three stages of labour. Each stage has to be completed before a normal delivery can be said to have occurred

1		This stage comprises the commencement of uterine contractions, cervical dilation and the progressive descent of the foetus.
2		This stage commences at full cervical dilatation and culminates with the delivery of the baby
3		This stage involves the delivery of the complete placenta which indicates the end of normal delivery process

STAGES OF LABOUR

FIRST STAGE



This stage Includes:

a. Uterine Contraction
b. Cervical Dilation, and
c. Foetal Descent

The first stage has two parts:

The Latent phase which commences at the start of labour until the cervix is 5cm dilated

- The duration of this period depends on the parity of the women

Active phase starts from approximately 5cm of cervical dilatation to complete dilation.

- In this phase, cervical dilatation progresses faster compared to the latent phase.
- The duration of the active phase also varies with the parity of the women, but generally lasts for about 10 hours in a multipara and 12 hours in a primipara

STAGES OF LABOUR

SECOND STAGE



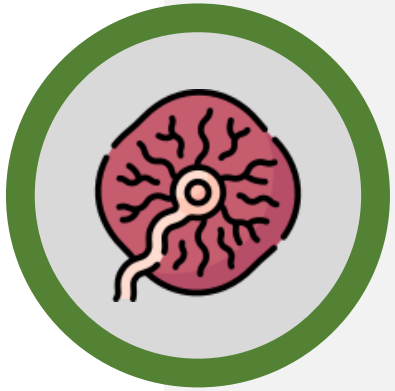
This is the stage of labour from full cervical dilatation of 10cm till the baby is delivered. It comprises of two phases

Phase 1: this is from the full cervical dilatation to when the leading part of the foetus is on the pelvic floor. It is characterized by strong contractions, mother's urge to push and a descending part. When something is wrong or phase is abnormal, this phase is marked by poor contractions and maternal exhaustion.

Phase 2: This is from when the presenting part touches the pelvic floor to the delivery of the baby which could be assisted. It is characterized by strong contractions and assistance could be in the form of episiotomy.

STAGES OF LABOUR

THIRD STAGE



This is the delivery of the placenta after the baby. An abnormal third stage is characterized by poor uterine contractions, poor or no placental separation and expulsion and blood loss >500mls. Activities should include:

- Routine prevention of Postpartum Haemorrhage
  - Active management of third stage of labour (Administration of a Uterotonic (oxytocin, carbetocin, misoprostol) after placental delivery
- Monitoring Examination of the placenta
- Examination of the membranous sac
- Examination of the maternal surface of the placenta

ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR

Active Management of Third Stage of Labor (AMTSL) should be performed for all women (AMTSL. Always do the following after delivery of the placenta:

- Routine examination of the placenta and membranes as a significant number of maternal deaths are caused by retained placenta.
- Routine examination of vagina and perineum for lacerations and injury

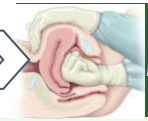
The active management of the third stage of labour achieves the following:

- Increase in the ability of the uterus to contract
- Delivery of the placenta
- Prevention of uterine atony

In Many Studies; The Incidence Of Postpartum Haemorrhage Is 2 - 3 Times Lower In The Group Of Women Who Receive AMTSL

ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR (AMTSL)

AMTSL involves three simple procedures:

	 Administration of a uterotonic drug	 Controlled Cord traction of the umbilical cord	 Massage of the uterus
Description	▪ IM Oxytocin (10IU) or IM Carbetocin (100MCG) within 1 minute after birth ▪ Misoprostol 3 tablets (600µg) immediately after birth	Involves traction on the cord while maintaining counter-pressure upwards on the lower segment of the uterus, using a hand placed on the lower abdomen	Massage of the uterus through the abdomen after the delivery of the foetus and the placenta

Rationale

The use of AMTSL reduces:

- Incidence of PPH
- Quantity of blood loss
- Need for Blood transfusion
- The risk of death

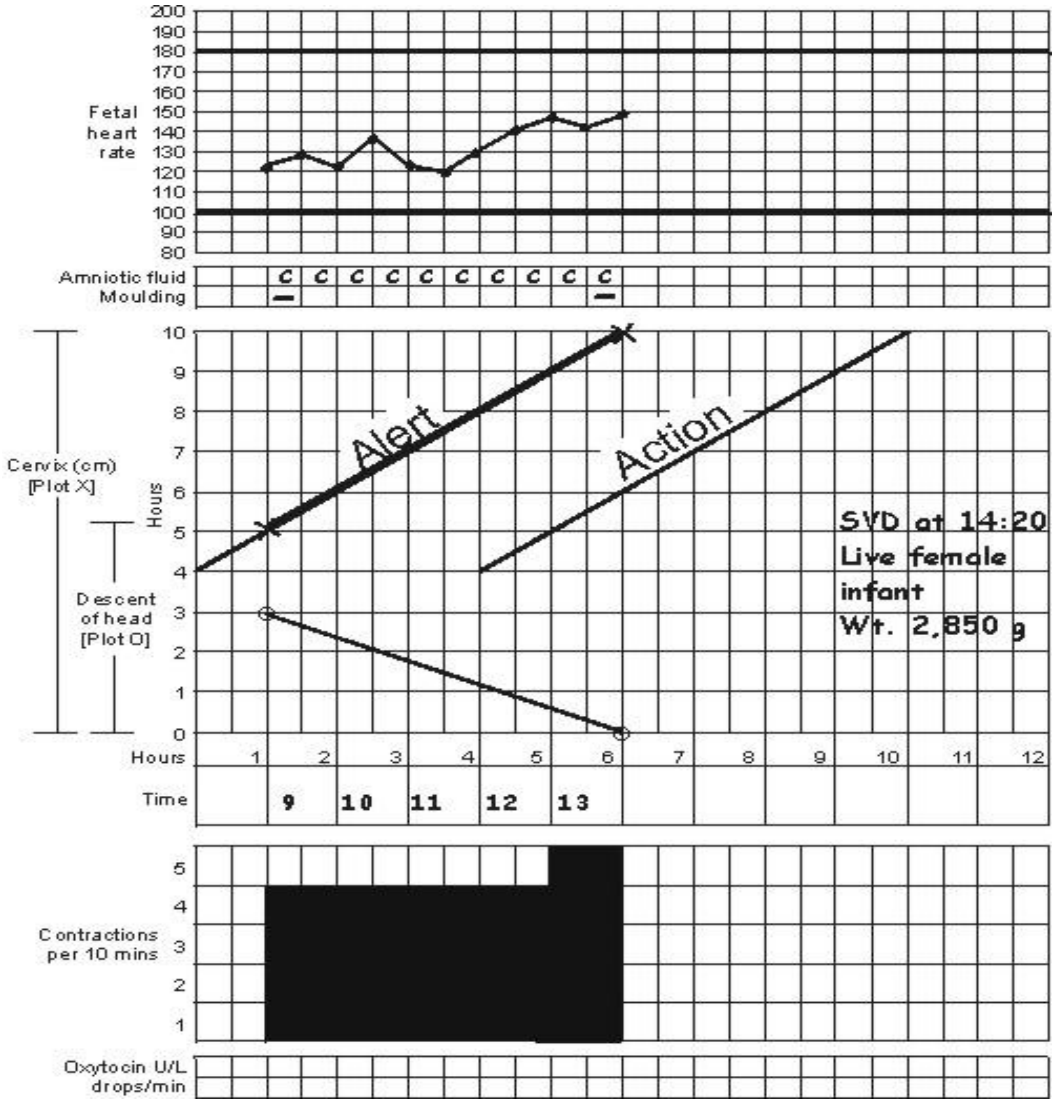
THE PARTOGRAPH

The Partograph is a useful tool for monitoring the progress of Labour to:

- Ensure close monitoring of the woman in Labour
- Intervene in a timely manner to avoid maternal and neonatal morbidity or mortality

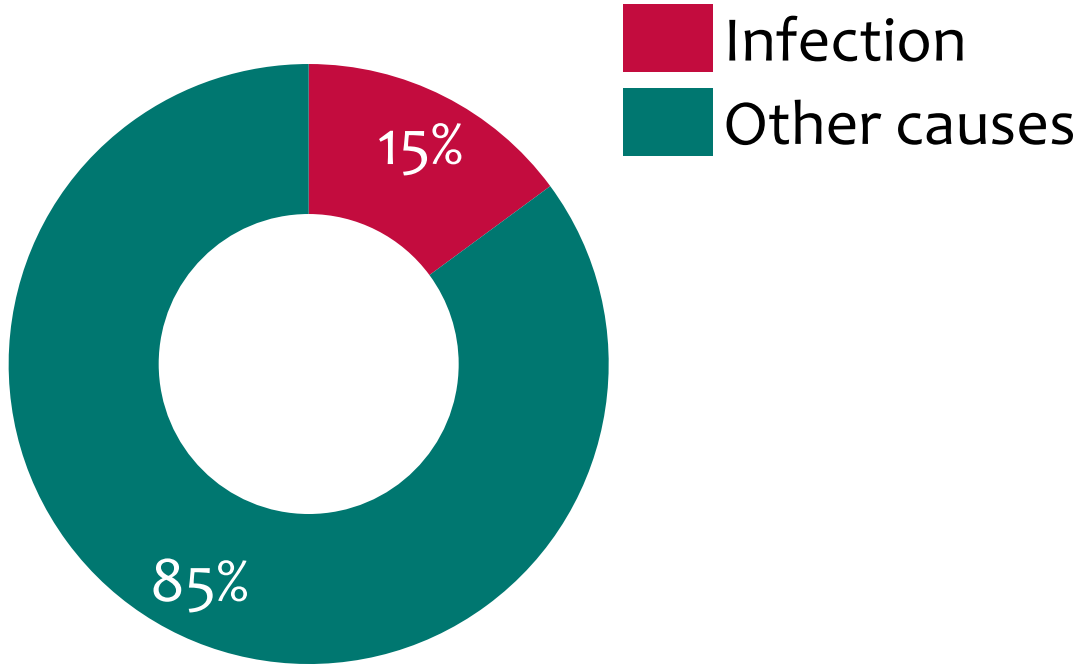
The Partograph is useful for the assessment of:

- Progress of Labour
- Maternal well being
- Fetal well being



CLEAN CHILDBIRTH

Causes of maternal death in Nigeria



- Infection accounts for 14.9% of all maternal deaths in Nigeria.
- These deaths can be avoided with infection prevention practices.

INFECTION PREVENTION PRACTICES

1. Use disposable materials once and decontaminate reusable materials throughout labor and childbirth
2. Wear gloves during vaginal examination, during birth of newborn, and when handling placenta
3. Wear protective clothing (shoes, apron, glasses)
4. Wash hands
5. Wash the woman's perineum with soap and water and keep it clean
6. Ensure that the surfaces on which the newborn is delivered are kept clean
7. Use high-level disinfected instruments, gauze and ties for the cord

BEST PRACTICES

Labour and childbirth

- Use non-invasive, non-pharmacological methods of pain relief during labor (massage, relaxation techniques, etc.)
- Offer oral fluids throughout labor and childbirth



SUPPORT THE WOMAN

Give the woman as much information and explanation as she desires

Provide care in labour and childbirth at a level where the woman feels safe and confident

Provide empathetic support during labour and childbirth







Avoid physical and verbal abuse by health workers

Allow a companion of choice during labour and delivery as appropriate

Facilitate good communication between caregivers, the woman, and her companions

BEST PRACTICES: POSTPARTUM

01	Close monitoring during the first 6 hours postpartum
02	Monitor blood pressure, pulse, vaginal bleeding, well contracted uterus
03	Empty the bladder
04	Massaging the uterus
05	Dry baby immediately and put on mother's chest to keep warm
06	Cord care using 4% chlorhexidine gel
07	Check for danger signs
08	Early initiation of breastfeeding

HARMFUL ROUTINES

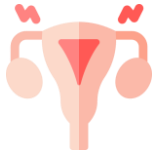




Use of enema



Pubic shaving



Lavage of the uterus after childbirth



Manual exploration of the uterus after childbirth



Rectal examination



Routine use of supine position during labour



Routine use of lithotomy position with or without stirrups before 2nd Stage of labour

HARMFUL INTERVENTIONS

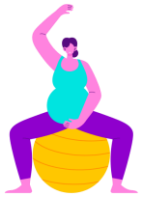




Frequent use of oxytocin before delivery of baby to prevent uncontrolled effect.



Sustained, directed bearing down efforts during the second stage of labor.



Massaging and stretching the perineum during the second stage of labor (no evidence)



Fundal pressure during labor

KEY MESSAGES



Birth preparedness involves the health worker, client, family, and community. The use of a partograph is very important in monitoring, and assessing the progress of labor to prevent maternal and neonatal morbidity or mortality.



The active management of the 3rd stage of labour achieves, an increase in the ability of the uterus to contract, delivery of the placenta, and prevention of uterine atony. Promote best practices in labor and avoid harmful routine practices

SESSION 6.13: OBSTRUCTED LABOUR

OBSTRUCTED LABOUR

01

Obstructed labor in the context of PHC refers to a situation where the progress of the baby through the birth canal is impeded, usually due to mechanical reasons. This is a critical obstetric emergency that requires prompt and appropriate management to prevent maternal and fetal complications

02

There is an interplay between the powers(uterine contraction), passages of the birth canal(bony pelvis & soft tissues of pelvic floor and perineum), and the passenger (fetus) to effect delivery. Faults with any of these processes can impede or halt the progress of labour

BIRTH CANAL

The birth canal has various shapes & sizes

At the brim (pelvic inlet)

- Transverse diameter ---------- 13.5 cm
- Anteroposterior diameter ---------- 11 cm

At the mid-cavity

- Both transverse and anteroposterior diameter ---------- 12 cm

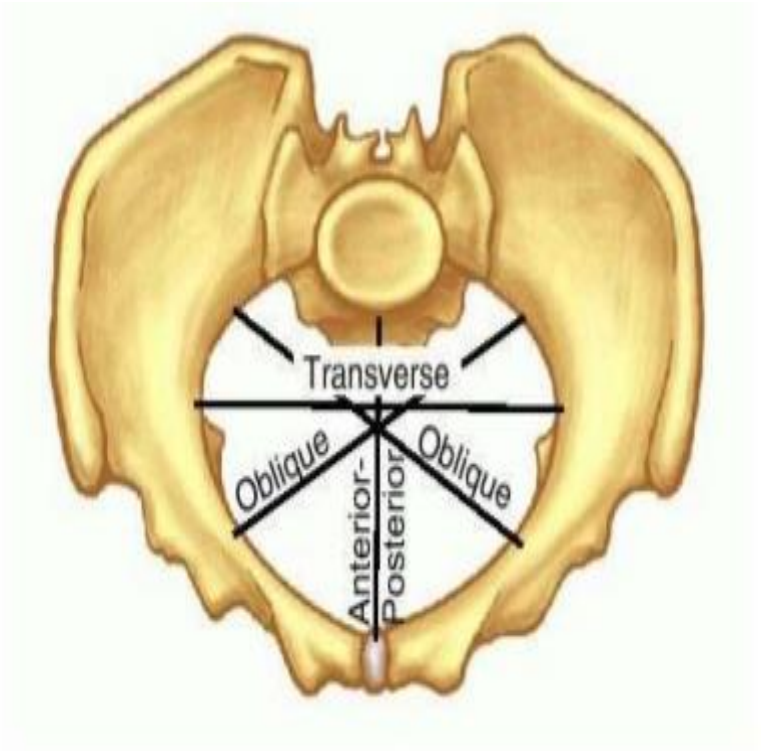
At the outlet

- Transverse diameter ---------- 13.5 cm
- Anteroposterior diameter ---------- 11cm

Faults in passenger (fetus) refers to fetal size, presentation, and position.

NORMAL PELVIS (GYNAECOID)

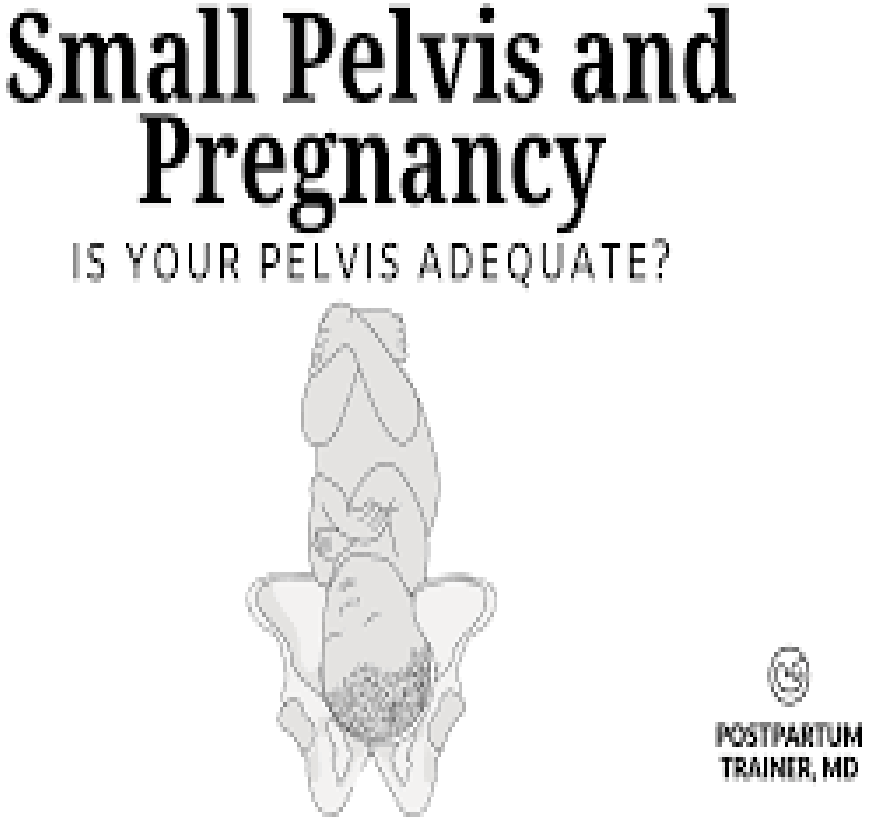
Pelvis	Diameter (cm)		
	Anteroposterior	Transverse	Oblique
Pelvic Inlet	11	13	12
Pelvic Cavity	12	12	12
Pelvic Outlet	13	11	.

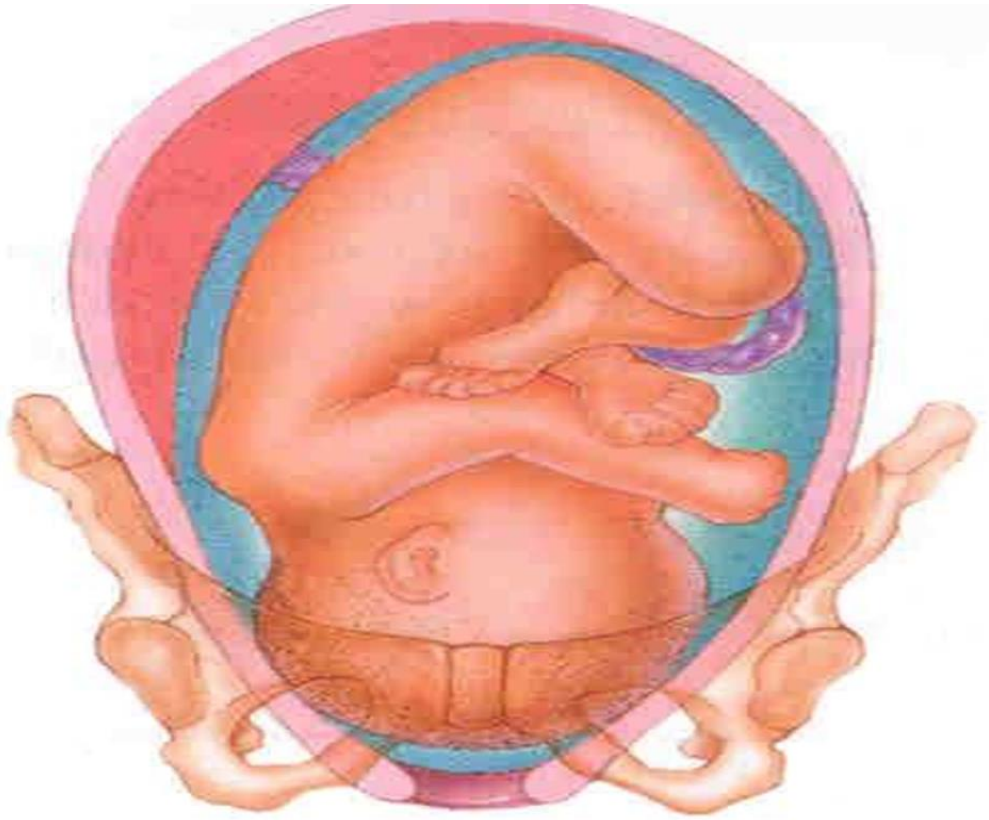


ABNORMALITIES IN PASSAGE

- The passages through which the baby is expelled during normal labour include soft passages of the birth canal. These are supported by ligaments, fascia, and fat & bony pelvis. The bony pelvis may cause delays in labour progress
- Maternal stature, previous pelvic fractures and metabolic diseases may be associated with reduced pelvic dimensions
- Fibroids in the lower uterine segment can impede the descent of fetal head
- A non compliant cervix is usually a consequence of previous scarring and will fail to dilate slowing labour.

PASSENGERS





- The fetus undergoes a series of changes in position and attitudes during its passage through the birth canal. This is what constitutes the mechanism of labour.

CEPHALOPELVIC DISPROPOERTION (CPD)

- Implies anatomical disproportion between the leading part of the fetus & the maternal pelvis.
- Can be elicited clinically in late pregnancy & labour
- It can be due to large fetal head, small pelvis, or combination of the two
- More common in socioeconomically deprived communities and early marriage
- It is the commonest cause of obstructed labour

CPD AETIOLOGY/RISKS

1 FETAL FACTORS

- Big foetus
- Abnormal foetus e.g. conjoined twins, hydrocephalus, foetal tumours
- Malposition
- Malpresentation

2 PELVIC FACTORS

- Contracted pelvis from poor nutrition, immature pelvis from early marriage
- Abnormal pelvic shape
- Pelvic deformity from rickets, polio, TB spine with kyphoscoliosis

MACROSOMIA

Definition

Macrosomia is defined as birth weight **> 4000g**

Aetiology

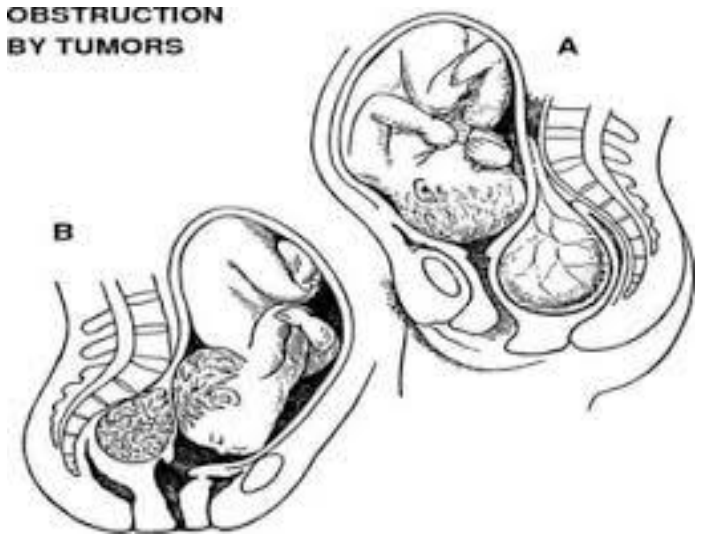
- Maternal diabetes
- Prolonged pregnancy
- Maternal obesity



MALPRESENTATIONS

Malpresentations are commoner in women of high parity

- Tight application of the fetal presenting part to the cervix is vital for the progress of labour. Breach and face presentations may fail to do this resulting in slow progress of labour
- Brow presentations present with a mento-vertical diameter which is too large to fit into a bony pelvis
- Shoulder presentations cannot have a vaginal delivery
- Android pelvis can prevent internal rotation & cause DTA (fetal head arrested at the level of ischial spines)







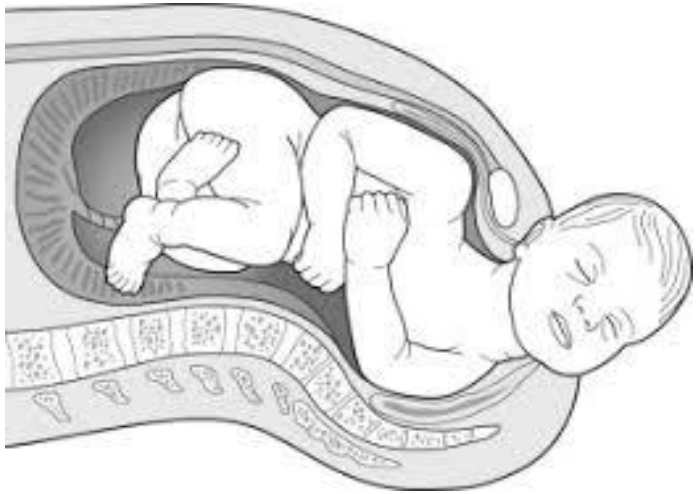




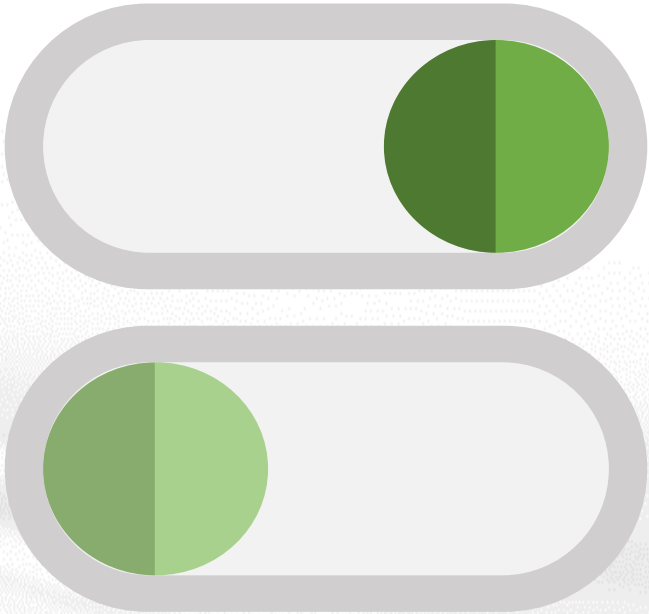
Figure 1. Radiograph of AP pelvis – disruption of the pelvic ring



SHOULDER DYSTOCIA

Definition

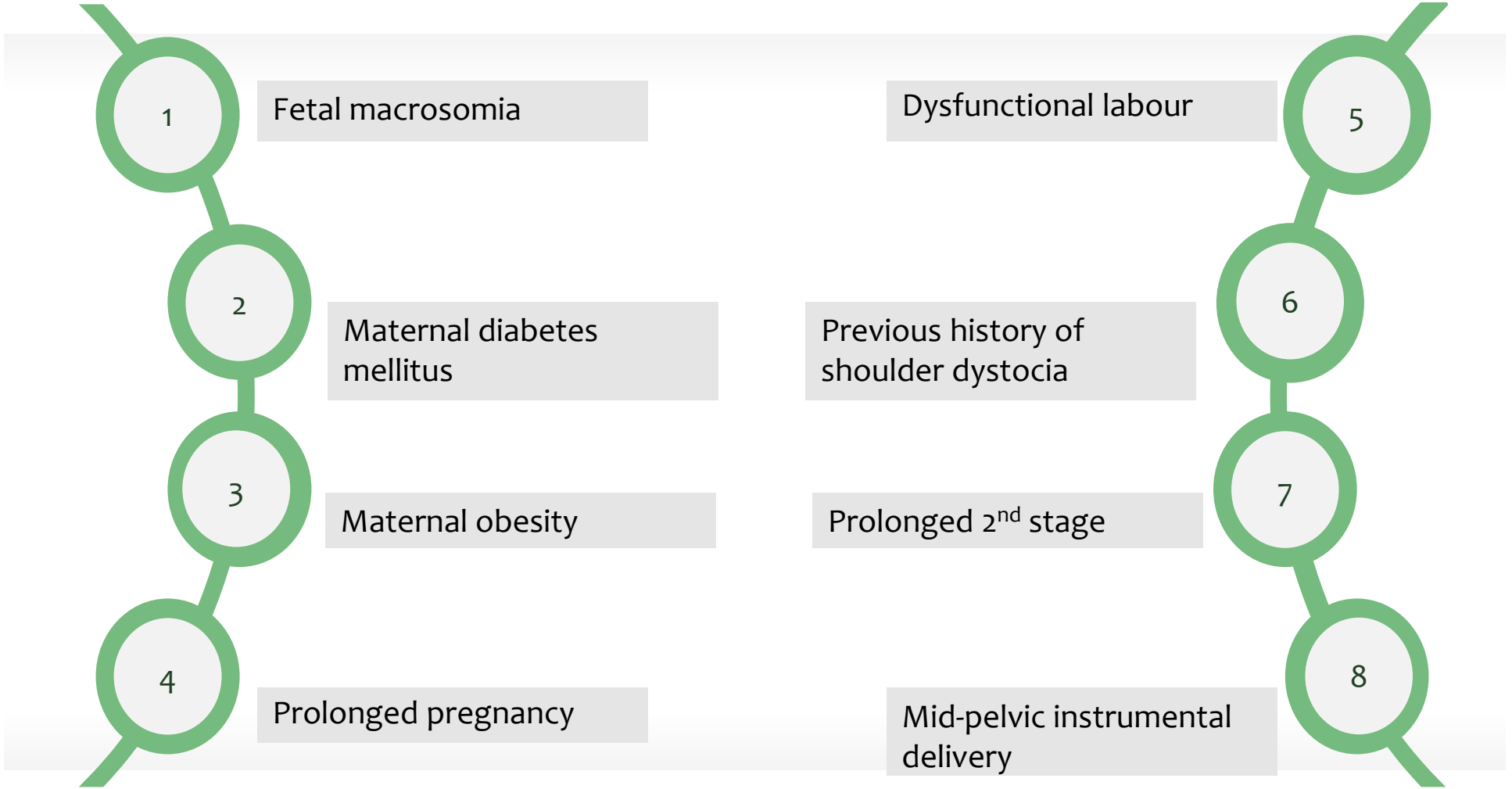
- A serious obstetric emergency that is unpredictable & is associated with a high risk of fetal injury & death if not properly managed
- Occurs when the anterior shoulder fails to pass below the maternal symphysis pubis after delivery of the head



Causes

- Disproportion between the fetal chest & maternal pelvis
- Malrotation of the fetal shoulder at the pelvic inlet
- Maternal pelvis that is flattened anteroposteriorly (platypelloid pelvis)

RISK FACTORS



- A combination of risk factors may increase the risk

COMPLICATIONS OF OBSTRUCTED LABOUR

01 Fetal	02 Maternal
• Birth asphyxia	• Genital tract lacerations
• Brachial plexus palsy	• Uterine atony
• C5,C7-Erb's paralysis	• PPH
• Pelvic fractures	• Ruptured uterus
• T1-Klumpke's paralysis –less common & has worse outcome	

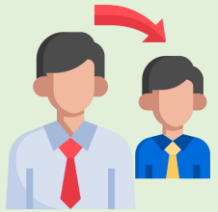
MANAGEMENT

Focus	Description
Early detection	▪ The early detection of potential risk factors during antenatal care is crucial. ▪ Skilled healthcare providers in PHC settings should identify the risk factors and causes of having an index of suspicions.
Referral systems	▪ Once obstructed labor is suspected or encountered (using partogragh) must be referred immediately to the higher centers that have adequate facilities to manage. ▪ Define the high-level goal of conducting the workshop and the intended outcome
Education and awareness	▪ PHC providers play a crucial role in educating pregnant women and their families about the signs of obstructed labor and the importance of seeking timely medical assistance
Community engagement	▪ Recurrent engagement with the community to raise awareness about the importance of timely healthcare-seeking behavior during labor

KEY MESSAGES



Early detection of danger signs during pregnancy and labour is key to reducing maternal mortality



Once obstructed labor is suspected or encountered (using partogragh) must be referred immediately to the higher centers that have adequate facilities to manage.



Demand creation for ANC attendance in the community should be encouraged.

SESSION 6.14: HYPERTENSION IN PREGNANCY, PRE-ECLAMPSIA/ECLAMPSIA

LEARNING OBJECTIVES

At the end of this session, participants should be able to:



- Identify elevated blood pressure in pregnancy
- Pre-eclampsia and eclampsia
- Administer the first dose of magnesium sulphate
- Refer to the next level of care

PRE - ECLAMPSIA/ ECLAMPSIA

PLEASE NOTE THAT PATIENTS WITH PRE-ECLAMPSIA/ECLAMPSIA SHOULD BE REFERRED IMMEDIATELY TO A HIGHER CENTER

IDENTIFICATION OF ELEVATED BLOOD PRESSURE IN PREGNANCY

SKILLS OF A GOOD COUNSELLOR

Elevated blood pressure in a woman with no previous evidence of hypertension with :

1	Systolic blood pressure **≥140 mmHg**
2	Diastolic blood pressure **≥ 90 mmHg**
3	On at least two occasions four or more hours apart
4	Occurring in the second half of pregnancy (20 weeks and above)

PRE - ECLAMPSIA

Women over 20 weeks gestation with:

- Two readings of blood pressure 4 hours apart (≥140/ 90 mmHg)
- Proteinuria up to 2+
- No other signs/symptoms of severe pre-eclampsia



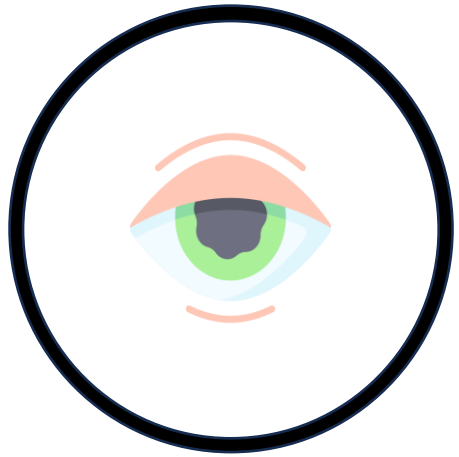
SIGNS AND SYMPTOMS OF SEVERE PRE–ECLAMPSIA



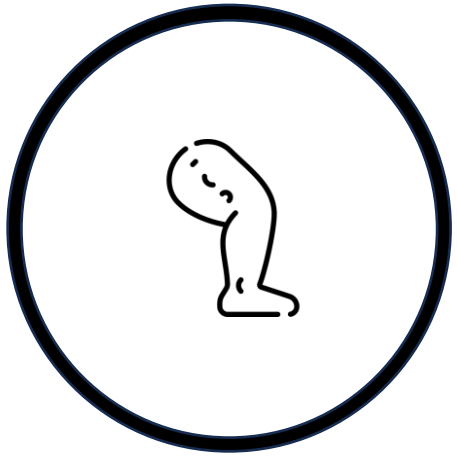
Epigastric tenderness



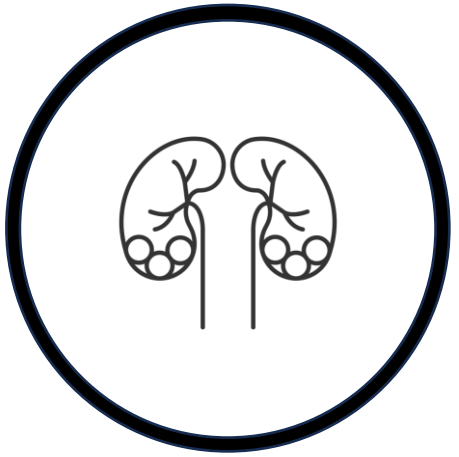
Severe headache



Blurred vision



Pedal edema



Reduced passage of urine

ECLAMPSIA



- Eclampsia is the occurrence of generalized tonic-clonic convulsion in a patient with pre-eclampsia, in the absence of a neurological disease

- It can occur before delivery (ante-partum eclampsia) during delivery (intrapartum eclampsia), or after delivery (post-partum eclampsia)

ACTIONS TO BE TAKEN IN PATIENTS WITH SEVERE PRE-ECLAMPSIA

1. Give appropriate antihypertensive medications 
2. Catheterize bladder to monitor urine output and proteinuria 
3. Give loading dose of magnesium sulphate and **REFER** 
4. Never leave a woman alone 
5. Accompany woman to referral health facility 

GUIDELINES FOR ADMINISTRATION OF MAGNESIUM SULFATE

- Withhold magnesium sulfate temporarily if:
  - Respiration rate < 16 breaths/min.
  - Urine output < 30 mL/hour during preceding 4 hours the

- If the woman is unarousable or in case of respiratory arrest:
  - Assist ventilation

- Give calcium gluconate 1 g (10 mL of 10% solution) IV slowly

MAGNESIUM SULFATE LOADING DOSE



1. Give magnesium sulfate 20% solution 4 g IV slowly over 5 min
2. Follow promptly with magnesium sulfate 50% solution 5 g deep IM injection in each buttock with lignocaine 2% solution 1 mL deep IM injection into each buttock.
3. If convulsions recur after 15 min., give magnesium sulfate 50% solution 2 g IV over 5 min.
4. Maintenance dose at the secondary facility

KEY MESSAGES



Hypertensive disorders can occur during pregnancy, childbirth, and after childbirth



REFER clients with severe preeclampsia, eclampsia and chronic hypertension to a secondary health facility after stabilization

SESSION 6.5: VAGINAL BLEEDING IN EARLY PREGNANCY

DEFINITION



Vaginal bleeding in early pregnancy is any bleeding that occurs during the first 28 weeks of pregnancy

DIFFERENTIAL DIAGNOSIS OF BLEEDING IN EARLY PREGNANCY

1. Spontaneous abortion - the loss of a pregnancy before fetal viability (28 weeks gestation).
2. Threatened abortion (pregnancy may continue)
3. Inevitable abortion (pregnancy will not continue)
4. Incomplete abortion (products of conception are partially expelled)
5. Complete abortion (products of conception are completely expelled)
6. Ectopic pregnancy - any pregnancy occurring outside the uterus
7. Molar pregnancy - pregnancy resulting from tissues that becomes an abnormal growth in the uterus caused by a problem with genetic information

CLINICAL DIAGNOSIS OF ABORTION



History

- Vaginal bleeding, lower abdominal pain ± passage of tissue



Examination

- Bleeding, cervical is open or closed



Treatment plan

- Inevitable or incomplete abortion
  - Initiate treatment (e.g., infusion of fluids) based on clinical status
- Threatened abortion
  - Bed rest
  - Avoid intercourse and strenuous activities



Referral

- Refer to higher centers

OTHER COMPONENTS OF POST ABORTION CARE

- Reassure the woman that spontaneous abortion does occur but may not hinder her chances of future conception.
- Encourage her to delay next pregnancy for at least 6 months.
- Provide counseling for women who have had unsafe abortion
- Counsel the woman to take up a modern contraceptive method
- Cancer awareness and screening

SESSION OBJECTIVES

At the end of the session, participants should be able to:

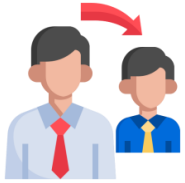


1. Define vagina bleeding in pregnancy
2. Know the differential diagnosis of vagina bleeding in pregnancy
3. Manage vagina bleeding in pregnancy

ECTOPIC PREGNANCY

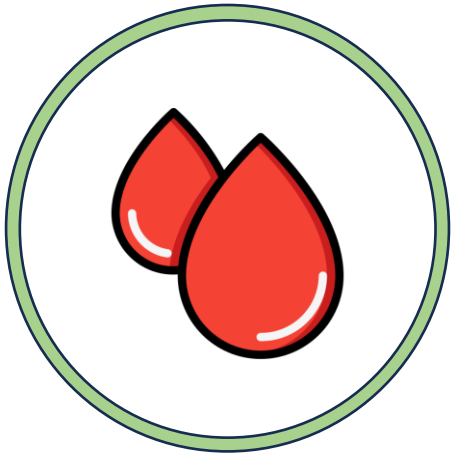


In any woman in the reproductive age group with anemia, or unusual complaints about abdominal pain and PV bleeding, **consider ectopic pregnancy**



If an ectopic pregnancy is suspected, please refer to a higher level of care

KEY MESSAGES







Vaginal bleeding in early pregnancy has a wide differential diagnosis

Diagnosis can often be made clinically, saving time, expenses, and life

Refer all suspected cases of bleeding in pregnancy to secondary facilities

SESSION 6.16: VAGINAL BLEEDING IN LATE PREGNANCY

LEARNING OBJECTIVES

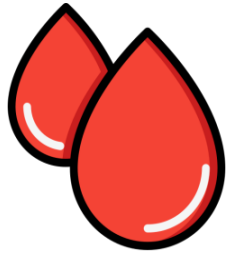
By the end of the session, participants should be able to:

Define late vagina bleeding in pregnancy, placenta previa and abruptio placenta

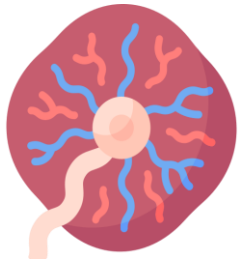
Understand actions to be taken when a patient present with late vagina bleeding in pregnancy



DEFINITION OF TERMS



Vaginal bleeding in late pregnancy is bleeding that occurs after 28 weeks of pregnancy and before the onset of labour.



Abruptio Placenta is the detachment of the normally located placenta from the uterus before the fetus is delivered

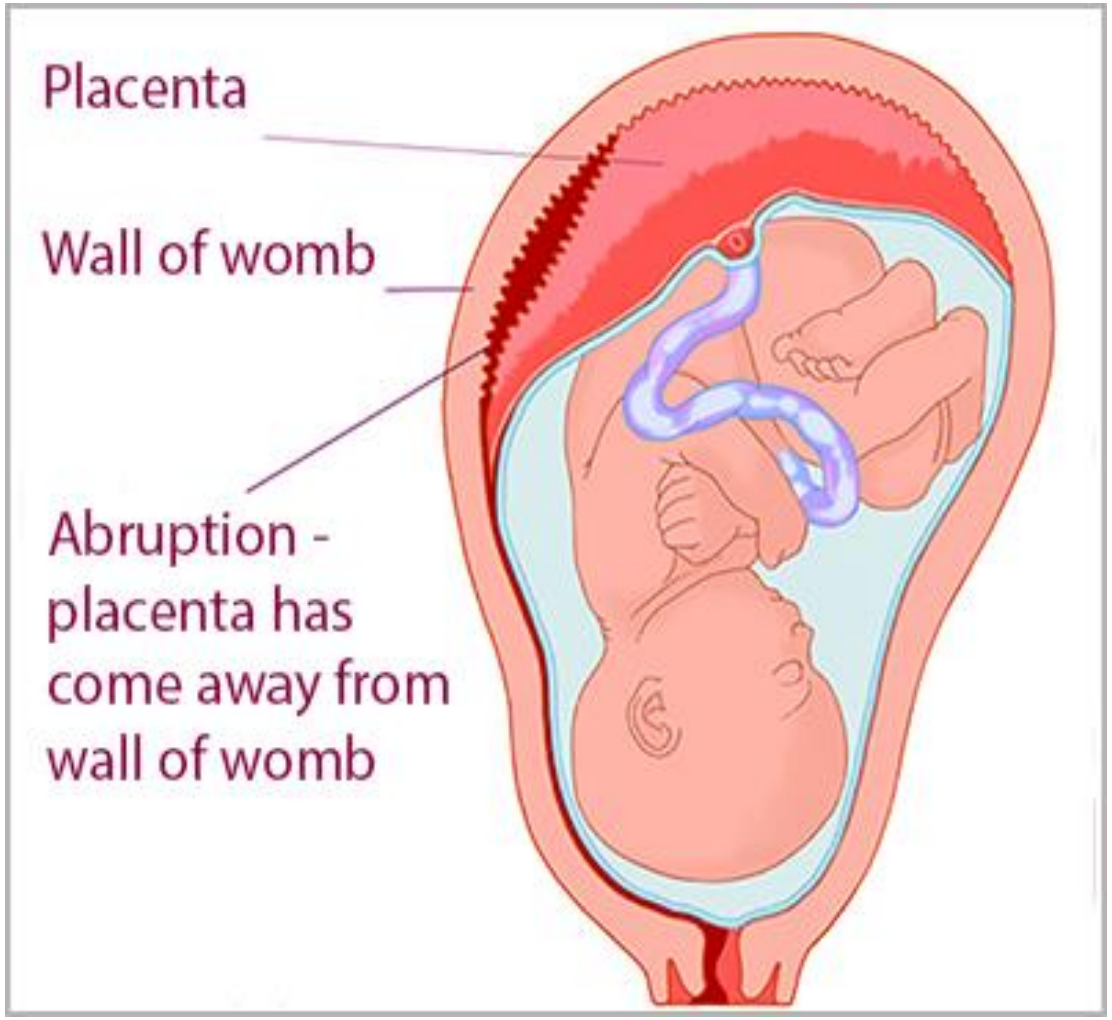


Placenta previa is the implantation of the placenta at or near the cervix (lower uterine segment)

DIAGNOSIS OF BLEEDING IN LATE PREGNANCY

Abruptio Placenta

Bleeding (this may be "occult" or retained in the uterus) after 28 weeks gestation
Intermittent or constant abdominal pain/tetanic uterine contractions
Shock
Tense/tender uterus
Decreased/absent fetal movements
Fetal distress or absent fetal heart sounds



DIAGNOSIS OF BLEEDING IN LATE PREGNANCY

Placenta previa

Bleeding after 28 weeks gestation

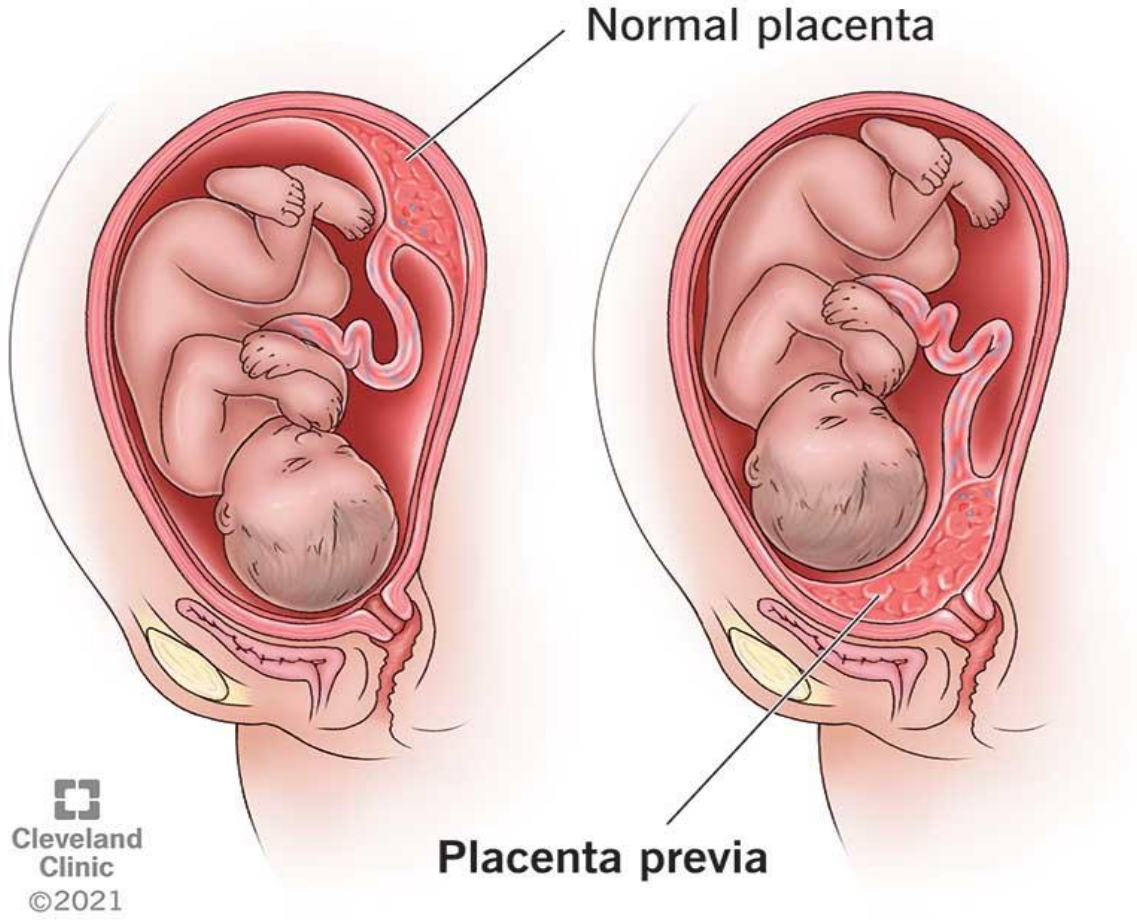
Bleeding may be precipitated by intercourse/ exercise and is usually painless

Shock

Relaxed uterus

Fetal presentation not in pelvis/lower uterine pole feels empty

Normal fetal condition



ACTIONS TO BE TAKEN IN PATIENTS WITH BLEEDING IN LATE PREGNANCY



1. Set up an IV line
2. Oxygen by face mask
3. Refer to higher centers

- Note: **DO NOT** perform a vaginal examination in patients with vaginal bleeding in late pregnancy

KEY MESSAGES



The 2 main causes of bleeding in late pregnancy are abruptio placentae and placenta previa



DO NOT perform a vaginal examination in patients with vaginal bleeding in late pregnancy



Refer any suspected case of vaginal bleeding in late pregnancy to higher-level facilities

Session 6.7 VAGINAL BLEEDING IN LABOUR

LEARNING OBJECTIVES

By the end of the session, participants should be able to know the:

Definition of vagina bleeding in labour

Diagnosis of vagina bleeding in labour

General management and prevention of vagina bleeding in labour



VAGINAL BLEEDING IN LABOUR

Definition

Vaginal bleeding in labour is bleeding that occurs during labor before childbirth

General Management

- Get help—mobilize personnel
- Rapidly evaluate breathing and state of consciousness
- Check airway, pulse, and blood pressure
- If shock is suspected, immediately begin treatment for shock as outlined above
- Infuse IV fluids and O2 and Refer to higher centres immediately



DIAGNOSIS OF BLEEDING IN LABOUR





- **Ruptured uterus**
  - Contraction stop
  - Persistent pains
  - Fetus fully palpable per abdomen
  - Fetal heart sounds are usually absent



- **Features of shock**

VAGINAL BLEEDING IN LABOUR (POST PARTUM HAEMORRHAGE)

MANAGEMENT AND PREVENTION

Introduction



1. Primary PPH is the loss of 500ml or more of blood from the genital tract within 24 hours after the birth of a baby

2. PPH can be
   - Minor (500 – 1000ml)
   - Moderate (1000 – 2000ml)
   - Severe (> 2000ml)

3. Secondary PPH is defined as abnormal or excessive bleeding from the birth canal between 24 hours to 45 days post-natal.

Challenges in estimating blood loss

Bleeding is underestimated because:

01 Visual quantification is difficult

02 Blood is mixed with other fluids (amniotic fluid, urine) and therefore underestimated

03 Bleeding may occur slowly over several hours and condition may not be recognized until woman suddenly enters shock

Initial assessment and management (1/2)

1. Call for help - mobilize personnel
2. Evaluate woman's condition including vital signs
3. If shock suspected, immediately begin treatment as outlined below
4. Massage uterus to expel clots and feel to see that it is contracted - recheck intermittently
5. Give oxytocin 10 units IM or misoprostol 800µg by mouth or through the anus
6. Infuse IV fluids

Initial assessment and management (2/2)

7	Catheterize bladder, if needed
8	Check to see that placenta has been expelled - examine for completeness
9	Examine the cervix, vagina and perineum for tears
10	Refer as soon as possible to higher centres

***Remember** the ABCs: Resuscitate if in shock*

Prevention strategies

Prevention Strategies		
1 Birth preparedness	2 Skilled provider at childbirth	3 Treatment of anemia
4 Active management of third stage of Labour (Recall; Labour and Delivery chapter)	5 Avoid unnecessary procedures (e.g., episiotomy)	6 Active management of third stage of labour
7 Use of a Uterotonic (Oxytocin 10 units or Carbetocin 100 mcg) IM within 1 minute of childbirth	8 Controlled cord traction	9 Fundal massage after delivery of placenta

Key messages

Postpartum hemorrhage is a leading cause of death in mothers

Stop bleeding:

- Uterine massage
- Examine perineum, vagina and cervix
- Oxytocics (first choice oxytocin)
- Empty bladder
- Examine placenta



Begin resuscitation immediately

Refer to higher level centers


COME TO HOSPITAL IF YOU EXPERIENCE
ANY OF THESE SIGNS
DANGER !!
SIGNS IN PREGNANCY
Vaginal bleeding
Severe nausea and vomiting
Feel a flood of water rush down your legs
Persistent severe headache
Abdominal pain
Visual disturbance
(blurry vision, flashes of light)
Pain or burning sensation while urinating
Decreased level of baby activity or movement
Fever
Unusual vaginal discharge

Role play

Dangers in pregnancy

Exercise:

Instruction:

Divide the class into 2 for a Role play on prompt identification and management of dangers in pregnancy

- Severe pre-Eclampsia
- Ante-partum Haemorrhage and Liquor drainage (25 min)

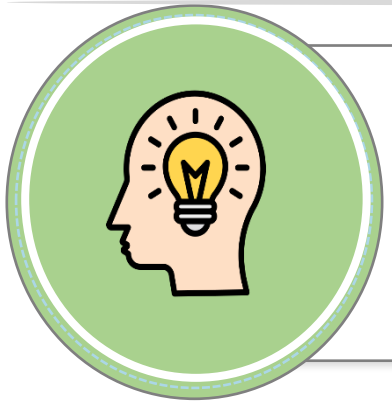


SESSION 6.8 RESPECFUL MATERNITY CARE

Photo Credit: Merck for **mothers**

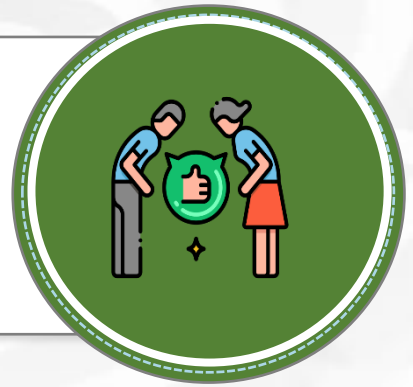
Learning Objectives

At the end of this session participants should



Understand the need to respect every woman that come to the facility for ANC and delivery.

Develop good rapport so that trust is establish between the HCWs and the ANC clients.



Task 2

1

List some of the Disrespect and abuse that can be encountered by pregnant women in the facilities

Take some minutes to reflect, how disrespect and abuse lead to reduced quality of care. List down your points

2



KEY MESSAGES

Everyone has the right to freedom from harm and ill-treatment.

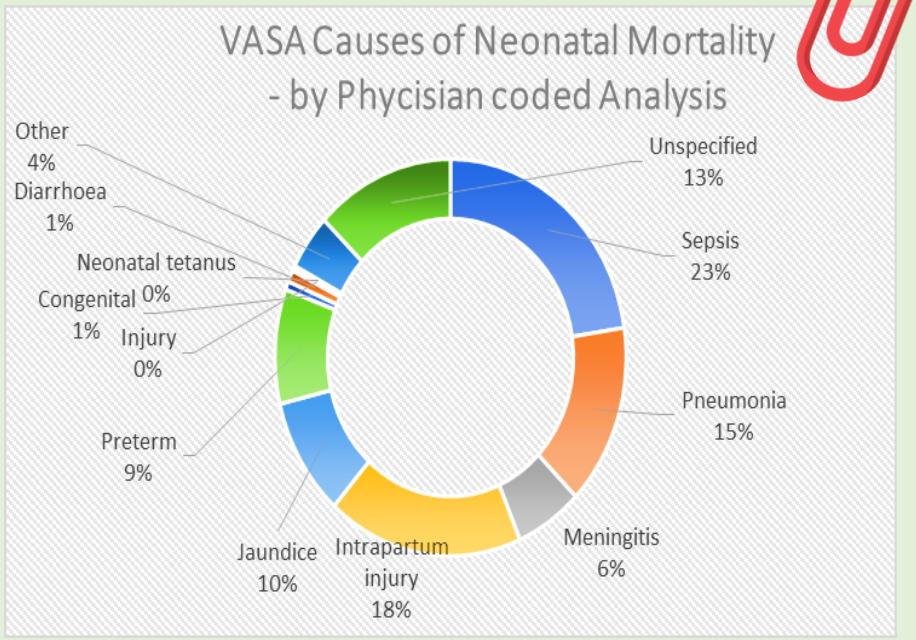
Disrespect and abuse lead to poor utilization of PHC services

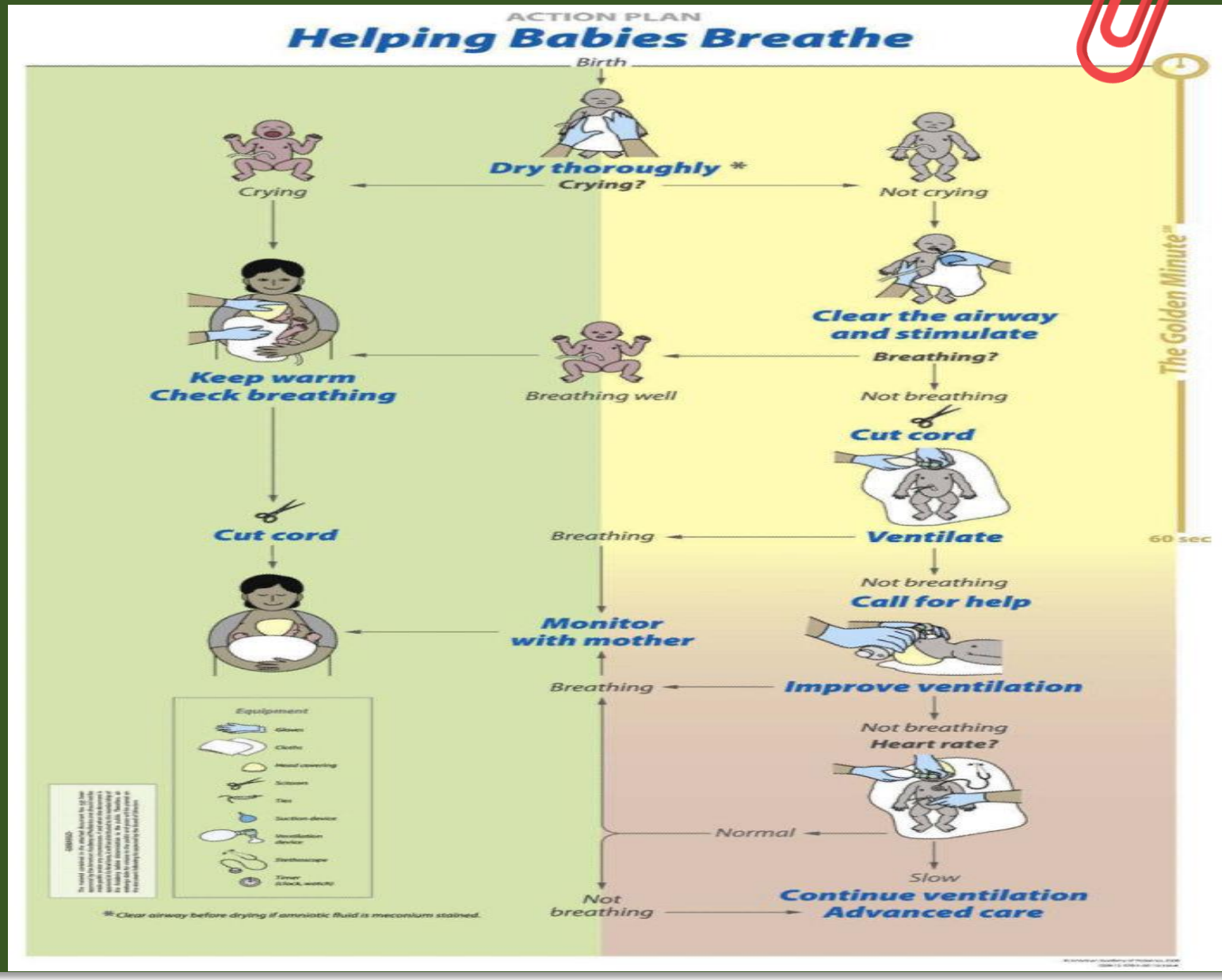


Session 6.9 OVERVIEW OF ESSENTIAL CARE OF THE NEWBORN

INTRODUCTION

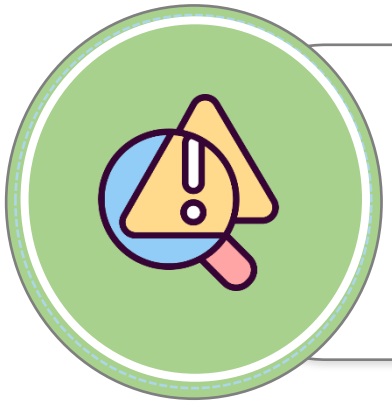
- Newborn babies should be kept with their mothers rather than in a separate nursery
- WHO defines essential newborn care as the care of the newborn at birth, including:
  - Cleaning, drying, and keeping the infant warm through skin to skin contact with the mother
  - Early initiation of breastfeeding (within 1-hour of delivery)
  - Umbilical cord care




ACTION PLAN
Helping Babies Breathe
Birth
Dry thoroughly *
Crying?
Crying
Not crying
Clear the airway and stimulate
Breathing?
Not breathing
Keep warm
Check breathing
Breathing well
Cut cord
Cut cord
Ventilate
Breathing
Not breathing
Call for help
Monitor with mother
Improve ventilation
Breathing
Not breathing
Heart rate?
Normal
Slow
Continue ventilation
Advanced care
Not breathing
The Golden Minute"
60 sec
Equipment
* Clear airway before drying if amniotic fluid is meconium stained.

Learning Objectives

At the end of this session participants should



Be familiar with identification And Referral Of Babies With Problems Or Danger Signs 1/2

IDENTIFICATION AND REFERRAL OF BABIES WITH PROBLEMS OR DANGER SIGNS

Babies with some problems should receive some interventions and re-evaluated for danger signs

1. If very small baby, jaundiced or bleeding, refer immediately in KMC position (these category of children do not need any pre-referral treatment, refer immediately)
2. If having problem with suckling, use alternative feeding method by expressing breastmilk and feed with cup, if not responding, this is a danger sign, refer.
3. If abnormal temperature (too high or too low), improve thermal care and re-assess after one hour, if still abnormal, refer
4. If not suckling well, not feeding well, crying excessively, too sleepy, give pre-referral antibiotic and refer in KMC position for advance care
5. If any other signs, refer immediately in KMC position.

Key points

- Every baby with sign of life should be given opportunity of being assisted to breath at the time of birth
- Every baby should breath within the first minute of life – Golden Minute
- Babies with danger sign should be referred immediately
- Babies with LBW should be referred in KMC position






NATIONAL PRIMARY HEALTHCARE
DEVELOPMENT AGENCY
Partnership for Service


Thank
you

MODULE 6.10: INTRODUCTION TO FAMILY PLANNING /CHILD-BIRTH SPACING

Overview of family planning/childbirth spacing

6.11	Introduction to Family Planning/Child-birth spacing
6.12	Balanced Counselling Strategy
6.13	Client evaluation in Family Planning/Child-birth spacing
6.14	Family planning/Child-birth spacing methods
6.15	Male involvement in Family planning
6.16	Male involvement in Family planning

SESSION 6.11: OVERVIEW OF FAMILY PLANNING AND CHILD SPACING

Session overview



Concept of Family Planning/Childbirth Spacing



Benefits of Family Planning/Childbirth Spacing

Learning Objectives

At the end of this session, Participants will be able to;

1. Explain the concept of family planning/childbirth spacing
2. List and explain the benefits of family planning/childbirth spacing

Introduction

- Family Planning is one of the key PHC strategies with important benefits for both maternal and child health.
- It is a component of the strategies adopted by WHO to reduce maternal mortality and morbidity.
- The goal of this session is to strengthen the capacity of PHC workers.



Concept of Family Planning/Child-Birth Spacing

Family Planning is “a way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitudes and responsible decision by individuals and couples in order to promote health and welfare of the family group and thus contribute effectively to the social development of the country” (WHO)



Benefits of family planning/child spacing



Offers a couple the opportunity to have a family they can carter for



Helps women protect themselves against unintended/high-risk pregnancies



Improves family well being and quality of life



Investment in family planning can reduce poverty and ultimately increase the GDP of the country

Key Messages



Family planning is considered a **“best buy”** among health investments, being one of the most cost-effective, high-yield interventions that exist today



Family planning offers **immediate** and **long-term** health, social and economic benefits for individuals, families and communities

SESSION 6.12 BALANCED COUNSELLING STRATEGY

Session overview



Define Balanced Counselling Strategy (BCS)



Objectives of BCS



Tools and job aids necessary for offering BCS



The steps in the BCS

Learning Objectives

At the end of this session, Participants will be able to;

1. Understand Balanced Counselling Strategy (BCS)
2. Explain the objectives of the Balanced Counselling Strategy
3. Understand the tools and job aids necessary for offering BCS
4. Effectively counsel clients on FP using the steps, tools and job-aids in the BCS

Balanced Counselling Strategy(BCS)

Balance Counselling Strategy(BCS) is a **practical, interactive,** and **client-friendly** strategy for improving counselling within family planning consultations.

It assumes that the motive of a client's visit is for family planning and the strategy ensures that the client has ownership of any decision made to use family planning



Tools/Job Aids For Offering BCS

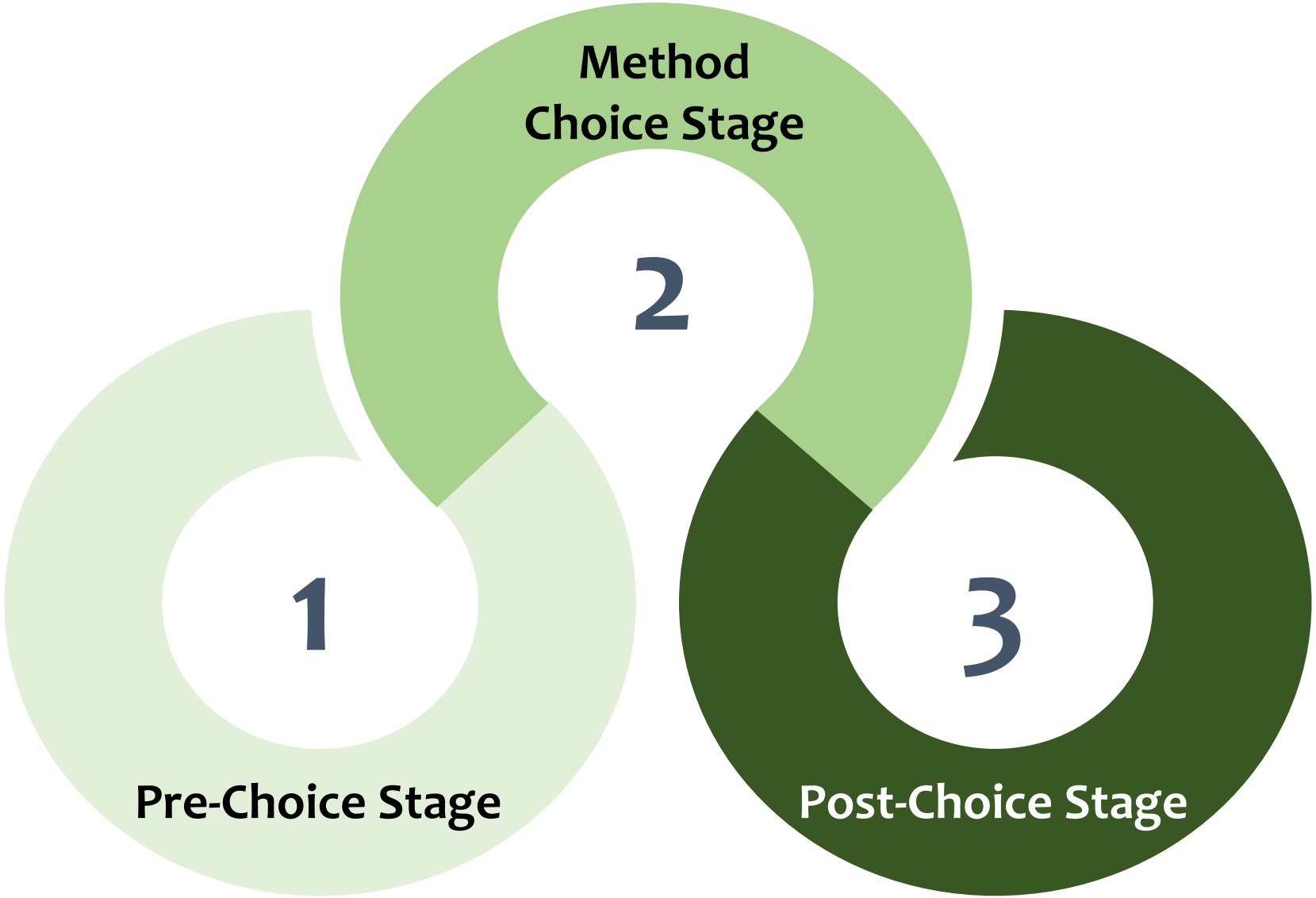
The BCS Algorithm

The Counselling Cards

Method brochures



Steps in the Balanced Counselling Strategy



Role play

On effective counselling of family planning clients using the steps, tools and job-aids in the Balanced Counselling Strategy







Key messages

- The BCS is a systematic tool used to facilitate quality counselling during family planning consultation



- It comprises three key tools/job aids which guides the service provider to ensure the client makes an informed choice

Session 6.13 CLIENT EVALUATION IN FAMILY PLANNING/CHILDBIRTH SPACING

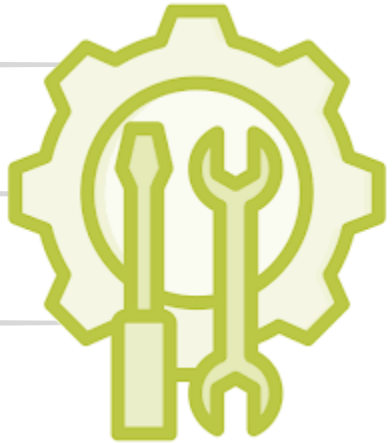
Learning Objectives

At the end of this session, Participants will be able to;

1. Identify the equipment and materials required for Family Planning(FP)/Child Birth Spacing(CBS)
2. Be familiar with the preparation of the client for FP/CBS
3. Know the steps in performing specific examinations
4. Know the laboratory tests that may be required in family planning

Equipment

Blood pressure apparatus	Sims/Cusco's Speculum (bi - valve)
Stethoscope	Gallipot for lubricant
Weighing scale	Sponge holding forceps
Torch/angle-poised lamp	Torch/angle-poised lamp
Pedal Bin for soiled dressings	Kidney dish
Trolley	Examination couch
Bowl for lotion/water	Gloves
Bowl for cotton wool/gauze	Bucket for HLD



Materials and consumables

- Laboratory request forms
- Glass slide
- Wooden spatula for cervical smear
- 95% alcohol
- Acetic acid
- PT strip
- HIV strip
- Hydrochloride
- Brush and soap



Preparation of clients



1

Ensure the client's comfort and privacy



2

Explain every procedure to the client



3

Ask client to empty bladder



4

Wash hands with soap and water before and after examining the woman (or having any direct contact)

History Taking

1.1	Source of referral
1.2	Client profile
1.3	Social habit history
1.4	Medical history
1.5	Gynecological/Obstetrical history
1.6	Sexual history
1.7	Contraceptive history

Discussions

1) How to perform self breast examination

2) How to examine the breast in the clinic

Steps In Performing Physical Examination

General examination

- Observe the gait, facial expression, pronounced disability or obvious ill-health
- Check temperature, pulse, respiration rate, BP, weight and record



Breast examination

- There are two positions for breast examination – standing and lying.

Laboratory Investigations

- Pregnancy test to confirm pregnancy
- During speculum examination, obtain laboratory specimen for:
  - Pap smear
  - HVS for M/C/S



SESSION 6.14: FAMILY PLANNING / CHILDBIRTH SPACING METHODS

Learning Objectives

At the end of this session, Participants will be able to;

1. To understand the various methods of family planning
2. To understand the advantages and disadvantages of the various methods
3. To know the various methods of family planning
4. To offer family planning services seamlessly

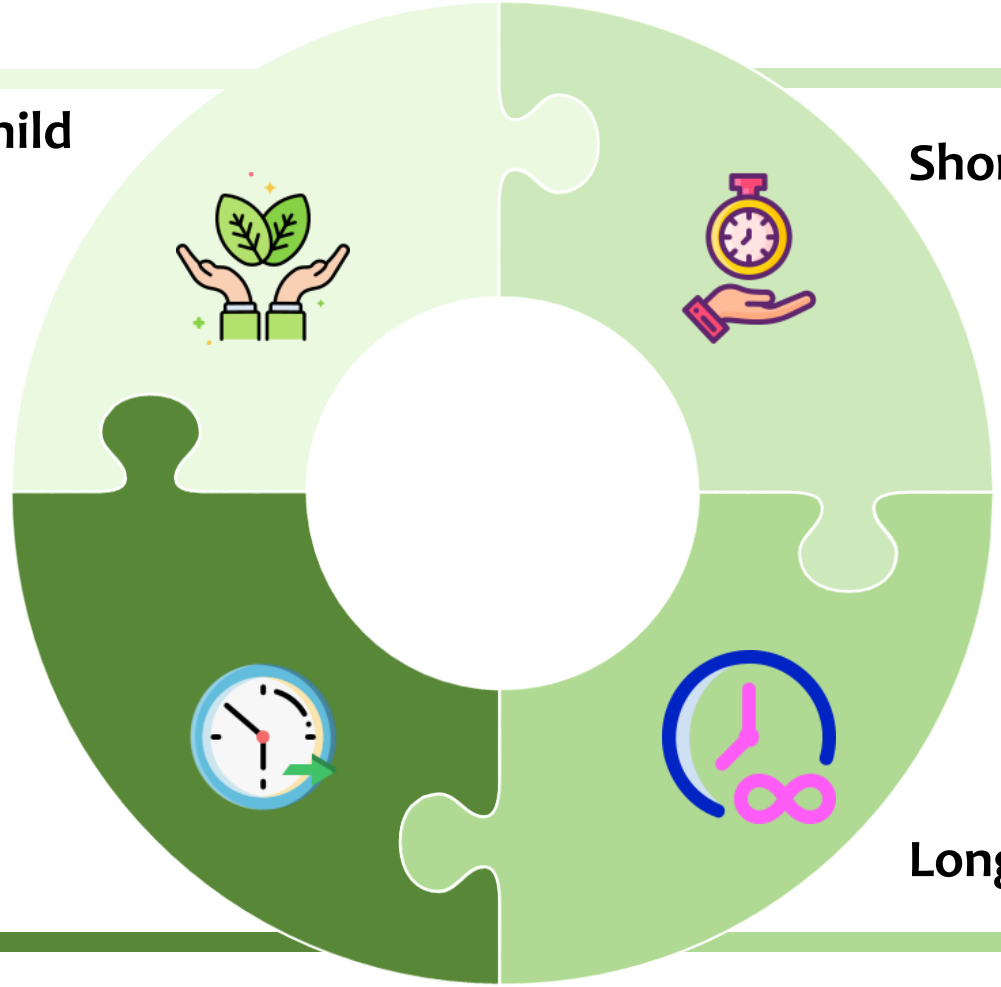
WHO recommends that mothers should wait for an interval of at least 24 months before attempting next pregnancy

World Health Organization

Family Planning/Child Birth Spacing Methods

1 Natural Family Planning/Child Spacing Methods

2 Short Term Methods



4 Permanent Methods

3 Long Acting Methods

Natural Family Planning/Child Spacing methods

1. Calendar Method
2. Basal Body Temperature (BBT) Method
3. Cervical Mucus Method
4. Sympto-thermal Method
5. Standard Days Method (Cycle Beads)
6. Lactational Amenorrhea Method (LAM)



Short Acting Methods

Barrier methods



- Male and female condoms
- Spermicidal

Hormonal methods



- Pills (ECs, COCs and POPs
- Injectables (DMP, Noristerat, Cyclofem and Megiterat

Long Acting Methods

Long acting methods



- Jadelle (double rod)
- Implanon (single rod)
- Intra-Uterine contraceptive device (IUCD)

Permanent Methods

Permanent methods (Voluntary surgical contraception)



- Bilateral Tubal Ligation (BTL)
- Vasectomy

Management of Side Effects

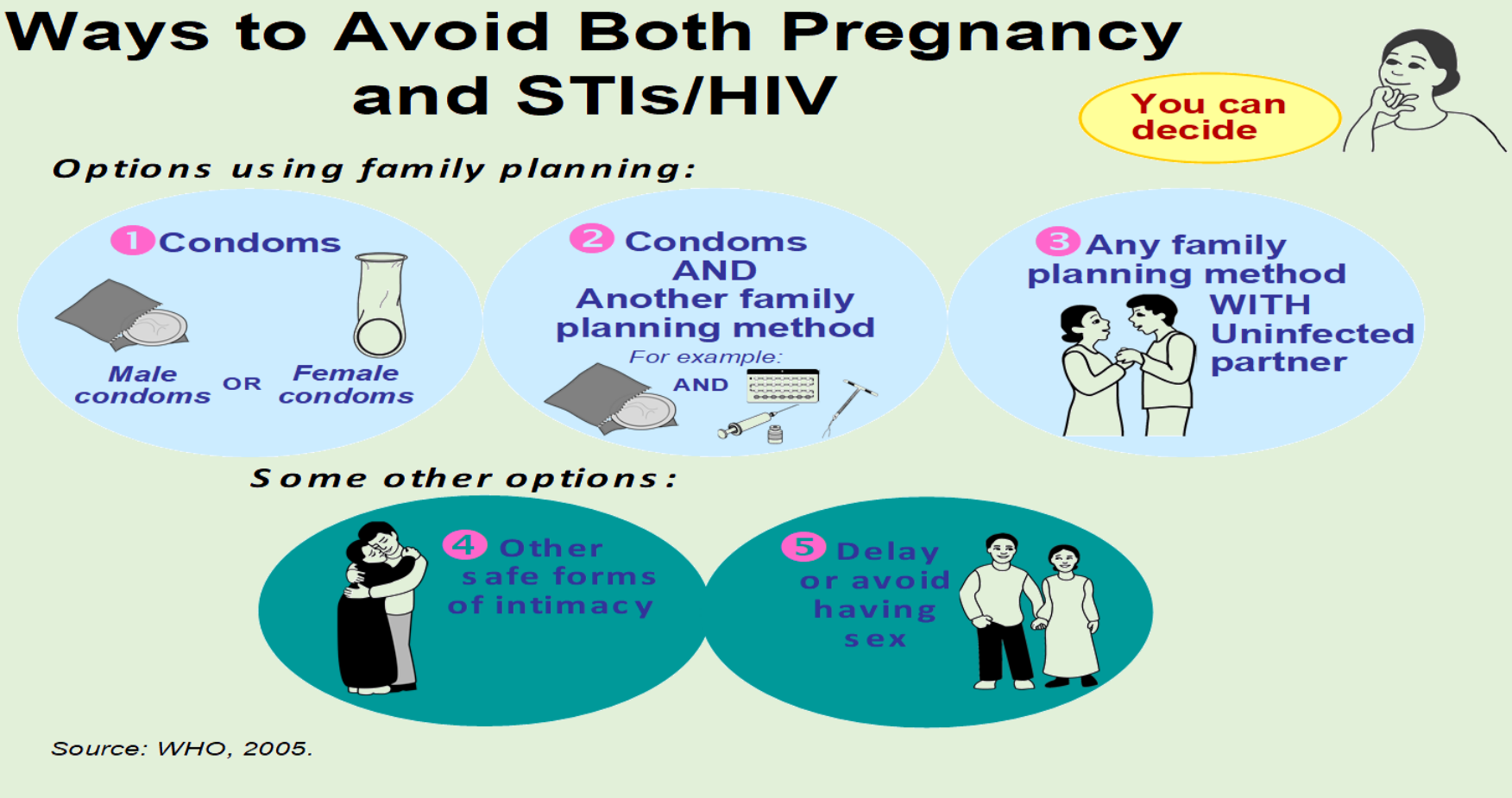
1. Each service provider should be equipped to manage side effects of family planning

2. Refer to relevant page of the manual to discuss management of side effects, possible complications and how to address them



Dual Protection

The World Health Organization has recommended some options to prevent pregnancy and protect individuals from STIs and HIV



Medical Eligibility For Contraceptive Use In Women



Evidence-based intervention



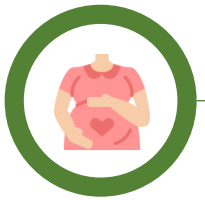
Process of improving quality of care in FP



Contraceptive methods available



Safety of each contraceptive method is determined in the context of the medical condition of client



Safety of method should be weighed along the benefits of preventing unwanted pregnancy

WHO Eligibility Criteria For Contraceptive Use

Category	Description	When clinical judgment is available
1	No restriction for use	Use the method under any circumstances
2	Benefits generally outweigh risks	Generally use the method
3	Risks generally outweigh benefits	Use of method not usually recommended, unless other methods are not available/acceptable
4	Unacceptable health risk	Method not to be used unless other methods are not available

WHO Eligibility Criteria Examples

Category	Contraceptive method	Medical condition/Characteristic
1	COCs	Uterine fibroids
2	IUDs	Anaemia
3	DMPA	Breastfeeding a baby less than 6 weeks postpartum
4	Hormonal implants	Current breast cancer

Source: WHO, 2004

Key Messages

There are **four** categories of child birth spacing methods which include **Natural** methods, **short acting** methods, **long acting** methods and **permanent** method



Every woman **must** be evaluated for the method that **suits** her taking into the cognizance her **desires** and the **side effect** profile



Remember there are at least **19** Contraceptives in use so offer as many as are available at your clinic



Always use the **WHO eligibility criteria** to help determine what contraceptives are appropriate

SESSION 6.15: MALE INVOLVEMENT IN FAMILY PLANNING

Learning Objectives

At the end of this session, Participants will be able to;

1. The importance of male involvement in Family Planning
2. The roles of men in Family Planning
3. The barriers to male involvement in Family planning
4. The methods that could be used to motivate men to be involved in Family Planning

Importance of Male Involvement in Family Planning

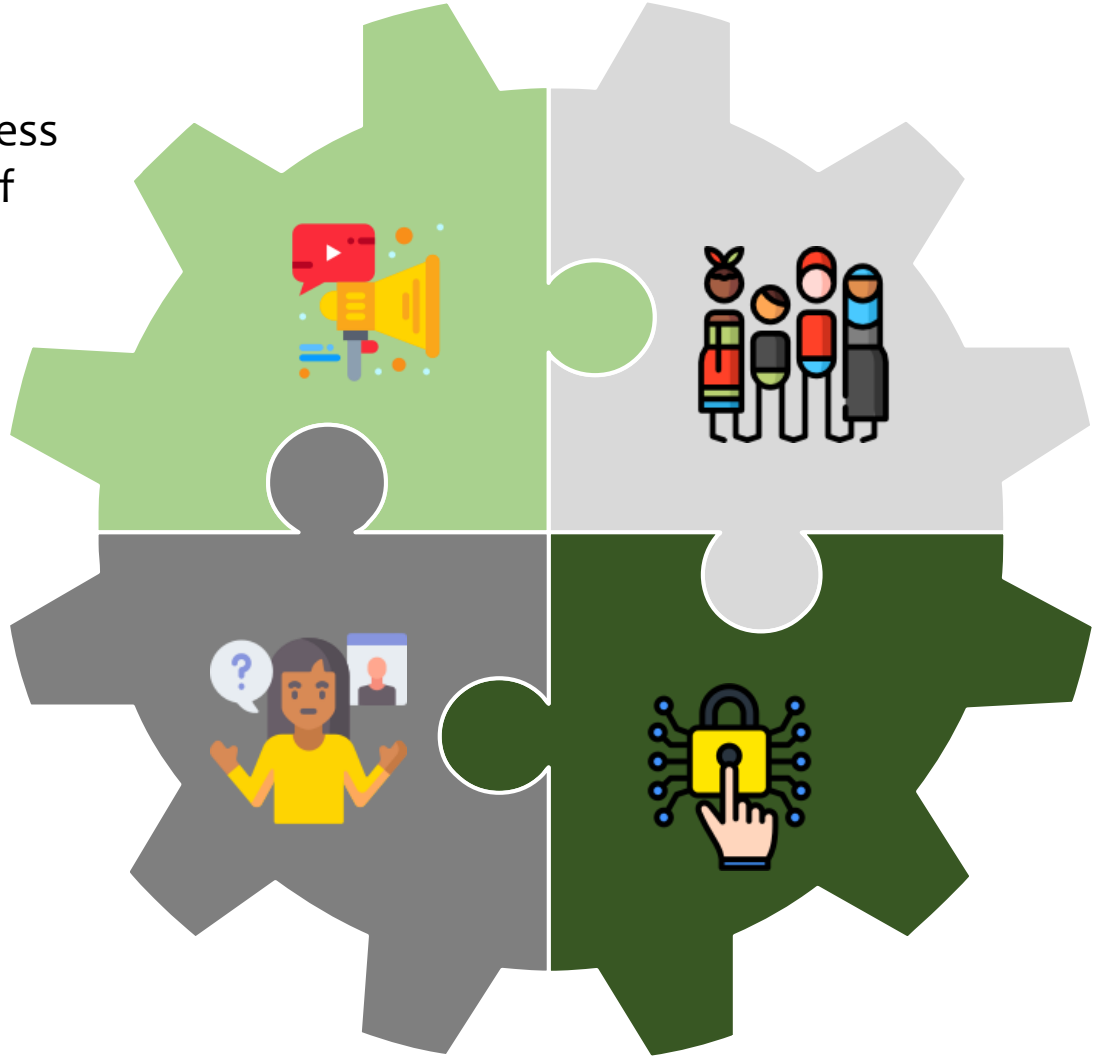


1. Men are an underserved audience in FP services
2. In some cultures men decide whether women can or can not access contraceptive services
3. Secure male recognition and acceptance of FP and RH issues within the community
4. Enables men share responsibilities with their partners and the need for child spacing

Barriers To Male Involvement

1. Low level of awareness about the benefits of family planning

2. Cultural and religious factors



3. Lack of availability/accessibility of family planning services and supplies either due to distance or men dedicating more time to economic activities

4. Lack of couple communication and trust in counselling

Roles of Men in Family Planning

Roles

Increasing the uptake of contraceptive methods

Support their partner's/spouse's contraceptive use:

- By reminding their partner's/spouse's about appointments and when to take pills or injections
- By visiting the FP clinic with their partners/spouses

The Use the forum of FP and RH to promote gender equity as well as women and men's social roles

Methods of Motivating men

Activities that might motivate men

1.1	Targeting male-only groups for dialogue on FP
1.2	Using male peer educators to educate men
1.3	Using traditional and religious leaders to provide information
1.4	Special health facility times for men
1.5	Couple counselling
1.6	Condom promotion programmes
1.7	Support their partners/spouses FP decision
1.8	Advocate to their fellow men on FP
1.9	Accompany their partners/spouses to the HF
2.0	Provide financial support for their partners/spouses to go for FP services
2.1	Cooperate with their partners/spouses if natural FP methods are being used

Key Messages



Men are primary decision makers on family size and family planning



Interspousal communication and contraceptive decision-making positively affects contraceptive uptake and continued use



Addressing myths and misconceptions is necessary to increase family planning uptake



Low awareness on family planning among men is a major factor for poor male involvement in family planning

SESSION 6.16: ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH (ASRH)

Learning Objectives

At the end of this session, Participants will be able to;



1. How to create awareness about the unique needs and vulnerabilities of adolescents
2. How to provide effective, evidence based ASRH service provision
3. How to provide guidance on appropriate approaches and techniques in relating with adolescents

Definitions

Adolescents are young people transitioning from childhood to adulthood

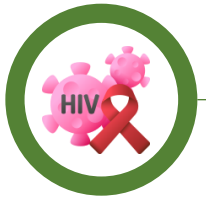
Adolescence is commonly defined by age (10 to 19 years old), and as a life stage characterized by rapid physical, social, emotional and cognitive changes

They have a high burden of maternal mortality and morbidity with one of the highest rates of unmet need for family planning.



Introduction

Adolescents are;



Vulnerable to contracting HIV and other STIs



Exposed to sexual violence especially in humanitarian emergencies



Typically do not have access to high quality sexual and reproductive health information and services.

Characteristics of adolescent friendly RH services



Operational Characteristics



Have a **written guideline** on provision of adolescence FP/RH services



Ensure provision of **wide range** of **RH services** (FP, STI treatment and prevention, HIV counselling and testing, ante- and post-natal care, delivery care)



Availability of wide range of **FP methods** including **LARC** and **condoms** for young men and women



Make available FP/RH **educational materials, posters** or **job aids** on site, which are designed to reach adolescents



Ensure **referral mechanisms** are in place (for medical emergencies, for mental health and psychosocial support, etc.)



Ensure adolescent-specific **indicators** are **monitored** on a **regular** basis (e.g. number of adolescent clients, disaggregated by age and sex



Encourage the **involvement** of adolescence (female and male) in the **design**, **operation** and **monitoring** of services of the health facility

Provider Characteristics

- Ensure **providers** are **trained** to provide adolescent-friendly services
- Ensure **all** staff is oriented to provide **confidential** adolescent-friendly services
- Ensure **privacy** and **confidentiality** of adolescence client
- Dedicate **sufficient time** for **client-provider** interaction for adolescence client
- Listen **carefully** and ask **open ended** questions
- Use **simple** terms and **avoid** medical terms
- Use terms that **suit** young people
- Avoid being **judgmental** and **prescriptive**
- Ensure their **choices**, **rights** and **power** to make decisions about sex are respected



Health Facility Characteristics

- Give **priority** to **flexible** facility op**ening hours** that are convenient for adolescents
- Dedicate **specific** clinic times or spaces for **adolescents**
- Ensure **FP/ RH services** offered for **free**, or at rates **affordable** to adolescents
- Ensure a **separate**, **discreet**, entrance for are treated within the same facility /structure
- Ensure there is a **transparent**, and **confidential** mechanism for adolescents to submit **complaints** or **feedback** about SRH services at the facility
- Ensure **counseling** and **treatment** rooms allow for **privacy** (both visual and auditory
- Develop and ensure health provider adhere to a **Code of Conduct** with regards to dealing with adolescents.





Key messages



The adolescent age group is one with a lot of biological and psychological challenges



Adolescent friendly RH services must have specific characteristics as it concerns the operations of the facility, the health provider and health facility itself


Thank
you