Integrated Management of Pregnancy and Childbirth

Pregnancy, Childbirth, Postpartum and Newborn Care:
A guide for essential practice

World Health Organization

UNFPA

UNICEF

The World Bank Group

Department of Reproductive Health and Research, Family and Community Health, World Health Organization, Geneva
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World Health Organization
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In modern times, improvements in knowledge and technological advances have greatly improved the health of mother and children. However, the past decade was marked by limited progress in reducing maternal mortality and a slow-down in the steady decline of childhood mortality observed since the mid 1950s in many countries, the latter being largely due to a failure to reduce neonatal mortality.

Every year, over four million babies less than one month of age die, most of them during the critical first week of life; and for every newborn who dies, another is stillborn. Most of these deaths are a consequence of the poor health and nutritional status of the mother coupled with inadequate care before, during, and after delivery. Unfortunately, the problem remains unrecognized or worse-accepted as inevitable in many societies, in large part because it is so common.

Recognizing the large burden of maternal and neonatal ill-health on the development capacity of individuals, communities and societies, world leaders reaffirmed their commitment to invest in mothers and children by adopting specific goals and targets to reduce maternal and childhood-infant mortality as part of the Millennium Declaration.

There is a widely shared but mistaken idea that improvements in newborn health require sophisticated and expensive technologies and highly specialized staff. The reality is that many conditions that result in perinatal death can be prevented or treated without sophisticated and expensive technology. What is required is essential care during pregnancy, the assistance of a person with midwifery skills during childbirth and the immediate postpartum period, and a few critical interventions for the newborn during the first days of life.

It is against this background that we are proud to present the document Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice, as new additions to the Integrated Management of Pregnancy and Childbirth tool kit. The guide provides a full range of updated, evidence-based norms and standards that will enable health care providers to give high quality care during pregnancy, delivery and in the postpartum period, considering the needs of the mother and her newborn baby.

We hope that the guide will be helpful for decision-makers, programme managers and health care providers in charting out their roadmap towards meeting the health needs of all mothers and children. We have the knowledge, our major challenge now is to translate this into action and to reach those women and children who are most in need.

Dr. Tomris Türmen
Executive director
Family and Community Health (FCH)
Maternal and newborn health has long been a priority area of concern and activity of the Department of Health. In order for gains in women’s health to be sustainable, capacity and capability development is the key. The Department of Health is proud to present and adapt this manual, *The Essential Care Practice Guideline for Pregnancy, Childbirth and Newborn Care*, as part of its continuing commitment to learning and sharing lessons and best practices for developing human and institutional capacity in the field of emergency obstetrics.

This is a technical document with a development aim. In its technical sense, the manual provides evidence-based recommendations to guide health care professionals in the management of women during pregnancy, childbirth and postpartum, post abortion, and newborns during their first week of life. All recommendations are for skilled birth attendants working as a team at the primary level of health care, either at the facility or in the community. They apply to all women attending antenatal care, in delivery, postpartum or post abortion care, or who come for emergency care, and to all newborns at birth and during the first week of life. But its broader purpose is one of development to enhance the ability of people and the community in regions and provinces with high maternal mortality to identify key challenges and generate effective responses to them.

The manual offers a way of thinking on decision making, rather than just a set of instructions and forms on how to do it. In both its form and its function, the manual is about building capacity and capability. At another level, of course, the manual is about improving the health of women. Women are crucial to the social and economic development of their societies, as members of the work force and the backbone of households. They are the creators of new life, and the caretakers of daily life. Although saving a woman’s life has tremendous benefits for her family and her community, it is the horrible and needless deaths of the women themselves that call for our action. The technology to avert maternal deaths has been known for decades, yet it is still unavailable to a large number of women in developing countries. Beyond the social and economic benefits, this manual is about saving women’s lives.

The strategies and instruments presented in the manual were developed by the World Health Organization and pilot-tested by the Maternal and Child Health Program of the Department of Health in cooperation with various stakeholders. Since its inception 2 years ago, the manual has embodied many of the concepts currently practice in obstetrics and gynecology in the local setting. In fact, the experience of the Department of Health in the launching and pilot-testing of the manual represents one of the department’s great success stories in capacity and capability development.
ACKNOWLEDGEMENTS

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The concept and first drafts were developed by Sandra Gove and Patricia Whitesell/ACT International, Atlanta, Jerker Liljestrand, Denise Roth, Betty Sweet, Anne Thompson, and Jelka Zupan.

Revisions were subsequently carried out by Annie Portela, Luc de Bernis, Ornella Lincetto, Rita Kabra, Maggie Usher, Agostino Borra, Rick Guidotti, Elisabeth Hoff, Mathews Matthai, Monir Islam, Felicity Savage, Adepeyu Olukoya, and Aafje Rietveld.

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- Communicable Diseases
- Nutrition for Health and Development
- Essential Drugs and Medicines Policy
- Vaccines and Biologicals
- Mental Health and Substance Dependence
- Gender and Women’s Health
- Blindness and Deafness

 Editing: Nina Mattock
 Layout: rsdesigns.com sàrl
 Cover design: Maire Ni Mheardín

WHO acknowledges with gratitude the generous contribution of over 100 individuals and organizations in the field of maternal and newborn health, who took time to review this document at different stages of its development. They came from over 35 countries and brought their expertise and wide experience to the final text.

This guide represents a common understanding between WHO, UNFPA, UNICEF, and the World Bank of key elements of an approach to reducing maternal and perinatal mortality and morbidity. These agencies co-operate closely in efforts to reduce maternal and perinatal mortality and morbidity. The principles and policies of each agency are governed by the relevant decisions of each agency’s governing body and each agency implements the interventions described in this document in accordance with these principles and policies and within the scope of its mandate.

The guide has also been reviewed and endorsed by the International Confederation of Midwives, the International Federation of Gynecology and Obstetrics and International Pediatric Association.

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TABLE OF CONTENTS

INTRODUCTION

Introduction
How to read the Guide
Acronyms
Content
Structure and presentation
Assumptions underlying the guide

PRINCIPLES OF GOOD CARE

A1 Communication
A2 Workplace and administrative procedures
A3 Universal precautions and cleanliness
A4 Organising a visit

QUICK CHECK, RAPID ASSESSMENT AND MANAGEMENT OF WOMEN OF CHILDBEARING AGE

B1 Quick check
B2 Rapid assessment and management
B3 Airway and breathing
B4 Circulation (shock)
B5 Vaginal bleeding
B6 Convulsions or unconscious
B7 Severe abdominal pain
B8 Dangerous fever
B9 Labour
B10 Other danger signs or symptoms
B11 If no emergency or priority signs, non urgent

Table of contents
**CANTENATAL CARE**

- **C2** Assess the pregnant woman: pregnancy status, birth and emergency plan
  - **C3** Check for pre-eclampsia
  - **C4** Check for anaemia
  - **C5** Check for syphilis
  - **C6** Check for HIV status

- **C7** Respond to observed signs or volunteered problems
  - **C7** If no fetal movement
  - **C7** If ruptured membranes and no labour
  - **C8** If fever or burning on urination
  - **C9** If vaginal discharge
  - **C10** If signs suggesting HIV infection
  - **C10** If smoking, alcohol or drug abuse, or history of violence
  - **C11** If cough or breathing difficulty
  - **C11** If taking antituberculosis drugs

- **C12** Give preventive measures
- **C13** Advise and counsel on nutrition and self-care
- **C14-C15** Develop a birth and emergency plan
  - **C14** Facility delivery
  - **C14** Home delivery with a skilled attendant
  - **C15** Advise on labour signs
  - **C15** Advise on danger signs
  - **C15** Discuss how to prepare for an emergency in pregnancy

- **C16** Advise and counsel on family planning
  - **C16** Counsel on the importance of family planning
  - **C16** Special consideration for family planning counselling during pregnancy

- **C17** Advise on routine and follow-up visits
- **C18** Home delivery without a skilled attendant

**D CHILDBIRTH – LABOUR, DELIVERY AND IMMEDIATE POSTPARTUM CARE**

- **D2** Examine the woman in labour or with ruptured membranes
- **D3** Decide stage of labour
- **D4-D6** Respond to obstetrical problems on admission
- **D6-D7** Give supportive care throughout labour
  - **D6** Communication
  - **D6** Cleanliness
  - **D6** Mobility
  - **D6** Urination
  - **D6** Eating, drinking
  - **D6** Breathing technique
  - **D6** Pain and discomfort relief
  - **D7** Birth companion

- **D8-D9** First stage of labour
  - **D8** Not in active labour
  - **D9** In active labour

- **D10-D11** Second stage of labour: deliver the baby and give immediate newborn care

- **D12-D13** Third stage of labour: deliver the placenta

- **D14-D18** Respond to problems during labour and delivery
  - **D14** If fetal heart rate <120 or >160 beats per minute
  - **D15** If prolapsed cord
  - **D16** If breech presentation
  - **D17** If stuck shoulders (Shoulder dystocia)
  - **D18** If multiple births

- **D19** Care of the mother and newborn within first hour of delivery of placenta

- **D20** Care of the mother one hour after delivery of placenta

- **D21** Assess the mother after delivery

- **D22-D25** Respond to problems immediately postpartum
  - **D22** If vaginal bleeding
  - **D23** If fever (temperature >38 °C)
  - **D23** If perineal tear or episiotomy (done for lifesaving circumstances)
  - **D24** If elevated diastolic blood pressure
  - **D24** If pallor on screening, check for anaemia
  - **D25** If mother severely ill or separated from the child
  - **D25** If baby stillborn or dead

- **D25** Give preventive measures
### Table of Contents

#### Childhood - Labour, Delivery and Immediate Postpartum Care (Continued)
- Advise on postpartum care
- Advise on postpartum care and hygiene
- Counsel on nutrition
- Counsel on birth spacing and family planning
- Counsel on the importance of family planning
- Lactation amenorrhea method (LAM)
- Advise on when to return
- Routine postpartum visits
- Follow-up visits for problems
- Advise on danger signs
- Discuss how to prepare for an emergency in postpartum
- Home delivery by skilled attendant
- Preparation for home delivery
- Delivery care
- Immediate postpartum care of mother
- Postpartum care of newborn

#### Postpartum Care
- Postpartum examination of the mother (up to 6 weeks)
- Respond to observed signs or volunteered problems
  - If elevated diastolic blood pressure
  - If pallor, check for anaemia
  - Check for HIV status
  - If heavy vaginal bleeding
  - If fever or foul-smelling lochia
  - If dribbling urine
  - If pus or perineal pain
  - If feeling unhappy or crying easily
  - If vaginal discharge 4 weeks after delivery
  - If breast problem
  - If cough or breathing difficulty
  - If taking anti-tuberculosis drugs
  - If signs suggesting HIV infection

#### Preventive Measures and Additional Treatments for the Woman
- Preventive measures
  - Give tetanus toxoid
  - Give vitamin A postpartum
  - Give iron and folic acid
  - Give mebendazole
  - Motivate on compliance with iron treatment
  - Give preventive intermittent treatment for falciparum malaria
  - Advise to use insecticide-treated bednet
  - Give appropriate oral antimalarial treatment
  - Give paracetamol
- Additional treatments for the woman
  - Give appropriate oral antibiotics
  - Give benzathine penicillin IM
  - Observe for signs of allergy
**Inform and Counsel on HIV**

<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>G2</td>
<td>Provide key information on HIV</td>
</tr>
<tr>
<td>G2</td>
<td>What is HIV and how is HIV transmitted?</td>
</tr>
<tr>
<td>G2</td>
<td>Advantage of knowing the HIV status in pregnancy</td>
</tr>
<tr>
<td>G2</td>
<td>Counsel on correct and consistent use of condoms</td>
</tr>
<tr>
<td>G3</td>
<td>Voluntary counselling and testing (VCT) services</td>
</tr>
<tr>
<td>G3</td>
<td>Voluntary counselling and testing services</td>
</tr>
<tr>
<td>G3</td>
<td>Discuss confidentiality of the result</td>
</tr>
<tr>
<td>G3</td>
<td>Implications of test result</td>
</tr>
<tr>
<td>G4</td>
<td>Benefits of involving and testing the male partner(s)</td>
</tr>
<tr>
<td>G4</td>
<td>Care and counselling on family planning for the HIV-positive woman</td>
</tr>
<tr>
<td>G4</td>
<td>Additional care for the HIV-positive woman</td>
</tr>
<tr>
<td>G4</td>
<td>Counsel the HIV-positive woman on family planning</td>
</tr>
<tr>
<td>G5</td>
<td>Support to the HIV-positive woman</td>
</tr>
<tr>
<td>G5</td>
<td>Provide emotional support to the woman</td>
</tr>
<tr>
<td>G5</td>
<td>How to provide support</td>
</tr>
<tr>
<td>G6</td>
<td>Prevent mother-to-child transmission of HIV</td>
</tr>
<tr>
<td>G6</td>
<td>Give antiretroviral drug to prevent MCTC of HIV</td>
</tr>
<tr>
<td>G6</td>
<td>Antiretroviral drug for prevention of MCTC of HIV</td>
</tr>
<tr>
<td>G7</td>
<td>Counsel on infant feeding choice</td>
</tr>
<tr>
<td>G7</td>
<td>Explain the risks of HIV transmission through breastfeeding and not breastfeeding</td>
</tr>
<tr>
<td>G7</td>
<td>If a woman has unknown or negative HIV status</td>
</tr>
<tr>
<td>G7</td>
<td>If a woman knows and accepts that she is HIV-positive</td>
</tr>
<tr>
<td>G8</td>
<td>If the mother chooses replacement feeding</td>
</tr>
<tr>
<td>G8</td>
<td>Teach the mother replacement feeding</td>
</tr>
<tr>
<td>G8</td>
<td>Explain the risks of replacement feeding</td>
</tr>
<tr>
<td>G8</td>
<td>Follow-up for replacement feeding</td>
</tr>
<tr>
<td>G8</td>
<td>Give special counselling to the mother who is HIV-positive and chooses breastfeeding</td>
</tr>
</tbody>
</table>

**The Woman with Special Needs**

<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2</td>
<td>Emotional support for the woman with special needs</td>
</tr>
<tr>
<td>H2</td>
<td>Sources of support</td>
</tr>
<tr>
<td>H2</td>
<td>Emotional support</td>
</tr>
<tr>
<td>H3</td>
<td>Special considerations in managing the pregnant adolescent</td>
</tr>
<tr>
<td>H3</td>
<td>When interacting with the adolescent</td>
</tr>
<tr>
<td>H3</td>
<td>Help the girl consider her options and to make decisions which best suit her needs</td>
</tr>
<tr>
<td>H4</td>
<td>Special considerations for supporting the woman living with violence</td>
</tr>
<tr>
<td>H4</td>
<td>Support the woman living with violence</td>
</tr>
<tr>
<td>H4</td>
<td>Support the health service response to needs of women living with violence</td>
</tr>
</tbody>
</table>

**Community Support for Maternal and Newborn Health**

<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>I2</td>
<td>Establish links</td>
</tr>
<tr>
<td>I2</td>
<td>Coordinate with other health care providers and community groups</td>
</tr>
<tr>
<td>I2</td>
<td>Establish links with traditional birth attendants and traditional healers</td>
</tr>
<tr>
<td>I3</td>
<td>Involve the community in quality of services</td>
</tr>
</tbody>
</table>
NEWBORN CARE

Examine the newborn
- If preterm, birth weight <2500 g or twin
- Assess breastfeeding
- Check for special treatment needs
- Look for signs of jaundice and local infection
- If danger signs
- If swelling, bruises or malformation
- Assess the mother's breasts if complaining of nipple or breast pain

Additional care of a small baby (or twin)

BREASTFEEDING, CARE, PREVENTIVE MEASURES AND TREATMENT FOR THE NEWBORN

Counsel on breastfeeding
- Counsel on importance of exclusive breastfeeding
- Help the mother to initiate breastfeeding
- Support exclusive breastfeeding
- Teach correct positioning and attachment for breastfeeding
- Give special support to breastfeed the small baby (preterm and/or low birth weight)
- Give special support to breastfeed twins

Alternative feeding methods
- Express breast milk
- Hand express breast milk directly into the baby's mouth
- Cup feeding expressed breast milk
- Quantity to feed by cup
- Signs that baby is receiving adequate amount of milk

Weigh and assess weight gain
- Weigh baby in the first month of life
- Assess weight gain
- Scale maintenance

Other breastfeeding support
- Give special support to the mother who is not yet breastfeeding
- If the baby does not have a mother
- Advise the mother who is not breastfeeding at all on how to relieve engorgement

Ensure warmth for the baby
- Keep the baby warm
- Keep a small baby warm
- Rewarm the baby skin-to-skin

Other baby care
- Cord care
- Sleeping
- Hygiene

Newborn resuscitation
- Keep the baby warm
- Open the airway
- If still not breathing, ventilate
- If breathing less than 30 breaths per minute or severe chest in-drawing, stop ventilating
- If not breathing or gasping at all after 20 minutes of ventilation

Treat and immunize the baby
- Treat the baby
- Give 2 IM antibiotics (first week of life)
- Give IM benzathine penicillin to baby (single dose) if mother tested RPR-positive
- Give IM antibiotic for possible gonococcal eye infection (single dose)
- Treat local infection
- Give isoniazid (INH) prophylaxis to newborn
- Immunize the newborn

Advise when to return with the baby
- Routine visits
- Follow-up visits
- Advise the mother to seek care for the baby
- Refer baby urgently to hospital
Table of contents

EQUIPMENT, SUPPLIES, DRUGS AND LABORATORY TESTS

- Equipment, supplies, drugs and tests for pregnancy and postpartum care
- Equipment, supplies and drugs for childbirth care
- Laboratory tests
  - Check urine for protein
  - Check haemoglobin
- Perform rapid plamareagin (RPR) test for syphilis
- Interpreting results

INFORMATION AND COUNSELLING SHEETS

- Care during pregnancy
- Preparing a birth and emergency plan
- Care for the mother after birth
- Care after an abortion
- Care for the baby after birth
- Breastfeeding
- Clean home delivery

RECORDS AND FORMS

- Referral record
- Feedback record
- Labour record
- Partograph
- Postpartum record
- International form of medical certificate of cause of death

GLOSSARY AND ACRONYMS

- M2-M9
- M8-M9
- L2-L9
The aim of Pregnancy, childbirth, postpartum and newborn care guide for essential practice (PCPNC) is to provide evidence-based recommendations to guide health care professionals in the management of women during pregnancy, childbirth and postpartum, and post abortion, and newborns during their first week of life.

All recommendations are for skilled attendants working at the primary level of health care, either at the facility or in the community. They apply to all women attending antenatal care, in delivery, postpartum or post abortion care, or who come for emergency care, and to all newborns at birth and during the first week of life (or later) for routine and emergency care.

The PCPNC is a guide for clinical decision-making. It facilitates the collection, analysis, classification and use of relevant information by suggesting key questions, essential observations and/or examinations, and recommending appropriate research-based interventions. It promotes the early detection of complications and the initiation of early and appropriate treatment, including timely referral, if necessary.

Correct use of this guide should help reduce the high maternal and perinatal mortality and morbidity rates prevalent in many parts of the developing world, thereby making pregnancy and childbirth safer.

The guide is not designed for immediate use. It is a generic guide and should first be adapted to local needs and resources. It should cover the most serious endemic conditions that the skilled birth attendant must be able to treat, and be made consistent with national treatment guidelines and other policies. It is accompanied by an adaptation guide to help countries prepare their own national guides and training and other supporting materials.

The first section, How to use the guide, describes how the guide is organized, the overall content and presentation. Each chapter begins with a short description of how to read and use it, to help the reader use the guide correctly.
Content

The Guide includes routine and emergency care for women and newborns during pregnancy, labour and delivery, postpartum and post abortion, as well as key preventive measures required to reduce the incidence of endemic and other diseases which add to maternal and perinatal morbidity and mortality.

Most women and newborns using the services described in the Guide are not ill and/or do not have complications. They are able to wait in line when they come for a scheduled visit. However, the small proportion of women/newborns who are ill, have complications or are in labour, need urgent attention and care.

The clinical content is divided into six sections which are as follows:

- Quick check (triage), emergency management (called Rapid Assessment and Management or RAM) and referral, followed by a chapter on emergency treatments for the woman.
- Post-abortion care.
- Antenatal care.
- Labour and delivery.
- Postpartum care.
- Newborn care.

In each of the six clinical sections listed above there is a series of flow, treatment and information charts which include:

- Guidance on routine care, including monitoring the well-being of the mother and/or baby.
- Early detection and management of complications.
- Preventive measures.
- Advice and counselling.

In addition to the clinical care outlined above, other sections in the guide include:

- Advice on HIV.
- Support for women with special needs.
- Links with the community.
- Drugs, supplies, equipment, universal precautions and laboratory tests.
- Examples of clinical records.
- Counselling and key messages for women and families.

There is an important section at the beginning of the Guide entitled Principles of good care. This includes principles of good care for all women, including those with special needs. It explains the organization of each visit to a healthcare facility, which applies to overall care. The principles are not repeated for each visit.

Recommendations for the management of complications at secondary (referral) health care level can be found in the following guides for midwives and doctors:

- Managing complications of pregnancy and childbirth (WHO/RHR/00.7)
- Managing newborn problems.

These and other documents referred to in this Guide can be obtained from the Department of Reproductive Health and Research, Family and Community Health, World Health Organization, Geneva, Switzerland. E-mail: rhrpublications@who.int.
This Guide is a tool for clinical decision-making. The content is presented in a framework of coloured flow charts supported by information and treatment charts which provide further details of care.

The framework is based on a syndromic approach whereby the skilled attendant identifies a limited number of key clinical signs and symptoms, enabling her/him to classify the condition according to severity and give appropriate treatment. Severity is marked in colour: red for emergencies, yellow for less urgent conditions which nevertheless need attention, and green for normal care.

Flow charts
The flow charts include the following information:
1. Key questions to be asked.
2. Important observations and examinations to be made.
3. Possible findings (signs) based on information elicited from the questions, observations, and, where appropriate, examinations.
4. Classification of the findings.
5. Treatment and advice related to the signs and classification.

“Treat, advise” means giving the treatment indicated (performing a procedure, prescribing drugs or other treatments, advising on possible side-effects and how to overcome them) and giving advice on other important practices. The treat and advise column is often cross-referenced to other treatment and/or information charts. Turn to these charts for more information.

Use of colour
Colour is used in the flow charts to indicate the severity of a condition.
6. Green usually indicates no abnormal condition and therefore normal care is given, as outlined in the guide, with appropriate advice for home care and follow up.
7. Yellow indicates that there is a problem that can be treated without referral.
8. Red highlights an emergency which requires immediate treatment and, in most cases, urgent referral to a higher level health facility.

Key sequential steps
The charts for normal and abnormal deliveries are presented in a framework of key sequential steps for a clean safe delivery. The key sequential steps for delivery are in a column on the left side of the page, while the column on the right has interventions which may be required. The treat and advise column contains interventions which may be needed if problems arise during delivery. Interventions may be linked to relevant treatment and/or information pages, and are cross-referenced to other parts of the Guide.

Treatment and information pages
The flow charts are linked (cross-referenced) to relevant treatment and/or information pages in other parts of the Guide. These pages include information which is too detailed to include in the flow charts:

- Treatments.
- Advice and counselling.
- Preventive measures.
- Relevant procedures.

Information and counselling sheets
These contain appropriate advice and counselling messages to provide to the woman, her partner and family. In addition, a section is included at the back of the Guide to support the skilled attendant in this effort. Individual sheets are provided with simplified versions of the messages on care during pregnancy (preparing a birth and emergency plan, clean home delivery, care for the mother and baby after delivery, breastfeeding and care after an abortion) to be given to the mother, her partner and family at the appropriate stage of pregnancy and childbirth.

These sheets are presented in a generic format. They will require adaptation to local conditions and language, and the addition of illustrations to enhance understanding, acceptability and attractiveness. Different programmes may prefer a different format such as a booklet or flip chart.
Assumptions underlying the Guide

Recommendations in the Guide are generic, made on many assumptions about the health characteristics of the population and the health care system (the setting, capacity and organization of services, resources and staffing).

Population and endemic conditions

- High maternal and perinatal mortality
- Many adolescent pregnancies
- High prevalence of endemic conditions: → Anaemia
  → Stable transmission of falciparum malaria
  → Hookworms (Necator americanus and Ancylostoma duodenale)
  → Sexually transmitted infections, including HIV/AIDS
  → Vitamin A and iron/folate deficiencies.

Health care system

The Guide assumes that:
- Routine and emergency pregnancy, delivery and postpartum care are provided at the primary level of the health care, e.g. at the facility near where the woman lives. This facility could be a health post, health centre or maternity clinic. It could also be a hospital with a delivery ward and outpatient clinic providing routine care to women from the neighbourhood.
- A TEAM of skilled attendant, a doctor, nurse and midwife, is providing care and service either at the health care center, a birthing home, a maternity unit of a hospital or she may go to the woman’s home, if necessary or in case of imminent delivery or extreme emergency. However there may be other health workers
- Human resources, infrastructure, equipment, supplies and drugs are limited. However, essential drugs, IV fluids, supplies, gloves and essential equipment are available.
- If a health worker with higher levels of skill (at the facility or a referral hospital) is providing pregnancy, childbirth and postpartum care to women other than those referred, she follows the recommendations described in this Guide.
- Routine visits and follow-up visits are “scheduled” during office hours.
- Emergency services (“unscheduled” visits) for labour and delivery, complications, or severe illness or deterioration are provided 24/24 hours, 7 days a week.
- Women and babies with complications or expected complications are referred for further care to the secondary level of care, a referral hospital.
- Referral and transportation are appropriate for the distance and other circumstances. They must be safe for the mother and the baby.
- Some deliveries are conducted at home, attended by traditional birth attendants (TBAs) or relatives, or the woman delivers alone (but home delivery without a skilled attendant is not recommended).
- Links with the community and traditional providers are established. Primary health care services and the community are involved in
- Other programme activities, such as management of malaria, tuberculosis and other lung diseases, voluntary counselling and testing (VCT) for HIV, and infant feeding counselling, that require specific training, are delivered by a different provider, at the same facility or at the referral hospital. Detection, initial treatment and referral are done by the skilled attendant.

Knowledge and skills of care providers

This Guide assumes that professionals using it have the knowledge and skills in providing the care it describes. Other training materials must be used to bring the skills up to the level assumed by the Guide.

Adaptation of the Guide

It is essential that this generic Guide is adapted to national and local situations, not only within the context of existing health priorities and resources, but also within the context of respect and sensitivity to the needs of women, newborns and the communities to which they belong.

An adaptation guide is available to assist national experts in modifying the Guide according to national needs, for different demographic and epidemiological conditions, resources and settings. The adaptation guide offers some alternatives. It includes guidance on developing information and counselling tools so that each programme manager can develop a format which is most comfortable for her/him.
PRINCIPLES OF GOOD CARE

These principles of good care apply to all contacts between the skilled attendant and all women and their babies; they are not repeated in each section. Care-givers should therefore familiarize themselves with the following principles before using the Guide. The principles concern:

- Communication A2.
- Workplace and administrative procedures A3.
- Universal precautions and cleanliness A4.
- Organizing a visit A5.

COMMUNICATION

WORKPLACE AND ADMINISTRATIVE PROCEDURES

UNIVERSAL PRECAUTIONS AND CLEANLINESS

ORGANIZING A VISIT

Principles of good care
COMMUNICATION

Communicating with the woman (and her companion)

- Make the woman (and her companion) feel welcome.
- Be friendly, respectful and non-judgmental at all times.
- Use simple and clear language.
- Encourage her to ask questions.
- Support her in understanding her options and making decisions.
- At any examination or before any procedure:
  → seek her permission and
  → inform her of what you are doing.
- Summarize the most important information, including the information on routine laboratory tests and treatments.

Verify that she understands emergency signs, treatment instructions, and when and where to return. Check for understanding by asking her to explain or demonstrate treatment instructions.

Privacy and confidentiality

In all contacts with the woman and her partner:

- Ensure a private place for the examination and counselling.
- Ensure, when discussing sensitive subjects, that you cannot be overheard.
- Make sure you have the woman’s consent before discussing with her partner or family.
- Never discuss confidential information about clients with other providers, or outside the health facility.
- Organize the examination area so that, during examination, the woman is protected from the view of other people (curtain, screen, wall).
- Ensure all records are confidential and kept locked away.
- Limit access to logbooks and registers to responsible providers only.

Prescribing and recommending treatments and preventive measures for the woman and/or her baby

When giving a treatment (drug, vaccine, bednet, condom) at the clinic, or prescribing measures to be followed at home:

- Explain to the woman what the treatment is and why it should be given.
- Explain to her that the treatment will not harm her or her baby, and that not taking it may be more dangerous.
- Give clear and helpful advice on how to take the drug regularly:
  → for example: take 2 tablets 3 times a day, thus every 8 hours, in the morning, afternoon and evening with some water and after a meal, for 5 days.
- Demonstrate the procedure.
- Explain how the treatment is given to the baby. Watch her as she does the first treatment in the clinic.
- Explain the side-effects to her. Explain that they are not serious, and tell her how to manage them.
- Advise her to return if she has any problems or concerns about taking the drugs.
- Explore any barriers she or her family may have, or have heard from others, about using the treatment, where possible:
  → Has she or anyone she knows used the treatment or preventive measure before?
  → Were there problems?
  → Reinforce the correct information that she has, and try to clarify the incorrect information.
- Discuss with her the importance of buying and taking the prescribed amount. Help her to think about how she will be able to purchase this.
## Workplace and Administrative Procedures

### Workplace
- Service hours should be clearly posted.
- Be on time with appointments or inform the woman/women if she/they need to wait.
- Before beginning the services, check that equipment is clean and functioning and that supplies and drugs are in place.
- Keep the facility clean by regular cleaning.
- At the end of the service:
  - discard litter and sharps safely
  - prepare for disinfection; clean and disinfect equipment and supplies
  - replace linen, prepare for washing
  - replenish supplies and drugs
  - ensure routine cleaning of all areas.
- Hand over essential information to the colleague who follows on duty.

### Daily and occasional administrative activities
- Keep records of equipment, supplies, drugs and vaccines.
- Check availability and functioning of essential equipment (order stocks of supplies, drugs, vaccines and contraceptives before they run out).
- Establish staffing lists and schedules.
- Complete periodic reports on births, deaths and other indicators as required, according to instructions.

### Record keeping
- Always record findings on a clinical record and home-based record. Record treatments, reasons for referral, and follow-up recommendations at the time the observation is made.
- Do not record confidential information on the home-based record if the woman is unwilling.
- Maintain and file appropriately:
  - all clinical records
  - all other documentation.

### International conventions
The health facility should not allow distribution of free or low-cost supplies or products within the scope of the International Code of Marketing of Breast Milk Substitutes. It should also be tobacco free and support a tobacco-free environment.
Universal precautions and cleanliness

**UNIVERSAL PRECAUTIONS AND CLEANLINESS**

Observe these precautions to protect the woman and her baby, and you as the health provider, from infections with bacteria and viruses, including HIV.

**Wash hands**
- Wash hands with soap and water:
  - Before and after caring for a woman or newborn, and before any treatment procedure
  - Whenever the hands (or any other skin area) are contaminated with blood or other body fluids
  - After removing the gloves, because they may have holes
  - After changing soiled bedsheets or clothing.
- Keep nails short.

**Wear gloves**
- Wear sterile or highly disinfected gloves when performing vaginal examination, delivery, cord cutting, repair of episiotomy or tear, blood drawing.
- Wear long sterile or highly disinfected gloves for manual removal of placenta.
- Wear clean gloves when:
  - Handling and cleaning instruments
  - Handling contaminated waste
  - Cleaning blood and body fluid spills.

**Protect yourself from blood and other body fluids during deliveries**
- Wear gloves; cover any cuts, abrasions or broken skin with a waterproof bandage; take care when handling any sharp instruments (use good light); and practice safe sharps disposal.
- Wear a long apron made from plastic or other fluid resistant material, and shoes.
- If possible, protect your eyes from splashes of blood. Normal spectacles are adequate eye protection.

**Practice safe sharps disposal**
- Keep a puncture resistant container nearby.
- Use each needle and syringe only once.
- Do not recap, bend or break needles after giving an injection.
- Drop all used (disposable) needles, plastic syringes and blades directly into this container, without recapping, and without passing to another person.
- Empty or send for incineration when the container is three-quarters full.

**Practice safe waste disposal**
- Dispose of placenta or blood, or body fluid contaminated items, in leak-proof containers.
- Burn or bury contaminated solid waste.
- Wash hands, gloves and containers after disposal of infectious waste.
- Pour liquid waste down a drain or flushable toilet.
- Wash hands after disposal of infectious waste.

**Deal with contaminated laundry**
- Collect clothing or sheets stained with blood or body fluids and keep them separately from other laundry, wearing gloves or use a plastic bag. **DO NOT** touch them directly.
- Rinse off blood or other body fluids before washing with soap.

**Sterilize and clean contaminated equipment**
- Make sure that instruments which penetrate the skin (such as needles) are adequately sterilized, or that single-use instruments are disposed of after one use.
- Thoroughly clean or disinfect any equipment which comes into contact with intact skin (according to instructions).
- Use bleach for cleaning bowls and buckets, and for blood or body fluid spills.

**Clean and disinfect gloves**
- Wash the gloves in soap and water.
- Check for damage: Blow gloves full of air, twist the cuff closed, then hold under clean water and look for air leaks. Discard if damaged.
- Soak overnight in bleach solution with 0.5% available chlorine (made by adding 90 ml water to 10 ml bleach containing 5% available chlorine).
- Dry away from direct sunlight.
- Dust inside with talcum powder or starch.

This produces disinfect gloves. They are not sterile.

Good quality latex gloves can be disinfected 5 or more times.

**Sterilize gloves**
- Sterilize by autoclaving or highly disinfect by steaming or boiling.
ORGANIZING A VISIT

Receive and respond immediately
Receive every woman and newborn baby seeking care immediately after arrival (or organize reception by another provider).
- Perform Quick Check on all new incoming women and babies and those in the waiting room, especially if no-one is receiving them.
- At the first emergency sign on Quick Check, begin emergency assessment and management (RAM).
- If she is in labour, accompany her to an appropriate place and follow the steps as in Childbirth: labour, delivery and immediate postpartum care.
- If she has priority signs, examine her immediately using Antenatal care, Postpartum or Post-abortion care charts.
- If no emergency or priority sign on RAM or not in labour, invite her to wait in the waiting room.
- If baby is newly born, looks small, examine immediately. Do not let the mother wait in the queue.

Begin each emergency care visit
- Introduce yourself.
- Ask the name of the woman.
- Encourage the companion to stay with the woman.
- Explain all procedures, ask permission, and keep the woman informed as much as you can about what you are doing, if she is unconscious, talk to the companion.
- Ensure and respect privacy during examination and discussion.
- If she came with a baby and the baby is well, ask the companion to take care of the baby during the maternal examination and treatment.

Care of woman or baby referred for special care to secondary level facility
- When a woman or baby is referred to a secondary level care facility because of a specific problem or complications, the underlying assumption of the Guide is that, at referral level, the woman/baby will be assessed, treated, counselled and advised on follow-up for that particular condition/complexion.
- Follow-up for that specific condition will be either:
  - organized by the referral facility or
  - written instructions will be given to the woman/baby for the skilled attendant at the primary level who referred the woman/baby.
- the woman/baby will be advised to go for a follow-up visit within 2 weeks according to severity of the condition.
- Routine care continues at the primary care level where it was initiated.

Begin each routine visit (for the woman and/or the baby)
- Greet the woman and offer her a seat.
- Introduce yourself.
- Ask her name (and the name of the baby).
- Ask her:
  - Why did you come? For yourself or for your baby?
  - For a scheduled (routine) visit?
  - For specific complaints about you or your baby?
  - First or follow-up visit?
  - Do you want to include your companion or other family member (parent if adolescent) in the examination and discussion?
- If the woman is recently delivered, assess the baby or ask to see the baby if not with the mother.
- If antenatal care, always revise the birth plan at the end of the visit after completing the chart.
- For a postpartum visit, if she came with the baby also examine the baby:
  - Follow the appropriate charts according to pregnancy status/age of the baby and purpose of visit.
  - Follow all steps on the chart and in relevant boxes.
- Unless the condition of the woman or the baby requires urgent referral to hospital, give preventive measures if due even if the woman has a condition "in yellow" that requires special treatment.

- If follow-up visit is within a week, and if no other complaints:
  - Assess the woman for the specific condition requiring follow-up only
  - Compare with earlier assessment and re-classify
- If a follow-up visit is more than a week after the initial examination (but not the next scheduled visit):
  - Repeat the whole assessment as required for an antenatal, post-abortion, postpartum or newborn visit according to the schedule.
  - If antenatal visit, revise the birth plan.

During the visit
- Explain all procedures,
- Ask permission before undertaking an examination or test.
- Keep the woman informed throughout. Discuss findings with her (and her partner).
- Ensure privacy during the examination and discussion.

At the end of the visit
- Ask the woman if she has any questions.
- Summarize the most important messages with her.
- Encourage her to return for a routine visit (tell her when) and if she has any concerns.
- Fill the Home-Based Maternal Record (HBMR) and give her the appropriate information sheet.
- Ask her if there are any points which need to be discussed and would she like support for this.
Quick check, rapid assessment and management of women of childbearing age

**QUICK CHECK, RAPID ASSESSMENT AND MANAGEMENT OF WOMEN OF CHILDBEARING AGE**

- Perform Quick check immediately after the woman arrives. If any danger sign is seen, help the woman and send her quickly to the emergency room.

- Always begin a clinical visit with Rapid assessment and management (RAM) (5):
  - Check for emergency signs first.
  - If present, provide emergency treatment and refer the woman urgently to hospital.
  - Complete the referral form.
  - Check for priority signs. If present, manage according to charts.
  - If no emergency or priority signs, allow the woman to wait in line for routine care, according to pregnancy status.

**RAPID ASSESSMENT AND MANAGEMENT (RAM) (1)**
- Airway and breathing
- Circulation and shock

**RAPID ASSESSMENT AND MANAGEMENT (RAM) (2)**
- Vaginal bleeding

**RAPID ASSESSMENT AND MANAGEMENT (RAM) (3)**
- Vaginal bleeding: postpartum

**RAPID ASSESSMENT AND MANAGEMENT (RAM) (4)**
- Convulsions
- Severe abdominal pain
- Dangerous fever

**RAPID ASSESSMENT AND MANAGEMENT (RAM) (5)**
- Priority signs
- Labour
- Other danger signs or symptoms
- Non-urgent
**Quick check**

**QUICK CHECK**
A person responsible for initial reception of women of childbearing age and newborns seeking care should:
- assess the general condition of the careseeker(s) immediately on arrival
- periodically repeat this procedure if the line is long.

If a woman is very sick, talk to her companion.

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<th>ASK, CHECK RECORD</th>
<th>LOOK, LISTEN, FEEL</th>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT</th>
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<tr>
<td>■ Why did you come?</td>
<td>Is the woman being wheeled or carried in or:</td>
<td>If the woman is or has:</td>
<td>EMERGENCY</td>
<td>Transfer woman to a treatment room for Rapid assessment and management [33-37]. Call for help if needed. Reassure the woman that she will be taken care of immediately. Ask her companion to stay.</td>
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<td>→ for yourself?</td>
<td>■ bleeding vaginally</td>
<td>■ unconscious (does not answer)</td>
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<td>→ for the baby?</td>
<td>■ convulsing</td>
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<td>■ How old is the baby?</td>
<td>■ looking very ill</td>
<td>■ bleeding</td>
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<td>■ What is the concern?</td>
<td>■ unconscious</td>
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<td>■ severe difficulty breathing</td>
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<td>Check if baby is or has:</td>
<td>■ Imminent delivery or</td>
<td>LABOUR</td>
<td>Transfer the woman to the labour ward. Call for immediate assessment.</td>
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<td>■ very small</td>
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<td>EMERGENCY</td>
<td>Transfer the baby to the treatment room for immediate Newborn care [111-11]. Ask the mother to stay.</td>
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<td>FOR BABY</td>
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<td>ROUTINE CARE</td>
<td>Keep the woman and baby in the waiting room for routine care.</td>
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</table>
# RAPID ASSESSMENT AND MANAGEMENT (RAM)

Use this chart for rapid assessment and management (RAM) of all women of childbearing age, and also for women in labour, on first arrival and periodically throughout labour, delivery and the postpartum period. Assess for all emergency and priority signs and give appropriate treatments, then refer the woman to hospital.

---

**FIRST ASSESS**

### EMERGENCY SIGNS

<table>
<thead>
<tr>
<th>Airway and breathing</th>
<th>Circulation (shock)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very difficult breathing or</td>
<td>Cold moist skin or</td>
</tr>
<tr>
<td>Central cyanosis</td>
<td>Weak and fast pulse</td>
</tr>
</tbody>
</table>

**TREATMENT**

- Manage airway and breathing
- Refer woman urgently to hospital

**MEASURE**

- Measure blood pressure
- Count pulse

**TREATMENT**

- Position the woman on her left side with legs higher than chest.
- Insert an IV line
- Give fluids rapidly
- If not able to insert peripheral IV, use alternative
- Keep her warm (cover her)
- Refer her urgently to hospital

---

*But if birth is imminent (bulging, thin perineum during contractions, visible fetal head), transfer woman to labour room and proceed as on D1-D28.*

---

**Quicker check:**

- **Vaginal bleeding:**

---

### Rapid assessment and management (RAM) ➤ Airway and breathing, circulation (shock)
# Vaginal Bleeding

- **Assess pregnancy status**
- **Assess amount of bleeding**

## Pregnancy Status

<table>
<thead>
<tr>
<th>Early Pregnancy</th>
<th>Heavy Bleeding</th>
<th>Treatment</th>
</tr>
</thead>
</table>
| Not aware of pregnancy, or not pregnant (uterus NOT above umbilicus) | Pad or cloth soaked in < 5 minutes. | - Insert an IV line [B9].
- Give fluids rapidly [B9].
- Give 0.2 mg ergometrine IM [B10].
- Repeat 0.2 mg ergometrine IM/IV if bleeding continues.
- If suspect possible complicated abortion, give appropriate IM/IV antibiotics [B15].
- Refer woman urgently to hospital [B17]. |

## Light Bleeding

- Examine woman as on [B19].
- If pregnancy not likely, refer to other clinical guidelines.

## Late Pregnancy

- (uterus above umbilicus)

## Any Bleeding is Dangerous

- Do not do vaginal examination, but:
  - Insert an IV line [B9].
  - Give fluids rapidly if heavy bleeding or shock [B3].
  - Refer woman urgently to hospital [B17].

## During Labour

- Before delivery of baby

## Bleeding More Than 100 ML Since Labour Began

- Do not do vaginal examination, but:
  - Insert an IV line [B9].
  - Give fluids rapidly if heavy bleeding or shock [B3].
  - Refer woman urgently to hospital [B17].

* But if birth is imminent (bulging, thin perineum during contractions, visible fetal head), transfer woman to labour room and proceed as on [B19].

---

**Next:** Vaginal bleeding in postpartum
### PREGNANCY STATUS

**POSTPARTUM**  
(baby is born)

### BLEEDING

**HEAVY BLEEDING**
- Pad or cloth soaked in < 5 minutes
- Constant trickling of blood
- Bleeding >250 ml or delivered outside health centre and still bleeding

**CONTROLLED BLEEDING**
- Continue oxytocin infusion with 20 IU/1 litre of IV fluids at 20 drops/ min for at least one hour after bleeding stops
- Observe closely (every 30 minutes) for 4 hours. Keep nearby for 24 hours. If severe pallor, refer to health centre.
- Examine the woman using *Assess the mother after delivery*.

### TREATMENT

**Call for extra help.**
- Massage uterus until it is hard and give oxytocin 10 IU IM.
- Insert an IV line and give IV fluids with 20 IU oxytocin at 60 drops/ minute.
- Empty bladder. Catheterize if necessary.
- Check and record BP and pulse every 15 minutes and treat as on.

**When uterus is hard, deliver placenta by controlled cord traction.**
- If unsuccessful and bleeding continues, remove placenta manually and check placenta.
- Give appropriate IM/ IV antibiotics.
- If unable to remove placenta, refer woman urgently to hospital.
- During transfer, continue IV fluids with 20 IU of oxytocin at 30 drops/ minute.

**If placenta is complete:**
- Massage uterus to express any clots.
- If uterus remains soft, give ergometrine 0.2 mg IV.
- DO NOT give ergometrine to women with eclampsia, pre-eclampsia or known hypertension.
- Continue IV fluids with 20 IU oxytocin/ litre at 30 drops/ minute.
- Continue massaging uterus till it is hard.
- If placenta is incomplete (or not available for inspection):
  - Remove placental fragments.
  - Give appropriate IM/ IV antibiotics.
  - If unable to remove, refer woman urgently to hospital.

**If third degree tear (involving rectum or anus), refer woman urgently to hospital.**

**Continue IV fluids with 20 units of oxytocin at 30 drops/ minute. Insert second IV line.**
- Apply bimanual uterine or aortic compression.
- Give appropriate IM/ IV antibiotics.
- Refer woman urgently to hospital.

**If still bleeding**

**HEAVY BLEEDING**
- When uterus is hard, deliver placenta by controlled cord traction.
- If unsuccessful and bleeding continues, remove placenta manually and check placenta.
- Give appropriate IM/ IV antibiotics.
- If unable to remove placenta, refer woman urgently to hospital.

**CONTROLLED BLEEDING**
- Continue oxytocin infusion with 20 IU/1 litre of IV fluids at 20 drops/ min for at least one hour after bleeding stops.
- Observe closely (every 30 minutes) for 4 hours. Keep nearby for 24 hours. If severe pallor, refer to health centre.
- Examine the woman using *Assess the mother after delivery*.

**NEXT: Convulsions or unconscious**
## Rapid assessment and management (RAM) ➤ Emergency signs

### EMERGENCY SIGNS

#### CONVULSIONS OR UNCONSCIOUS
- Convulsing (now or recently), or
- Unconscious
- If unconscious, ask relative “has there been a recent convulsion?”

#### SEVERE ABDOMINAL PAIN
- Severe abdominal pain (not normal labour)

#### DANGEROUS FEVER
- Fever (temperature more than 38°C) and any of:
  - Very fast breathing
  - Stiff neck
  - Lethargy
  - Very weak/ not able to stand

### MEASURE

- Measure blood pressure
- Measure temperature
- Assess pregnancy status
- Measure BP and temperature
- Measure temperature
- Measure blood pressure

### TREATMENT

- Protect woman from fall and injury. Get help.
- Manage airway. "\[39\]"
- After convulsion ends, help woman onto her left side.
- Insert an IV line and give fluids slowly (30 drops/min) \[39\].
- Give magnesium sulphate \[113\].
- If early pregnancy, give diazepam IV or rectally \[114\].
- If diastolic BP >110 mm of Hg, give antihypertensive \[114\].
- If temperature >38°C, or history of fever, also give treatment for dangerous fever (below).
- Refer woman urgently to hospital* \[117\].

- Insert an IV line and give fluids \[89\].
- If temperature more than 38°C, give first dose of appropriate IM/ IV antibiotics \[115\].
- Refer woman urgently to hospital* \[117\].
- If systolic BP <90 mm Hg see \[13\].

- Insert an IV line \[39\].
- Give fluids slowly \[89\].
- Give first dose of appropriate IM/ IV antibiotics \[115\].
- Give artemether IM (if not available, give quinine IM) and glucose \[116\].
- Refer woman urgently to hospital* \[117\].

* But if birth is imminent (bulging, thin perineum during contractions, visible fetal head), transfer woman to labour room and proceed as on D1028.

### Notes

- This may be eclampsia.
- This may be ruptured uterus, obstructed labour, abruptio placenta, puerperal or post-abortion sepsis, ectopic pregnancy.
- This may be malaria, meningitis, pneumonia, septicaemia.

**NEXT:** Priority signs
<table>
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<tr>
<th>PRIORITY SIGNS</th>
<th>MEASURE</th>
<th>TREATMENT</th>
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</thead>
<tbody>
<tr>
<td><strong>LABOUR</strong></td>
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<tr>
<td>- Labour pains or</td>
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<td>Manage as for Childbirth [D1-D2]</td>
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<tr>
<td>- Ruptured membranes</td>
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<tr>
<td><strong>OTHER DANGER SIGNS OR SYMPTOMS</strong></td>
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<tr>
<td>If any of:</td>
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<tr>
<td>- Severe pallor</td>
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<tr>
<td>- Epigastric or abdominal pain</td>
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<tr>
<td>- Severe headache</td>
<td>Measure blood pressure</td>
<td>If pregnant (and not in labour), provide antenatal care [C1-C18]</td>
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<tr>
<td>- Blurred vision</td>
<td>Measure temperature</td>
<td>If recently given birth, provide postpartum care [D2] and [E1-E10]</td>
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<tr>
<td>- Fever (temperature more than 38°C)</td>
<td></td>
<td>If recent abortion, provide post-abortion care [B20-B21]</td>
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<tr>
<td>- Breathing difficulty</td>
<td></td>
<td>If early pregnancy, or not aware of pregnancy, check for ectopic pregnancy [B19]</td>
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</tbody>
</table>

**IF NO EMERGENCY OR PRIORITY SIGNS, NON URGENT**

| - No emergency signs or     |                                   |                                                                           |
| - No priority signs         |                                   |                                                                           |
| - No emergency signs or     |                                   |                                                                           |

- If pregnant (and not in labour), provide antenatal care [C1-C18]
- If recently given birth, provide postpartum care [D1-E10]
EMERGENCY TREATMENTS FOR THE WOMAN

AIRWAY, BREATHING AND CIRCULATION
Manage the airway and breathing
Insert IV line and give fluids

BLEEDING (1)
Massage uterus and expel clots
Apply bimanual uterine compression
Apply aortic compression
Give oxytocin
Give ergometrine

BLEEDING (2)
Remove placenta and fragments manually
After manual removal of the placenta

BLEEDING (3)
Repair the tear
Empty bladder

ECLAMPSIA AND PRE-ECLAMPSIA (1)
Important considerations in caring for a woman with eclampsia and pre-eclampsia
Give magnesium sulphate

ECLAMPSIA AND PRE-ECLAMPSIA (2)
Give diazepam
Give appropriate antihypertensive

INFECTION
Give appropriate IV/IM antibiotics

MALARIA
Give artemether or quinine IM
Give glucose IV

REFER THE WOMAN URGENTLY TO THE HOSPITAL
Refer the woman urgently to the hospital
Essential emergency drugs and supplies for transport and home delivery

- This section has details on emergency treatments identified during Rapid assessment and management (RAM) 83-86 to be given before referral.
- Give the treatment and refer the woman urgently to hospital 837.
- If drug treatment, give the first dose of the drugs before referral. Do not delay referral by giving non-urgent treatments.
Manage the airway and breathing

If the woman has great difficulty breathing and:

■ If you suspect obstruction:
  → Try to clear the airway and dislodge obstruction
  → Help the woman to find the best position for breathing
  → Urgently refer the woman to hospital.

■ If the woman is unconscious:
  → Keep her on her back, arms at the side
  → Tilt her head backwards (unless trauma is suspected)
  → Lift her chin to open airway
  → Inspect her mouth for foreign body; remove if found
  → Clear secretions from throat.

■ If the woman is not breathing:
  → Ventilate with bag and mask until she starts breathing spontaneously
  → If woman still has great difficulty breathing, keep her propped up, and
  → Refer the woman urgently to hospital.

Insert IV line and give fluids

■ Wash hands with soap and water and put on gloves.
■ Clean woman’s skin with spirit at site for IV line.
■ Insert an intravenous line (IV line) using a 16-18 gauge needle.
■ Attach Ringer’s lactate or normal saline. Ensure infusion is running well.

Give fluids at rapid rate if shock, systolic BP<90 mmHg, pulse>110/minute, or heavy vaginal bleeding:

■ Infuse 1 litre in 15-20 minutes (as rapid as possible).
■ Infuse 1 litre in 30 minutes at 30 ml/minute. Repeat if necessary.
■ Monitor every 15 minutes for:
  → blood pressure (BP) and pulse
  → shortness of breath or puffiness.
■ Reduce the infusion rate to 3 ml/minute (1 litre in 6-8 hours) when pulse slows to less than 100/minute, systolic BP increases to 100 mmHg or higher.
■ Reduce the infusion rate to 0.5 ml/minute if breathing difficulty or puffiness develops.
■ Monitor urine output.
■ Record time and amount of fluids given.

Give fluids at moderate rate if severe abdominal pain, obstructed labour, ectopic pregnancy, dangerous fever or dehydration:

■ Infuse 1 litre in 2-3 hours.

Give fluids at slow rate if severe anaemia/ severe pre-eclampsia or eclampsia:

■ Infuse 1 litre in 6-8 hours.

If intravenous access not possible

■ Give oral rehydration solution (ORS) by mouth if able to drink, or by nasogastric (NG) tube.
■ Quantity of ORS: 300 to 500 ml in 1 hour.

DO NOT give ORS to a woman who is unconscious or has convulsions.
BLEEDING

**Massage uterus and expel clots**
If heavy postpartum bleeding persists after placenta is delivered, or uterus is not well contracted (is soft):
- Place cupped palm on uterine fundus and feel for state of contraction.
- Massage fundus in a circular motion with cupped palm until uterus is well contracted.
- When well contracted, place fingers behind fundus and push down in one swift action to expel clots.
- Collect blood in a container placed close to the vulva. Measure or estimate blood loss, and record.

**Apply bimanual uterine compression**
If heavy postpartum bleeding persists despite uterine massage, oxytocin/ergometrine treatment and removal of placenta:
- Wear sterile or clean gloves.
- Introduce the right hand into the vagina, clenched fist, with the back of the hand directed posteriorly and the knuckles in the anterior fornix.
- Place the other hand on the abdomen behind the uterus and squeeze the uterus firmly between the two hands.
- Continue compression until bleeding stops (no bleeding if the compression is released).
- If bleeding persists, apply aortic compression and transport woman to hospital.

**Apply aortic compression**
If heavy postpartum bleeding persists despite uterine massage, oxytocin/ergometrine treatment and removal of placenta:
- Feel for femoral pulse.
- Apply pressure above the umbilicus to stop bleeding. Apply sufficient pressure until femoral pulse is not felt.
- After finding correct site, show assistant or relative how to apply pressure, if necessary.
- Continue pressure until bleeding stops. If bleeding persists, keep applying pressure while transporting woman to hospital.

---

**Give oxytocin**
If heavy postpartum bleeding

<table>
<thead>
<tr>
<th>Initial dose</th>
<th>Continuing dose</th>
<th>Maximum dose</th>
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</thead>
<tbody>
<tr>
<td>IM/IV: 10 IU</td>
<td>IM/IV: repeat 10 IU after 20 minutes if heavy bleeding persists</td>
<td>Not more than 3 litres of IV fluids containing oxytocin</td>
</tr>
</tbody>
</table>

**Give ergometrine**
If heavy bleeding in early pregnancy or postpartum bleeding (after oxytocin) but DO NOT give if eclampsia, pre-eclampsia, or hypertension

<table>
<thead>
<tr>
<th>Initial dose</th>
<th>Continuing dose</th>
<th>Maximum dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>IM/IV: 0.2 mg slowly</td>
<td>IM: repeat 0.2 mg</td>
<td>Not more than 5 doses (total 1.0 mg)</td>
</tr>
</tbody>
</table>
**EMERGENCY TREATMENTS FOR THE WOMAN**

**Bleeding (2)**

**Remove placenta and fragments manually**
- If placenta not delivered 1 hour after delivery of the baby, OR
- If heavy vaginal bleeding continues despite massage and oxytocin and placenta cannot be delivered by controlled cord traction, or if placenta is incomplete and bleeding continues.

**Preparation**
- Explain to the woman the need for manual removal of the placenta and obtain her consent.
- Insert an IV line. If bleeding, give fluids rapidly. If not bleeding, give fluids slowly.
- Assist woman to get onto her back.
- Give diazepam (10 mg IM/IV).
- Clean vulva and perineal area.
- Ensure the bladder is empty. Catheterize if necessary.
- Wash hands and forearms well and put on long sterile gloves (and apron or gown if available).

**Technique**
- With the left hand, hold the umbilical cord with the clamp. Then pull the cord gently until it is horizontal.
- Insert right hand into the vagina and up into the uterus.
- Leave the cord and hold the fundus with the left hand in order to support the fundus of the uterus and to provide counter-traction during removal.
- Move the fingers of the right hand sideways until edge of the placenta is located.
- Detach the placenta from the implantation site by keeping the fingers tightly together and using the edge of the hand to gradually make a space between the placenta and the uterine wall.
- Proceed gradually all around the placental bed until the whole placenta is detached from the uterine wall.
- Withdraw the right hand from the uterus gradually, bringing the placenta with it.
- Explore the inside of the uterine cavity to ensure all placental tissue has been removed.
- With the left hand, provide counter-traction to the fundus through the abdomen by pushing it in the opposite direction of the hand that is being withdrawn. This prevents inversion of the uterus.
- Examine the uterine surface of the placenta to ensure that lobes and membranes are complete. If any placental lobe or tissue fragments are missing, explore again the uterine cavity to remove them.

If hours or days have passed since delivery, or if the placenta is retained due to constriction ring or closed cervix, it may not be possible to put the hand into the uterus. **DO NOT persist. Refer urgently to hospital.**

If the placenta does not separate from the uterine surface by gentle sideways movement of the fingertips at the line of cleavage, suspect placenta accreta. **DO NOT persist in efforts to remove placenta. Refer urgently to hospital.**

---

**After manual removal of the placenta**
- Repeat oxytocin 10 IU IM/IV.
- Massage the fundus of the uterus to encourage a tonic uterine contraction.
- Give ampicillin 2 g IV/IM.
- If fever >38.5°C, foul-smelling lochia or history of rupture of membranes for 18 or more hours, also give gentamicin 80 mg IM.
- If bleeding stops:
  - → give fluids slowly for at least 1 hour after removal of placenta.
- If heavy bleeding continues:
  - → give ergometrine 0.2 mg IM
  - → give 20 IU oxytocin in each litre of IV fluids and infuse rapidly
  - → Refer urgently to hospital.
- If the placenta does not separate from the uterine surface by gentle sideways movement of the fingertips at the line of cleavage, suspect placenta accreta. **DO NOT persist in efforts to remove placenta. Refer urgently to hospital.**
REPAIR THE TEAR AND EMPTY BLADDER

**Repair the tear or episiotomy**

- Examine the tear and determine the degree:
  - The tear is small and involved only vaginal mucosa and connective tissues and underlying muscles (first or second degree tear). If the tear is not bleeding, leave the wound open.
  - The tear is long and deep through the perineum and involves the anal sphincter and rectal mucosa (third and fourth degree tear). Cover it with a clean pad and refer the woman urgently to hospital.
- If first or second degree tear and heavy bleeding persists after applying pressure over the wound:
  - Suture the tear or refer for suturing if no one is available with suturing skills.
  - Suture the tear using universal precautions, aseptic technique and sterile equipment.
  - Use a needle holder and a 21 gauge, 4 cm, curved needle.
  - Use absorbable polyglycon suture material.
  - Make sure that the apex of the tear is reached before you begin suturing.
  - Ensure that edges of the tear match up well.

**DO NOT** suture if more than 12 hours since delivery. Refer woman to hospital.

**Empty bladder**

If bladder is distended and the woman is unable to pass urine:

- Encourage the woman to urinate.
- If she is unable to urinate, catheterize the bladder:
  - Wash hands
  - Clean urethral area with antiseptic
  - Put on clean gloves
  - Spread labia. Clean area again
  - Insert catheter up to 4 cm
  - Measure urine and record amount
  - Remove catheter.
**Give magnesium sulphate**

If severe pre-eclampsia and eclampsia

**IV/IM combined dose (loading dose)**
- Insert IV line and give fluids slowly (normal saline or Ringer's lactate) —
  1 litre in 6-8 hours (3 ml/ minute) 
- Give 4 g of magnesium sulphate (20 ml of 20% solution) IV slowly over 20 minutes (woman may feel warm during injection).
AND:
- Give 10 g of magnesium sulphate IM: give 5 g (10 ml of 50% solution) IM deep in upper outer quadrant of each buttock with 1 ml of 2% lignocaine in the same syringe.

If unable to give IV, give IM only (loading dose)
- Give 10 g of magnesium sulphate IM: give 5 g (10 ml of 50% solution) IM deep in upper outer quadrant of each buttock with 1 ml of 2% lignocaine in the same syringe.

If convulsions recur
- After 15 minutes, give an additional 2 g of magnesium sulphate (10 ml of 20% solution) IV over 20 minutes. If convulsions still continue, give diazepam.

If referral delayed for long, or the woman is in late labour, continue treatment:
- Give 5 g of 50% magnesium sulphate solution IM with 1 ml of 2% lignocaine every 4 hours in alternate buttocks until 24 hours after birth or after last convulsion (whichever is later).
- Monitor urine output: collect urine and measure the quantity.
- Before giving the next dose of magnesium sulphate, ensure:
  → knee jerk is present
  → urine output >100 ml/ 4 hrs
  → respiratory rate >16/ min.
- **DO NOT** give the next dose if any of these signs:
  → knee jerk absent
  → urine output <100 ml/ 4 hrs
  → respiratory rate <16/ min.
- Record findings and drugs given.

**Important considerations in caring for a woman with eclampsia or pre-eclampsia**

- Do not leave the woman on her own.
  → Help her into the left side position and protect her from fall and injury
  → Place padded tongue blades between her teeth to prevent a tongue bite, and secure it to prevent aspiration (**DO NOT** attempt this during a convulsion).
- Give IV 20% magnesium sulphate slowly over 20 minutes. Rapid injection can cause respiratory failure or death.
  → If respiratory depression (breathing less than 16/ minute) occurs after magnesium sulphate, do not give any more magnesium sulphate. Give the antidote: calcium gluconate 1 g IV (10 ml of 10% solution) over 10 minutes.
- **DO NOT** give intravenous fluids rapidly.
- **DO NOT** give intravenously 50% magnesium sulphate without diluting it to 20%.
- Refer urgently to hospital unless delivery is imminent.
  → If delivery imminent, manage as in Childbirth and accompany the woman during transport
  → Keep her in the left side position
  → If a convulsion occurs during the journey, give magnesium sulphate and protect her from fall and injury

<table>
<thead>
<tr>
<th>Formulation of magnesium sulphate</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% solution: vial containing 5 g in 10 ml (1g/2ml)</td>
</tr>
<tr>
<td><strong>IM</strong></td>
</tr>
<tr>
<td>5 g</td>
</tr>
<tr>
<td>10 ml and 1 ml 2% lignocaine</td>
</tr>
<tr>
<td>Not applicable</td>
</tr>
<tr>
<td>2 g</td>
</tr>
<tr>
<td>10 ml</td>
</tr>
</tbody>
</table>

After receiving magnesium sulphate a woman feel flushing, thirst, headache, nausea or may vomit.
Eclampsia and pre-eclampsia (2)

Give diazepam
If convulsions occur in early pregnancy or
If magnesium sulphate toxicity occurs or magnesium sulphate is not available.

Loading dose IV
- Give diazepam 10 mg IV slowly over 2 minutes.
- If convulsions recur, repeat 10 mg.

Maintenance dose
- Give diazepam 40 mg in 500 ml IV fluids (normal saline or Ringer’s lactate) titrated over 6-8 hours to keep the woman sedated but rousable.
- Stop the maintenance dose if breathing <16 breaths/minute.
- Assist ventilation if necessary with mask and bag.
- Do not give more than 100 mg in 24 hours.
- If IV access is not possible (e.g. during convulsion), give diazepam rectally.

Loading dose rectally
- Give 20 mg (4 ml) in a 10 ml syringe (or urinary catheter):
  - Remove the needle, lubricate the barrel and insert the syringe into the rectum to half its length.
  - Discharge the contents and leave the syringe in place, holding the buttocks together for 10 minutes to prevent expulsion of the drug.
- If convulsions recur, repeat 10 mg.

Maintenance dose
- Give additional 10 mg (2 ml) every hour during transport.

<table>
<thead>
<tr>
<th>Diazepam: vial containing 10 mg in 2 ml</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IV</strong></td>
<td><strong>Rectally</strong></td>
</tr>
<tr>
<td>Initial dose</td>
<td></td>
</tr>
<tr>
<td>10 mg = 2 ml</td>
<td>20 mg = 4 ml</td>
</tr>
<tr>
<td>Second dose</td>
<td></td>
</tr>
<tr>
<td>10 mg = 2 ml</td>
<td>10 mg = 2 ml</td>
</tr>
</tbody>
</table>

Give appropriate antihypertensive drug
If diastolic blood pressure is > 110 mmHg:
- Give hydralazine 5 mg IV slowly (3-4 minutes). If IV not possible give IM.
- If diastolic blood pressure remains > 90 mmHg, repeat the dose at 30 minute intervals until diastolic BP is around 90 mmHg.
- Do not give more than 20 mg in total.
INFECTION

Give appropriate IV/IM antibiotics

- Give the first dose of antibiotic(s) before referral. If referral is delayed or not possible, continue antibiotics IM/IV for 48 hours after woman is fever free. Then give amoxicillin orally 500 mg 3 times daily until 7 days of treatment completed.
- If signs persist or mother becomes weak or has abdominal pain postpartum, refer urgently to hospital

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>ANTIBIOTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe abdominal pain</td>
<td>3 antibiotics</td>
</tr>
<tr>
<td>Dangerous fever/very severe febrile disease</td>
<td>Ampicillin</td>
</tr>
<tr>
<td>Complicated abortion</td>
<td>Gentamicin</td>
</tr>
<tr>
<td>Uterine and fetal infection</td>
<td>Metronidazole</td>
</tr>
<tr>
<td>Postpartum bleeding</td>
<td>2 antibiotics:</td>
</tr>
<tr>
<td>→ lasting &gt; 24 hours</td>
<td>Ampicillin</td>
</tr>
<tr>
<td>→ occurring &gt; 24 hours after delivery</td>
<td>Gentamicin</td>
</tr>
<tr>
<td>Upper urinary tract infection</td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td></td>
</tr>
<tr>
<td>Manual removal of placenta/fragments</td>
<td>1 antibiotic:</td>
</tr>
<tr>
<td>Risk of uterine and fetal infection</td>
<td>Ampicillin</td>
</tr>
<tr>
<td>In labour &gt; 24 hours</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Antibiotic</th>
<th>Preparation</th>
<th>Dosage/route</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ampicillin</td>
<td>Vial containing 500 mg as powder: to be mixed with 2.5 ml sterile water</td>
<td>First 2 g IV/IM then 1 g</td>
<td>every 6 hours</td>
</tr>
<tr>
<td>Gentamicin</td>
<td>Vial containing 40 mg/ml in 2 ml</td>
<td>80 mg IM</td>
<td>every 8 hours</td>
</tr>
<tr>
<td>Metronidazole</td>
<td>Vial containing 500 mg in 100 ml</td>
<td>500 mg or 100 ml IV infusion</td>
<td>every 8 hours</td>
</tr>
<tr>
<td>Erythromycin (if allergy to ampicillin)</td>
<td>Vial containing 500 mg as powder</td>
<td>500 mg IV/IM</td>
<td>every 6 hours</td>
</tr>
</tbody>
</table>
Malaria

**Give arthemeter or quinine IM**
If dangerous fever or very severe febrile disease

<table>
<thead>
<tr>
<th>Arthemeter</th>
<th>Quinine*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 ml vial containing 80 mg/ml</td>
<td>2 ml vial containing 300 mg/ml</td>
</tr>
</tbody>
</table>

- **Leading dose for assumed weight 50-60 kg**
  - Arthemeter: 3.2 mg/kg
  - Quinine: 20 mg/kg
  - 2 ml
  - 4 ml

- **Continue treatment if unable to refer**
  - Arthemeter: 1.6 mg/kg
  - Quinine: 10 mg/kg
  - 1 ml once daily for 3 days**
  - 2 ml/8 hours for a total of 7 days**

- Give the loading dose of the most effective drug, according to the national policy.
- If quinine:
  - divide the required dose equally into 2 injections and give 1 in each anterior thigh
  - always give glucose with quinine.
- Refer urgently to hospital B17.
- If delivery imminent or unable to refer immediately, continue treatment as above and refer after delivery.

* These dosages are for quinine dihydrochloride. If quinine base, give 8.2 mg/kg every 8 hours.

** Discontinue parenteral treatment as soon as woman is conscious and able to swallow. Begin oral treatment according to national guidelines.

**Give glucose IV**
If dangerous fever or very severe febrile disease treated with quinine

<table>
<thead>
<tr>
<th>Glucose Solution</th>
<th>50% glucose solution*</th>
<th>25% glucose solution</th>
<th>10% glucose solution (5 ml/kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-50 ml</td>
<td>50-100 ml</td>
<td>125-250 ml</td>
<td></td>
</tr>
</tbody>
</table>

- Make sure IV drip is running well. Give glucose by slow IV push.
- If no IV glucose is available, give sugar water by mouth or nasogastric tube.
- To make sugar water, dissolve 4 level teaspoons of sugar (20 g) in a 200 ml cup of clean water.

* 50% glucose solution is the same as 50% dextrose solution or D50. This solution is irritating to veins. Dilute it with an equal quantity of sterile water or saline to produce 25% glucose solution.
Refer the woman urgently to hospital

- After emergency management, discuss decision with woman and relatives.
- Quickly organize transport and possible financial aid.
- Inform the referral centre if possible by radio or phone.
- Accompany the woman if at all possible, or send:
  - a health worker trained in delivery care
  - a relative who can donate blood
  - baby with the mother, if possible
  - essential emergency drugs and supplies
- During journey:
  - watch IV infusion
  - if journey is long, give appropriate treatment on the way
  - keep record of all IV fluids, medications given, time of administration and the woman’s condition.

Essential emergency drugs and supplies for transport and home delivery

<table>
<thead>
<tr>
<th>Emergency drugs</th>
<th>Strength and Form</th>
<th>Quantity for carry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxytocin</td>
<td>10 IU vial</td>
<td>6</td>
</tr>
<tr>
<td>Ergometrine</td>
<td>0.2 mg vial</td>
<td>2</td>
</tr>
<tr>
<td>Magnesium sulphate</td>
<td>5 g vials (20 g)</td>
<td>4</td>
</tr>
<tr>
<td>Diazepam (parenteral)</td>
<td>10 mg vial</td>
<td>3</td>
</tr>
<tr>
<td>Calcium gluconate</td>
<td>1 g vial</td>
<td>1</td>
</tr>
<tr>
<td>Ampicillin</td>
<td>500 mg vial</td>
<td>4</td>
</tr>
<tr>
<td>Gentamicin</td>
<td>80 mg vial</td>
<td>3</td>
</tr>
<tr>
<td>Metronidazole</td>
<td>500 mg vial</td>
<td>2</td>
</tr>
<tr>
<td>Ringer’s lactate</td>
<td>1 litre bottle</td>
<td>4 (if distant referral)</td>
</tr>
</tbody>
</table>

Emergency supplies

| IV catheters and tubing | 2 sets |
| Gloves                  | 2 pairs, at least, one pair sterile |
| Sterile syringes and needles | 5 sets |
| Urinary catheter        | 1 |
| Antiseptic solution     | 1 small bottle |
| Container for sharps    | 1 |
| Bag for trash           | 1 |
| Torch and extra battery | 1 |

If delivery is anticipated on the way

| Soap, towels            | 2 sets |
| Disposable delivery kit (blade, 3 ties) | 2 sets |
| Clean cloths (3) for receiving, drying and wrapping the baby | 1 set |
| Clean clothes for the baby | 1 set |
| Plastic bag for placenta | 1 set |
| Resuscitation bag and mask for the baby | 1 set |
Bleeding in early pregnancy and post-abortion care

***BLEEDING IN EARLY PREGNANCY AND POST-ABORTION CARE***

- Always begin with Rapid assessment and management (RAM) [B3-B7].
- Next use the Bleeding in early pregnancy/post abortion care [B19] to assess the woman with light vaginal bleeding or a history of missed periods.
- Use chart on Preventive measures [B20] to provide preventive measures due to all women.
- Use Advise and counsel on post-abortion care [B21] to advise on self-care, danger signs, follow-up visit, family planning.
- Record all treatment given, positive findings, and the scheduled next visit in the home-based and clinic recording forms.
- If the woman is HIV positive, adolescent or has special needs, use [G1-G8] [H1-H4].
### EXAMINATION OF THE WOMAN WITH BLEEDING IN EARLY PREGNANCY, AND POST-ABORTION CARE

Use this chart if a woman has vaginal bleeding in early pregnancy or a history of missed periods.

<table>
<thead>
<tr>
<th><strong>ASK, CHECK RECORD</strong></th>
<th><strong>LOOK, LISTEN, FEEL</strong></th>
<th><strong>SIGNS</strong></th>
<th><strong>CLASSIFY</strong></th>
<th><strong>TREAT AND ADVISE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>When did bleeding start?</td>
<td>Look at amount of bleeding.</td>
<td>Vaginal bleeding and any of:</td>
<td><strong>COMPLICATED ABORTION</strong></td>
<td>Insert an IV line and give fluids [B9].</td>
</tr>
<tr>
<td>How much blood have you lost?</td>
<td>Note if there is foul-smelling vaginal discharge.</td>
<td>→ Foul-smelling vaginal discharge</td>
<td></td>
<td>Give paracetamol for pain [B4].</td>
</tr>
<tr>
<td>Are you still bleeding?</td>
<td>Feel for lower abdominal pain.</td>
<td>→ Abortion with uterine manipulation</td>
<td></td>
<td>Give appropriate IM/IV antibiotics [B15].</td>
</tr>
<tr>
<td>Is the bleeding increasing or decreasing?</td>
<td>Feel for fever. If hot, measure temperature.</td>
<td>→ Abdominal pain/tenderness</td>
<td></td>
<td>Refer urgently to hospital [B17].</td>
</tr>
<tr>
<td>Could you be pregnant?</td>
<td>Look for pallor.</td>
<td>→ Temperature &gt;38 °C.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When was your last period?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had a recent abortion?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you or anyone else do anything to induce an abortion?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you fainted recently?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have abdominal pain?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any other concerns to discuss?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**LOOK, LISTEN, FEEL**

- Look at amount of bleeding.
- Note if there is foul-smelling vaginal discharge.
- Feel for lower abdominal pain.
- Feel for fever. If hot, measure temperature.
- Look for pallor.

**SIGNS**

- Vaginal bleeding and any of:
  - Foul-smelling vaginal discharge
  - Abortion with uterine manipulation
  - Abdominal pain/tenderness
  - Temperature >38 °C.

**CLASSIFY**

- **COMPLICATED ABORTION**
- **THREATENED ABORTION**
- **COMPLETE ABORTION**
- **ECTOPIC PREGNANCY**

**TREAT AND ADVISE**

- Insert an IV line and give fluids [B9].
- Give paracetamol for pain [B4].
- Give appropriate IM/IV antibiotics [B15].
- Refer urgently to hospital [B17].
- Observe bleeding for 4-6 hours: If no decrease, refer to hospital.
- If decrease, let the woman go home.
- Advise the woman to return immediately if bleeding increases.
- Follow up in 2 days [B21].
- Check preventive measures [B20].
- Advise on self-care [B21].
- Advise and counsel on family planning [B21].
- Advise to return if bleeding does not stop within 2 days.
- Insert an IV line and give fluids [B9].
- Refer urgently to hospital [B17].

**NEXT:** Give preventive measures
### Give preventive measures

#### GIVE PREVENTIVE MEASURES

#### ASSESS, CHECK RECORDS
- Check tetanus toxoid (TT) immunization status.
- Check woman’s supply of the prescribed dose of iron/ folate.
- Check HIV status.
- Check RPR status in records.
- If no RPR results, do the RPR test.

#### TREAT AND ADVISE
- Give tetanus toxoid if due.
- Give 3 month’s supply of iron and counsel on compliance.
- If voluntary counselling and testing (VCT) status unknown, counsel on VCT.
- If known HIV-positive:
  - give support.
  - advise on opportunistic infection and need to seek medical help.
  - counsel on correct and consistent use of condoms.
- If HIV-negative, counsel on correct and consistent use of condoms.
- If Rapid plasma reagin (RPR) positive:
  - Treat the woman for syphilis with benzathine penicillin.
  - Advise on treating her partner.
  - Encourage VCT.
  - Reinforce use of condoms.
ADVISE AND COUNSEL ON POST-ABORTION CARE

Advise on self-care
- Rest for a few days, especially if feeling tired.
- Advise on hygiene
  - change pads every 4 to 6 hours
  - wash the perineum daily
  - avoid sexual relations until bleeding stops.
- Advise woman to return immediately if she has any of the following danger signs:
  - increased bleeding
  - continued bleeding for 2 days
  - foul-smelling vaginal discharge
  - abdominal pain
  - fever, feeling ill, weakness
  - dizziness or fainting.
- Advise woman to return in if delay (6 weeks or more) in resuming menstrual periods.

Advise and counsel on family planning
- Explain to the woman that she can become pregnant soon after the abortion - as soon as she has sexual intercourse — if she does not use a contraceptive:
  - Any family planning method can be used immediately after an uncomplicated first trimester abortion.
  - If the woman has an infection or injury: delay IUD insertion or female sterilization until healed. For information on options, see Methods for non-breastfeeding women on .
- Make arrangements for her to see a family planning counsellor as soon as possible, or counsel her directly. (See The decision-making tool for family planning clients and providers for information on methods and on the counselling process).
- Advise on correct and consistent condom use if she or her partner are at risk of sexually transmitted infection (STI) or HIV .

Provide information and support after abortion
A woman may experience different emotions after an abortion, and may benefit from support:
- Allow the woman to talk about her worries, feelings, health and personal situation. Ask if she has any questions or concerns.
- Facilitate family and community support, if she is interested (depending on the circumstances, she may not wish to involve others).
  - Speak to them about how they can best support her, by sharing or reducing her workload, helping out with children, or simply being available to listen.
  - Inform them that post-abortion complications can have grave consequences for the woman’s health. Inform them of the danger signs and the importance of the woman returning to the health worker if she experiences any.
  - Inform them about the importance of family planning if another pregnancy is not desired.
- If the woman is interested, link her to a peer support group or other women’s groups or community services which can provide her with additional support.
- If the woman discloses violence or you see unexplained bruises and other injuries which make you suspect she may be suffering abuse, see .
- Advise on correct and consistent use of condoms if she or her partner are at risk for STI or HIV .

Advise and counsel during follow-up visits
If threatened abortion and bleeding stops:
- Reassure the woman that it is safe to continue pregnancy.
- Provide antenatal care .

If bleeding continues:
- Assess and manage as in Bleeding in early pregnancy/ post-abortion care .
  - If fever, foul-smelling vaginal discharge, or abdominal pain, give first dose of appropriate IV/ IM antibiotics .
  - Refer woman to hospital.
Antenatal care

ANTENATAL CARE

Always begin with Rapid assessment and management (RAM) [B3-B7]. If the woman has no emergency or priority signs and has come for antenatal care, use this section for further care.

Next use the Pregnancy status and birth plan chart [C2] to ask the woman about her present pregnancy status, history of previous pregnancies, and check her for general danger signs. Decide on an appropriate place of birth for the woman using this chart and prepare the birth and emergency plan. The birth plan should be reviewed during every follow-up visit.

Check all women for pre-eclampsia, anaemia, syphilis and HIV status according to the charts [C3-C5].

In cases where an abnormal sign is identified (volunteered or observed), use the charts Respond to observed signs or volunteered problems [C7-C11] to classify the condition and identify appropriate treatment(s).

Give preventive measures due [C12].

Develop a birth and emergency plan [C14-C15].

Advise and counsel on nutrition [C13], family planning [C16], labour signs, danger signs [C18], routine and follow-up visits [C27] using Information and Counselling sheets [C17].

Record all positive findings, birth plan, treatments given and the next scheduled visit in the home-based maternal card/clinic recording form.

If the woman is HIV positive, adolescent or has special needs, see [G1-G8 | H1-H4].
Antenatal care
**ASSESS THE PREGNANT WOMAN: PREGNANCY STATUS, BIRTH AND EMERGENCY PLAN**

Use this chart to assess the pregnant woman at each of the four antenatal care visits. During first antenatal visit, prepare a birth and emergency plan using this chart and review them during following visits. Modify the birth plan if any complications arise.

### ASK, CHECK, RECORD

<table>
<thead>
<tr>
<th>ALL VISITS</th>
<th>LOOK, LISTEN, FEEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check duration of pregnancy.</td>
<td>Feel for trimester of pregnancy.</td>
</tr>
<tr>
<td>Where do you plan to deliver?</td>
<td></td>
</tr>
<tr>
<td>Any vaginal bleeding since last visit?</td>
<td></td>
</tr>
<tr>
<td>Is the baby moving? (after 4 months)</td>
<td></td>
</tr>
<tr>
<td>Check record for previous complications and treatments received during this pregnancy</td>
<td></td>
</tr>
<tr>
<td>Do you have any concerns?</td>
<td></td>
</tr>
</tbody>
</table>

### FIRST VISIT

<table>
<thead>
<tr>
<th>First birth.</th>
<th>Look for caesarean scar</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many months pregnant are you?</td>
<td></td>
</tr>
<tr>
<td>When was your last period?</td>
<td></td>
</tr>
<tr>
<td>When do you expect to deliver?</td>
<td></td>
</tr>
<tr>
<td>How old are you?</td>
<td></td>
</tr>
<tr>
<td>Have you had a baby before? If yes:</td>
<td></td>
</tr>
<tr>
<td>Check record for prior pregnancies or if there is no record ask about:</td>
<td></td>
</tr>
<tr>
<td>→ Number of prior pregnancies/deliveries</td>
<td></td>
</tr>
<tr>
<td>→ Prior caesarean section, forceps, or vacuum</td>
<td></td>
</tr>
<tr>
<td>→ Prior third degree tear</td>
<td></td>
</tr>
<tr>
<td>→ Heavy bleeding during or after delivery</td>
<td></td>
</tr>
<tr>
<td>→ Convulsions</td>
<td></td>
</tr>
<tr>
<td>→ Stillbirth or death in first day.</td>
<td></td>
</tr>
<tr>
<td>→ Do you smoke, drink alcohol or use any drugs?</td>
<td></td>
</tr>
</tbody>
</table>

### THIRD TRIMESTER

Has she been counselled on family planning? If yes, does she want tubal ligation or IUD

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>PLACE OF DELIVERY</th>
<th>ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior delivery by caesarean.</td>
<td>REFERRAL LEVEL</td>
<td>Explain why delivery needs to be at referral level [C14].</td>
</tr>
<tr>
<td>Age less than 14 years.</td>
<td></td>
<td>Develop the birth and emergency plan [C14].</td>
</tr>
<tr>
<td>Transverse lie or other obvious malpresentation within one month of expected delivery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obvious multiple pregnancy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tubal ligation or IUD desired immediately after delivery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documented third degree tear.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of or current vaginal bleeding or other complication during this pregnancy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First birth.</td>
<td>PRIMARY HEALTH CARE LEVEL</td>
<td>Explain why delivery needs to be at primary health care level [C14].</td>
</tr>
<tr>
<td>Last baby born dead or died in first day.</td>
<td></td>
<td>Develop the birth and emergency plan [C14].</td>
</tr>
<tr>
<td>Age less than 16 years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than six previous births.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior delivery with heavy bleeding.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior delivery with convulsions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior delivery by forceps or vacuum.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None of the above.</td>
<td>ACCORDING TO WOMAN'S PREFERENCE</td>
<td>Explain why delivery needs to be with a skilled birth attendant, preferably at a facility.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop the birth and emergency plan [C14].</td>
</tr>
</tbody>
</table>

**NEXT:** Check for pre-eclampsia
**CHECK FOR PRE-ECLAMPSIA**

Screen all pregnant women at every visit.

### ASK, CHECK RECORD
- Blood pressure at the last visit?

### LOOK, LISTEN, FEEL
- Measure blood pressure in sitting position.
- If diastolic blood pressure is $\geq 90$ mmHg, repeat after 1 hour rest.
- If diastolic blood pressure is still $\geq 90$ mmHg, ask the woman if she has:
  - severe headache
  - blurred vision
  - epigastric pain and
  - check protein in urine.

### SIGNS

<table>
<thead>
<tr>
<th>Blood pressure</th>
<th>Signs</th>
<th>Classify</th>
<th>Treat and Advise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diastolic blood pressure $\geq 110$ mmHg and 3+ proteinuria, or</td>
<td></td>
<td>SEVERE PRE-ECLAMPSIA</td>
<td>Give magnesium sulphate [113]</td>
</tr>
<tr>
<td></td>
<td>Diastolic blood pressure $\geq 90$ mmHg on two readings and 2+ proteinuria, and any of:</td>
<td></td>
<td>Give appropriate anti-hypertensives [114]</td>
</tr>
<tr>
<td></td>
<td>→ severe headache</td>
<td></td>
<td>Revise the birth plan [C2]</td>
</tr>
<tr>
<td></td>
<td>→ blurred vision</td>
<td></td>
<td>Refer urgently to hospital [B17]</td>
</tr>
<tr>
<td></td>
<td>→ epigastric pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>→ check protein in urine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diastolic blood pressure 90-110 mmHg on two readings and 2+ proteinuria.</td>
<td>PRE-ECLAMPSIA</td>
<td></td>
<td>Revise the birth plan [C2]</td>
</tr>
<tr>
<td>Diastolic blood pressure $\geq 90$ mmHg on 2 readings.</td>
<td>HYPERTENSION</td>
<td></td>
<td>Refer to hospital.</td>
</tr>
<tr>
<td>None of the above.</td>
<td>NO HYPERTENSION</td>
<td></td>
<td>Advise to reduce workload and to rest.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Advise on danger signs [C15]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reassess at the next antenatal visit or in 1 week if $&gt;8$ months pregnant.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If hypertension persists after 1 week or at next visit, refer to hospital or discuss case with the doctor or midwife, if available.</td>
</tr>
</tbody>
</table>

### TREAT AND ADVISE
- Give magnesium sulphate [113]
- Give appropriate anti-hypertensives [114]
- Revise the birth plan [C2]
- Refer urgently to hospital [B17]
- Revise the birth plan [C2]
- Refer to hospital.
- Advise on danger signs [C15]
- Reassess at the next antenatal visit or in 1 week if $>8$ months pregnant.
- If hypertension persists after 1 week or at next visit, refer to hospital or discuss case with the doctor or midwife, if available.
- Advise to reduce workload and to rest.
- No treatment required.

**ANTENATAL CARE**

- **NEXT:** Check for anaemia

**Assess the pregnant woman ▶ Check for pre-eclampsia**

C3
## CHECK FOR ANAEMIA

**Screen all pregnant women at every visit.**

### ASK, CHECK RECORD

- Do you tire easily?
- Are you breathless (short of breath) during routine household work?

### LOOK, LISTEN, FEEL

- **On first visit:**
  - Measure haemoglobin
- **On subsequent visits:**
  - Look for conjunctival pallor.
  - Look for palmar pallor. If pallor:
    - Is it severe pallor?
    - Some pallor?
    - Count number of breaths in 1 minute.

### SIGNS

- Haemoglobin <7 g/dl.
- Severe palmar and conjunctival pallor or
- Any pallor with any of
  - >30 breaths per minute
  - tires easily
  - breathlessness at rest

### CLASSIFY

**SEVERE ANAEMIA**

- Revise birth plan so as to deliver in a facility with blood transfusion services.
- Give double dose of iron (1 tablet twice daily) for 3 months.
- Counsel on compliance with treatment.
- Give appropriate oral antimalarial.
- Follow up in 2 weeks to check clinical progress, test results, and compliance with treatment.
- Refer urgently to hospital.

**MODERATE ANAEMIA**

- Haemoglobin 7-11 g/dl.
- Palmar or conjunctival pallor.

**NO CLINICAL ANAEMIA**

- Haemoglobin >11 g/dl.
- No pallor.

### TREAT AND ADVISE

- Give double dose of iron (1 tablet twice daily) for 3 months.
- Counsel on compliance with treatment.
- Give appropriate oral antimalarial if not given in the past month.
- Reassess at next antenatal visit (4-6 weeks). If anaemia persists, refer to hospital.
- Give iron 1 tablet once daily for 3 months.
- Counsel on compliance with treatment.
CHECK FOR SYPHILIS
Test all pregnant women at first visit. Check status at every visit.

ASK, CHECK RECORD
■ Have you been tested for syphilis during this pregnancy?
  → If not, perform the rapid plasma reagin (RPR) test.
■ If test was positive, have you and your partner been treated for syphilis?
  → If not, and test is positive, ask "Are you allergic to penicillin?"

LOOK, LISTEN, FEEL

TEST RESULT
■ RPR test positive.
  POSSIBLE SYPHILIS
  ■ Give benzathine benzylpenicillin IM. If allergy, give erythromycin.
  ■ Plan to treat the newborn.
  ■ Encourage woman to bring her sexual partner for treatment.
  ■ Advise on correct and consistent use of condoms to prevent new infection.
■ RPR test negative.
  NO SYPHILIS
  ■ Advise on correct and consistent use of condoms to prevent infection.

CLASSIFY

TREAT AND ADVISE

ASSIST: Check for HIV status

Assess the pregnant woman ▶ Check for syphilis
**Assess the pregnant woman ▶ Check for HIV status**

**CHECK FOR HIV STATUS**
Counsel all pregnant women for HIV at first visit. Check status during each visit.

<table>
<thead>
<tr>
<th>ASK, CHECK RECORD</th>
<th>LOOK, LISTEN, FEEL</th>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
</table>
| ■ Have you ever been tested for HIV?  
■ If yes, do you know the result?  
  (Explain to the woman that she has the right not to disclose the result.)  
■ Has the partner been tested? |  | ■ Known HIV-positive. | HIV-POSITIVE | ■ Ensure that she visited adequate staff and received necessary information about MTCT prevention.  
■ Enquire about the ARV prophylactic treatment prescribed and ensure that the woman knows when to start ARV prophylaxis.  
■ Enquire how she will be supplied with the drugs.  
■ Enquire about the infant feeding option chosen.  
■ Advise on additional care during pregnancy, delivery and postpartum.  
■ Advise on correct and consistent use of condoms.  
■ Counsel on benefits of involving and testing the partner. |
| |  | ■ No HIV test results or not willing to disclose result. | UNKNOWN HIV STATUS | ■ Provide key information on HIV.  
■ Inform her about VCT to determine HIV status.  
■ Advise on correct and consistent use of condoms.  
■ Counsel on benefits of involving and testing the partner. |
| |  | ■ Known HIV-negative. | HIV-NEGATIVE | ■ Provide key information on HIV.  
■ Counsel on benefits of involving and testing her partner.  
■ Counsel on the importance of staying negative by correct and consistent use of condoms. |

**NEXT**: Respond to observed signs or volunteered problems  
If no problem, go to page C6.
**RESPOND TO OBSERVED SIGNS OR VOLUNTEERED PROBLEMS**

<table>
<thead>
<tr>
<th>ASK, CHECK RECORD</th>
<th>LOOK, LISTEN, FEEL</th>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IF NO FETAL MOVEMENT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ When did the baby last move?</td>
<td>■ Feel for fetal movements.</td>
<td>■ No fetal movement.</td>
<td><strong>PROBABLY DEAD BABY</strong></td>
<td>■ Inform the woman and partner about the possibility of dead baby.</td>
</tr>
<tr>
<td>■ If no movement felt, ask woman to move around for some time, reassess fetal movement.</td>
<td>■ Listen for fetal heart after 6 months of pregnancy</td>
<td>■ No fetal heart beat.</td>
<td></td>
<td>■ Refer to hospital.</td>
</tr>
<tr>
<td></td>
<td>■ If no heart beat, repeat after 1 hour.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>WELL BABY</strong></td>
<td>■ Inform the woman that baby is fine and likely to be well but to return if problem persists.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IF RUPTURED MEMBRANES AND NO LABOUR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ When did the membranes rupture?</td>
<td>■ Look at pad or underwear for evidence of:</td>
<td>■ Fever 38°C.</td>
<td><strong>UTERINE AND FETAL INFECTION</strong></td>
<td>■ Give appropriate IM/IV antibiotics</td>
</tr>
<tr>
<td>■ When is your baby due?</td>
<td>■ → amniotic fluid</td>
<td></td>
<td></td>
<td>■ Refer urgently to hospital</td>
</tr>
<tr>
<td></td>
<td>■ → foul-smelling vaginal discharge</td>
<td>■ Foul-smelling vaginal discharge.</td>
<td><strong>RISK OF UTERINE AND FETAL INFECTION</strong></td>
<td>■ Give appropriate IM/IV antibiotic</td>
</tr>
<tr>
<td></td>
<td>■ If no evidence, ask her to wear a pad. Check again in 1 hour.</td>
<td>■ Rupture of membranes at &lt;8 months of pregnancy.</td>
<td></td>
<td>■ Refer urgently to hospital</td>
</tr>
<tr>
<td></td>
<td>■ Measure temperature.</td>
<td>■ Rupture of membranes at &gt;8 months of pregnancy.</td>
<td><strong>RUPTURE OF MEMBRANES</strong></td>
<td>■ Manage as Woman in childbirth</td>
</tr>
</tbody>
</table>

**NEXT**: If fever or burning on urination

Respond to observed signs or volunteered problems (1)
### Ask, Check Record

- **Have you had fever?**
- **Do you have burning on urination?**

### Look, Listen, Feel

- **If history of fever or feels hot:**
  - Measure axillary temperature.
  - Look or feel for stiff neck.
  - Look for lethargy.
- **Percuss flanks for tenderness.**

### Signs

<table>
<thead>
<tr>
<th>Fever &gt;38°C and any of:</th>
<th>VERY SEVERE FEBRILE DISEASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very fast breathing or</td>
<td>Insert IV line and give fluids slowly</td>
</tr>
<tr>
<td>Stiff neck</td>
<td>Give appropriate IM/IV antibiotics</td>
</tr>
<tr>
<td>Lethargy</td>
<td>Give artemether/quinine IM</td>
</tr>
<tr>
<td>Very weak/ not able to stand</td>
<td>Give glucose</td>
</tr>
<tr>
<td></td>
<td>Refer urgently to hospital</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fever &gt;38°C and any of:</th>
<th>UPPER URINARY TRACT INFECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flank pain</td>
<td>Give appropriate IM/IV antibiotics</td>
</tr>
<tr>
<td>Burning on urination.</td>
<td>Give appropriate oral antimalarial</td>
</tr>
<tr>
<td></td>
<td>Refer urgently to hospital</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fever &gt;38°C or history of fever (in last 48 hours).</th>
<th>MALARIA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Give appropriate oral antimalarial</td>
</tr>
<tr>
<td></td>
<td>If no improvement in 2 days or condition is worse, refer to hospital.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Burning on urination.</th>
<th>LOWER URINARY TRACT INFECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Give appropriate oral antibiotics</td>
</tr>
<tr>
<td></td>
<td>Encourage her to drink more fluids.</td>
</tr>
<tr>
<td></td>
<td>If no improvement in 2 days or condition is worse, refer to hospital.</td>
</tr>
</tbody>
</table>

### Classify

- **Upper Urinary Tract Infection**
- **Malaria**
- **Lower Urinary Tract Infection**

### Treat and Advise

- **Insert IV line and give fluids slowly**
- **Give appropriate IM/IV antibiotics**
- **Give artemether/quinine IM**
- **Give glucose**
- **Refer urgently to hospital**
- **Give appropriate oral antimalarial**
- **Refer urgently to hospital**
- **Give appropriate oral antibiotics**

**Next:** If vaginal discharge
**ASK, CHECK RECORD**

**LOOK, LISTEN, FEEL**

**IF VAGINAL DISCHARGE**

| Have you noticed changes in your vaginal discharge? |
| Do you have itching at the vulva? |
| Has your partner had a urinary problem? |

If partner is present in the clinic, ask the woman if she feels comfortable if you ask him similar questions. If yes, ask him if he has:

- urethral discharge or pus.
- burning on passing urine.

If partner could not be approached, explain importance of partner assessment and treatment to avoid reinfection. Schedule follow-up appointment for woman and partner (if possible).

| Separate the labia and look for abnormal vaginal discharge: |
| → amount |
| → colour |
| → odour/smell. |
| If no discharge is seen, examine with a gloved finger and look at the discharge on the glove. |

| Abnormal vaginal discharge. |
| Partner has urethral discharge or burning on passing urine. |

**SIGNS**

| Abnormal vaginal discharge. |
| Curd-like vaginal discharge. |
| Intense vulval itching. |
| Abnormal vaginal discharge |

| Possible gonorrhoea or chlamydia infection |
| Possible candida infection |
| Possible bacterial or trichomonas infection |

| Give appropriate oral antibiotics to woman |
| Give clotrimazole |
| Give metronidazole to woman |
| Treat partner with appropriate oral antibiotics |
| Treat partner with appropriate oral antibiotics |
| Advise on correct and consistent use of condoms |
| Advise on correct and consistent use of condoms |

**CLASSIFY**

**POSSIBLE GONORRHOEA OR CHLAMYDIA INFECTION**

**POSSIBLE CANDIDA INFECTION**

**POSSIBLE BACTERIAL OR TRICHOMONAS INFECTION**

**TREAT AND ADVISE**

NEXT: If signs suggesting HIV infection

Respond to observed signs or volunteered problems (3)
**Respond to observed signs or volunteered problems (4)**

<table>
<thead>
<tr>
<th>ASK, CHECK RECORD</th>
<th>LOOK, LISTEN, FEEL</th>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
</table>
| **IF SIGNS SUGGESTING HIV INFECTION**  
(HIV status unknown or known HIV-positive) | | | | |
| ▪ Have you lost weight?  
How long (>1 month)? | ▪ Look for visible wasting.  
▪ Look for ulcers and white patches in the mouth (thrush).  
▪ Look at the skin:  
→ Is there a rash?  
→ Are there blisters along the ribs on one side of the body? | ▪ Two of these signs:  
→ weight loss  
→ fever >1 month  
→ diarrhoea >1 month.  
OR  
▪ One of the above signs and  
→ one or more other signs or  
→ from a risk group. | **STRONG LIKELIHOOD OF HIV INFECTION** | ▪ Reinforce the need to know HIV status and advise where to go for VCT [G2-G3].  
▪ Counsel on the benefits of testing the partner [G3].  
▪ Advise on correct and consistent use of condoms [G2].  
▪ Examine further and manage according to national HIV guidelines or refer to appropriate HIV services.  
▪ Refer to TB centre if cough. |
| ▪ Do you have fever?  
How long (>1 month)?  
▪ Have you got diarrhoea (continuous or intermittent)?  
How long, >1 month?  
▪ Have you had cough?  
How long, >1 month? | | | | |
| Assess if in high risk group:  
▪ Occupational exposure?  
▪ Is the woman commercial sex worker?  
▪ Intravenous drug abuse?  
▪ History of blood transfusion?  
▪ Illness or death from AIDS in a sexual partner? | | | | |

**IF SMOKING, ALCOHOL OR DRUG ABUSE, OR HISTORY OF VIOLENCE**

| ▪ Counsel on stopping smoking  
| ▪ For alcohol/drug abuse, refer to specialized care providers.  
| ▪ For counselling on violence, see [H4]. |

**NEXT**: If cough or breathing difficulty
**IF COUGH OR BREATHING DIFFICULTY**

- How long have you been coughing?
- How long have you had difficulty in breathing?
- Do you have chest pain?
- Do you have any blood in sputum?
- Do you smoke?

- Look for breathlessness.
- Listen for wheezing.
- Measure temperature.

**ASK, CHECK RECORD**

**LOOK, LISTEN, FEEL**

**SIGNS**

- At least 2 of the following signs:
  - Fever >38°C.
  - Breathlessness.
  - Chest pain.

- At least 1 of the following signs:
  - Cough or breathing difficulty for >3 weeks
  - Blood in sputum
  - Wheezing

**CLASSIFY**

- POSSIBLE PNEUMONIA
  - Give first dose of appropriate IM/IV antibiotics.
  - Refer urgently to hospital.

- POSSIBLE CHRONIC LUNG DISEASE
  - Refer to hospital for assessment.
  - If severe wheezing, refer urgently to hospital.
  - Use Practical approach to lung health guidelines (PAL) for further management.

- UPPER RESPIRATORY TRACT INFECTION
  - Advise safe, soothing remedy.
  - If smoking, counsel to stop smoking.

**TREAT AND ADVISE**

- If taking anti-tuberculosis drugs?
  - Are you taking anti-tuberculosis drugs? If yes, since when?
  - Does the treatment include injection (streptomycin)?

- Taking anti-tuberculosis drugs.
- Receiving injectable anti-tuberculosis drugs.

- TUBERCULOSIS
  - If anti-tubercular treatment includes streptomycin (injection), refer the woman to district hospital for revision of treatment as streptomycin is ototoxic to the fetus.
  - If treatment does not include streptomycin, assure the woman that the drugs are not harmful to her baby, and urge her to continue treatment for a successful outcome of pregnancy.
  - If her sputum is TB positive within 2 months of delivery, plan to give INH prophylaxis to the newborn.
  - Reinforce advice to go for VCT.
  - If smoking, counsel to stop smoking.
  - Advise to screen immediate family members and close contacts for tuberculosis.

**NEXT:** Give preventive measures

Respond to observed signs or volunteered problems (5)
### Give preventive measures

#### GIVE PREVENTIVE MEASURES

**ANTENATAL CARE**

Advise and counsel all pregnant women at every antenatal care visit.

<table>
<thead>
<tr>
<th>ASSESS, CHECK RECORD</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Check tetanus toxoid (TT) immunization status.</td>
<td>■ Give tetanus toxoid if due [12].</td>
</tr>
<tr>
<td>■ Check woman’s supply of the prescribed dose of iron/folate</td>
<td>■ Give TT1, plan to give TT2 at next visit.</td>
</tr>
<tr>
<td>■ Check when last dose of mebendazole given.</td>
<td>■ Give 3 month’s supply of iron and counsel on compliance and safety [3].</td>
</tr>
<tr>
<td>■ Check when last dose of an antimalarial given.</td>
<td>■ Give mebendazole once in second or third trimester [3].</td>
</tr>
<tr>
<td>■ Ask if she (and children) are sleeping under insecticide treated bednets.</td>
<td>■ Give intermittent preventive treatment in second and third trimesters [4].</td>
</tr>
<tr>
<td></td>
<td>■ Encourage sleeping under insecticide treated bednets.</td>
</tr>
</tbody>
</table>

**First visit**
- Develop a birth and emergency plan [14].
- Counsel on nutrition [13].
- Counsel on importance of exclusive breastfeeding [12].
- Counsel on stopping smoking and alcohol and drug abuse.
- Counsel on safe sex and correct and consistent use of condoms.

**All visits**
- Review and update the birth and emergency plan according to new findings [14-15].
- Advise on when to seek care [17].
  - routine visits
  - follow-up visits
  - danger signs.

**Third trimester**
- Counsel on family planning [10].

■ Record all visits and treatments given.
ADVISE AND COUNSEL ON NUTRITION AND SELF-CARE

Use the information and counselling sheet to support your interaction with the woman, her partner and family.

Counsel on nutrition

- Advise the woman to eat a greater amount and variety of healthy foods, such as meat, fish, oils, nuts, seeds, cereals, beans, vegetables, cheese, milk, to help her feel well and strong (give examples of types of food and how much to eat).
- Spend more time on nutrition counselling with very thin women and adolescents.
- Determine if there are important taboos about foods which are nutritionally important for good health. Advise the woman against these taboos.
- Talk to family members such as the partner and mother-in-law, to encourage them to help ensure the woman eats enough and avoids hard physical work.

Advise on self-care during pregnancy

Advise the woman to:

- Take iron tablets (p.T3).
- Rest and avoid lifting heavy objects.
- Sleep under an insecticide impregnated bednet.
- Use condoms correctly and consistently, if at risk for STI or HIV*.
- Avoid alcohol and smoking during pregnancy.
- NOT to take medication unless prescribed at the health centre/hospital.

SCREENING FOR GESTATIONAL DIABETES*

<table>
<thead>
<tr>
<th>Ask</th>
<th>Look, listen and feel</th>
<th>Signs</th>
<th>Classify</th>
<th>Treat and advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Low risk)</td>
<td>Maternal age of 25 years old and above Family history of diabetes (first degree)</td>
<td>Look for signs of maternal overweight or obesity</td>
<td>Overweight or obesity</td>
<td>Low risk for gestational diabetes</td>
</tr>
<tr>
<td>(High risk)</td>
<td>Ask family history of diabetes (first degree) and history of overweight and obesity Ask past pregnancy for difficult labor, large babies, congenital malformations and previous unexplained fetal death</td>
<td>Look for signs of maternal overweight or obesity, polyhydramnios, signs of large baby, fetal abnormality and recurrent vaginal infections</td>
<td>Overweight and obesity Polyhydramnios Large fetus Fetal abnormality Recurrent vaginal infections</td>
<td>High risk for gestational diabetes</td>
</tr>
</tbody>
</table>

DEVELOP A BIRTH AND EMERGENCY PLAN

Use the information and counselling sheet to support your interaction with the woman, her partner and family.

Facility delivery

**Explain why birth in a facility is recommended**
- Any complication can develop during delivery - they are not always predictable.
- A facility has staff, equipment, supplies and drugs available to provide best care if needed, and a referral system.

Advise how to prepare
Review the arrangements for delivery:
- How will she get there? Will she have to pay for transport?
- How much will it cost to deliver at the facility? How will she pay?
- Can she start saving straight away?
- Who will go with her for support during labour and delivery?
- Who will help while she is away to care for her home and other children?

Advise when to go
- If the woman lives near the facility, she should go at the first signs of labour.
- If living far from the facility, she should go 2-3 weeks before baby due date and stay either at the maternity waiting home or with family or friends near the facility.
- Advise to ask for help from the community, if needed.

Advise what to bring
- Home-based maternal record.
- Clean cloths for washing, drying and wrapping the baby.
- Additional clean cloths to use as sanitary pads after birth.
- Clothes for mother and baby.
- Food and water for woman and support person.

Home delivery with a skilled attendant

**Advise how to prepare**
Review the following with her:
- Who will be the companion during labour and delivery?
- Who will be close by for at least 24 hours after delivery?
- Who will help to care for her home and other children?
- Advise to call the skilled attendant at the first signs of labour.
- Advise to have her home-based maternal record ready.
- Advise to ask for help from the community, if needed.

**Explain supplies needed for home delivery**
- Warm spot for the birth with a clean surface or a clean cloth.
- Clean cloths of different sizes: for the bed, for drying and wrapping the baby, for cleaning the baby's eyes, for the birth attendant to wash and dry her hands, for use as sanitary pads.
- Blankets.
- Buckets of clean water and some way to heat this water.
- Soap.
- Bowls: 2 for washing and 1 for the placenta.
- Plastic for wrapping the placenta.
Advise on labour signs
Advise to go to the facility or contact the skilled birth attendant if any of the following signs:
■ a bloody sticky discharge.
■ painful contractions every 20 minutes or less.
■ waters have broken.

Advise on danger signs
Advise to go to the hospital/health centre immediately, day or night, WITHOUT waiting if any of the following signs:
■ vaginal bleeding.
■ convulsions.
■ severe headaches with blurred vision.
■ fever and too weak to get out of bed.
■ severe abdominal pain.
■ fast or difficult breathing.

She should go to the health centre as soon as possible if any of the following signs:
■ fever.
■ abdominal pain.
■ feels ill.
■ swelling of fingers, face, legs.

Discuss how to prepare for an emergency in pregnancy
■ Discuss emergency issues with the woman and her partner/family:
  → where will she go?
  → how will they get there?
  → how much it will cost for services and transport?
  → can she start saving straight away?
  → who will go with her for support during labour and delivery?
  → who will care for her home and other children?
■ Advise the woman to ask for help from the community, if needed.
■ Advise her to bring her home-based maternal record to the health centre, even for an emergency visit.
Advise and counsel on family planning

ADVISE AND COUNSEL ON FAMILY PLANNING

Counsel on the importance of family planning

- If appropriate, ask the woman if she would like her partner or another family member to be included in the counselling session.
- Explain that after birth, if she has sex and is not exclusively breastfeeding, she can become pregnant as soon as four weeks after delivery. Therefore it is important to start thinking early on about what family planning method they will use.
  - Ask about plans for having more children. If she (and her partner) want more children, advise that waiting at least 2-3 years between pregnancies is healthier for the mother and child.
  - Information on when to start a method after delivery will vary depending whether a woman is breastfeeding or not.
  - Make arrangements for the woman to see a family planning counsellor, or counsel her directly (see the Decision-making tool for family planning providers and clients for information on methods and on the counselling process).
- Advise on correct and consistent use of condoms for dual protection from sexually transmitted infections (STI) or HIV and pregnancy. Promote especially if at risk for STI or HIV.
- Her partner can decide to have a vasectomy (male sterilization) at any time.

Method options for the non-breastfeeding woman

<table>
<thead>
<tr>
<th>Can be used immediately postpartum</th>
<th>Lactational amenorrhoea method (LAM)</th>
</tr>
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<tbody>
<tr>
<td>Condoms</td>
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</tr>
<tr>
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<td>Delay 6 months</td>
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<td>Diaphragm</td>
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<tr>
<td>Fertility awareness methods</td>
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Special considerations for family planning counselling during pregnancy

Counselling should be given during the third trimester of pregnancy.

- If the woman chooses female sterilization:
  - can be performed immediately postpartum if no sign of infection (ideally within 7 days, or delay for 6 weeks).
  - plan for delivery in hospital or health centre where they are trained to carry out the procedure.
  - ensure counselling and informed consent prior to labour and delivery.
- If the woman chooses an intrauterine device (IUD):
  - can be inserted immediately postpartum if no sign of infection (up to 48 hours, or delay 4 weeks)
  - plan for delivery in hospital or health centre where they are trained to insert the IUD.

Method options for the breastfeeding woman

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ADVISE ON ROUTINE AND FOLLOW-UP VISITS

Encourage the woman to bring her partner or family member to at least 1 visit.

Routine antenatal care visits

<table>
<thead>
<tr>
<th>Visit</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Before 4 months</td>
</tr>
<tr>
<td>2nd</td>
<td>6 months</td>
</tr>
<tr>
<td>3rd</td>
<td>8 months</td>
</tr>
<tr>
<td>4th</td>
<td>9 months</td>
</tr>
</tbody>
</table>

- All pregnant women should have 4 routine antenatal visits.
- First antenatal contact should be as early in pregnancy as possible.
- During the last visit, inform the woman to return if she does not deliver within 2 weeks after the expected date of delivery.
- More frequent visits or different schedules may be required according to national malaria or HIV policies.

Follow-up visits

<table>
<thead>
<tr>
<th>Problem</th>
<th>Return in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>1 week if &gt;8 months pregnant</td>
</tr>
<tr>
<td>Severe anaemia</td>
<td>2 weeks</td>
</tr>
</tbody>
</table>

Advise on routine and follow-up visits
HOME DELIVERY WITHOUT A SKILLED ATTENDANT

Reinforce the importance of delivery with a skilled birth attendant

Instruct mother and family on clean and safer delivery at home

If the woman has chosen to deliver at home without a skilled attendant, review these simple instructions with the woman and family members.

- Give them a disposable delivery kit and explain how to use it.
- Tell her/them:
  - To ensure a clean delivery surface for the birth.
  - To ensure that the attendant should wash her hands with clean water and soap before/after touching mother/baby. She should also keep her nails clean.
  - To, after delivery, place the baby on the mother’s chest with skin-to-skin contact and wipe the baby’s eyes using a clean cloth for each eye.
  - To cover the mother and the baby.
  - To use the ties and razor blade from the disposable delivery kit to tie and cut the cord. The cord is cut when it stops pulsating.
  - To dry the baby after cutting the cord. To wipe clean but not bathe the baby until after 6 hours.
  - To wait for the placenta to deliver on its own.
  - To start breastfeeding when the baby shows signs of readiness, within the first hour after birth.
  - To NOT leave the mother alone for the first 24 hours.
  - To keep the mother and baby warm. To dress or wrap the baby, including the baby’s head.
  - To dispose of the placenta in a correct, safe and culturally appropriate manner (burn or bury).

Advise to avoid harmful practices

For example:
- **NOT** to use local medications to hasten labour.
- **NOT** to wait for waters to stop before going to health facility.
- **NOT** to insert any substances into the vagina during labour or after delivery.
- **NOT** to push on the abdomen during labour or delivery.
- **NOT** to pull on the cord to deliver the placenta.
- **NOT** to put ashes, cow dung or other substance on umbilical cord/stump.

Encourage helpful traditional practices:

- [ ] ____________________________
- [ ] ____________________________

Advise on danger signs

If the mother or baby has any of these signs, she/they must go to the health centre immediately, day or night, **WITHOUT waiting**

**Mother**
- Waters break and not in labour after 6 hours.
- Labour pains/contractions continue for more than 12 hours.
- Heavy bleeding after delivery (pad/cloth soaked in less than 5 minutes).
- Bleeding increases.
- Placenta not expelled 1 hour after birth of the baby.

**Baby**
- Very small.
- Difficulty in breathing.
- Fits.
- Fever.
- Feels cold.
- Bleeding.
- Not able to feed.
Childbirth: labour, delivery and immediate postpartum care

CARE OF THE MOTHER ONE HOUR AFTER DELIVERY OF PLACENTA

ASSESS THE MOTHER AFTER DELIVERY

RESPOND TO PROBLEMS IMMEDIATELY POSTPARTUM (1)
If vaginal bleeding
If fever
If perineal tear or episiotomy

RESPOND TO PROBLEMS IMMEDIATELY POSTPARTUM (2)
If elevated diastolic blood pressure

RESPOND TO PROBLEMS IMMEDIATELY POSTPARTUM (3)
If pallor on screening, check for anaemia
If mother severely ill or separated from baby
If baby stillborn or dead

GIVE PREVENTIVE MEASURES

ADVISE ON POSTPARTUM CARE
Advise on postpartum care and hygiene
Counsel on nutrition

COUNSEL ON BIRTH SPACING AND FAMILY PLANNING
Counsel on importance of family planning
Lactation and amenorrhoea method (LAM)

IMMEDIATELY POSTPARTUM

RESPOND TO PROBLEMS

ADVISE ON WHEN TO RETURN
Routine postpartum visits
Advise on danger signs
Discuss how to prepare for an emergency postpartum

HOME DELIVERY BY SKILLED ATTENDANT
Preparation for home delivery
Delivery care
Immediate postpartum care of the mother
Postpartum care of the newborn

ADVISE ON RETURN TO NORMALITY
Advise on when to return
Examine the woman in labour or with ruptured membranes
Assess the clinical situation and obstetrical history and decide the stage of labour

If an abnormal sign is identified, use the chart on Respond to obstetrical problems on admission

Care for the woman according to the stage of labour
and respond to problems during labour and delivery

Use Give supportive care throughout labour to provide support and care throughout labour and delivery

Record findings continually on labour record and partograph

Keep mother and baby in labour room for one hour after delivery and use charts Care of the mother and newborn within first hour of delivery placenta

Next use Care of the mother after the first hour following delivery of placenta to provide care until discharge. Use chart on Preventive measures and Advise on postpartum care to advise on care, danger signs, when to seek routine or emergency care, and family planning

Examine the mother for discharge using chart on

Do not discharge mother from the facility before 12 hours.

If the mother is HIV-positive or adolescent, or has special needs, see

If attending a delivery at the woman’s home, see
Examine the woman in labour or with ruptured membranes

EXAMINE THE WOMAN IN LABOUR OR WITH RUPTURED MEMBRANES
First do Rapid assessment and management. Then use this chart to assess the woman’s and fetal status and decide stage of labour.

ASK, CHECK RECORD

History of this labour:
■ When did contractions begin?
■ How frequent are contractions? How strong?
■ Have your waters broken? If yes, when? Were they clear or green?
■ Have you had any bleeding? If yes, when? How much?
■ Is the baby moving?
■ Do you have any concern?

Check record, or if no record:
■ Ask when the delivery is expected.
■ Determine if preterm (less than 8 months pregnant).
■ Review the birth plan.

If prior pregnancies:
■ Number of prior pregnancies/deliveries.
■ Any prior caesarean section, forceps, or vacuum, or other complication such as postpartum haemorrhage?
■ Any prior third degree tear?

Current pregnancy:
■ RPR status.
■ Hb results.
■ Tetanus immunization status.
■ HIV status.
■ Infant feeding plan.

LOOK, LISTEN, FEEL

■ Observe the woman’s response to contractions:
  → Is she coping well or is she distressed?
  → Is she pushing or grunting?
■ Check abdomen for:
  → caesarean section scar.
  → horizontal ridge across lower abdomen (if present, empty bladder and observe again).
■ Feel abdomen for:
  → contractions frequency, duration, any continuous contractions?
  → fetal lie—longitudinal or transverse?
  → fetal presentation—head, breech, other?
  → more than one fetus?
  → fetal movement.
■ Listen to the fetal heart beat:
  → Count number of beats in 1 minute.
  → If less than 100 beats per minute, or more than 180, turn woman on her left side and count again.
■ Measure blood pressure.
■ Measure temperature.
■ Look for pallor.
■ Look for sunken eyes, dry mouth.
■ Pinch the skin of the forearm: does it go back quickly?

NEXT: Perform vaginal examination and decide stage of labour
**DETERMINE STAGE OF LABOUR**

**ASK, CHECK RECORD**

- Explain to the woman that you will give her a vaginal examination and ask for her consent.

**LOOK, LISTEN, FEEL**

- Look at vulva for:
  - bulging perineum
  - any visible fetal parts
  - vaginal bleeding
  - leaking amniotic fluid; if yes, is it meconium stained, foul-smelling?
  - warts, keloid tissue or scars that may interfere with delivery.

Perform vaginal examination

- **DO NOT** shave the perineal area.
- Prepare:
  - clean gloves
  - swabs, pads.
- Wash hands with soap before and after each examination.
- Wash vulva and perineal areas.
- Put on gloves.
- Position the woman with legs flexed and apart.

- **DO NOT** perform vaginal examination if bleeding now or at any time after 7 months of pregnancy.

Perform gentle vaginal examination (do not start during a contraction):

- Determine cervical dilatation in centimetres.
- Feel for presenting part. Is it hard, round and smooth (the head)? If not, identify the presenting part.
- Feel for membranes - are they intact?
- Feel for cord - is it felt? Is it pulsating? If so, act immediately as on D15.

**SIGNS**

- Bulging thin perineum, vagina gaping and head visible, full cervical dilatation.
- Cervical dilatation:
  - multigravida ≥5 cm
  - primigravida ≥6 cm
- Cervical dilatation ≥4 cm.
- Cervical dilatation: 0-3 cm; contractions weak and <2 in 10 minutes.

**CLASSIFY**

- IMMINENT DELIVERY
- LATE ACTIVE LABOUR
- EARLY ACTIVE LABOUR
- NOT YET IN ACTIVE LABOUR

**MANAGE**

- See second stage of labour D10-D11.
- Record in partograph N5.
- See first stage of labour - active labour D9.
- Start plotting partograph N9.
- Record in labour record N9.
- See first stage of labour — not active labour D8.
- Record in labour record N8.

**NEXT:** Respond to obstetrical problems on admission.
### Respond to Obstetrical Problems on Admission

#### Use this chart if abnormal findings on assessing pregnancy and fetal status

<table>
<thead>
<tr>
<th>Signs</th>
<th>Classify</th>
<th>Treat and Advise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transverse lie.</td>
<td>Obstructed Labour</td>
<td>If distressed, insert an IV line and give fluids</td>
</tr>
<tr>
<td>Continuous contractions.</td>
<td></td>
<td>If in labour &gt;24 hours, give appropriate IM/IV</td>
</tr>
<tr>
<td>Constant pain between contractions.</td>
<td></td>
<td>antibiotics</td>
</tr>
<tr>
<td>Sudden and severe abdominal pain.</td>
<td></td>
<td>Refer urgently to hospital</td>
</tr>
<tr>
<td>Horizontal ridge across lower abdomen.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labour &gt;24 hours.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Signs**
  - Rupture of membranes and any of:
    - Fever >38°C
    - Foul-smelling vaginal discharge.
  - Rupture of membranes at <8 months of pregnancy.
  - Diastolic blood pressure >90 mmHg.
  - Severe palmar and conjunctival pallor and/or haemoglobin <7 g/dl.
  - Breech or other malpresentation
  - Multiple pregnancy
  - Fetal distress
  - Prolapsed cord

- **Classify**
  - Uterine and Fetal Infection
  - Risk of Uterine and Fetal Infection
  - Pre-Eclampsia
  - Severe Anaemia
  - Obstetrical Complication

- **Treat and Advise**
  - Give appropriate IM/IV antibiotics
  - If late labour, deliver and refer to hospital after delivery
  - Plan to treat newborn
  - Discontinue antibiotic for mother after delivery if no signs of infection
  - Plan to treat newborn
  - Follow specific instructions

**For all situations in red below, refer urgently to hospital if in early labour, manage only if in late labour.**

- **Signs**
  - Rupture of membranes and any of:
    - Fever >38°C
    - Foul-smelling vaginal discharge.
  - Rupture of membranes at <8 months of pregnancy.
  - Diastolic blood pressure >90 mmHg.
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  - Plan to treat newborn
  - Discontinue antibiotic for mother after delivery if no signs of infection
  - Plan to treat newborn
  - Follow specific instructions

(See page numbers in left column.)
Respond to obstetrical problems on admission

**SIGNS**
- Warts, keloid tissue that may interfere with delivery.
- Prior third degree tear.
- Bleeding any time in third trimester.
- Prior delivery by:
  - caesarean section
  - forceps or vacuum delivery
- Age less than 14 years.
- Labour before 8 completed months of pregnancy (more than one month before estimated date of delivery).
- Fetal heart rate <120 or >160 beats per minute.
- Rupture of membranes at term and before labour.
- If two or more of the following signs:
  - thirsty
  - sunken eyes
  - dry mouth
  - skin pinch goes back slowly.
- HIV test positive.
- Counselling on ARV treatment and infant feeding.
- No fetal movement, and no fetal heart beat on repeated examination.

**CLASSIFY**

**RISK OF OBSTETRICAL COMPLICATION**
- Do a generous episiotomy and carefully control delivery of the head.
- If late labour, deliver.
- Have help available during delivery.
- Reassess fetal presentation (breech more common).
- If woman is lying, encourage her to lie on her left side.
- Call for help during delivery.
- Conduct delivery very carefully as small baby may pop out suddenly. In particular, control delivery of the head.
- Prepare equipment for resuscitation of newborn.

**PRETERM LABOUR**
- Manage as on.

**POSSIBLE FETAL DISTRESS**
- Give appropriate IM/IV antibiotics if rupture of membrane >18 hours.
- Plan to treat the newborn.
- Give oral fluids.
- If not able to drink, give 1 litre IV fluids over 3 hours.

**RUPTURE OF MEMBRANES**
- Ensure that the woman takes ARV drugs as soon as labour starts.
- Support her choice of infant feeding.

**DEHYDRATION**
- Explain to the parents that the baby is not doing well.

**POSSIBLE FETAL DEATH**
- Give supportive care throughout labour.

**TREAT AND ADVISE**
- Do a generous episiotomy and carefully control delivery of the head.
- If late labour, deliver.
- Have help available during delivery.
- Reassess fetal presentation (breech more common).
- If woman is lying, encourage her to lie on her left side.
- Call for help during delivery.
- Conduct delivery very carefully as small baby may pop out suddenly. In particular, control delivery of the head.
- Prepare equipment for resuscitation of newborn.
- Manage as on.
- Give appropriate IM/IV antibiotics if rupture of membrane >18 hours.
- Plan to treat the newborn.
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- If not able to drink, give 1 litre IV fluids over 3 hours.
- Ensure that the woman takes ARV drugs as soon as labour starts.
- Support her choice of infant feeding.
- Explain to the parents that the baby is not doing well.

**CLASSIFY RISK OF OBSTETRICAL COMPLICATION**
- PRETERM LABOUR
- POSSIBLE FETAL DISTRESS
- RUPTURE OF MEMBRANES
- DEHYDRATION
- HIV-POSITIVE
- POSSIBLE FETAL DEATH
**Give supportive care throughout labour**

Use this chart to provide a supportive, encouraging atmosphere for birth, respectful of the woman’s wishes.

### Communication
- Explain all procedures, seek permission, and discuss findings with the woman.
- Keep her informed about the progress of labour.
- Praise her, encourage and reassure her that things are going well.
- Ensure and respect privacy during examinations and discussions.
- If known HIV positive, find out what she has told the companion. Respect her wishes.

### Cleanliness
- Encourage the woman to bathe or shower or wash herself and genitals at the onset of labour.
- Wash the vulva and perineal areas before each examination.
- Wash your hands with soap before and after each examination. Use clean gloves for vaginal examination.
- Ensure cleanliness of labour and birthing area(s).
- Clean up spills immediately.
- **DO NOT** give enema.

### Mobility
- Encourage the woman to walk around freely during the first stage of labour.
- Support the woman’s choice of position (left lateral, squatting, kneeling, standing supported by the companion) for each stage of labour and delivery.

### Urination
- Encourage the woman to empty her bladder frequently. Remind her every 2 hours.

### Eating, drinking
- Encourage the woman to eat and drink as she wishes throughout labour.
- Nutritious liquid drinks are important, even in late labour.
- If the woman has visible severe wasting or tires during labour, make sure she eats and drinks.

### Breathing technique
- Teach her to notice her normal breathing.
- Encourage her to breathe out more slowly, making a sighing noise, and to relax with each breath.
- If she feels dizzy, unwell, is feeling pins-and-needles (tingling) in her face, hands and feet, encourage her to breathe more slowly.
- To prevent pushing at the end of first stage of labour, teach her to pant, to breathe with an open mouth, to take in 2 short breaths followed by a long breath out.
- During delivery of the head, ask her not to push but to breathe steadily or to pant.

### Pain and discomfort relief
- Suggest change of position.
- Encourage mobility, as comfortable for her.
- Encourage companion to:
  - massage the woman’s back if she finds this helpful.
  - hold the woman’s hand and sponge her face between contractions.
- Encourage her to use the breathing technique.
- Encourage warm bath or shower, if available.
- If woman is distressed or anxious, investigate the cause \[D2-D3\].
- If pain is constant (persisting between contractions) and very severe or sudden in onset \[D4\].
Birth companion

- Encourage support from the chosen birth companion throughout labour.
- Describe to the birth companion what she or he should do:
  - Always be with the woman.
  - Encourage her.
  - Help her to breathe and relax.
  - Rub her back, wipe her brow with a wet cloth, do other supportive actions.
  - Give support using local practices which do not disturb labour or delivery.
  - Encourage woman to move around freely as she wishes and to adopt the position of her choice.
  - Encourage her to drink fluids and eat as she wishes.
  - Assist her to the toilet when needed.

- Ask the birth companion to call for help if:
  - The woman is bearing down with contractions.
  - There is vaginal bleeding.
  - She is suddenly in much more pain.
  - She loses consciousness or has fits.
  - There is any other concern.

- Tell the birth companion what she or he SHOULD NOT DO and explain why:
  - DO NOT encourage woman to push.
  - DO NOT give advice other than that given by the health worker.
  - DO NOT keep woman in bed if she wants to move around.
**FIRST STAGE OF LABOUR: NOT IN ACTIVE LABOUR**

Use this chart for care of the woman when NOT IN ACTIVE LABOUR, when cervix dilated 0-3 cm and contractions are weak, less than 2 in 10 minutes.

**MONITOR EVERY HOUR:**
- For emergency signs, using rapid assessment (RAM) [B3-B7].
- Frequency, intensity and duration of contractions.
- Fetal heart rate [D14].
- Mood and behaviour (distressed, anxious) [D6].
- Record findings regularly in Labour record and Partograph [N4-N6].
- Record time of rupture of membranes and colour of amniotic fluid.
- Give Supportive care [D6-07].
- Never leave the woman alone.

**MONITOR EVERY 4 HOURS:**
- Cervical dilatation [D3-D15].
  - Unless indicated, **DO NOT** do vaginal examination more frequently than every 4 hours.
- Temperature.
- Pulse [B3].
- Blood pressure [B23].

**ASSESS PROGRESS OF LABOUR**

- After 8 hours if:
  - Contractions stronger and more frequent but
  - No progress in cervical dilatation with or without membranes ruptured.

- After 8 hours if:
  - no increase in contractions, and
  - membranes are not ruptured, and
  - no progress in cervical dilatation.

- Cervical dilatation 4 cm or greater.

**TREAT AND ADVISE, IF REQUIRED**

- Refer the woman urgently to hospital [B17].

- Discharge the woman and advise her to return if:
  - pain/discomfort increases
  - vaginal bleeding
  - membranes rupture.

- Begin plotting the partograph [N5] and manage the woman as in Active labour [D9].
# First Stage of Labour: In Active Labour

**Use this chart when the woman is IN ACTIVE LABOUR, when cervix dilated 4 cm or more.**

## Monitor Every 30 Minutes:
- For emergency signs, using rapid assessment (RAM)
- Frequency, intensity and duration of contractions
- Fetal heart rate
- Mood and behaviour (distressed, anxious)
- Record findings regularly in Labour record and Partograph
- Record time of rupture of membranes and colour of amniotic fluid.
- Give Supportive care
- Never leave the woman alone.

## Monitor Every 4 Hours:
- Cervical dilatation
- Temperature
- Pulse
- Blood pressure

## Assess Progress of Labour
- Partograph passes to the right of ALERT LINE.
- Partograph passes to the right of ACTION LINE.
- Cervix dilated 10 cm or bulging perineum.

## Treat and Advise, If Required
- Reassess woman and consider criteria for referral.
- Call senior person if available. Alert emergency transport services.
- Encourage woman to empty bladder.
- Ensure adequate hydration but omit solid foods.
- Encourage upright position and walking if woman wishes.
- Monitor intensively. Reassess in 2 hours and refer if no progress. If referral takes a long time, refer immediately (DO NOT wait to cross action line).
- Refer urgently to hospital unless birth is imminent.
- Manage as in Second stage of labour.
SECOND STAGE OF LABOUR: DELIVER THE BABY AND GIVE IMMEDIATE NEWBORN CARE

Use this chart when cervix dilated 10 cm or bulging thin perineum and head visible.

**MONITOR EVERY 5 MINUTES:**

- For emergency signs, using rapid assessment (RAM).
- Frequency, intensity and duration of contractions.
- Fetal heart rate.
- Perineum thinning and bulging.
- Visible descent of fetal head or during contraction.
- Mood and behaviour (distressed, anxious).
- Record findings regularly in Labour record and Partograph.
- Give Supportive care.
- Never leave the woman alone.

**DELIVER THE BABY**

- Ensure all delivery equipment and supplies, including newborn resuscitation equipment, are available, and place of delivery is clean and warm (25°C).
- Ensure bladder is empty.
- Assist the woman into a comfortable position of her choice, as upright as possible.
- Stay with her and offer her emotional and physical support.
- Allow her to push as she wishes with contractions.
- Wait until head visible and perineum distending.
- Wash hands with clean water and soap. Put on gloves just before delivery.
- See Universal precautions during labour and delivery.

**TREAT AND ADVISE IF REQUIRED**

- If unable to pass urine and bladder is full, empty bladder.
- **DO NOT** let her lie flat (horizontally) on her back.
- If the woman is distressed, encourage pain discomfort relief.
- **DO NOT** urge her to push.
- If, after 30 minutes of spontaneous expulsive efforts, the perineum does not begin to thin and stretch with contractions, do a vaginal examination to confirm full dilatation of cervix.
- If cervix is not fully dilated, await second stage. Place woman on her left side and discourage pushing. Encourage breathing technique.
- If second stage lasts for 2 hours or more without visible steady descent of the head, call for staff trained to use vacuum extractor or refer urgently to hospital.
- If obvious obstruction to progress (warts/scarring/keloid tissue/previous third degree tear), do a generous episiotomy. **DO NOT** perform episiotomy routinely.
- If breech or other malpresentation, manage as on.
DELIVER THE BABY

- Ensure controlled delivery of the head:
  - Keep one hand gently on the head as it advances with contractions.
  - Support perineum with other hand and cover anus with pad held in position by side of hand during delivery.
  - Leave the perineum visible (between thumb and first finger).
  - Ask the mother to breathe steadily and not to push during delivery of the head.
  - Encourage rapid breathing with mouth open.

- Feel gently around baby’s neck for the cord.
- Check if the face is clear of mucus and membranes.

- Await spontaneous rotation of shoulders and delivery (within 1-2 minutes).
- Apply gentle downward pressure to deliver top shoulder.
- Then lift baby up, towards the mother’s abdomen to deliver lower shoulder.
- Place baby on abdomen or in mother’s arms.
- Note time of delivery.

- Thoroughly dry the baby immediately. Wipe eyes. Discard wet cloth.
- Assess baby’s breathing while drying.
- If the baby is not crying, observe breathing:
  - breathing well (chest rising)?
  - not breathing or gasping?

- Exclude second baby.
- Palpate mother’s abdomen.
- Give 10 IU oxytocin IM to the mother.
- Watch for vaginal bleeding.

- Change gloves. If not possible, wash gloved hands.
- Clamp and cut the cord.
  - put ties tightly around the cord at 2 cm and 5 cm from baby’s abdomen.
  - cut between ties with sterile instrument.
  - observe for oozing blood.

- Leave baby on the mother’s chest in skin-to-skin contact. Place identification label.
- Cover the baby, cover the head with a hat.
- Encourage initiation of breastfeeding.

TREAT AND ADVISE, IF REQUIRED

- If potentially damaging expulsive efforts, exert more pressure on perineum.
- Discard soiled pad to prevent infection.

- If cord present and loose, deliver the baby through the loop of cord or slip the cord over the baby’s head; if cord is tight, clamp and cut cord, then unwind.
- Gently wipe face clean with gauze or cloth, if necessary.

- If delay in delivery of shoulders:
  - DO NOT panic but call for help and ask companion to assist.
  - Manage as in Stuck shoulders D17.
- If placing newborn on abdomen is not acceptable, or the mother cannot hold the baby, place the baby in a clean, warm, safe place close to the mother.

- If second baby, DO NOT give oxytocin now. GET HELP.
- Deliver the second baby. Manage as in Multiple pregnancy D18.
- If blood oozing, place a second tie between the skin and the first tie.
  - DO NOT apply any substance to the stump.
  - DO NOT bandage or bind the stump.

- If room cool (less than 25°C), use additional blanket to cover the mother and baby.
- If HIV-positive mother has chosen replacement feeding, feed accordingly.
- Check ARV treatment needed G6.
**THIRD STAGE OF LABOUR: DELIVER THE PLACENTA**

Use this chart for care of the woman between birth of the baby and delivery of placenta.

**MONITOR MOTHER EVERY 5 MINUTES:**
- For emergency signs, using rapid assessment (RAM) B3-B7.
- Feel if uterus is well contracted.
- Mood and behaviour (distressed, anxious) D6.
- Time since third stage began (time since birth).
- Record findings, treatments and procedures in Labour record and Partograph (pp.N4-N6).
- Give Supportive care D6-D7.
- Never leave the woman alone.

**MONITOR BABY EVERY 15 MINUTES:**
- Breathing: listen for grunting, look for chest in-drawing and fast breathing J2.
- Warmth: check to see if feet are cold to touch J2.

**DELIVER THE PLACENTA**
- Ensure 10IU oxytocin IM is given D11.
- Await strong uterine contraction (2-3 minutes) and deliver placenta by **controlled cord traction:**
  → Place side of one hand (usually left) above symphysis pubis with palm facing towards the mother’s umbilicus. This applies counter traction to the uterus during controlled cord traction. At the same time, apply steady, sustained controlled cord traction.
  → If placenta does not descend during 30-40 seconds of controlled cord traction, release both cord traction and counter traction on the abdomen and wait until the uterus is well contracted again. Then repeat controlled cord traction with counter traction.
  → As the placenta is coming out, catch in both hands to prevent tearing of the membranes.
  → If the membranes do not slip out spontaneously gently twist them into a rope and move them up and down to assist separation without tearing them.
- Check that placenta and membranes are complete.

**TREAT AND ADVISE IF REQUIRED**
- If, after 30 minutes of giving oxytocin, the placenta is not delivered and the woman is NOT bleeding:
  → Empty bladder B12
  → Encourage breastfeeding
  → Repeat controlled cord traction.
- If woman is bleeding, manage as on B5.
- If placenta is not delivered in another 30 minutes (1 hour after delivery):
  → Remove placenta manually B11
  → Give appropriate IM/IV antibiotic B15.
- If in 1 hour unable to remove placenta:
  → Refer the woman to hospital B17
  → Insert an IV line and give fluids with 20 IU of oxytocin at 30 drops per minute during transfer B16.
  **DO NOT** exert excessive traction on the cord.
  **DO NOT** squeeze or push the uterus to deliver the placenta.
- If placenta is incomplete:
  → Remove placental fragments manually B11
  → Give appropriate IM/IV antibiotic B15.
DELIVER THE PLACENTA

- Check that uterus is well contracted and there is no heavy bleeding.
- Repeat check every 5 minutes.

- Examine perineum, lower vagina and vulva for tears.

- Collect, estimate and record blood loss throughout third stage and immediately afterwards.

- Clean the woman and the area beneath her. Put sanitary pad or folded clean cloth under her buttocks to collect blood. Help her to change clothes if necessary.

- Keep the mother and baby in delivery room for a minimum of one hour after delivery of placenta.

- Dispose of placenta in the correct, safe and culturally appropriate manner.

TREAT AND ADVISE, IF REQUIRED

- If heavy bleeding:
  - Massage uterus to expel clots if any, until it is hard
  - Give oxytocin 10 IU IM
  - Call for help.
  - Start an IV line add 20 IU of oxytocin to IV fluids and give at 60 drops per minute.
  - Empty the bladder.

- If bleeding persists and uterus is soft:
  - Continue massaging uterus until it is hard.
  - Apply bimanual or aortic compression.
  - Continue IV fluids with 20 IU of oxytocin at 30 drops per minute.
  - **Refer woman urgently to hospital.**

- If third degree tear (involving rectum or anus), **refer urgently to hospital.**
- For other tears: apply pressure over the tear with a sterile pad or gauze and put legs together.
  - **DO NOT** cross ankles.
  - Check after 5 minutes. If bleeding persists, repair the tear.
  - If blood loss ≈ 250 ml but bleeding has stopped:
    - Plan to keep the woman in the facility for 24 hours.
    - Monitor intensively (every 30 minutes) for 4 hours:
      - BP, pulse
      - vaginal bleeding
      - uterus, to make sure it is well contracted.
      - Assist the woman when she first walks after resting and recovering.
      - If not possible to observe at the facility, **refer to hospital.**

- If disposing placenta:
  - Use gloves when handling placenta.
  - Put placenta into a bag and place it into a leak-proof container.
  - Always carry placenta in a leak-proof container.
  - Incinerate the placenta or bury it at least 10 m away from a water source, in a 2 m deep pit.
### Respond to problems during labour and delivery (1)
If FHR <120 or >160 bpm

#### Respond to problems during labour and delivery

<table>
<thead>
<tr>
<th>ASK, CHECK RECORD</th>
<th>LOOK, LISTEN, FEEL</th>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position the woman on her left side.</td>
<td>If membranes have ruptured, look at vulva for prolapsed cord.</td>
<td>Cord seen at vulva.</td>
<td><strong>PROLAPSED CORD</strong></td>
<td>Manage urgently as on D15</td>
</tr>
</tbody>
</table>
| See if liquor was meconium stained. | Repeat FHR count after 15 minutes. | FHR remains >160 or <120 after 30 minutes observation. | **BABY NOT WELL** | If early labour:  
  → Refer the woman urgently to hospital B17  
  → Keep her lying on her left side.  
If late labour:  
  → Call for help during delivery  
  → Monitor after every contraction. If FHR does not return to normal in 15 minutes explain to the woman (and her companion) that the baby may not be well.  
  → Prepare for newborn resuscitation K11 |
| FHR returns to normal. | **BABY WELL** | **Monitor FHR every 15 minutes.** |
**IF PROLAPSED CORD**

The cord is visible outside the vagina or can be felt in the vagina below the presenting part.

**ASK, CHECK RECORD  LOOK, LISTEN, FEEL**

- Look at or feel the cord gently for pulsations.
- Feel for transverse lie.
- Do vaginal examination to determine status of labour.

**SIGNS**

- Transverse lie
- Cord is pulsating
- Cord is not pulsating

**CLASSIFY**

- OBSTRUCTED LABOUR
- FETUS ALIVE
- FETUS PROBABLY DEAD

**TREAT**

- Refer urgently to hospital \[\text{D17}.\]
- If early labour:
  - Push the head or presenting part out of the pelvis and hold it above the brim/pelvis with your hand on the abdomen until caesarean section is performed.
  - Instruct assistant (family, staff) to position the woman’s buttocks higher than the shoulder.
  - Refer urgently to hospital \[\text{D17}.\]
  - If transfer not possible, allow labour to continue.

- If late labour:
  - Call for additional help if possible (for mother and baby).
  - Prepare for Newborn resuscitation \[\text{K11}.\]
  - Ask the woman to assume an upright or squatting position to help progress.
  - Expedite delivery by encouraging woman to push with contraction.
  - Explain to the parents that baby may not be well.

**NEXT**: If breech presentation

Respond to problems during labour and delivery (2) ➤ If prolapsed cord
Respond to problems during labour and delivery (3) ➤ If breech presentation

### IF BREECH PRESENTATION

<table>
<thead>
<tr>
<th>LOOK, LISTEN, FEEL</th>
<th>SIGN</th>
<th>TREAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>On external examination fetal head felt in fundus.</td>
<td>If early labour</td>
<td>Refer urgently to hospital.</td>
</tr>
<tr>
<td>Soft body part (leg or buttocks) felt on vaginal examination.</td>
<td>If late labour</td>
<td>Call for additional help.</td>
</tr>
<tr>
<td>Legs or buttocks presenting at perineum.</td>
<td></td>
<td>Confirm full dilatation of the cervix by vaginal examination.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ensure bladder is empty. If unable to empty bladder see Empty bladder.</td>
</tr>
</tbody>
</table>

#### TREAT
- Deliver the baby:
  - Assist the woman into a position that will allow the baby to hang down during delivery, for example, propped up with buttocks at edge of bed or onto her hands and knees (all fours position).
  - When buttocks are distending, make an episiotomy.
  - Allow buttocks, trunk and shoulders to deliver spontaneously during contractions.
  - After delivery of the shoulders allow the baby to hang until next contraction.
- Place the baby astride your left forearm with limbs hanging on each side.
- Place the middle and index fingers of the left hand over the malar cheek bones on either side to apply gentle downwards pressure to aid flexion of head.
- Keeping the left hand as described, place the index and ring fingers of the right hand over the baby's shoulders and the middle finger on the baby's head to gently aid flexion until the hairline is visible.
- When the hairline is visible, raise the baby in upward and forward direction towards the mother's abdomen until the nose and mouth are free. The assistant gives supra pubic pressure during the period to maintain flexion.
- Feel the baby's chest for arms. If not felt:
  - Hold the baby gently with hands around each thigh and thumbs on sacrum.
  - Gently guiding the baby down, turn the baby keeping the back uppermost until the shoulder which was posterior (below) is now anterior (at the top) and the arm is released.
  - Then turn the baby back, again keeping the back uppermost to deliver the other arm.
  - Then proceed with delivery of head as described above.
- Tie a 1 kg weight to the baby's feet and await full dilatation.
- Then proceed with delivery of head as described above.

**NEVER** pull on the breech.

**DO NOT** allow the woman to push until the cervix is fully dilated. Pushing too soon may cause the head to be trapped.
### IF STUCK SHOULDERS (SHOULDER DYSTOCIA)

<table>
<thead>
<tr>
<th>SIGN</th>
<th>TREAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal head is delivered, but shoulders are stuck and cannot be delivered.</td>
<td>Call for additional help.</td>
</tr>
<tr>
<td></td>
<td>Prepare for newborn resuscitation.</td>
</tr>
<tr>
<td></td>
<td>Explain the problem to the woman and her companion.</td>
</tr>
<tr>
<td></td>
<td>Ask the woman to lie on her back while gripping her legs tightly flexed against her chest, with knees wide apart. Ask the companion or other helper to keep the legs in that position.</td>
</tr>
<tr>
<td></td>
<td>Perform an adequate episiotomy.</td>
</tr>
<tr>
<td></td>
<td>Ask an assistant to apply continuous pressure downwards, with the palm of the hand on the abdomen directly above the pubic area, while you maintain continuous downward traction on the fetal head.</td>
</tr>
<tr>
<td>If the shoulders are still not delivered and surgical help is not available immediately.</td>
<td>Remain calm and explain to the woman that you need her cooperation to try another position.</td>
</tr>
<tr>
<td></td>
<td>Assist her to adopt a kneeling on “all fours” position and ask her companion to hold her steady - this simple change of position is sometimes sufficient to dislodge the impacted shoulder and achieve delivery.</td>
</tr>
<tr>
<td></td>
<td>Introduce the right hand into the vagina along the posterior curve of the sacrum.</td>
</tr>
<tr>
<td></td>
<td>Attempt to deliver the posterior shoulder or arm using pressure from the finger of the right hand to hook the posterior shoulder and arm downwards and forwards through the vagina.</td>
</tr>
<tr>
<td></td>
<td>Complete the rest of delivery as normal.</td>
</tr>
<tr>
<td></td>
<td>If not successful, refer urgently to hospital [D17].</td>
</tr>
</tbody>
</table>

**DO NOT** pull excessively on the head.
### CHILDBIRTH: LABOUR, DELIVERY AND IMMEDIATE POSTPARTUM CARE

#### IF MULTIPLE BIRTHS

<table>
<thead>
<tr>
<th>SIGN</th>
<th>TREAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Prepare for delivery</td>
<td>■ Prepare delivery room and equipment for birth of 2 or more babies. Include:</td>
</tr>
<tr>
<td>■ Prepare for delivery</td>
<td>→ more warm cloths</td>
</tr>
<tr>
<td>■ Prepare for delivery</td>
<td>→ two sets of cord ties and razor blades</td>
</tr>
<tr>
<td>■ Prepare for delivery</td>
<td>→ resuscitation equipment for 2 babies.</td>
</tr>
<tr>
<td>■ Prepare for delivery</td>
<td>■ Arrange for a helper to assist with the births and care of the babies.</td>
</tr>
<tr>
<td>■ Second stage of labour</td>
<td>■ Deliver the first baby following the usual procedure. Resuscitate if necessary. Label her/him Twin 1.</td>
</tr>
<tr>
<td>■ Second stage of labour</td>
<td>■ Add another helper to assist with the births and care of the babies.</td>
</tr>
<tr>
<td>■ Second stage of labour</td>
<td>■ Deliver the first baby following the usual procedure. Resuscitate if necessary. Label her/him Twin 1.</td>
</tr>
<tr>
<td>■ Second stage of labour</td>
<td>■ Ask helper to attend to the first baby.</td>
</tr>
<tr>
<td>■ Second stage of labour</td>
<td>■ Palpate uterus immediately to determine the lie of the second baby. If transverse or oblique lie, gently turn the baby by abdominal manipulation to head or breech presentation.</td>
</tr>
<tr>
<td>■ Second stage of labour</td>
<td>■ Check the presentation by vaginal examination. Check the fetal heart rate.</td>
</tr>
<tr>
<td>■ Second stage of labour</td>
<td>■ Await the return of strong contractions and spontaneous rupture of the second bag of membranes, usually within 1 hour of birth of first baby but may be longer.</td>
</tr>
<tr>
<td>■ Second stage of labour</td>
<td>■ Stay with the woman and continue monitoring her and the fetal heart rate intensively.</td>
</tr>
<tr>
<td>■ Second stage of labour</td>
<td>■ Remove wet cloths from underneath her. If feeling chilled, cover her.</td>
</tr>
<tr>
<td>■ Second stage of labour</td>
<td>■ When the membranes rupture, perform vaginal examination to check for prolapsed cord. If present, see Prolapsed cord. Do not attempt to deliver the placenta until all the babies are born.</td>
</tr>
<tr>
<td>■ Second stage of labour</td>
<td>■ When strong contractions restart, ask the mother to bear down when she feels ready.</td>
</tr>
<tr>
<td>■ Second stage of labour</td>
<td>■ Deliver the second baby. Resuscitate if necessary. Label her/him Twin 2.</td>
</tr>
<tr>
<td>■ Second stage of labour</td>
<td>■ After cutting the cord, ask the helper to attend to the second baby.</td>
</tr>
<tr>
<td>■ Second stage of labour</td>
<td>■ Palpate the uterus for a third baby. If a third baby is felt, proceed as described above. If no third baby is felt, go to third stage of labour.</td>
</tr>
<tr>
<td>■ Third stage of labour</td>
<td>Do not attempt to deliver the placenta until all the babies are born.</td>
</tr>
<tr>
<td>■ Third stage of labour</td>
<td>Do not give the mother oxytocin until after the birth of all babies.</td>
</tr>
<tr>
<td>■ Third stage of labour</td>
<td>■ Give oxytocin 10 IU IM after making sure there is not another baby.</td>
</tr>
<tr>
<td>■ Third stage of labour</td>
<td>■ When the uterus is well contracted, deliver the placenta and membranes by controlled cord traction, applying traction to all cords together.</td>
</tr>
<tr>
<td>■ Third stage of labour</td>
<td>■ Before and after delivery of the placenta and membranes, observe closely for vaginal bleeding because this woman is at greater risk of postpartum haemorrhage. If bleeding, see Haemorrhage.</td>
</tr>
<tr>
<td>■ Immediate postpartum care</td>
<td>■ Monitor intensively as risk of bleeding is increased.</td>
</tr>
<tr>
<td>■ Immediate postpartum care</td>
<td>■ Provide immediate Postpartum care.</td>
</tr>
<tr>
<td>■ Immediate postpartum care</td>
<td>■ In addition:</td>
</tr>
<tr>
<td>■ Immediate postpartum care</td>
<td>→ Keep mother in health centre for longer observation</td>
</tr>
<tr>
<td>■ Immediate postpartum care</td>
<td>→ Plan to measure haemoglobin postpartum if possible</td>
</tr>
<tr>
<td>■ Immediate postpartum care</td>
<td>→ Give special support for care and feeding of babies J11 and J4.</td>
</tr>
</tbody>
</table>

**NEXT:** Care of the mother and newborn within first hour of delivery of placenta
### CARE OF THE MOTHER AND NEWBORN WITHIN FIRST HOUR OF DELIVERY OF PLACENTA

Use this chart for woman and newborn during the first hour after complete delivery of placenta.

#### MONITOR MOTHER EVERY 15 MINUTES:

- For emergency signs, using rapid assessment (RAM) [B3-B7]
- Feel if uterus is hard and round.
- Record findings, treatments and procedures in Labour record and Partograph [N4-N6]
- Keep mother and baby in delivery room - do not separate them.
- Never leave the woman and newborn alone.

#### MONITOR BABY EVERY 15 MINUTES:

- Breathing: listen for grunting, look for chest in-drawing and fast breathing [J2]
- Warmth: check to see if feet are cold to touch [J2]

#### CARE OF MOTHER AND NEWBORN

**WOMAN**

- Assess the amount of vaginal bleeding.
- Encourage the woman to eat and drink.
- Ask the companion to stay with the mother.
- Encourage the woman to pass urine.

**NEWBORN**

- Wipe the eyes.
- Apply an antimicrobial within 1 hour of birth.
  - either 1% silver nitrate drops or 2.5% povidone iodine drops or 1% tetracycline ointment.
- DO NOT wash away the eye antimicrobial.
- If blood or meconium, wipe off with wet cloth and dry.
- DO NOT remove vernix or bathe the baby.
- Continue keeping the baby warm and in skin-to-skin contact with the mother.
- Encourage the mother to initiate breastfeeding when baby shows signs of readiness. Offer her help.
- DO NOT give artificial teats or pre-lacteal feeds to the newborn: no water, sugar water, or local feeds.

**INTERVENTIONS, IF REQUIRED**

- If pad soaked in less than 5 minutes, or constant trickle of blood, manage as on [D22].
- If uterus soft, manage as on [B10].
- If bleeding from a perineal tear, repair if required [B12] or refer to hospital [B17].
- If breathing with difficulty — grunting, chest in-drawing or fast breathing, examine the baby as on [J2-J8].
- If feet are cold to touch or mother and baby are separated:
  - Ensure the room is warm. Cover mother and baby with a blanket.
  - Reassess in 1 hour. If still cold, measure temperature. If less than 36.5°C, manage as on [J2-J8].
- If breathing with difficulty — grunting, chest in-drawing or fast breathing, examine the baby as on [J2-J8].
- If unable to initiate breastfeeding (mother has complications):
  - Plan for alternative feeding method [K5-K6].
  - If mother HIV+ and chooses replacement feeding, feed accordingly [K9].
- If baby is stillborn or dead, give supportive care to mother and her family.
- Refer to hospital now if woman had serious complications at admission or during delivery but was in late labour.
Care of the mother one hour after delivery of placenta

CARE OF THE MOTHER ONE HOUR AFTER DELIVERY OF PLACENTA

Use this chart for continuous care of the mother until discharge. See J10 for care of the baby.

MONITOR MOTHER AT 2, 3 AND 4 HOURS, THEN EVERY 4 HOURS:

- For emergency signs, using rapid assessment (RAM).
- Feel uterus if hard and round.
- Record findings, treatments and procedures in Labour record and Partograph N4-N6.
- Keep the mother and baby together.
- Never leave the woman and newborn alone.
- DO NOT discharge before 12 hours.

CARE OF MOTHER

- Accompany the mother and baby to ward.
- Advise on Postpartum care and hygiene D26.
- Ensure the mother has sanitary napkins or clean material to collect vaginal blood.
- Encourage the mother to eat, drink and rest.
- Ensure the room is warm (25°C).
- Ask the mother's companion to watch her and call for help if bleeding or pain increases, if mother feels dizzy or has severe headaches, visual disturbance or epigastric distress.
- Encourage the mother to empty her bladder and ensure that she has passed urine.
- Check record and give any treatment or prophylaxis which is due.
- Advise the mother on postpartum care and nutrition D26.
- Advise when to seek care D23.
- Counsel on birth spacing and other family planning methods D27.
- Repeat examination of the mother before discharge using Assess the mother after delivery D21. For baby, see J2-J8.

INTERVENTIONS, IF REQUIRED

Make sure the woman has someone with her and they know when to call for help.

- If heavy vaginal bleeding, palpate the uterus.
  - If uterus not firm, massage the fundus to make it contract and expel any clots B8.
  - If pad is soaked in less than 5 minutes, manage as on B6.
  - If bleeding is from perineal tear, repair or refer to hospital B17.
- If the mother cannot pass urine or the bladder is full (swelling over lower abdomen) and she is uncomfortable, help her by gently pouring water on vulva.
  DO NOT catheterize unless you have to.
- If tubal ligation or IUD desired, make plans before discharge.
- If mother is on antibiotics because of rupture of membranes >18 hours but shows no signs of infection now, discontinue antibiotics.
### ASSESS THE MOTHER AFTER DELIVERY

**Use this chart to examine the mother the first time after delivery (at 1 hour after delivery or later) and for discharge.**

**For examining the newborn use the chart on J2-J8.**

### ASK, CHECK RECORD

- Check record:
  - → bleeding more than 250 ml?
  - → completeness of placenta and membranes?
  - → complications during delivery or postpartum?
  - → special treatment needs?
  - → needs tubal ligation or IUD?

- How are you feeling?
- Do you have any pains?
- Do you have any concerns?
- How is your baby?
- How do your breasts feel?

### LOOK, LISTEN, FEEL

- Measure temperature.
- Feel the uterus. Is it hard and round?
- Look for vaginal bleeding
- Look at perineum.
  - → Is there a tear or cut?
  - → Is it red, swollen or draining pus?
- Look for conjunctival pallor.
- Look for palmar pallor.

### SIGNS

- Uterus hard.
- Little bleeding.
- No perineal problem.
- No pallor.
- No fever.
- Blood pressure normal.
- Pulse normal.

### CLASSIFY

- **MOTHER WELL**
  - Keep the mother at the facility for 12 hours after delivery.
  - Ensure preventive measures D25.
  - Advise on postpartum care and hygiene D26.
  - Counsel on nutrition D26.
  - Counsel on birth spacing and family planning D27.
  - Advise on when to seek care and next routine postpartum visit D28.
  - Reassess for discharge D21.
  - Continue any treatments initiated earlier.
  - If tubal ligation desired, refer to hospital within 7 days of delivery. If IUD desired, refer to appropriate services within 48 hours.

### TREAT AND ADVISE

- Keep the mother at the facility for 12 hours after delivery.
- Ensure preventive measures D25.
- Advise on postpartum care and hygiene D26.
- Counsel on nutrition D26.
- Counsel on birth spacing and family planning D27.
- Advise on when to seek care and next routine postpartum visit D28.
- Reassess for discharge D21.
- Continue any treatments initiated earlier.
- If tubal ligation desired, refer to hospital within 7 days of delivery. If IUD desired, refer to appropriate services within 48 hours.

---

**NEXT:** Respond to problems immediately postpartum if no problems, go to page D25.

---

Assess the mother after delivery
## Respond to problems immediately postpartum (1)

### Ask, Check Record  | Look, Listen, Feel  | Signs  | Classify  | Treat and Advise

### IF VAGINAL BLEEDING
- A pad is soaked in less than 5 minutes.
- More than 1 pad soaked in 5 minutes
- Uterus not hard and not round
- See B5 for treatment.
- Refer urgently to hospital B17.

### IF FEVER (TEMPERATURE >38°C)
- Time since rupture of membranes
- Abdominal pain
- Chills
- Repeat temperature measurement after 2 hours
- If temperature is still >38°C
  - Look for abnormal vaginal discharge.
  - Listen to fetal heart rate
  - Feel lower abdomen for tenderness
- Temperature still >38°C and any of:
  - Chills
  - Foul-smelling vaginal discharge
  - Low abdomen tenderness
  - FHR remains >160 after 30 minutes of observation
  - Rupture of membranes >18 hours
- Insert an IV line and give fluids rapidly B9.
- Give appropriate IM/IV antibiotics B15.
- If baby and placenta delivered:
  - Give oxytocin 10 IU IM B10.
  - Refer woman urgently to hospital B17.
  - Assess the newborn J2-J8.
  - Treat if any sign of infection.

### IF PERINEAL TEAR OR EPISIOTOMY (DONE FOR LIFESAVING CIRCUMSTANCES)
- Is there bleeding from the tear or episiotomy
- Tear extending to anus or rectum
- Third degree tear
- Uterine and fetal infection
- Risk of uterine and fetal infection
- If bleeding persist, repair the tear or episiotomy B12.
- Encourage woman to drink plenty of fluids.
- Measure temperature every 4 hours.
- If temperature persists for >12 hours, is very high or rises rapidly, give appropriate antibiotic and refer to hospital B15.

---

**NEXT:** If elevated diastolic blood pressure
### IF ELEVATED DIASTOLIC BLOOD PRESSURE

**ASK, CHECK RECORD  LOOK, LISTEN, FEEL**

- If diastolic blood pressure is \( \geq 90 \) mmHg, repeat after 1 hour rest.
- If diastolic blood pressure is still \( \geq 90 \) mmHg, ask the woman if she has:
  - severe headache
  - blurred vision
  - epigastric pain and
  - check protein in urine.

**SIGNS**

<table>
<thead>
<tr>
<th>DIASTOLIC BLOOD PRESSURE</th>
<th>SEVERE PRE-ECLAMPSIA</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \geq 110 ) mmHg OR</td>
<td></td>
<td>Give magnesium sulphate.</td>
</tr>
<tr>
<td>( \geq 90 ) mmHg and 2+ proteinuria and any of: *</td>
<td></td>
<td>If in early labour or postpartum, refer urgently to hospital.</td>
</tr>
<tr>
<td></td>
<td>* severe headache</td>
<td>If late labour:</td>
</tr>
<tr>
<td></td>
<td>* blurred vision</td>
<td>* continue magnesium sulphate treatment.</td>
</tr>
<tr>
<td></td>
<td>* epigastric pain</td>
<td>* monitor blood pressure every hour.</td>
</tr>
<tr>
<td></td>
<td>* check protein in urine.</td>
<td>* DO NOT give ergometrine after delivery.</td>
</tr>
</tbody>
</table>

**CLASSIFY**

<table>
<thead>
<tr>
<th>DIASTOLIC BLOOD PRESSURE</th>
<th>PRE-ECLAMPSIA</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-110 mmHg on two readings.</td>
<td></td>
<td>If early labour, refer urgently to hospital.</td>
</tr>
<tr>
<td>2+ proteinuria (on admission).</td>
<td></td>
<td>If late labour:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* monitor blood pressure every hour.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* DO NOT give ergometrine after delivery.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If BP remains elevated after delivery, refer to hospital.</td>
</tr>
</tbody>
</table>

**HYPERTENSION**

<table>
<thead>
<tr>
<th>DIASTOLIC BLOOD PRESSURE</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \geq 90 ) mmHg on 2 readings.</td>
<td>Monitor blood pressure every hour.</td>
</tr>
<tr>
<td></td>
<td>DO NOT give ergometrine after delivery.</td>
</tr>
<tr>
<td></td>
<td>If blood pressure remains elevated after delivery, refer woman to hospital.</td>
</tr>
</tbody>
</table>

**NEXT:** If pallor on screening, check for anaemia

**RESPOND TO PROBLEMS IMMEDIATELY POSTPARTUM (2)**
Respond to problems immediately postpartum (3)

<table>
<thead>
<tr>
<th>ASK, CHECK RECORD</th>
<th>LOOK, LISTEN, FEEL</th>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IF PALLOR ON SCREENING, CHECK FOR ANAEMIA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Bleeding during labour, delivery or postpartum.</td>
<td>■ Measure haemoglobin, if possible.</td>
<td>■ Haemoglobin &lt;7 g/dl. AND/OR</td>
<td>■ If early labour or postpartum, refer urgently to hospital B17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Look for conjunctival pallor.</td>
<td>■ Severe palmar and conjunctival pallor or Any pallor with &gt;30 breaths per minute.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Look for palmar pallor. If pallor:</td>
<td></td>
<td>■ If late labour:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>→ Is it severe pallor?</td>
<td>■ Any bleeding.</td>
<td>→ monitor intensively</td>
<td></td>
</tr>
<tr>
<td></td>
<td>→ Some pallor?</td>
<td>■ Haemoglobin 7-11 g/dl. Palmar or conjunctival pallor.</td>
<td>→ minimize blood loss</td>
<td></td>
</tr>
<tr>
<td></td>
<td>→ Count number of breaths in 1 minute</td>
<td>■ Haemoglobin &gt;11 g/dl No pallor.</td>
<td>→ refer urgently to hospital after delivery B17</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ NO ANAEMIA</td>
<td>■ DO NOT discharge before 24 hours.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>■ Check haemoglobin after 3 days.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>■ Give double dose of iron for 3 months F3.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>■ Follow up in 4 weeks.</td>
<td></td>
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<tr>
<td><strong>IF MOTHER SEVERELY ILL OR SEPARATED FROM THE BABY</strong></td>
<td></td>
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<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>IF BABY STILLBORN OR DEAD</strong></td>
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<td></td>
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</tr>
</tbody>
</table>

**NEXT**: Give preventive measures
## GIVE PREVENTIVE MEASURES

Ensure that all are given before discharge.

### ASSESS, CHECK RECORDS
- Check RPR status in records.
- If no RPR during this pregnancy, do the RPR test.
- Check tetanus toxoid (TT) immunization status.
- Check when last dose of mebendazole was given.
- Check woman's supply of prescribed dose of iron/folate.
- Check if vitamin A given.
- Ask whether woman and baby are sleeping under insecticide treated bednet.
- Counsel and advise all women.
- Record all treatments given.

### TREAT AND ADVISE
- If RPR positive:
  - Treat woman and the partner with benzathine penicillin.
  - Treat the newborn.
- Give tetanus toxoid if due.
- Give mebendazole once in 6 months.
- Give 3 month's supply of iron and counsel on compliance.
- Give vitamin A if due.
- Encourage sleeping under insecticide treated bednet.
- Advise on postpartum care.
- Counsel on nutrition.
- Counsel on birth spacing and family planning.
- Counsel on breastfeeding.
- Counsel on correct and consistent use of condoms.
- Advise on routine and follow-up postpartum visits.
- Advise on danger signs.
- Discuss how to prepare for an emergency in postpartum.
Advise on postpartum care

Advise on postpartum care and hygiene
Advise and explain to the woman:
■ To always have someone near her for the first 24 hours to respond to any change in her condition.
■ Not to insert anything into the vagina.
■ To have enough rest and sleep.
■ The importance of washing to prevent infection of the mother and her baby:
→ wash hands before handling baby
→ wash perineum daily and after faecal excretion
→ change perineal pads every 4 to 6 hours, or more frequently if heavy lochia
→ wash used pads or dispose of them safely
→ wash the body daily
■ To avoid sexual intercourse until the perineal wound heals.

Counsel on nutrition
■ Advise the woman to eat a greater amount and variety of healthy foods, such as meat, fish, oils, nuts, seeds, cereals, beans, vegetables, cheese, milk, to help her feel well and strong (give examples of types of food and how much to eat).
■ Reassure the mother that she can eat any normal foods – these will not harm the breastfeeding baby.
■ Spend more time on nutrition counselling with very thin women and adolescents.
■ Determine if there are important taboos about foods which are nutritionally healthy.
Advise the woman against these taboos.
■ Talk to family members such as partner and mother-in-law, to encourage them to help ensure the woman eats enough and avoids hard physical work.
Counsel on birth spacing and family planning

Counsel on the importance of family planning
■ If appropriate, ask the woman if she would like her partner or another family member to be included in the counselling session.
■ Explain that after birth, if she has sex and is not exclusively breastfeeding, she can become pregnant as soon as 4 weeks after delivery. Therefore it is important to start thinking early about what family planning method they will use.
→ Ask about plans for having more children. If she (and her partner) want more children, advise that waiting at least 2-3 years between pregnancies is healthier for the mother and child.
→ Information on when to start a method after delivery will vary depending on whether a woman is breastfeeding or not.
→ Make arrangements for the woman to see a family planning counsellor, or counsel her directly (see the Decision-making tool for family planning providers and clients for information on methods and on the counselling process).
■ Advise the correct and consistent use of condoms for dual protection from sexually transmitted infection (STI) or HIV and pregnancy. Promote their use, especially if at risk for sexually transmitted infection (STI) or HIV.
■ For HIV-positive women, see for family planning considerations.
■ Her partner can decide to have a vasectomy (male sterilization) at any time.

Method options for the non-breastfeeding woman
Can be used immediately postpartum
- Condoms
- Progestogen-only oral contraceptives
- Progestogen-only injectables
- Implant
- Spermicide
- Female sterilization (within 7 days or delay 6 weeks)
- IUD (within 48 hours or delay 4 weeks)

Delay 3 weeks
- Combined oral contraceptives
- Combined injectables
- Diaphragm
- Fertility awareness methods

Delay 6 weeks
- Progestogen-only oral contraceptives
- Progestogen-only injectables
- Implants
- Diaphragm

Delay 6 months
- Combined oral contraceptives
- Combined injectables
- Fertility awareness methods

Lactational amenorrhoea method (LAM)
■ A breastfeeding woman is protected from pregnancy only if:
→ she is no more than 6 months postpartum, and
→ she is breastfeeding exclusively (8 or more times a day, including at least once at night: no daytime feedings more than 4 hours apart and no night feedings more than 6 hours apart; no complementary foods or fluids), and
→ her menstrual cycle has not returned.

■ A breastfeeding woman can also choose any other family planning method, either to use alone or together with LAM.

Method options for the breastfeeding woman
Can be used immediately postpartum
- Lactational amenorrhoea method (LAM)
- Condoms
- Spermicide
- Female sterilisation (within 7 days or delay 6 weeks)
- IUD (within 48 hours or delay 4 weeks)

Delay 6 weeks
- Progestogen-only oral contraceptives
- Progestogen-only injectables
- Implants
- Diaphragm

Delay 6 months
- Combined oral contraceptives
- Combined injectables
- Fertility awareness methods
## Routine postpartum care visits

**FIRST VISIT**
- Within the first week, preferably within 2-3 days

**SECOND VISIT**
- 4-6 weeks

## Follow-up visits for problems

<table>
<thead>
<tr>
<th>If the problem was:</th>
<th>Return in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>2 days</td>
</tr>
<tr>
<td>Lower urinary tract infection</td>
<td>2 days</td>
</tr>
<tr>
<td>Perineal infection or pain</td>
<td>2 days</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1 week</td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td>1 week</td>
</tr>
<tr>
<td>Severe anaemia</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Postpartum blues</td>
<td>2 weeks</td>
</tr>
<tr>
<td>HIV-positive</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Moderate anaemia</td>
<td>4 weeks</td>
</tr>
</tbody>
</table>

If treated in hospital for any complication: According to hospital instructions or according to national guidelines, but no later than in 2 weeks.

### Advise on danger signs

Advise to go to a hospital or health centre immediately, day or night, WITHOUT WAITING, if any of the following signs:
- Vaginal bleeding: more than 2 or 3 pads soaked in 20-30 minutes after delivery OR bleeding increases rather than decreases after delivery.
- Convulsions.
- Fast or difficult breathing.
- Fever and too weak to get out of bed.
- Severe abdominal pain.

Go to health centre as soon as possible if any of the following signs:
- Fever
- Abdominal pain
- Feels ill
- Breasts swollen, red or tender breasts, or sore nipple
- Urine dribbling or pain on micturition
- Pain in the perineum or draining pus
- Foul-smelling lochia

### Discuss how to prepare for an emergency in postpartum

- Advise to always have someone near for at least 24 hours after delivery to respond to any change in condition.
- Discuss with woman and her partner and family about emergency issues:
  - Where to go if danger signs
  - How to reach the hospital
  - Costs involved
  - Family and community support.
- Advise the woman to ask for help from the community if needed.
- Advise the woman to bring her home-based maternal record to the health centre, even for an emergency visit.
HOME DELIVERY BY SKILLED ATTENDANT

Use these instructions if you are attending delivery at home.

Preparation for home delivery

- Check emergency arrangements.
- Keep emergency transport arrangements up-to-date.
- Carry with you all essential drugs, records, and the delivery kit.
- Ensure that the family prepares, as on C18.

Delivery care

- Follow the labour and delivery procedures D2-D28, K11.
- Observe universal precautions K4.
- Give Supportive care. Involve the companion in care and support D6-D7.
- Maintain the partograph and labour record N4-N6.
- Provide newborn care B28.
- Refer to facility as soon as possible if any abnormal finding in mother or baby B17 B14.

Immediate postpartum care of mother

- Stay with the woman for first two hours after delivery of placenta C2 C13-C14.
- Examine the mother before leaving her D21.
- Advise on postpartum care, nutrition and family planning D26-D27.
- Ensure that someone will stay with the mother for the first 24 hours.

Postpartum care of newborn

- Stay until baby has had the first breastfeed and help the mother good positioning and attachment B2.
- Advise on breastfeeding and breast care B3.
- Examine the baby before leaving B12.
- Immunize the baby if possible B13.
- Advise on newborn care B2-B12.
- Advise the family about danger signs and when and where to seek care B14.
- If possible, return within a day to check the mother and baby.
- Advise a postpartum visit for the mother and baby within the first week B14.

Home delivery by skilled attendant

D29
Always begin with Rapid assessment and management (RAM) [82-87].

Next use the Postpartum examination of the mother [E2].

If an abnormal sign is identified (volunteered or observed), use the charts Respond to observed signs or volunteered problems [E3-E10].

Record all treatment given, positive findings, and the scheduled next visit in the home-based and clinic recording form.

For the first or second postpartum visit during the first week after delivery, use the Postpartum examination chart [D21] and Advise and counselling section [D26] to examine and advise the mother.

If the woman is HIV positive, adolescent or has special needs, use [G1-G8] H1-H4.
## Postpartum care

### Postpartum examination of the mother (up to 6 weeks)

Use this chart for examining the mother after discharge from a facility or after home delivery

If she delivered less than a week ago without a skilled attendant, use the chart Assess the mother after delivery D23.

<table>
<thead>
<tr>
<th>ASK, CHECK RECORD</th>
<th>LOOK, LISTEN, FEEL</th>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ When and where did you deliver?</td>
<td>▪ Measure blood pressure and temperature.</td>
<td>▪ Mother feeling well.</td>
<td>▪ Make sure woman and family know what to watch for and when to seek care D26.</td>
<td></td>
</tr>
<tr>
<td>▪ How are you feeling?</td>
<td>▪ Feel uterus. Is it hard and round?</td>
<td>▪ Did not bleed &gt;250 ml.</td>
<td>▪ Advise on Postpartum care and hygiene, and counsel on nutrition D29.</td>
<td></td>
</tr>
<tr>
<td>▪ Have you had any pain or fever or bleeding since delivery?</td>
<td>▪ Look at vulva and perineum for:</td>
<td>▪ Uterus well contracted and hard.</td>
<td>▪ Counsel on the importance of birth spacing and family planning D27.</td>
<td></td>
</tr>
<tr>
<td>▪ Do you have any problem with passing urine?</td>
<td>→ tear</td>
<td>▪ No perineal swelling.</td>
<td>Refer for family planning counselling.</td>
<td></td>
</tr>
<tr>
<td>▪ Have you decided on any contraception?</td>
<td>→ swelling</td>
<td>▪ Blood pressure, pulse and temperature normal.</td>
<td>▪ Dispense 3 months iron supply and counsel on compliance F3.</td>
<td></td>
</tr>
<tr>
<td>▪ How do your breasts feel?</td>
<td>→ pus.</td>
<td>▪ No pallor.</td>
<td>▪ Give any treatment or prophylaxis due:</td>
<td></td>
</tr>
<tr>
<td>▪ Do you have any other concerns?</td>
<td>▪ Look at pad for bleeding and lochia.</td>
<td>▪ No breast problem, is breastfeeding well.</td>
<td>→ tetanus immunization if she has not had full course F2.</td>
<td></td>
</tr>
<tr>
<td>▪ Check records:</td>
<td>→ Does it smell?</td>
<td>▪ No fever or pain or concern.</td>
<td>▪ Promote use of impregnated bednet for the mother and baby.</td>
<td></td>
</tr>
<tr>
<td>→ Receiving any treatments?</td>
<td>▪ Look for pallor.</td>
<td></td>
<td>▪ Advise to return to health centre within 4-6 weeks.</td>
<td></td>
</tr>
<tr>
<td>→ HIV status.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Normal postpartum**

- Mother feeling well.
- Did not bleed >250 ml.
- Uterus well contracted and hard.
- No perineal swelling.
- Blood pressure, pulse and temperature normal.
- No pallor.
- No breast problem, is breastfeeding well.
- No fever or pain or concern.
- No problem with urination.

**Next:** Respond to observed signs or volunteered problems
### IF ELEVATED DIASTOLIC BLOOD PRESSURE

<table>
<thead>
<tr>
<th>Ask, check record</th>
<th>Look, listen, feel</th>
<th>Signs</th>
<th>Classify</th>
<th>Treat and advise</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ History of pre-eclampsia or eclampsia in pregnancy, delivery or after delivery?</td>
<td>■ If diastolic blood pressure is ≥90 mmHg, repeat after a 1 hour rest.</td>
<td>■ Diastolic blood pressure ≥110 mmHg.</td>
<td><strong>Severe Hypertension</strong></td>
<td>■ Give appropriate antihypertensive. <strong>E14</strong>. ■ Refer urgently to hospital <strong>B17</strong>.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Diastolic blood pressure ≥90 mmHg on 2 readings.</td>
<td><strong>Moderate Hypertension</strong></td>
<td>■ Reassess in 1 week. If hypertension persists, refer to hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Diastolic blood pressure &lt;90 mmHg after 2 readings.</td>
<td><strong>Blood Pressure Normal</strong></td>
<td>■ No additional treatment.</td>
</tr>
</tbody>
</table>

**NEXT**: If pallor, check for anaemia
## Postpartum Care

### IF PALLOR, CHECK FOR ANAEMIA

**ASK, CHECK RECORD**
- Check record for bleeding in pregnancy, delivery or postpartum.
- Have you had heavy bleeding since delivery?
- Do you tire easily?
- Are you breathless (short of breath) during routine housework?

**LOOK, LISTEN, FEEL**
- Measure haemoglobin if history of bleeding.
- Look for conjunctival pallor.
- Look for palmar pallor.
  - If pallor:
    - Is it severe pallor?
    - Some pallor?
  - Count number of breaths in 1 minute.

**SIGNS**
- Haemoglobin <7 g/dl
  - AND/OR
  - Severe palmar and conjunctival pallor
  - Any pallor and any of:
    - >30 breaths per minute
    - Tires easily
    - Breathlessness at rest.

**CLASSIFY**
- SEVERE ANAEMIA
- MODERATE ANAEMIA
- NO ANAEMIA

**TREAT AND ADVISE**
- Give double dose of iron (1 tablet 60 mg twice daily for 3 months)
- Refer urgently to hospital
- Follow up in 2 weeks to check clinical progress and compliance with treatment.
- Give double dose of iron for 3 months altogether.
- Reassess at next postnatal visit (in 4 weeks). If anaemia persists, refer to hospital.
- Continue treatment with iron for 3 months altogether.

---

**NEXT:** Check for HIV status
**POSTPARTUM CARE**

**CHECK FOR HIV STATUS**

If HIV status not already discussed.

**ASK, CHECK RECORD**

- Have you ever been tested for HIV?
- If yes, do you know the result? (Explain to the woman that she has the right not to disclose the result.)
- Has her partner been tested?

**LOOK, LISTEN, FEEL**

<table>
<thead>
<tr>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known HIV-positive.</td>
<td>HIV-POSITIVE</td>
<td>Find out what she knows about HIV. Make sure she has key information on HIV G2.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advise on additional care during postpartum G4.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Counsel on the benefits of involving and testing her partner G3.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advise on correct and consistent use of condoms G2.</td>
</tr>
<tr>
<td></td>
<td>UNKNOWN HIV STATUS</td>
<td>Inform her about VCT to determine HIV status G3.</td>
</tr>
<tr>
<td>Not been tested, no HIV test results, or not willing to disclose result.</td>
<td></td>
<td>Counsel on the benefits of involving and testing her partner G3.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advise on correct and consistent use of condoms G2.</td>
</tr>
<tr>
<td>Known HIV-negative.</td>
<td>HIV-NEGATIVE</td>
<td>Find out what she knows about HIV. Make sure she has key information on HIV G2.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Counsel on the benefits of involving and testing her partner G3.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Counsel on the importance of staying negative by correct and consistent use of condoms G2.</td>
</tr>
</tbody>
</table>

**NEXT**: If heavy vaginal bleeding

Respond to observed signs or volunteered problems (3) ▶ Check for HIV status
Respond to observed signs or volunteered problems (4)

<table>
<thead>
<tr>
<th>ASK, CHECK RECORD</th>
<th>LOOK, LISTEN, FEEL</th>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
</table>

### IF HEAVY VAGINAL BLEEDING
- Have you had:
  - heavy bleeding?
  - foul-smelling lochia?
  - burning on urination?
- Feel lower abdomen and flanks for tenderness.
- Look for abnormal lochia.
- Measure temperature.
- Look or feel for stiff neck.
- Look for lethargy.
- More than 1 pad soaked in 5 minutes.
- Temperature >38°C and any of:
  - very weak
  - abdominal tenderness
  - foul-smelling lochia
  - profuse lochia
  - uterus not well contracted
  - lower abdominal pain
  - history of heavy vaginal bleeding.
- Fever >38°C and any of:
  - burning on urination
  - flank pain.
- Burning on urination.
- Temperature >38°C and any of:
  - stiff neck
  - lethargy.
- Fever >38°C.
- Give 0.2 mg ergometrine IM.
- Give appropriate IM/IV antibiotics.
- Manage as in Rapid assessment and management.
- Refer urgently to hospital.

### IF FEVER OR FOUL- SMELLING LOCHIA
- Have you had:
  - heavy bleeding?
  - foul-smelling lochia?
  - burning on urination?
- Have you had:
  - very weak
  - abdominal tenderness
  - foul-smelling lochia
  - profuse lochia
  - uterus not well contracted
  - lower abdominal pain
  - history of heavy vaginal bleeding.
- Have you had:
  - burning on urination
  - flank pain.
- Have you had:
  - stiff neck
  - lethargy.
- Have you had:
  - fever >38°C.
- Insert an IV line and give fluids rapidly.
- Give appropriate IM/IV antibiotics.
- Refer urgently to hospital.

### POSTPARTUM BLEEDING
- Insert an IV line.
- Give appropriate IM/IV antibiotics.
- Give artemether IM (or quinine IM if artemether not available) and glucose.
- Refer urgently to hospital.
- Give oral antimalarial.
- Follow up in 2 days. If no improvement, refer to hospital.

### CLASSIFY
- Postpartum bleeding
- Uterine infection
- Upper urinary tract infection
- Lower urinary tract infection
- Very severe febrile disease
- Malaria

NEXT: If dribbling urine
## POSTPARTUM CARE

### ASK, CHECK RECORD  LOOK, LISTEN, FEEL

<table>
<thead>
<tr>
<th>IF DRIBBLING URINE</th>
<th>SIGN</th>
<th>CLASSIFY</th>
<th>TREAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dribbling or leaking urine.</td>
<td>URINARY INCONTINENCE</td>
<td>Check perineal trauma.</td>
<td>Review perineal trauma.</td>
</tr>
<tr>
<td>Give appropriate oral antibiotics for lower urinary tract infection.</td>
<td></td>
<td>If conditions persists more than 1 week, refer the woman to hospital.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IF PUS OR PERINEAL PAIN</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive swelling of vulva or perineum.</td>
<td>PERINEAL TRAUMA</td>
<td>Remove sutures, if present.</td>
<td>Clean wound. Counsel on care and hygiene.</td>
</tr>
<tr>
<td>Pain in perineum.</td>
<td>PERINEAL INFECTION OR PAIN</td>
<td>Follow up in 2 days. If no improvement, refer to hospital.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IF FEELING UNHAPPY OR CRYING EASILY</th>
<th>SIGN</th>
<th>CLASSIFY</th>
<th>TREAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more of the following symptoms during the same 2 week period representing a change from normal:</td>
<td>POSTPARTUM DEPRESSION (USUALLY AFTER FIRST WEEK)</td>
<td>Provide emotional support.</td>
<td>Refer urgently the woman to hospital.</td>
</tr>
<tr>
<td>Inappropriate guilt or negative feeling towards self.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cries easily.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased interest or pleasure.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feels tired, agitated all the time.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disturbed sleep (sleeping too much or too little, waking early).</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Diminished ability to think or concentrate.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marked loss of appetite.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any of the above, for less than 2 weeks.</td>
<td>POSTPARTUM BLUES (USUALLY IN FIRST WEEK)</td>
<td>Assert the woman that this is very common.</td>
<td>Listen to her concerns. Give emotional encouragement and support.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Counsel partner and family to provide assistance to the woman.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Follow up in 2 weeks, and refer if no improvement.</td>
<td></td>
</tr>
</tbody>
</table>

---

**NEXT**: If vaginal discharge 4 weeks after delivery
**RESPOND TO OBSERVED SIGNS OR VOLUNTEERED PROBLEMS (6)**

---

**POSTPARTUM CARE**

**ASK, CHECK RECORD | LOOK, LISTEN, FEEL | SIGNS | CLASSIFY | TREAT AND ADVISE**

### IF VAGINAL DISCHARGE 4 WEEKS AFTER DELIVERY

- **ASK, CHECK RECORD**
  - Do you have itching at the vulva?
  - Has your partner had a urinary problem?

- **LOOK, LISTEN, FEEL**
  - Separate the labia and look for abnormal vaginal discharge:
    - amount
    - colour
    - odour/smell.
  - If no discharge is seen, examine with a gloved finger and look at the discharge on the glove.

- **SIGNS**
  - Abnormal vaginal discharge, and partner has urethral discharge or burning on passing urine.
  - Curd-like vaginal discharge and/or intense vulval itching.
  - Abnormal vaginal discharge.

- **CLASSIFY**
  - **POSSIBLE GONORRHOEA OR CHLAMYDIA INFECTION**
  - **POSSIBLE CANDIDA INFECTION**
  - **POSSIBLE BACTERIAL OR TRICHOMONAS INFECTION**

- **TREAT AND ADVISE**
  - Give appropriate oral antibiotics to woman.
  - Give clotrimazole.
  - Give metronidazole to woman.
  - Advise on correct and consistent use of condoms.
  - Advise on correct and consistent use of condoms.
  - If no improvement, refer the woman to hospital.

---

**IF BREAST PROBLEM**

- See [J9](#).

---

**NEXT:** If cough or breathing difficulty
**POSTPARTUM CARE**

**ASK, CHECK RECORD**

**LOOK, LISTEN, FEEL**

**IF COUGH OR BREATHING DIFFICULTY**
- How long have you been coughing?
- How long have you had difficulty in breathing?
- Do you have chest pain?
- Do you have any blood in sputum?
- Do you smoke?

- Look for breathlessness.
- Listen for wheezing.
- Measure temperature.

**SIGNS**

**CLASSIFY**

**TREAT AND ADVISE**

**POSSIBLE PNEUMONIA**
- Temperature >38º C.
- Breathlessness.
- Chest pain.

- Give first dose of appropriate IM/IV antibiotics.
- Refer urgently to hospital.

**POSSIBLE CHRONIC LUNG DISEASE**
- Cough or breathing difficulty for >3 weeks.
- Blood in sputum.
- Wheezing.

- Refer to hospital for assessment.
- If severe wheezing, refer urgently to hospital.
- Use *Practical Approach to Lung* health guidelines (PAL) for further management.

**UPPER RESPIRATORY TRACT INFECTION**
- Temperature <38º C.
- Cough for <3 weeks.

- Advise safe, soothing remedy.
- If smoking, counsel to stop smoking.

**TUBERCULOSIS**
- Taking anti-tuberculosis drugs.

- Assure the woman that the drugs are not harmful to her baby, and of the need to continue treatment.
- If her sputum is TB-positive within 2 months of delivery, plan to give INH prophylaxis to the newborn.
- Reinforce advice to go for VCT.
- If smoking, counsel to stop smoking.
- Advise to screen immediate family members and close contacts for tuberculosis.

**IF TAKING ANTI-TUBERCULOSIS DRUGS**
- Are you taking anti-tuberculosis drugs? If yes, since when?

- Taking anti-tuberculosis drugs.

**NEXT**: If signs suggesting HIV infection

**Respond to observed signs or volunteered problems (7)**
IF SIGNS SUGGESTING HIV INFECTION

HIV status unknown or known HIV-positive.

ASK, CHECK RECORD

- Have you lost weight?
- Do you have fever?
  How long (>1 month)?
- Have you got diarrhoea (continuous or intermittent)?
  How long (>1 month)?
- Have you had cough?
  How long (>1 month)?

Assess if in a high risk group:
- Occupational exposure
- Is the woman a commercial sex worker?
- Intravenous drug abuse
- History of blood transfusion.
- Illness or death from AIDS in a sexual partner.

LOOK, LISTEN, FEEL

- Look for visible wasting.
- Look for ulcers and white patches in the mouth (thrush).
- Look at the skin:
  - Is there a rash?
  - Are there blisters along the ribs on one side of the body?

SIGNs

- Two of the following:
  - weight loss
  - fever >1 month
  - diarrhoea >1 month.

OR

- One of the above signs and
  - one or more other sign or
  - from a high-risk group.

CLASSIFY

STRENGTH OF LIKELIHOOD OF HIV INFECTION

TREAT AND ADVISE

- Reinforce the need to know HIV status and advise where to go for VCT G3.
- Counsel on the benefits of testing her partner G3.
- Advise on correct and consistent use of condoms G3.
- Examine further and manage according to national HIV guidelines or refer to appropriate HIV services.
- Refer to TB centre if cough.
This section has details on preventive measures and treatments prescribed in pregnancy and postpartum.

- General principles are found in the section on good practice.
- For emergency treatment for the woman see.
- For treatment for the newborn see.

Preventive measures and additional treatments for the woman

PREVENTIVE MEASURES AND ADDITIONAL TREATMENTS FOR THE WOMAN

PREVENTIVE MEASURES (1)
- Give tetanus toxoid
- Give vitamin A postpartum

PREVENTIVE MEASURES (2)
- Give iron and folic acid
- Motivate on compliance with iron treatment
- Give mebendazole

PREVENTIVE MEASURES (3)
- Give benzathine penicillin IM
- Observe for signs of allergy

ADDITIONAL TREATMENTS FOR THE WOMAN (1)
- Give preventive intermittent treatment for falciparum malaria
- Advise to use insecticide-treated bednet
- Give paracetamol

ADDITIONAL TREATMENTS FOR THE WOMAN (2)
- Give appropriate oral antibiotics

ADDITIONAL TREATMENTS FOR THE WOMAN (3)
- Give sulfadoxine-pyrimethamine at the beginning of the second and third trimester to all women
- Give preventive intermittent treatment for malaria

Iron and folate
- Woman

Mastitis
- In pregnancy
- Postpartum and

Vaginal candida infection
- Vaginal infection
- Trichomonas or bacterial

Paracetamol
- 1 tablet = 60mg, folic acid = 400µg
- Check woman's supply of iron and folic acid at each visit and dispense 3 months supply.

Tetanus toxoid status
- Explained to the woman that the vaccine is safe to be given in pregnancy; it will not harm the baby.
- Check the woman's tetanus toxoid (TT) immunization status:
  - When was TT last given?
  - At least 1 year after TT4. TT5
  - At least 1 year after TT3. TT4
  - at first antenatal care visit, as early as possible. TT1
  - Record on mother's card.
- Advise on how to take the tablets
  - Take tablets after food or at night to avoid nausea
  - If constipated, drink more water
  - Do not worry about black stools. This is normal.
- Advise woman when next dose is due.
- If no dose in last month, give sulfadoxine-pyrimethamine, 3 tablets in clinic.
- For treatment for the newborn see.

Iron is essential for her health during pregnancy and after delivery
- Explain that these side effects are not serious
- Discuss any incorrect perceptions.
- Advise on how to take the tablets
- Do not leave the woman on her own.
- If necessary, discuss with family member, TBA, other community-based health workers or other

Preventive measures and additional treatments for the woman

F1
**PREVENTIVE MEASURES**

**Give tetanus toxoid**
- Immunize all women.
- Check the woman’s tetanus toxoid (TT) immunization status:
  - When was TT last given?
  - Which dose of TT was this?
- If immunization status unknown, give TT1.
Plan to give TT2 in 4 weeks.

**If due:**
- Explain to the woman that the vaccine is safe to be given in pregnancy; it will not harm the baby.
- The injection site may become a little swollen, red and painful, but this will go away in a few days.
- If she has heard that the injection has contraceptive effects, assure her it does not, that it only protects her from disease.
- Give 0.5 ml TT IM, upper arm.
- Advise woman when next dose is due.
- Record on mother’s card.

**Tetanus toxoid schedule**

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>At first contact with woman of childbearing age or at first antenatal care visit, as early as possible.</td>
<td>TT1</td>
</tr>
<tr>
<td>At least 4 weeks after TT1 (at next antenatal care visit).</td>
<td>TT2</td>
</tr>
<tr>
<td>At least 6 months after TT2.</td>
<td>TT3</td>
</tr>
<tr>
<td>At least 1 year after TT3.</td>
<td>TT4</td>
</tr>
<tr>
<td>At least 1 year after TT4.</td>
<td>TT5</td>
</tr>
</tbody>
</table>

**Give vitamin A postpartum**
- Give 200 000 IU vitamin A capsules after delivery or within 6 weeks of delivery.
- Explain to the woman that the capsule with vitamin A will help her to recover better, and that the baby will receive the vitamin through her breast milk.
  - Ask her to swallow the capsule in your presence.
  - Explain to her that if she feels nauseated or has a headache, it should pass in a couple of days.
- **DO NOT** give capsules with high dose of vitamin A during pregnancy.

**Vitamin A**

<table>
<thead>
<tr>
<th>Beer</th>
<th>IU</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 capsule</td>
<td>200 000 IU</td>
<td>1 capsule after delivery or within 6 weeks of delivery</td>
</tr>
</tbody>
</table>
Give iron and folic acid

To all pregnant, postpartum and post-abortion women:
- Routinely once daily in pregnancy and until 3 months after delivery or abortion.
- Twice daily as treatment for anaemia (double dose).
- Check woman’s supply of iron and folic acid at each visit and dispense 3 months supply.
- Advise to store iron safely:
  - Where children cannot get it
  - In a dry place.

Iron and folate
1 tablet = 60 mg, folic acid = 400 µg

<table>
<thead>
<tr>
<th></th>
<th>All women</th>
<th>Women with anaemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>In pregnancy</td>
<td>1 tablet</td>
<td>2 tablets</td>
</tr>
<tr>
<td>Postpartum and post-abortions</td>
<td>3 months</td>
<td>3 months</td>
</tr>
</tbody>
</table>

Give mebendazole

- Give 500 mg to every woman once in 6 months.
- DO NOT give it in the first trimester.

Mebendazole
500 mg tablet 100 mg tablet
1 tablet 5 tablets

Motivate on compliance with iron treatment

Explore local perceptions about iron treatment (examples of incorrect perceptions: making more blood will make bleeding worse, iron will cause too large a baby).
- Explain to mother and her family:
  - Iron is essential for her health during pregnancy and after delivery
  - The danger of anaemia and need for supplementation.
- Discuss any incorrect perceptions.
- Explore the mother’s concerns about the medication:
  - Has she used the tablets before?
  - Were there problems?
  - Any other concerns?
- Advise on how to take the tablets:
  - With meals or, if once daily, at night
  - Iron tablets may help the patient feel less tired. Do not stop treatment if this occurs
  - Do not worry about black stools. This is normal.
- Give advice on how to manage side-effects:
  - If constipated, drink more water
  - Take tablets after food or at night to avoid nausea
  - Explain that these side effects are not serious
  - Advise her to return if she has problems taking the iron tablets.
- If necessary, discuss with family member, TBA, other community-based health workers or other women, how to help in promoting the use of iron and folate tablets.
- Counsel on eating iron-rich foods – see D26, D28.
Give preventive intermittent treatment for falciparum malaria

- Give sulfadoxine-pyrimethamine at the beginning of the second and third trimester to all women according to national policy.
- Check when last dose of sulfadoxine-pyrimethamine given:
  - If no dose in last month, give sulfadoxine-pyrimethamine, 3 tablets in clinic.
- Advise woman when next dose is due.
- Monitor the baby for jaundice if given just before delivery.
- Record on home-based record.

Sulfadoxine pyrimethamine

1 tablet = 500 mg + 25 mg pyrimethamine sulfadoxine

<table>
<thead>
<tr>
<th>Second trimester</th>
<th>Third trimester</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 tablets</td>
<td>3 tablets</td>
</tr>
</tbody>
</table>

Advise to use insecticide-treated bednet

- Ask whether woman and newborn will be sleeping under a bednet.
- If yes,
  - Has it been dipped in insecticide?
  - When?
  - Advise to dip every 6 months.
- If not, advise to use insecticide-treated bednet, and provide information to help her do this.

Give appropriate oral antimalarial treatment

A highly effective antimalarial (even if second-line) is preferred during pregnancy:

<table>
<thead>
<tr>
<th>Chloroquine</th>
<th>Sulfadoxine + Pyrimethamine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give daily for 3 days</td>
<td>Give single dose in clinic</td>
</tr>
<tr>
<td>Tablet (130 mg base)</td>
<td>Tablet (100 mg base)</td>
</tr>
</tbody>
</table>

Pregnant woman (for weight around 50 kg)

- Day 1: 4 tablets
- Day 2: 4 tablets
- Day 3: 2 tablets
- Day 1: 6 tablets
- Day 2: 6 tablets
- Day 3: 3 tablets

Give paracetamol

If severe pain

<table>
<thead>
<tr>
<th>Paracetamol</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 tablet = 500 mg</td>
<td>1-2 tablets</td>
<td>every 4-6 hours</td>
</tr>
</tbody>
</table>
### Give appropriate oral antibiotics

<table>
<thead>
<tr>
<th>Indication</th>
<th>Antibiotic</th>
<th>Dose</th>
<th>Frequency</th>
<th>Duration</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mastitis</strong></td>
<td>CLOXACILLIN</td>
<td>500 mg</td>
<td>every 6 hours</td>
<td>10 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 capsule (500 mg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lower urinary tract infection</strong></td>
<td>AMOXICILLIN</td>
<td>500 mg</td>
<td>every 8 hours</td>
<td>3 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 tablet (500 mg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OR TRIMETHOPRIM+SULPHAMETHOXAZOLE</td>
<td>80 mg trimethoprim + 400 mg sulphamethoxazole</td>
<td>two tablets every 12 hours</td>
<td>3 days</td>
<td>Avoid in late pregnancy and two weeks after delivery when breastfeeding.</td>
</tr>
<tr>
<td></td>
<td>1 tablet (80 mg + 400 mg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gonorrhoea</strong></td>
<td>CEFTRIAXONE</td>
<td>250 mg IM injection</td>
<td>once only</td>
<td>once only</td>
<td></td>
</tr>
<tr>
<td><strong>Woman</strong></td>
<td>CIPROFLOXACIN</td>
<td>500 mg (2 tablets)</td>
<td>once only</td>
<td>once only</td>
<td></td>
</tr>
<tr>
<td><strong>Partner only</strong></td>
<td>ERYTHROMYCIN</td>
<td>500 mg (2 tablets)</td>
<td>every 6 hours</td>
<td>7 days</td>
<td></td>
</tr>
<tr>
<td><strong>Chlamydia</strong></td>
<td>1 tablet=250 mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Woman</strong></td>
<td>TETRACYCLINE</td>
<td>500 mg (2 tablets)</td>
<td>every 6 hours</td>
<td>7 days</td>
<td></td>
</tr>
<tr>
<td><strong>Partner only</strong></td>
<td>OR DOXYCYCLINE</td>
<td>100 mg every 12 hours</td>
<td></td>
<td>7 days</td>
<td></td>
</tr>
<tr>
<td><strong>Trichomonas or bacterial vaginal infection</strong></td>
<td>METRONIDAZOLE</td>
<td>2 g or 500 mg</td>
<td>once only every 12 hours</td>
<td>once only</td>
<td>Do not use in the first trimester of pregnancy.</td>
</tr>
<tr>
<td><strong>Vaginal candida infection</strong></td>
<td>CLOTRIMazole</td>
<td>200 mg or 500 mg</td>
<td>every night</td>
<td>3 days</td>
<td></td>
</tr>
<tr>
<td><strong>Additional treatments for the woman</strong></td>
<td>1 pessary 200 mg or 500 mg</td>
<td></td>
<td></td>
<td></td>
<td>Teach the woman how to insert a pessary into vagina and to wash hands before and after each application.</td>
</tr>
</tbody>
</table>
**Additional treatments for the woman (3) ▶ Give benzathine penicillin IM**

**GIVE BENZATHINE PENICILLIN IM**

Treat the partner. Rule out history of allergy to antibiotics.

<table>
<thead>
<tr>
<th>INDICATION</th>
<th>ANTIBIOTIC</th>
<th>DOSE</th>
<th>FREQUENCY</th>
<th>DURATION</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis RPR test positive</td>
<td>BENZATHINE PENICILLIN IM (2.4 million units in 5 ml)</td>
<td>2.4 million units IM injection</td>
<td>once only</td>
<td>once only</td>
<td>Give as two IM injections at separate sites. Plan to treat newborn. Counsel on correct and consistent use of condoms.</td>
</tr>
<tr>
<td>If woman has allergy to penicillin</td>
<td>ERYTHROMYCIN (1 tablet = 250 mg)</td>
<td>500 mg (2 tablets)</td>
<td>every 6 hours</td>
<td>15 days</td>
<td></td>
</tr>
<tr>
<td>If partner has allergy to penicillin</td>
<td>TETRACYCLINE (1 tablet = 250 mg) OR DOXYCYCLINE (1 tablet = 100 mg)</td>
<td>500 mg (2 tablets)</td>
<td>every 6 hours</td>
<td>15 days</td>
<td>Not safe for pregnant or lactating woman.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100 mg</td>
<td>every 12 hours</td>
<td>15 days</td>
<td></td>
</tr>
</tbody>
</table>

**OBSERVE FOR SIGNS OF ALLERGY**

After giving penicillin injection, keep the woman for a few minutes and observe for signs of allergy.

<table>
<thead>
<tr>
<th>ASK, CHECK RECORD</th>
<th>LOOK, LISTEN, FEEL</th>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>How are you feeling?</td>
<td>Look at the face, neck and tongue for swelling. Look at the skin for rash or hives. Look at the injection site for swelling and redness. Look for difficult breathing. Listen for wheezing.</td>
<td>Any of these signs: Tightness in the chest and throat. Feeling dizzy and confused. Swelling of the face, neck and tongue. Injection site swollen and red. Rash or hives. Difficult breathing or wheezing.</td>
<td>ALLERGY TO PENICILLIN</td>
<td>▶ Open the airway. Insert IV line and give fluids. Give 0.5 ml adrenaline 1:1000 in 10 ml saline solution IV slowly. Repeat in 5-15 minutes, if required. DO NOT leave the woman on her own. Refer urgently to hospital.</td>
</tr>
<tr>
<td>Do you feel tightness in the chest and throat?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel dizzy and confused?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
INFORM AND COUNSEL ON HIV

Inform and counsel on HIV

IF THE MOTHER CHOOSES ANTIRETROVIRAL PROPHYLACTIC TREATMENT TO PREVENT MOTHER-TO-CHILD TRANSMISSION IS A POLICY, GIVE TREATMENT ACCORDING TO THAT POLICY.

■ INFORM AND COUNSEL ON HIV
■ PROVIDE KEY INFORMATION ON HIV
■ VOLUNTARY COUNSELLING AND TESTING (VCT)
■ CARE AND COUNSELLING ON FAMILY PLANNING
■ SUPPORT TO THE HIV-POSITIVE WOMAN
■ PREVENT MOTHER-TO-CHILD TRANSMISSION OF HIV
■ COUNSEL ON INFANT FEEDING CHOICE
■ USE THIS SECTION WHEN ACCURATE INFORMATION ON HIV MUST BE GIVEN TO THE WOMAN AND HER FAMILY.
■ PROVIDE KEY INFORMATION ON HIV TO ALL WOMEN AND EXPLAIN AT THE FIRST ANTENATAL CARE VISIT HOW HIV IS TRANSMITTED AND THE ADVANTAGES OF KNOWING THE HIV STATUS IN PREGNANCY.
■ IF THE WOMAN IS HIV-POSITIVE (AND WILLING TO DISCLOSE THE RESULTS):
  • PROVIDE ADDITIONAL CARE DURING PREGNANCY, CHILDBIRTH AND POSTPARTUM.
  • GIVE ANY PARTICULAR SUPPORT THAT SHE MAY REQUIRE.
  • IF ANTIRETROVIRAL PROPHYLACTIC TREATMENT TO PREVENT MOTHER-TO-CHILD TRANSMISSION IS A POLICY, GIVE TREATMENT ACCORDING TO THAT POLICY.
  • IF A TRAINED COUNSELLOR ON INFANT FEEDING IS NOT AVAILABLE, ADVISE THE WOMAN ABOUT THE CHOICES.
  • IF THE WOMAN IS HIV-POSITIVE, COUNSEL HER AND SUPPORT THE INFANT FEEDING SHE HAS CHosen - REPLACEMENT FEEDING OR BREASTFEEDING.
  • COUNSEL ALL WOMEN ON CORRECT AND CONSISTENT USE OF CONDOMS DURING AND AFTER PREGNANCY.

WHAT IS HIV AND HOW IS HIV TRANSMITTED?
Advantage of knowing the HIV status in pregnancy
Counsel on correct and consistent use of condoms

VOLUNTARY COUNSELLING AND TESTING (VCT)
Voluntary counselling and testing services
Discuss confidentiality of the result
Implications of test result
Benefits of involving and testing the male partner(s)

CARE AND COUNSELLING ON FAMILY PLANNING
Additional care for the HIV-positive woman
Counsel the HIV-positive woman on family planning

SUPPORT TO THE HIV-POSITIVE WOMAN
Provide emotional support to the woman
How to provide support

PREVENT MOTHER-TO-CHILD TRANSMISSION OF HIV
Give antiretroviral drug to prevent MTCT
Antiretroviral drugs for MTCT of HIV

COUNSEL ON INFANT FEEDING CHOICE
Explain the risks of HIV transmission through breastfeeding and not breastfeeding
If a woman has unknown or negative HIV status
If a woman knows and accepts that she is HIV-positive

EXPLAIN TO HER THAT TO RECEIVE ARV PROPHYLACTIC TREATMENT, SHE MUST:
■ PROTECT HER SEXUAL PARTNER(S) FROM INFECTION.
■ GET APPROPRIATE MEDICAL CARE AND INTERVENTIONS TO TREAT AND/OR PREVENT HIV-ASSOCIATED ILLNESSES.
■ KNOWING THE HIV STATUS DURING PREGNANCY IS IMPORTANT SO THAT THE WOMAN CAN:
  • A SPECIAL BLOOD TEST IS DONE TO FIND OUT IF THE PERSON IS INFECTED WITH HIV.
  • EXPLAIN TO HER THE RISKS OF HIV TRANSMISSION.
  • COUNSEL ON THE NEED TO KNOW THE HIV STATUS AND WHERE TO GO FOR VCT.
  • ENCOURAGE EXCLUSIVE BREASTFEEDING.
  • COUNSEL ON THE IMPORTANCE OF EXCLUSIVE BREASTFEEDING.
  • CONNECT HER WITH OTHER EXISTING SUPPORT SERVICES INCLUDING SUPPORT GROUPS, INCOME-GENERATING RESPONSIBILITY, TO IDENTIFY A FIGURE FROM THE COMMUNITY WHO WILL SUPPORT AND CARE FOR HER.
  • EXPLAIN ABOUT VCT SERVICES:
    • HOW THE TEST IS PERFORMED.
    • THE RISKS OF REPLACEMENT FEEDING.
    • HOW THE MOTHER CAN HELP TO INCREASE SUPPORT TO THEIR PARTNER.
    • HOW THE MOTHER CAN HELP TO DECREASE THE RISK OF SUSPICION AND VIOLENCE.

IF THE WOMAN IS HIV-NEGATIVE OR RESULT IS UNKNOWN:
Use the advice and counselling sections on during antenatal care and during postpartum.
Counsel the HIV-positive woman on family planning.

SAFER SEX IS ANY SEXUAL PRACTICE THAT REDUCES THE RISK OF TRANSMITTING HIV AND HEALTHIER FOR HER AND THE BABY.

IF THE TEST RESULT IS NEGATIVE:
■ ASSURE THE WOMAN THAT HER TEST RESULT IS CONFIDENTIAL.
■ DISCUSS CONFIDENTIALITY OF THE RESULT.
■ HOW THE RESULT IS PERFORMED.
■ EXPLAIN THE RISKS OF REPLACEMENT FEEDING.
■ EXPLAIN THE BENEFITS OF USING A FAMILY PLANNING METHOD.
■ REVISE THE BIRTH PLAN.
■ HELD OUTSIDE THE CLINIC IN ORDER TO NOT REVEAL THE HIV STATUS OF THE WOMAN INVOLVED.
■ GIVE SPECIAL COUNSELLING TO THE MOTHER WHO IS HIV-POSITIVE AND CHOOSES BREASTFEEDING.

IF THE WOMAN HAS NOT BEEN TESTED OR DOES NOT DISCLOSE THE RESULT:
If the woman is HIV-positive, and willing to disclose the results:
  • PROVIDE ADDITIONAL CARE DURING PREGNANCY, CHILDBIRTH AND POSTPARTUM.
  • GIVE ANY PARTICULAR SUPPORT THAT SHE MAY REQUIRE.
  • IF ANTIRETROVIRAL PROPHYLACTIC TREATMENT TO PREVENT MOTHER-TO-CHILD TRANSMISSION IS A POLICY, GIVE TREATMENT ACCORDING TO THAT POLICY.
  • IF A TRAINED COUNSELLOR ON INFANT FEEDING IS NOT AVAILABLE, ADVISE THE WOMAN ABOUT THE CHOICES.
  • IF THE WOMAN IS HIV-POSITIVE, COUNSEL HER AND SUPPORT THE INFANT FEEDING SHE HAS CHOSEN - REPLACEMENT FEEDING OR BREASTFEEDING.
  • COUNSEL ALL WOMEN ON CORRECT AND CONSISTENT USE OF CONDOMS DURING AND AFTER PREGNANCY.

EXPLAIN TO HER THAT TO RECEIVE ARV PROPHYLACTIC TREATMENT, SHE MUST:
■ PROTECT HER SEXUAL PARTNER(S) FROM INFECTION.
■ GET APPROPRIATE MEDICAL CARE AND INTERVENTIONS TO TREAT AND/OR PREVENT HIV-ASSOCIATED ILLNESSES.
■ KNOWING THE HIV STATUS DURING PREGNANCY IS IMPORTANT SO THAT THE WOMAN CAN:
  • A SPECIAL BLOOD TEST IS DONE TO FIND OUT IF THE PERSON IS INFECTED WITH HIV.
  • EXPLAIN TO HER THE RISKS OF HIV TRANSMISSION.
  • COUNSEL ON THE NEED TO KNOW THE HIV STATUS AND WHERE TO GO FOR VCT.
  • ENCOURAGE EXCLUSIVE BREASTFEEDING.
  • COUNSEL ON THE IMPORTANCE OF EXCLUSIVE BREASTFEEDING.
  • CONNECT HER WITH OTHER EXISTING SUPPORT SERVICES INCLUDING SUPPORT GROUPS, INCOME-GENERATING RESPONSIBILITY, TO IDENTIFY A FIGURE FROM THE COMMUNITY WHO WILL SUPPORT AND CARE FOR HER.
  • EXPLAIN ABOUT VCT SERVICES:
    • HOW THE TEST IS PERFORMED.
    • THE RISKS OF REPLACEMENT FEEDING.
    • HOW THE MOTHER CAN HELP TO INCREASE SUPPORT TO THEIR PARTNER.
    • HOW THE MOTHER CAN HELP TO DECREASE THE RISK OF SUSPICION AND VIOLENCE.

IF THE WOMAN IS HIV-NEGATIVE OR RESULT IS UNKNOWN:
Use the advice and counselling sections on during antenatal care and during postpartum.
Counsel the HIV-positive woman on family planning.

SAFER SEX IS ANY SEXUAL PRACTICE THAT REDUCES THE RISK OF TRANSMITTING HIV AND HEALTHIER FOR HER AND THE BABY.

IF THE TEST RESULT IS NEGATIVE:
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■ DISCUSS CONFIDENTIALITY OF THE RESULT.
■ HOW THE RESULT IS PERFORMED.
■ EXPLAIN THE RISKS OF REPLACEMENT FEEDING.
■ EXPLAIN THE BENEFITS OF USING A FAMILY PLANNING METHOD.
■ REVISE THE BIRTH PLAN.
■ HELD OUTSIDE THE CLINIC IN ORDER TO NOT REVEAL THE HIV STATUS OF THE WOMAN INVOLVED.
■ GIVE SPECIAL COUNSELLING TO THE MOTHER WHO IS HIV-POSITIVE AND CHOOSES BREASTFEEDING.

IF THE WOMAN HAS NOT BEEN TESTED OR DOES NOT DISCLOSE THE RESULT:
If the woman is HIV-positive, and willing to disclose the results:
  • PROVIDE ADDITIONAL CARE DURING PREGNANCY, CHILDBIRTH AND POSTPARTUM.
  • GIVE ANY PARTICULAR SUPPORT THAT SHE MAY REQUIRE.
  • IF ANTIRETROVIRAL PROPHYLACTIC TREATMENT TO PREVENT MOTHER-TO-CHILD TRANSMISSION IS A POLICY, GIVE TREATMENT ACCORDING TO THAT POLICY.
  • IF A TRAINED COUNSELLOR ON INFANT FEEDING IS NOT AVAILABLE, ADVISE THE WOMAN ABOUT THE CHOICES.
  • IF THE WOMAN IS HIV-POSITIVE, COUNSEL HER AND SUPPORT THE INFANT FEEDING SHE HAS CHOSEN - REPLACEMENT FEEDING OR BREASTFEEDING.
  • COUNSEL ALL WOMEN ON CORRECT AND CONSISTENT USE OF CONDOMS DURING AND AFTER PREGNANCY.
PROVIDE KEY INFORMATION ON HIV

What is HIV (human immunodeficiency virus) and how is HIV transmitted?

■ HIV is a virus that destroys parts of the body's immune system. A person infected with HIV may not feel sick at first, but slowly the body's immune system is destroyed. The person becomes ill and unable to fight infection. Once a person is infected with HIV, she or he can give the virus to others.

■ HIV can be transmitted through:
  → Exchange of HIV-infected body fluids such as semen, vaginal fluid or blood during unprotected sexual intercourse.
  → HIV-infected blood transfusions or contaminated needles.
  → Sharing of instruments and needles for drug abuse or tattoos.
  → From an infected mother to her child (MTCT) during:
    → pregnancy
    → labour and delivery
    → postpartum through breastfeeding.

■ HIV cannot be transmitted through hugging or mosquito bites.

A special blood test is done to find out if the person is infected with HIV.

Advantage of knowing the HIV status in pregnancy

Knowing the HIV status during pregnancy is important so that the woman can:

■ get appropriate medical care and interventions to treat and/or prevent HIV-associated illnesses.

■ reduce the risk of transmission of infection to the baby:
  → by taking antiretroviral drugs such as AZT in pregnancy, or niverapine during labour.
  → by adapting infant feeding practices.
  → by adapting birth plan and delivery practices.

■ protect her sexual partner(s) from infection.

■ make a choice about future pregnancies.

Counsel on correct and consistent use of condoms

SAFER SEX IS ANY SEXUAL PRACTICE THAT REDUCES THE RISK OF TRANSMITTING HIV AND SEXUALLY TRANSMITTED INFECTIONS (STIs) FROM ONE PERSON TO ANOTHER

THE BEST PROTECTION IS OBTAINED BY:

■ Correct and consistent use of condoms during every sexual act.

■ Choosing sexual activities that do not allow semen, fluid from the vagina, or blood to enter the mouth, anus or vagina of the partner, or to touch the skin of the partner where there is an open cut or sore.

IF THE WOMAN IS HIV-POSITIVE:

■ Explain to the woman that she is infected and can transmit the infection to her partner. They should use a condom during every sexual act.

■ Explain the importance of avoiding reinfection during pregnancy and breastfeeding. The risk of infecting the baby is higher if the mother is reinfeeted.

■ If her partner's status is unknown, counsel her on the benefits of testing her partner.

IF THE WOMAN IS HIV-NEGATIVE OR RESULT IS UNKNOWN:

■ Explain to her that she is at risk of HIV and that it is important to remain negative during pregnancy and breastfeeding. The risk of infecting the baby is higher if the mother is newly infected.

■ If her partner's status is unknown, counsel her on the benefits of testing her partner.

■ Make sure she knows how to use condoms and where to get them.
Voluntary counselling and testing (VCT) services

Explain about VCT services:
- VCT is used to determine the HIV status of an individual.
- Testing is voluntary. The woman has a right to refuse.
- VCT provides an opportunity to learn and accept the HIV status in a confidential environment.
- VCT includes pre-test counselling, blood testing and post-test counselling.

If VCT is available in your setting and you are trained to do VCT, use national HIV guidelines to provide:
- Pre-test counselling.
- Post-test counselling.
- Infant feeding counselling.

If VCT is not available in your setting, inform the woman about:
- Where to go.
- How the test is performed.
- How confidentiality is maintained.
- When and how results are given.
- Costs involved.
- Address of VCT service in your area:

Discuss confidentiality of the result:
- Assure the woman that her test result is confidential.
- Her result will be shared only with herself and any individual chosen by her.
- She has a right not to disclose her results.

Implications of test result
- Although the woman will have been counselled at the VCT site, she may need further counselling and support from the health worker who referred her for testing.
- Ask the woman if she is willing to disclose the result. Reassure her that you will keep the result confidential.

IF TEST RESULT IS POSITIVE:
- Explain to the woman that a positive test result means that she is carrying the infection and has a (40%) possibility of transmitting the infection to her unborn child without any intervention.

IF TEST RESULT IS NEGATIVE:
- Explain to the woman that a negative result can mean either that she is not infected with HIV, or that she is infected with HIV but has not yet made antibodies against the virus (this is sometimes called the “window” period). Repeat HIV-testing can be offered after 3 months.
- Counsel on the importance of staying negative by correct and consistent use of condoms.

IF THE WOMAN HAS NOT BEEN TESTED OR DOES NOT DISCLOSE THE RESULT:
- Assure her that you would keep the result confidential if she were to disclose it.
- Reinforce the importance of testing and the benefits of knowing the result.

Benefits of involving and testing the male partner(s)
- Men are generally the decision-makers in the family and community. Involving them will:
  - Have greater impact on the increasing acceptance of condom use and practice of safer sex to avoid infection or unwanted pregnancy.
  - Help to decrease the risk of suspicion and violence.
  - Help to increase support to their partners.
  - Encourage the woman to motivate her partner(s) to be tested.
Additional care for the HIV-positive woman

- Determine how much the woman has told her partner, labour companion and family, then respect this confidentiality.
- Be sensitive to her special concerns and fears. Give psychosocial support.
- Advise on the importance of good nutrition.
- Use universal precautions as for all women.
- Advise her that she is more prone to infections and should seek medical help as soon as possible if she has:
  - fever
  - persistent diarrhoea
  - cold and cough — respiratory infections
  - burning urination
  - vaginal itching/foul-smelling discharge
  - severe weight loss
  - skin infections
  - foul-smelling lochia.

DURING PREGNANCY:

- Revise the birth plan.
  - Advise her to deliver in a facility.
  - Advise her to go to a facility as soon as her membranes rupture or labour starts.
- Counsel her on antiretroviral prophylactic treatment.
- Discuss the infant feeding plan.
- Modify preventive treatment for malaria, according to national strategy.
- Use universal precautions as for all women.

DURING THE POSTPARTUM PERIOD:

- Tell her that lochia can cause infection in other people and therefore she should dispose of blood-stained sanitary pads safely (list local options).
- If not breastfeeding exclusively, advise her to use a family planning method immediately.
- If not breastfeeding, advise her on breast care.

Counsel the HIV-positive woman on family planning

- Use the advice and counselling sections on during antenatal care and during postpartum visits. The following advice should be highlighted:
  - Explain to the woman that future pregnancies can have significant health risks for her and her baby. These include: transmission of HIV to the baby (during pregnancy, delivery or breastfeeding), miscarriage, preterm labour, stillbirth, low birth weight, ectopic pregnancy and other complications.
  - If she wants more children, advise her that waiting at least 2-3 years between pregnancies is healthier for her and the baby.
  - A family planning method needs to be chosen to protect from pregnancy and from infection with other sexually transmitted infections (STI) or HIV re-infection, and prevent transmission of STI or HIV to her partner. Condoms are the best option for the woman with HIV.
- Advise the woman on correct and consistent use of condoms.
- With the condom, another family planning method can be used for additional protection against pregnancy. However, not all methods are appropriate for the HIV-positive woman:
  - Given the woman’s HIV status, she may not choose to exclusively breastfeed, and lactational amenorrhoea method (LAM) may not be a suitable method.
  - Intrauterine device (IUD) use is only recommended if other methods are not available or acceptable.
  - Fertility awareness methods may be difficult if the woman has AIDS or is on treatment for HIV infections due to changes in the menstrual cycle and elevated temperatures.
  - If the woman is taking pills for tuberculosis (rifampin), she usually cannot use contraceptive pills, monthly injectables or implants.

The family planning counsellor will provide more information.
**SUPPORT TO THE HIV-POSITIVE WOMAN**

Pregnant women who are HIV-positive benefit greatly from the following support after the first impact of the test result has been overcome. Special training is required to counsel HIV-positive women and this guide does not substitute for special training. However, if a trained counsellor is not available or the woman will not seek the help of a trained counsellor, advise her as follows:

### Provide emotional support to the woman

- Empathize with her concerns and fears.
- Use good counselling skills.
- Help her to assess her situation and decide which is the best option for her, her (unborn) child and her sexual partner. Support her choice.
- Connect her with other existing support services including support groups, income-generating activities, religious support groups, orphan care, home care.
- Help her to find ways to involve her partner and/or extended family members in sharing responsibility, to identify a figure from the community who will support and care for her.
- Discuss how to provide for the other children and help her identify a figure from the extended family or community who will support her children.
- Confirm and support information given during VCT on mother-to-child transmission, the possibility of ARV treatment, safer sex, infant feeding and family planning advice (help her to absorb the information and apply it in her own case).
- If the woman has signs of AIDS and/or of terminal illness, respond. Refer her to appropriate services.

### How to provide support

- Conduct peer support groups for women who have tested HIV-positive and couples affected by HIV/AIDS:
  - Led by a social worker and/or woman who has come to terms with her own HIV-positive status.
  - Held outside the clinic in order to not reveal the HIV status of the woman involved.
- Establish and maintain constant linkages with other health, social and community workers support services:
  - To exchange information for the coordination of interventions
  - To make a plan for each family involved.
- Refer individuals or couples for counselling by community counsellors.
Prevent mother-to-child transmission of HIV

**PREVENT MOTHER-TO-CHILD TRANSMISSION (MTCT) OF HIV**

Give antiretroviral (ARV) drug to prevent mother-to-child transmission (MTCT) of HIV

- Explain to the pregnant woman that the drug has been shown to greatly reduce the risk of infection of the baby.
- Explain to her that to receive ARV prophylactic treatment, she must:
  - attend antenatal care regularly
  - know her HIV status
  - be counselled on infant feeding
  - deliver with a skilled attendant preferably in a hospital
  - be able and willing to take drugs as prescribed.
- If treatment with zidovudine (ZDV, AZT) is planned:
  - obtain a haemoglobin determination early; if less than 8 g/dl, treat anaemia urgently and remeasure to assure adequate level for treatment.
  - determine when woman will be at 36 weeks gestation and explain to her when to start treatment.
- Supply her with enough tablets for the beginning of labour, in case of any delay in reaching the hospital or clinic.
- Tell her to take the labour dose of the drug as soon as labour starts and show her how to take it.

**Antiretroviral drugs for prevention of MTCT of HIV (give according to national policy)**

<table>
<thead>
<tr>
<th>Drug</th>
<th>When to give</th>
<th>Dose</th>
<th>Frequency</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zidovudine</td>
<td>From 36 weeks of pregnancy till onset of labour</td>
<td>300 mg (1 tablet)</td>
<td>every 12 hours</td>
<td>No treatment for the baby.</td>
</tr>
<tr>
<td>1 tablet = 300 mg</td>
<td>From onset of labour to delivery</td>
<td>300 mg (1 tablet)</td>
<td>every 3 hours</td>
<td></td>
</tr>
<tr>
<td>OR Nevirapine</td>
<td>For woman: as early as possible in labour</td>
<td>200 mg (1 tablet)</td>
<td>once only</td>
<td>If she vomits within first hour, repeat dose</td>
</tr>
<tr>
<td>1 tablet = 200 mg (woman)</td>
<td>For newborn: Give within 72 hours of birth (before discharge from facility)</td>
<td>2 mg/kg (2 kg baby: 0.4 ml) (3 kg baby: 0.6 ml)</td>
<td>once only</td>
<td>If mother received nevirapine less than 1 hour before delivery, give the treatment to the newborn soon after birth.</td>
</tr>
</tbody>
</table>
COUNSEL ON INFANT FEEDING CHOICE

Special training is required to counsel an HIV-positive mother about infant feeding choices and to support her chosen method. This guide does not substitute for special training. HIV-positive women should be referred to a health worker trained in infant-feeding counselling. However, if a trained counsellor is not available, or the woman will not seek the help of a trained counsellor, counsel her as follows.

Explain the risks of HIV transmission through breastfeeding and not breastfeeding

- Five out of 20 babies born to known HIV-positive mothers will be infected during pregnancy and delivery without ARV medication. Three more may be infected by breastfeeding.
- The risk may be reduced if the baby is breastfed exclusively using good technique, so that the breasts stay healthy.
- Mastitis and nipple fissures increase the risk that the baby will be infected.
- The risk of not breastfeeding may be much higher because replacement feeding carries risks too:
  - diarrhoea because of contamination from unclean water, unclean utensils or because the milk is left out too long.
  - malnutrition because of insufficient quantity given to the baby, the milk is too watery, or because of recurrent episodes of diarrhoea.
- Mixed feeding may also increase the risk of HIV transmission and diarrhoea.

If a woman has unknown HIV status

- Counsel on the importance of exclusive breastfeeding.
- Encourage exclusive breastfeeding.
- Counsel on the need to know the HIV status and where to go for VCT.
- Explain to her the risks of HIV transmission:
  - even if many women have HIV, most women are negative
  - the risk of infecting the baby is higher if the mother is newly infected
  - explain that it is very important to avoid infection during pregnancy and the breastfeeding period.

If a woman knows and accepts that she is HIV-positive

- Inform her about the options for feeding, the advantages and risks:
  - if acceptable, feasible, safe and sustainable (affordable), she might choose replacement feeding with home-prepared formula or commercial formula.
  - Exclusive breastfeeding, stopping as soon as replacement feeding is possible. If replacement feeding is introduced early, she must stop breastfeeding.
  - Exclusive breastfeeding for 6 months, then continued breastfeeding plus complementary feeding after 6 months of age, as recommended for HIV-negative women and women who do not know their status.
- In some situations additional possibilities are:
  - expressing and heat-treating her breast milk
  - wet nursing by an HIV-negative woman.
- Help her to assess her situation and decide which is the best option for her, and support her choice.
- If the mother chooses breastfeeding, give her special advice.
- Make sure the mother understands that if she chooses replacement feeding this includes enriched complementary feeding up to 2 years.
  - if this cannot be ensured, exclusive breastfeeding, stopping early when replacement feeding is feasible, is an alternative.
  - All babies receiving replacement feeding need regular follow-up, and their mothers need support to provide correct replacement feeding.
If the mother chooses replacement feeding

IF THE MOTHER CHOOSES REPLACEMENT FEEDING

Teach the mother replacement feeding

- Ask the mother what kind of replacement feeding she chose.
- For the first few feeds after delivery, prepare the formula for the mother, then teach her how to prepare the formula and feed the baby by cup:
  - Wash hands with water and soap
  - Boil the water for five minutes
  - Clean the cup thoroughly with water, soap and, if possible, boil or pour boiled water in it
  - Decide how much milk the baby needs from the instructions
  - Measure the milk and water and mix them
  - Teach the mother how to feed the baby by cup
  - Let the mother feed the baby 8 times a day (in the first month). Teach her to be flexible and respond to the baby's demands
  - If the baby does not finish the feed within 1 hour of preparation, give it to an older child or add to cooking. **DO NOT** give the milk to the baby for the next feed
  - Wash the utensils with water and soap soon after feeding the baby
  - Make a new feed every time.
- Give her written instructions on safe preparation of formula.
- Explain the risks of replacement feeding and how to avoid them.
- Advise when to seek care.
- Advise about the follow-up visit.

Explain the risks of replacement feeding

- Her baby may get diarrhoea if:
  - hands, water, or utensils are not clean
  - the milk stands out too long.
- Her baby may not grow well if:
  - s/he receives too little formula each feed or too few feeds
  - the milk is too watery
  - s/he has diarrhoea.

Follow-up for replacement feeding

- Ensure regular follow-up visits for growth monitoring.
- Ensure the support to provide safe replacement feeding.
- Advise the mother to return if:
  - the baby is feeding less than 6 times, or is taking smaller quantities
  - the baby has diarrhoea
  - there are other danger signs.

Give special counselling to the mother who is HIV-positive and chooses breastfeeding

- Support the mother in her choice of breastfeeding.
- Ensure good attachment and sucking to prevent mastitis and nipple damage.
- Advise the mother to return immediately if:
  - she has any breast symptoms or signs
  - the baby has any difficulty feeding.
- Ensure a visit in the first week to assess attachment and positioning and the condition of the mother's breasts.
- Arrange for further counselling to prepare for the possibility of stopping breastfeeding early.
- Give psychosocial support.
THE WOMAN WITH SPECIAL NEEDS

EMOTIONAL SUPPORT FOR THE WOMAN WITH SPECIAL NEEDS
Sources of support
Emotional support

SPECIAL CONSIDERATIONS IN MANAGING THE PREGNANT ADOLESCENT
When interacting with the adolescent
Help the girl consider her options and to make decisions which best suit her needs

SPECIAL CONSIDERATIONS FOR SUPPORTING THE WOMAN LIVING WITH VIOLENCE
Support the woman living with violence
Support the health service response to the needs of women living with violence

If a woman is an adolescent or living with violence, she needs special consideration. During interaction with such women, use this section to support them.
EMOTIONAL SUPPORT FOR THE WOMAN WITH SPECIAL NEEDS

You may need to refer many women to another level of care or to a support group. However, if such support is not available, or if the woman will not seek help, counsel her as follows. Your support and willingness to listen will help her to heal.

Sources of support

A key role of the health worker includes linking the health services with the community and other support services available. Maintain existing links and, when possible, explore needs and alternatives for support through the following:

- Community groups, women’s groups, leaders.
- Peer support groups.
- Other health service providers.
- Community counsellors.
- Traditional providers.

Emotional support

Principles of good care, including suggestions on communication with the woman and her family, are provided on page 16. When giving emotional support to the woman with special needs it is particularly important to remember the following:

- Create a comfortable environment:
  - Be aware of your attitude
  - Be open and approachable
  - Use a gentle, reassuring tone of voice.

- Guarantee confidentiality and privacy:
  - Communicate clearly about confidentiality. Tell the woman that you will not tell anyone else about the visit, discussion or plan.
  - If brought by a partner, parent or other family member, make sure you have time and space to talk privately. Ask the woman if she would like to include her family members in the examination and discussion. Make sure you seek her consent first.
  - Make sure the physical area allows privacy.

- Convey respect:
  - Do not be judgmental
  - Be understanding of her situation
  - Overcome your own discomfort with her situation.

- Give simple, direct answers in clear language:
  - Verify that she understands the most important points.

- Provide information according to her situation which she can use to make decisions.

- Be a good listener:
  - Be patient. Women with special needs may need time to tell you their problem or make a decision
  - Pay attention to her as she speaks.

- Follow-up visits may be necessary.
SPECIAL CONSIDERATIONS IN MANAGING THE PREGNANT ADOLESCENT

Special training is required to work with adolescent girls and this guide does not substitute for special training. However, when working with an adolescent, whether married or unmarried, it is particularly important to remember the following.

When interacting with the adolescent

■ Do not be judgemental. You should be aware of, and overcome, your own discomfort with adolescent sexuality.
■ Encourage the girl to ask questions and tell her that all topics can be discussed.
■ Use simple and clear language.
■ Repeat guarantee of confidentiality [A2] [G3].
■ Understand adolescent difficulties in communicating about topics related to sexuality (fears of parental discovery, adult disapproval, social stigma, etc).

Support her when discussing her situation and ask if she has any particular concerns:
■ Does she live with her parents, can she confide in them? Does she live as a couple? Is she in a long-term relationship? Has she been subject to violence or coercion?
■ Determine who knows about this pregnancy — she may not have revealed it openly.
■ Support her concerns related to puberty, social acceptance, peer pressure, forming relationships, social stigmas and violence.

Help the girl consider her options and to make decisions which best suit her needs.

■ Birth planning: delivery in a hospital or health centre is highly recommended. She needs to understand why this is important, she needs to decide if she will do it and how she will arrange it.
■ Prevention of STI or HIV/AIDS is important for her and her baby. If she or her partner are at risk of STI or HIV/AIDS, they should use a condom in all sexual relations. She may need advice on how to discuss condom use with her partner.
■ Spacing of the next pregnancy — for both the woman and baby’s health, it is recommended that any next pregnancy be spaced by at least 2 or 3 years. The girl, with her partner if applicable, needs to decide if and when a second pregnancy is desired, based on their plans. Healthy adolescents can safely use any contraceptive method. The girl needs support in knowing her options and in deciding which is best for her. Be active in providing family planning counselling and advice.
SPECIAL CONSIDERATIONS FOR SUPPORTING THE WOMAN LIVING WITH VIOLENCE

Violence against women by their intimate partners affects women's physical and mental health, including their reproductive health. While you may not have been trained to deal with this problem, women may disclose violence to you or you may see unexplained bruises and other injuries which make you suspect she may be suffering abuse.

The following are some recommendations on how to respond and support her.

Support the woman living with violence

■ Provide a space where the woman can speak to you in privacy where her partner or others cannot hear. Do all you can to guarantee confidentiality and reassure her of this.
■ Gently encourage her to tell you what is happening to her. You may ask indirect questions to help her tell her story.
■ Listen to her in a sympathetic manner. Listening can often be of great support. Do not blame her or make a joke of the situation. She may defend her partner's action. Reassure her that she does not deserve to be abused in any way.
■ Help her to assess her present situation. If she thinks she or her children are in danger, explore together the options to ensure her immediate safety (e.g. can she stay with her parents or friends? Does she have, or could she borrow, money?)
■ Explore her options with her. Help her identify local sources of support, either within her family, friends, and local community or through NGOs, shelters or social services, if available. Remind her that she has legal recourse, if relevant.
■ Offer her an opportunity to see you again. Violence by partners is complex, and she may be unable to resolve her situation quickly.
■ Document any forms of abuse identified or concerns you may have in the file.

Support the health service response to needs of women living with violence

■ Help raise awareness among health care staff about violence against women and its prevalence in the community the clinic serves.
■ Find out what if training is available to improve the support that health care staff can provide to those women who may need it.
■ Display posters, leaflets and other information that condemn violence, and information on groups that can provide support.
■ Make contact with organizations working to address violence in your area. Identify those that can provide support for women in abusive relationships. If specific services are not available, contact other groups such as churches, women's groups, elders, or other local groups and discuss with them support they can provide or other what roles they can play, like resolving disputes. Ensure you have a list of these resources available.
COMMUNITY SUPPORT FOR MATERNAL AND NEWBORN HEALTH

Everyone in the community should be informed and involved in the process of improving the health of their community members. This section provides guidance on how their involvement can help improve the health of women and newborns.

Different groups should be asked to give feedback and suggestions on how to improve the services the health facilities provide.

Use the following suggestions when working with families and communities to support the care of women and newborns during pregnancy, delivery, post-abortion and postpartum periods.

Community support for maternal and newborn health
Establish links

**Establish links with traditional birth attendants and traditional healers**

- Contact traditional birth attendants and healers who are working in the health facility's catchment area. Discuss how you can support each other.
- Respect their knowledge, experience and influence in the community.
- Share with them the information you have and listen to their opinions on this. Provide copies of health education materials that you distribute to community members and discuss the content with them. Have them explain knowledge that they share with the community. Together you can create new knowledge which is more locally appropriate.
- Review how together you can provide support to women, families and groups for maternal and newborn health.
- Involve TBAs and healers in counselling sessions in which advice is given to families and other community members. Include TBAs in meetings with community leaders and groups.
- Discuss the recommendation that all deliveries should be performed by a skilled birth attendant. When not possible or not preferred by the woman and her family, discuss the requirements for safer delivery at home, postpartum care, and when to seek emergency care.
- Invite TBAs to act as labour companions for women they have followed during pregnancy, if this is the woman’s wish.
- Make sure TBAs are included in the referral system.
- Clarify how and when to refer, and provide TBAs with feedback on women they have referred.

**Establish links with traditional birth attendants and traditional healers**

- Meet with others in the community to discuss and agree messages related to pregnancy, delivery, postpartum and post-abortion care of women and newborns.
- Work together with leaders and community groups to discuss the most common health problems and find solutions. Groups to contact and establish relations which include:
  - other health care providers
  - traditional birth attendants and healers
  - maternity waiting homes
  - adolescent health services
  - schools
  - nongovernmental organizations
  - breastfeeding support groups
  - district health committees
  - women’s groups
  - agricultural associations
  - neighbourhood committees
  - youth groups
  - church groups.
- Establish links with peer support groups and referral sites for women with special needs, including women living with HIV, adolescents and women living with violence. Have available the names and contact information for these groups and referral sites, and encourage the woman to seek their support.

**Establish links with other health care providers and community groups**

- Meet with others in the community to discuss and agree messages related to pregnancy, delivery, postpartum and post-abortion care of women and newborns.
- Work together with leaders and community groups to discuss the most common health problems and find solutions. Groups to contact and establish relations which include:
  - other health care providers
  - traditional birth attendants and healers
  - maternity waiting homes
  - adolescent health services
  - schools
  - nongovernmental organizations
  - breastfeeding support groups
  - district health committees
  - women’s groups
  - agricultural associations
  - neighbourhood committees
  - youth groups
  - church groups.
INVOLVE THE COMMUNITY IN QUALITY OF SERVICES

All in the community should be informed and involved in the process of improving the health of their members. Ask the different groups to provide feedback and suggestions on how to improve the services the health facility provides.

- Find out what people know about maternal and newborn mortality and morbidity in their locality. Share data you may have and reflect together on why these deaths and illnesses may occur. Discuss with them what families and communities can do to prevent these deaths and illnesses. Together prepare an action plan, defining responsibilities.
- Discuss the different health messages that you provide. Have the community members talk about their knowledge in relation to these messages. Together determine what families and communities can do to support maternal and newborn health.
- Discuss some practical ways in which families and others in the community can support women during pregnancy, post-abortion, delivery and postpartum periods:
  - Recognition of and rapid response to emergency/danger signs during pregnancy, delivery and postpartum periods
  - Provision of food and care for children and other family members when the woman needs to be away from home during delivery, or when she needs to rest
  - Accompanying the woman after delivery
  - Support for payment of fees and supplies
  - Motivation of male partners to help with the workload, accompany the woman to the clinic, allow her to rest and ensure she eats properly. Motivate communication between males and their partners, including discussing postpartum family planning needs.
- Support the community in preparing an action plan to respond to emergencies. Discuss the following with them:
  - Emergency/danger signs - knowing when to seek care
  - Importance of rapid response to emergencies to reduce mother and newborn death, disability and illness
  - Transport options available, giving examples of how transport can be organized
  - Reasons for delays in seeking care and possible difficulties, including heavy rains
  - What services are available and where
  - What options are available
  - Costs and options for payment
  - A plan of action for responding in emergencies, including roles and responsibilities.
NEWBORN CARE

1. EXAMINE THE NEWBORN
2. IF PRETERM, BIRTH WEIGHT <2500 G OR TWIN
3. ASSESS BREASTFEEDING
4. CHECK FOR SPECIAL TREATMENT NEEDS
5. LOOK FOR SIGNS OF JAUNDICE AND LOCAL INFECTION
6. IF DANGER SIGNS
7. IF SWELLING, BRUISES OR MALFORMATION
8. ASSESS THE MOTHER’S BREASTS IF COMPLAINING OF NIPPLE OR BREAST PAIN
9. CARE OF THE NEWBORN
10. ADDITIONAL CARE OF A SMALL BABY (OR TWIN)

Also see:
- Counsel on choices of infant feeding and HIV-related issues [07-08]
- Equipment, supplies and drugs [L1-L5]
- Records [N1-N7]
- Baby died [O2]

Newborn care
**NEWBORN CARE**

Use this chart to assess the newborn after birth, classify and treat, possibly around an hour; for discharge (not before 12 hours); and during the first week of life at routine, follow-up, or sick newborn visit. Record the findings on the postpartum record **NB**.

Always examine the baby in the presence of the mother.

### ASK, CHECK RECORD

<table>
<thead>
<tr>
<th>Check maternal and newborn record or ask the mother:</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ How old is the baby?</td>
</tr>
<tr>
<td>■ Preterm (less than 37 weeks or 1 month or more early)?</td>
</tr>
<tr>
<td>■ Breech birth?</td>
</tr>
<tr>
<td>■ Difficult birth?</td>
</tr>
<tr>
<td>■ Resuscitated at birth?</td>
</tr>
<tr>
<td>■ Has baby had convulsions?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ask the mother:</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Do you have concerns?</td>
</tr>
<tr>
<td>■ How is the baby feeding?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is the mother very ill or transferred?</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Weigh the baby.</td>
</tr>
</tbody>
</table>

### LOOK, LISTEN, FEEL

- Assess breathing (baby must be calm)
  - listen for grunting
  - count breaths: are they 30-60 per minute? Repeat the count if not.
  - look at the chest for in-drawing.
- Look at the movements: are they normal and symmetrical?
- Look at the presenting part — is there swelling and bruises?
- Look at abdomen for pallor.
- Feel the tone: is it normal?
- Feel for warmth. If cold, or very warm, measure temperature.

### SIGNS

| Normal weight baby (2500g or more). |
| Feeding well — suckling effectively 8 times in 24 hours, day and night. |
| No danger signs. |
| No special treatment needs or treatment completed. |
| Small baby feeding well and gaining weight adequately. |

### CLASSIFY

<table>
<thead>
<tr>
<th>WELL BABY</th>
</tr>
</thead>
</table>

If first examination:

- Ensure care for the newborn [J10].
- Examine again for discharge.

If pre-discharge examination:

- Immunize if due [J3].
- Advise on baby care [K2 K9-K10].
- Advise on routine visit at age 3-7 days [K4].
- Advise on when to return if danger signs [K4].
- Record in home-based record.
- If further visits, repeat advices.

### TREAT AND ADVISE

<table>
<thead>
<tr>
<th>MILD HYPOTHERMIA</th>
</tr>
</thead>
</table>

- Re-warm the baby skin-to-skin [K9].
- If temperature not rising after 2 hours, reassess the baby.

<table>
<thead>
<tr>
<th>MOTHER NOT ABLE TO TAKE CARE FOR BABY</th>
</tr>
</thead>
</table>

- Help the mother express breast milk [K5].
- Consider alternative feeding methods until mother is well [K5-K6].
- Provide care for the baby, ensure warmth [K9].
- Ensure mother can see the baby regularly.
- Transfer the baby with the mother if possible.
- Ensure care for the baby at home.

---

**NEXT:** If preterm, birth weight <2500 g or twin
**IF PRETERM, BIRTH WEIGHT <2500 G OR TWIN**

**ASK, CHECK RECORD**
- Baby just born.
- Birth weight → <1500 g → 1500 g to <2500 g.
- Preterm → <32 weeks → 33-36 weeks.
- Twin.

**LOOK, LISTEN, FEEL**
- If this is repeated visit, assess weight gain.

**SIGNS**
- Birth weight <1500 g.
- Very preterm <32 weeks or >2 months early.
- Birth weight 1500 g to <2500 g.
- Preterm baby (32-36 weeks or 1-2 months early).
- Several days old and weight gain inadequate.
- Feeding difficulty.
- Twin

**CLASSIFY**

<table>
<thead>
<tr>
<th><strong>VERY SMALL BABY</strong></th>
<th><strong>TREAT AND ADVISE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Refer baby urgently to hospital [K4].</td>
<td></td>
</tr>
<tr>
<td>• Ensure extra warmth during referral.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SMALL BABY</strong></th>
<th><strong>TREAT AND ADVISE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Give special support to breastfeed the small baby [K4].</td>
<td></td>
</tr>
<tr>
<td>• Ensure additional care for a small baby [J11].</td>
<td></td>
</tr>
<tr>
<td>• Reassess daily [K14].</td>
<td></td>
</tr>
<tr>
<td>• Do not discharge before feeding well, gaining weight and body temperature stable.</td>
<td></td>
</tr>
<tr>
<td>• If feeding difficulties persist for 3 days and otherwise well, refer for breastfeeding counselling.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>TWIN</strong></th>
<th><strong>TREAT AND ADVISE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Give special support to the mother to breastfeed twins [J11].</td>
<td></td>
</tr>
<tr>
<td>• Do not discharge until both twins can go home.</td>
<td></td>
</tr>
</tbody>
</table>

**NEWBORN CARE**

**NEXT:** Assess breastfeeding
### ASSESS BREASTFEEDING

Assess breastfeeding in every baby as part of the examination. If mother is complaining of nipple or breast pain, also assess the mother's breasts.

<table>
<thead>
<tr>
<th>ASK, CHECK RECORD</th>
<th>LOOK, LISTEN, FEEL</th>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask the mother</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ How is the breastfeeding going?</td>
<td>■ Observe a breastfeeding. If the baby has not fed in the previous hour, ask the mother to put the baby on her breasts and observe breastfeeding for about 5 minutes.</td>
<td>■ Suckling effectively.</td>
<td><strong>FEEDING WELL</strong></td>
<td>■ Encourage the mother to continue breastfeeding on demand.</td>
</tr>
<tr>
<td>■ Has your baby fed in the previous hour?</td>
<td>■ Is the baby able to attach correctly?</td>
<td>■ Not yet breastfed (first hours of life).</td>
<td><strong>FEEDING DIFFICULTY</strong></td>
<td>■ Support exclusive breastfeeding.</td>
</tr>
<tr>
<td>■ Is there any difficulty?</td>
<td>■ Is the baby well-positioned?</td>
<td>■ Breastfeeding less than 8 times per 24 hours.</td>
<td></td>
<td>■ Help the mother to initiate breastfeeding.</td>
</tr>
<tr>
<td>■ Is your baby satisfied with the feed?</td>
<td>■ Is the baby well-attached?</td>
<td>■ Receiving other foods or drinks.</td>
<td></td>
<td>■ Teach correct positioning and attachment.</td>
</tr>
<tr>
<td>■ Have you fed your baby any other foods or drinks?</td>
<td>■ Is the baby suckling effectively?</td>
<td>■ Several days old and inadequate weight gain.</td>
<td></td>
<td>■ Advise to feed more frequently, day and night. Reassure her that she has enough milk.</td>
</tr>
<tr>
<td>■ How do your breasts feel?</td>
<td></td>
<td></td>
<td></td>
<td>■ Advise the mother to stop feeding the baby other foods or drinks.</td>
</tr>
<tr>
<td>■ Do you have any concerns?</td>
<td></td>
<td></td>
<td></td>
<td>■ Reassess at the next feed or follow-up visit in 2 days.</td>
</tr>
<tr>
<td><strong>If baby more than one day old:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ How many times has your baby fed in 24 hours?</td>
<td>If mother has fed in the last hour, ask her to tell you when her baby is willing to feed again.</td>
<td>■ Not suckling (after 6 hours of age).</td>
<td><strong>NOT ABLE TO FEED</strong></td>
<td>■ Refer baby urgently to hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Stopped feeding.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NEXT**: Check for special treatment needs
**CHECK FOR SPECIAL TREATMENT NEEDS**

**ASK, CHECK RECORD**

- Check record for special treatment needs
  - Has the mother had within 2 days of delivery:
    - fever >38°C?
    - infection treated with antibiotics?
  - Membranes ruptured >18 hours before delivery?
  - Mother tested RPR-positive?
  - Mother tested HIV+?
  - Is the mother receiving TB treatment which began <2 months ago?

**LOOK, LISTEN, FEEL SIGNS**

<table>
<thead>
<tr>
<th>Signs</th>
<th>Classify</th>
<th>Treat and Advise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby &lt;1 day old and membranes ruptured &gt;18 hours before delivery, or Mother being treated with antibiotics for infection, or Mother has fever &gt;38ºC.</td>
<td>Risk of bacterial infection</td>
<td>Give baby 2 IM antibiotics for 5 days, Assess baby daily</td>
</tr>
<tr>
<td>Mother tested RPR-positive.</td>
<td>Risk of congenital syphilis</td>
<td>Give baby single dose of benzathine penicillin, Ensure mother and partner are treated, Follow up in 2 weeks.</td>
</tr>
<tr>
<td>Mother known to be HIV-positive, Mother has not been counselled on infant feeding, Mother chose breastfeeding.</td>
<td>Risk of HIV transmission</td>
<td>Give special counselling to mother who is breastfeeding, Refer for counselling on infant feeding, Follow up in 2 weeks.</td>
</tr>
<tr>
<td>Mother started TB treatment &lt;2 months before delivery.</td>
<td>Risk of tuberculosis</td>
<td>Give baby isoniazid prophylaxis for 6 months, Give BCG vaccination to the baby only when baby’s treatment completed, Follow up in 2 weeks.</td>
</tr>
</tbody>
</table>

**NEXT:** Look for signs of jaundice and local infection
Look for signs of jaundice and local infection

**LOOK FOR SIGNS OF JAUNDICE AND LOCAL INFECTION**

**ASK, CHECK RECORD** | **LOOK, LISTEN, FEEL**
---|---
■ What has been applied to the umbilicus?  
■ Look at the skin, is it yellow?  
  → If baby is less than 24 hours old, look at skin on the face  
  → If baby is 24 hours old or more, look at palms and soles.  
■ Look at the eyes. Are they swollen and draining pus?  
■ Look at the skin, especially around the neck, armpits, inguinal area:  
  → Are there skin pustules?  
  → Is there swelling, hardness or large bullae?  
■ Look at the umbilicus:  
  → Is it red?  
  → Draining pus?  
  → Does redness extend to the skin?

**SIGNS**

- Yellow skin on face and only <24 hours old.
- Yellow palms and soles and ≥24 hours old.

**CLASSIFY**

- JAUNDICE

**TREAT AND ADVISE**

- Refer baby urgently to hospital.
- Encourage breastfeeding on the way.
- If feeding difficulty, give expressed breast milk by cup.

- Give single dose of appropriate antibiotic for eye infection.
- Teach mother to treat eyes.
- Follow up in 2 days. If no improvement or worse, refer urgently to hospital.
- Assess and treat mother and her partner for possible gonorrhea.

- Teach mother to treat umbilical infection.
- If no improvement in 2 days, or if worse, refer urgently to hospital.

- Teach mother to treat skin infection.
- Follow up in 2 days.
- If no improvement of pustules in 2 days or more, refer urgently to hospital.

- Yellow skin on face and only <24 hours old.
- Yellow palms and soles and ≥24 hours old.
## IF DANGER SIGNS

### SIGNS

- Fast breathing (more than 60 breaths per minute).
- Slow breathing (less than 30 breaths per minute).
- Severe chest in-drawing
- Grunting
- Convulsions.
- Floppy or stiff.
- Fever (temperature >38°C).
- Temperature <35°C or not rising after rewarming.
- Umbilicus draining pus or umbilical redness extending to skin.
- More than 10 skin pustules or bullae, or swelling, redness, hardness of skin.
- Bleeding from stump or cut.
- Pallor.

### CLASSIFY

- **POSSIBLE SERIOUS ILLNESS**

### TREAT AND ADVISE

- Give first dose of 2 IM antibiotics.
- Refer baby urgently to hospital.

**In addition:**

- Re-warm and keep warm during referral.
- Treat local umbilical infection before referral.
- Treat skin infection before referral.
- Stop the bleeding.

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**NEXT: If swelling, bruises or malformation**

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**If danger signs**
# If swelling, bruises or malformation

**IF SWELLING, BRUISES OR MALFORMATION**

<table>
<thead>
<tr>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Bruises, swelling on buttocks.</td>
<td>BIRTH INJURY</td>
<td>■ Explain to parents that it does not hurt the baby.</td>
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<tr>
<td>■ Swollen head — bump on one or both sides.</td>
<td></td>
<td>■ it will disappear in a week or two and no special</td>
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<tr>
<td>■ Abnormal position of legs (after breech presentation).</td>
<td></td>
<td>■ treatment is needed.</td>
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<tr>
<td>■ Asymmetrical arm movement, arm does not move.</td>
<td></td>
<td>■ DO NOT force legs into a different position.</td>
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<tr>
<td>■ Club foot</td>
<td>MALFORMATION</td>
<td>■ Gently handle the limb that is not moving, do not</td>
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<tr>
<td>■ Cleft palate or lip</td>
<td></td>
<td>■ pull.</td>
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<tr>
<td>■ Odd looking, unusual appearance</td>
<td></td>
<td>■ Refer for special treatment if available.</td>
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<tr>
<td>■ Open tissue on head, abdomen or back</td>
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<td>■ Help mother to breastfeed. If not successful,</td>
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<tr>
<td>■ Other abnormal appearance.</td>
<td>SEVERE</td>
<td>■ teach her alternative feeding methods [K5-K6].</td>
</tr>
<tr>
<td>■ Refer for special evaluation.</td>
<td>MALFORMATION</td>
<td>■ Plan to follow up.</td>
</tr>
<tr>
<td>■ Refer for special treatment if available.</td>
<td></td>
<td>■ Advise on surgical correction at age of several</td>
</tr>
<tr>
<td>■ Manage according to national guidelines.</td>
<td></td>
<td>■ months.</td>
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</table>

- **NEXT**: Assess the mother’s breasts if complaining of nipple or breast pain
### Assess the mother’s breasts if complaining of nipple or breast pain

**ASK, CHECK RECORD**
- How do your breasts feel?
- Look at the nipple for fissure
- Look at the breasts for:
  - swelling
  - shininess
  - redness.
- Feel gently for painful part of the breast.
- Measure temperature.
- Observe a breastfeeding if not yet done.

**LOOK, LISTEN, FEEL**
- Look at the nipple for fissure
- Normal body temperature.
- Nipple not sore and no fissure visible.
- Baby well attached.
- Nipple sore or fissured.
- Baby not well attached.
- Both breasts are swollen, shiny and patchy red.
- Temperature <38°C.
- Baby not well attached.
- Not yet breastfeeding.
- Part of breast is painful, swollen and red.
- Temperature >38°C
- Feels ill.

**SIGNS**
- No swelling, redness or tenderness.
- Nipple not sore and fissure visible.
- Baby well attached.
- Nipple sore or fissured.
- Baby not well attached.
- Both breasts are swollen, shiny and patchy red.
- Temperature <38°C.
- Baby not well attached.
- Not yet breastfeeding.
- Part of breast is painful, swollen and red.
- Temperature >38°C
- Feels ill.

**CLASSIFY**
- Breasts Healthy
- Nipple soreness or fissure
- Breast engorgement
- Mastitis

**TREAT AND ADVISE**
- Reassure the mother.
- Encourage the mother to continue breastfeeding.
- Teach correct positioning and attachment.
- Reassess after 2 feeds (1 day). If not better, teach the mother how to express breast milk from the affected breast and feed baby by cup, and continue breastfeeding on the healthy side.
- Encourage the mother to continue breastfeeding.
- Teach correct positioning and attachment.
- Advise to feed more frequently.
- Reassess after 2 feeds (1 day). If not better, teach the mother how to express enough breast milk before the feed to relieve discomfort.
- Encourage mother to continue breastfeeding.
- Teach correct positioning and attachment.
- Give cloxacillin for 10 days.
- Reassess in 2 days. If no improvement or worse, refer to hospital.
- If mother is HIV+ let her breastfeed on the healthy breast. Express milk from the affected breast and discard until no fever.
- If severe pain, give paracetamol.

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**NEXT:** Care of the newborn
CARE OF THE NEWBORN
Use this chart for care of all babies until discharge.

CARE AND MONITORING

■ Ensure the room is warm (not less than 25ºC and no draught).
■ Keep the baby in the room with the mother, in her bed or within easy reach.
■ Let the mother and baby sleep under a bednet.

■ Support exclusive breastfeeding on demand day and night.
■ Ask the mother to alert you if breastfeeding difficulty.
■ Assess breastfeeding in every baby before planning for discharge.
DO NOT discharge if baby is not yet feeding well.

■ Teach the mother how to care for the baby.
   → Keep the baby warm J10
   → Give cord care K10
   → Ensure hygiene K10
DO NOT expose the baby in direct sun.
DO NOT put the baby on any cold surface.
DO NOT bath the baby before 6 hours.

■ Ask the mother and companion to watch the baby and alert you if
  → Feet cold
  → Breathing difficulty: grunting, fast or slow breathing, chest in-drawing
  → Any bleeding.

■ Give prescribed treatments according to the schedule K12.

■ Examine every baby before planning to discharge mother and baby J2-J7.
DO NOT discharge before baby is 12 hours old.

RESPOND TO ABNORMAL FINDINGS

■ If the baby is in a cot, ensure baby is dressed or wrapped and covered by a blanket.
   Cover the head with a hat.

■ If mother reports breastfeeding difficulty, assess breastfeeding and help the mother with positioning and attachment J3.

■ If the mother is unable to take care of the baby, provide care or teach the companion K9-K10.
■ Wash hands before and after handling the baby.

■ If feet are cold:
  → Teach the mother to put the baby skin-to-skin K14.
  → Reassess in 1 hour; if feet still cold, measure temperature and re-warm the baby K9.
■ If bleeding from cord, check if tie is loose and retie the cord.
■ If other bleeding, assess the baby immediately J2-J7.
■ If breathing difficulty or mother reports any other abnormality, examine the baby as on J2-J7.

NEXT: Additional care of a small baby (or twin)
### ADDITIONAL CARE OF A SMALL BABY (OR TWIN)

#### Use this chart for additional care of a small baby: preterm, 1-2 months early or weighing 1500g-<2500g. Refer to hospital a very small baby: >2 months early, weighing <1500g

#### CARE AND MONITORING

- Plan to keep the small baby longer before discharging.
- Allow visits to the mother and baby.
- Give special support for breastfeeding the small baby (or twins):
  - Encourage the mother to breastfeed every 2-3 hours.
  - Assess breastfeeding daily: attachment, sucking, duration and frequency of feeds, and baby satisfaction with the feed
  - If alternative feeding method is used, assess the total daily amount of milk given.
  - Weigh daily and assess weight gain.
- Ensure additional warmth for the small baby:
  - Ensure the room is very warm (25º–28º C).
  - Teach the mother how to keep the small baby warm in skin-to-skin contact.
  - Provide extra blankets for mother and baby.
- Ensure hygiene.
  - DO NOT bath the small baby. Wash as needed.
- Assess the small baby daily:
  - Measure temperature
  - Assess breathing (baby must be quiet, not crying): listen for grunting; count breaths per minute, repeat the count if >60 or <30; look for chest in-drawing
  - Look for jaundice (first 10 days of life): first 24 hours on the abdomen, then on palms and soles.
- Plan to discharge when:
  - Breastfeeding well
  - Gaining weight adequately on 3 consecutive days
  - Body temperature between 36.5º and 37.5º C on 3 consecutive days
  - Mother able and confident in caring for the baby
  - No maternal concerns.
- Assess the baby for discharge.

#### RESPONSE TO ABNORMAL FINDINGS

- If the small baby is not suckling effectively and does not have other danger signs, consider alternative feeding methods:
  - Teach the mother how to hand express breast milk directly into the baby's mouth
  - Teach the mother to express breast milk and cup feed the baby
  - Determine appropriate amount for daily feeds by age.
- If feeding difficulty persists for 3 days, or weight loss greater than 10% of birth weight and no other problems, refer for breastfeeding counselling and management.
- If difficult to keep body temperature within the normal range (36.5ºC to 37.5ºC):
  - Keep the baby in skin-to-skin contact with the mother as much as possible.
  - If body temperature below 36.5ºC persists for 2 hours despite skin-to-skin contact with mother, assess the baby.
- If breathing difficulty assess the baby.
- If jaundice, refer the baby for phototherapy.
- If any maternal concern, assess the baby and respond to the mother.
- If the mother and baby are not able to stay, ensure daily (home) visits or send to hospital.
Breastfeeding, care, preventive measures and treatment for the newborn

**OTHER BREASTFEEDING SUPPORT**
- Give special support to the mother who is not yet breastfeeding
- Advise the mother who is not breastfeeding at all on how to relieve engorgement
- If the baby does not have a mother

**ENSURE WARMTH FOR THE BABY**
- Keep the baby warm
- Keep a small baby warm
- Rewarm the baby skin-to-skin

**OTHER BABY CARE**
- Cord care
- Sleeping
- Hygiene

**NEWBORN RESUSCITATION**
- Keep the baby warm
- Open the airway
- If still not breathing, ventilate
- If breathing or crying, stop ventilating
- If not breathing or gasping at all after 20 minutes of ventilation

**TREAT AND IMMUNIZE THE BABY (1)**
- Treat the baby
- Give 2 IM antibiotics (first week of life)
- Give IM benzathine penicillin to baby (single dose) if mother tested RPR positive
- Give IM antibiotic for possible gonococcal eye infection (single dose)

**TREAT AND IMMUNIZE THE BABY (2)**
- Treat local infection
- Giveisoniazid (INH) prophylaxis to newborn
- Immunize the newborn

**COUNSEL ON BREASTFEEDING (1)**
- Counsel on importance of exclusive breastfeeding
- Help the mother to initiate breastfeeding

**COUNSEL ON BREASTFEEDING (2)**
- Support exclusive breastfeeding
- Teach correct positioning and attachment for breastfeeding

**COUNSEL ON BREASTFEEDING (3)**
- Give special support to breastfeed the small baby (preterm and/or low birth weight)
- Give special support to breastfeed twins

**ALTERNATIVE FEEDING METHODS (1)**
- Express breast milk
- Hand express breast milk directly into the baby's mouth

**ALTERNATIVE FEEDING METHODS (2)**
- Cup feeding expressed breast milk
- Quantity to feed by cup
- Signs that baby is receiving adequate amount of milk

**WEIGH AND ASSESS WEIGHT GAIN**
- Weigh baby in the first month of life
- Assess weight gain
- Scale maintenance

**OTHER BREASTFEEDING SUPPORT**
- Give special support to the mother who is not yet breastfeeding
- Advise the mother who is not breastfeeding at all on how to relieve engorgement
- If the baby does not have a mother

**ENSURE WARMTH FOR THE BABY**
- Keep the baby warm
- Keep a small baby warm
- Rewarm the baby skin-to-skin
Counsel on importance of exclusive breastfeeding during pregnancy and after birth

**INCLUDE PARTNER OR OTHER FAMILY MEMBERS IF POSSIBLE**

**Explain to the mother that:**
- Breast milk contains exactly the nutrients a baby needs → is easily digested and efficiently used by the baby's body → protects a baby against infection.
- Babies should start breastfeeding within 1 hour of birth. They should not have any other food or drink before they start to breastfeed.
- Babies should be exclusively breastfed for the first 6 months of life.

- Breastfeeding → helps baby's development and mother/baby attachment → can help delay a new pregnancy (see G7 for breastfeeding and family planning).

For counselling if mother HIV-positive, see G7.

**Help the mother to initiate breastfeeding within 1 hour, when baby is ready**
- After birth, let the baby rest comfortably on the mother's chest in skin-to-skin contact.
- Tell the mother to help the baby to her breast when the baby seems to be ready, usually within the first hour. Signs of readiness to breastfeed are:
  → baby looking around/moving
  → mouth open
  → searching.
- Check that position and attachment are correct at the first feed. Offer to help the mother at any time K3.
- Let the baby release the breast by her/himself; then offer the second breast.
- If the baby does not feed in 1 hour, examine the baby J2–J9. If healthy, leave the baby with the mother to try later. Assess in 3 hours, or earlier if the baby is small J4.
- If the mother is ill and unable to breastfeed, help her to express breast milk and feed the baby by cup J5. On day 1 express in a spoon and feed by spoon.
- If mother cannot breastfeed at all, use one of the following options:
  - home-made or commercial formula
  - donated heat-treated breast milk.
Support exclusive breastfeeding

- Keep the mother and baby together in bed or within easy reach. **DO NOT** separate them.
- Encourage breastfeeding on demand, day and night, as long as the baby wants.
  - A baby needs to feed day and night, 8 or more times in 24 hours from birth. Only on the first day may a full-term baby sleep many hours after a good feed.
  - A small baby should be encouraged to feed, day and night, at least 8 times in 24 hours from birth.
- Help the mother whenever she wants, and especially if she is a first time or adolescent mother.
- Let baby release the breast, then offer the second breast.
- If mother must be absent, let her express breast milk and let somebody else feed the expressed breast milk to the baby by cup.

**DO NOT** force the baby to take the breast.
**DO NOT** interrupt feed before baby wants.
**DO NOT** give any other feeds or water.
**DO NOT** use artificial teats or pacifiers.

- Advise the mother on medication and breastfeeding
  - Most drugs given to the mother in this guide are safe and the baby can be breastfed.
  - If mother is taking cotrimoxazole or fansidar, monitor baby for jaundice.

Teach correct positioning and attachment for breastfeeding

- Show the mother how to hold her baby. She should:
  - make sure the baby's head and body are in a straight line
  - make sure the baby is facing the breast, the baby's nose is opposite her nipple
  - hold the baby's body close to her body
  - support the baby's whole body, not just the neck and shoulders
- Show the mother how to help her baby to attach. She should:
  - touch her baby's lips with her nipple
  - wait until her baby's mouth is opened wide
  - move her baby quickly onto her breast, aiming the infant's lower lip well below the nipple.

- Look for signs of good attachment and effective suckling (that is, slow, deep sucks, sometimes pausing). If the attachment or suckling is not good, try again. Then reassess.
- If breast engorgement, express a small amount of breast milk before starting breastfeeding to soften nipple area so that it is easier for the baby to attach.

If mother is HIV-positive, see G7 for special counselling to the mother who is HIV-positive and breastfeeding.

If mother chose replacement feedings, see G8.
**COUNSEL ON BREASTFEEDING**

Give special support to breastfeed the small baby (preterm and/or low birth weight)

**COUNSEL THE MOTHER:**
- Reassure the mother that she can breastfeed her small baby and she has enough milk.
- Explain that her milk is the best food for such a small baby. Feeding for her/him is even more important than for a big baby.
- Explain how the milk's appearance changes: milk in the first days is thick and yellow, then it becomes thinner and whiter. Both are good for the baby.
- A small baby does not feed as well as a big baby in the first days:
  - may tire easily and suck weakly at first
  - may suckle for shorter periods before resting
  - may fall asleep during feeding
  - may have long pauses between sucking and may feed longer
  - does not always wake up for feeds.
- Explain that breastfeeding will become easier if the baby suckles and stimulates the breast her/himself and when the baby becomes bigger.
- Encourage skin-to-skin contact since it makes breastfeeding easier.

**HELP THE MOTHER:**
- Initiate breastfeeding within 1 hour of birth.
- Feed the baby every 2-3 hours. Wake the baby for feeding, even if she/he does not wake up alone, 2 hours after the last feed.
- Always start the feed with breastfeeding before offering a cup. If necessary, improve the milk flow (let the mother express a little breast milk before attaching the baby to the breast).
- Keep the baby longer at the breast. Allow long pauses or long, slow feed. Do not interrupt feed if the baby is still trying.
- If the baby is not yet suckling well and long enough, do whatever works better in your setting:
  - Let the mother express breast milk into baby's mouth.
  - Let the mother express breast milk and feed baby by cup.
  - On the first day express breast milk into, and feed colostrum by spoon.
- Teach the mother to observe swallowing if giving expressed breast milk.
- Weigh the baby daily (if accurate and precise scales available), record and assess weight gain.

Give special support to breastfeed twins

**COUNSEL THE MOTHER:**
- Reassure the mother that she has enough breast milk for two babies.
- Encourage her that twins may take longer to establish breastfeeding since they are frequently born preterm and with low birth weight.

**HELP THE MOTHER:**
- Start feeding one baby at a time until breastfeeding is well established.
- Help the mother find the best method to feed the twins:
  - if one is weaker, encourage her to make sure that the weaker twin gets enough milk.
  - if necessary, she can express milk for her/him and feed her/him by cup after initial breastfeeding.
  - Daily alternate the side each baby is offered.
Express breast milk

- The mother needs clean containers to collect and store the milk.
  - A wide necked jug, jar, bowl or cup can be used.
- Once expressed, the milk should be stored with a well-fitting lid or cover.
- Teach the mother to express breast milk:
  - To provide milk for the baby when she is away. To feed the baby if the baby is small and too weak to suckle
  - To relieve engorgement and to help baby to attach
  - To drain the breast when she has severe mastitis or abscesses.
- Teach the mother to express her milk by herself. **DO NOT** do it for her.
- Teach her how to:
  - Wash her hands thoroughly.
  - Sit or stand comfortably and hold a clean container underneath her breast.
  - Put her first finger and thumb on either side of the areola, behind the nipple.
  - Press slightly inwards towards the breast between her finger and thumb.
  - Express one side until the milk flow slows. Then express the other side.
  - Continue alternating sides for at least 20-30 minutes.
- If milk does not flow well:
  - Apply warm compresses.
  - Have someone massage her back and neck before expressing.
  - Teach the mother breast and nipple massage.
  - Feed the baby by cup immediately. If not, store expressed milk in a cool, clean and safe place.
- If necessary repeat the procedure to express breast milk at least 8 times in 24 hours. Express as much as the baby would take or more, every 3 hours.
- When not breastfeeding at all, express just a little to relieve pain. **K5**.
- If mother is very ill, help her to express or do it for her.

Hand express breast milk directly into the baby’s mouth

- Teach the mother to express breast milk.
- Hold the baby in skin-to-skin contact, the mouth close to the nipple.
- Express the breast until some drops of breast milk appear on the nipple.
- Wait until the baby is alert and opens mouth and eyes, or stimulate the baby lightly to awaken her/him.
- Let the baby smell and lick the nipple, and attempt to suck.
- Let some breast milk fall into the baby’s mouth.
- Wait until the baby swallows before expressing more drops of breast milk.
- After some time, when the baby has had enough, she/he will close her/his mouth and take no more breast milk.
- Ask the mother to repeat this process every 1-2 hours if the baby is very small (or every 2-3 hours if the baby is not very small).
- Be flexible at each feed, but make sure the intake is adequate by checking daily weight gain.
ALTERNATIVE FEEDING METHODS

Cup feeding expressed breast milk

- Teach the mother to feed the baby with a cup. Do not feed the baby yourself. The mother should:
  - Measure the quantity of milk in the cup
  - Hold the baby sitting semi-upright on her lap
  - Hold the cup of milk to the baby's lips:
    - rest cup lightly on lower lip
    - touch edge of cup to outer part of upper lip
    - tip cup so that milk just reaches the baby's lips
    - but do not pour the milk into the baby's mouth.
  - Baby becomes alert, opens mouth and eyes, and starts to feed.
  - The baby will suck the milk, spilling some.
  - Small babies will start to take milk into their mouth using the tongue.
  - Baby swallows the milk.
  - Baby finishes feeding when mouth closes or when not interested in taking more.
  - If the baby does not take the calculated amount:
    - Feed for a longer time or feed more often
    - Teach the mother to measure the baby's intake over 24 hours, not just at each feed.
  - If mother does not express enough milk in the first few days, or if the mother cannot breastfeed at all, use one of the following feeding options:
    - donated heat-treated breast milk
    - home-made or commercial formula.
  - Feed the baby by cup if the mother is not available to do so.
  - Baby is cup feeding well if required amount of milk is swallowed, spilling little, and weight gain is maintained.

Quantity to feed by cup

- Start with 80 ml/kg body weight per day for day 1. Increase total volume by 10-20 ml/kg per day until baby takes 150 ml/kg/day. See table below.
- Divide total into 8 feeds. Give every 2-3 hours to a small size or ill baby.
- Check the baby's 24 hour intake. Size of individual feeds may vary.
- Continue until baby takes the required quantity.
- Wash the cup with water and soap after each feed.

| APPROXIMATE QUANTITY TO FEED BY CUP (IN ML) EVERY 2-3 HOURS FROM BIRTH (BY WEIGHT) |
|----------------------------------|---|---|---|---|---|---|---|---|
| Weight (kg)          | Day 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 1.5-1.9              | 15ml  | 17ml | 19ml | 21ml | 23ml | 25ml | 27ml | 27+ml |
| 2.0-2.4              | 20ml  | 22ml | 25ml | 27ml | 30ml | 32ml | 35ml | 35+ml |
| 2.5+                 | 25ml  | 28ml | 30ml | 35ml | 40+ml | 45+ml | 50+ml |

Signs that baby is receiving adequate amount of milk

- Baby is satisfied with the feed.
- Weight loss is less than 10% in the first week of life.
- Baby gains at least 160 g in the following weeks or a minimum 300 g in the first month.
- Baby wets every day as frequently as baby is feeding.
- Baby's stool is changing from dark to light brown or yellow by day 3.
WEIGH AND ASSESS WEIGHT GAIN

Weigh baby in the first month of life

**WEIGH THE BABY**
- Monthly if birth weight normal and breastfeeding well. Every 2 weeks if replacement feeding or treatment with isoniazid.
- When the baby is brought for examination because not feeding well, or ill.

**WEIGH THE SMALL BABY**
- Every day until 3 consecutive times gaining weight (at least 15 g/day).
- Weekly until 4-6 weeks of age (reached term).

Assess weight gain

Use this table for guidance when assessing weight gain in the first month of life

<table>
<thead>
<tr>
<th>Age</th>
<th>Acceptable weight loss/gain in the first month of life</th>
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<tbody>
<tr>
<td>1 week</td>
<td>Loss up to 10%</td>
</tr>
<tr>
<td>2-4 weeks</td>
<td>Gain at least 160 g per week (at least 15 g/day)</td>
</tr>
<tr>
<td>1 month</td>
<td>Gain at least 300 g in the first month</td>
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</tbody>
</table>

If weighing daily with a precise and accurate scale

| First week | No weight loss or total less than 10%                   |
| Afterward  | Daily gain in small babies at least 20 g               |

Scale maintenance

Daily/weekly weighing requires precise and accurate scale (10 g increment):
- Calibrate it daily according to instructions.
- Check it for accuracy according to instructions.

Simple spring scales are not precise enough for daily/weekly weighing.
Other breastfeeding support

OTHER BREASTFEEDING SUPPORT

Give special support to the mother who is not yet breastfeeding (Mother or baby ill, or baby too small to suckle)

- Teach the mother to express breast milk. Help her if necessary.
- Use the milk to feed the baby by cup.
- If mother and baby are separated, help the mother to see the baby or inform her about the baby’s condition at least twice daily.
- If the baby was referred to another institution, ensure the baby gets the mother’s expressed breast milk if possible.
- Encourage the mother to breastfeed when she or the baby recovers.

If the baby does not have a mother

- Give donated heat treated breast milk or home-based or commercial formula by cup.
- Teach the carer how to prepare milk and feed the baby.
- Follow up in 2 weeks; weigh and assess weight gain.

Advise the mother who is not breastfeeding at all on how to relieve engorgement (Baby died or stillborn, mother chose replacement feeding)

- Breasts may be uncomfortable for a while.
- Avoid stimulating the breasts.
- Support breasts with a well-fitting bra or cloth. Do not bind the breasts tightly as this may increase her discomfort.
- Apply a compress. Warmth is comfortable for some mothers, others prefer a cold compress to reduce swelling.
- Teach the mother to express enough milk to relieve discomfort. Expressing can be done a few times a day when the breasts are overfull. It does not need to be done if the mother is uncomfortable. It will be less than her baby would take and will not stimulate increased milk production.
- Relieve pain. An analgesic such as ibuprofen, or paracetamol may be used. Some women use plant products such as teas made from herbs, or plants such as raw cabbage leaves placed directly on the breast to reduce pain and swelling.
- Advise to seek care if breasts become painful, swollen, red, if she feels ill or temperature greater than 38°C.

Pharmacological treatments to reduce milk supply are not recommended.
The above methods are considered more effective in the long term.
ENSURE WARMTH FOR THE BABY

Keep the baby warm

AT BIRTH AND WITHIN THE FIRST HOUR(S)
- Warm delivery room: for the birth of the baby the room temperature should be 25-28°C, no draught.
- Dry baby: immediately after birth, place the baby on the mother’s abdomen or on a warm, clean and dry surface. Dry the whole body and hair thoroughly, with a dry cloth.
- Skin-to-skin contact: Leave the baby on the mother’s abdomen (before cord cut) or chest (after cord cut) after birth for at least 2 hours. Cover the baby with a soft dry cloth.
- If the mother cannot keep the baby skin-to-skin because of complications, wrap the baby in a clean, dry, warm cloth and place in a cot. Cover with a blanket. Use a radiant warmer if room not warm or baby small.

SUBSEQUENTLY (FIRST DAY)
- Explain to the mother that keeping baby warm is important for the baby to remain healthy.
- Dress the baby or wrap in soft dry clean cloth. Cover the head with a cap for the first few days, especially if baby is small.
- Ensure the baby is dressed or wrapped and covered with a blanket.
- Keep the baby within easy reach of the mother. Do not separate them (rooming-in).
- If the mother and baby must be separated, ensure baby is dressed or wrapped and covered with a blanket.
- Assess warmth every 4 hours by touching the baby’s feet: if feet are cold use skin-to-skin contact, add extra blanket and reassess (see Rewarm the newborn).
- Keep the room for the mother and baby warm. If the room is not warm enough, always cover the baby with a blanket and/or use skin-to-skin contact.

AT HOME
- Explain to the mother that babies need one more layer of clothes than other children or adults.
- Keep the room or part of the room warm, especially in a cold climate.
- During the day dress or wrap the baby.
- At night, let the baby sleep with the mother or within easy reach to facilitate breastfeeding.
- Do not put the baby on any cold or wet surface.
- Do not bath the baby at birth. Wait at least 6 hours before bathing.
- Do not swaddle – wrap too tightly. Swaddling makes them cold.
- Do not leave the baby in direct sun.

Keep a small baby warm
- The room for the baby should be warm (not less than 25 °C) with no draught.
- Explain to the mother the importance of warmth for a small baby.
- After birth, encourage the mother to keep the baby in skin-to-skin contact as long as possible.
- Advise to use extra clothes, socks and a cap, blankets, to keep the baby warm or when the baby is not with the mother.
- Wash or bath a baby in a very warm room, in warm water. After bathing, dry immediately and thoroughly. Keep the baby warm after the bath. Avoid bathing small babies.
- Check frequently if feet are warm. If cold, rewarm the baby (see below).
- Seek care if the baby’s feet remain cold after rewarming.

Rewarm the baby skin-to-skin
- Before rewarming, remove the baby’s cold clothing.
- Place the newborn skin-to-skin on the mother’s chest in a pre-warmed shirt open at the front, a nappy (diaper), hat and socks.
- Cover the infant on the mother’s chest with her clothes and an additional (pre-warmed) blanket.
- Check the temperature every hour until normal.
- Keep the baby with the mother until the baby’s body temperature is in normal range.
- If the baby is small, encourage the mother to keep the baby in skin-to-skin contact for as long as possible, day and night.
- Be sure the temperature of the room where the rewarming takes place is at least 25 °C.
- If the baby’s temperature is not 36.5°C or more after 2 hours of rewarming, reassess the baby.
- If referral needed, keep the baby in skin-to-skin position/contact with the mother or other person accompanying the baby.
OTHER BABY CARE

Always wash hands before and after taking care of the baby. DO NOT share supplies with other babies.

Cord care

- Wash hands before and after cord care.
- Put nothing on the stump.
- Fold nappy (diaper) below stump.
- Keep cord stump loosely covered with clean clothes.
- If stump is soiled, wash it with clean water and soap. Dry it thoroughly with clean cloth.
- If umbilicus is red or draining pus or blood, examine the baby and manage accordingly.
- Explain to the mother that she should seek care if the umbilicus is red or draining pus or blood.

DO NOT bandage the stump or abdomen.
DO NOT apply any substances or medicine to stump.
Avoid touching the stump unnecessarily.

Hygiene (washing, bathing)

AT BIRTH:

- Only remove blood or meconium.
- DO NOT remove vernix.
- DO NOT bathe the baby until at least 6 hours of age.

LATER AND AT HOME:

- Wash the face, neck, underarms daily.
- Wash the buttocks when soiled. Dry thoroughly.
- Bath when necessary:
  - Ensure the room is warm, no draught
  - Use warm water for bathing
  - Thoroughly dry the baby, dress and cover after bath.

OTHER BABY CARE:

- Use cloth on baby's bottom to collect stool. Dispose of the stool as for woman’s pads. Wash hands.

DO NOT bathe the baby before 6 hours old or if the baby is cold.
DO NOT apply anything in the baby's eyes except an antimicrobial at birth.

SMALL BABIES REQUIRE MORE CAREFUL ATTENTION:

- The room must be warmer when changing, washing, bathing and examining a small baby.
NEWBORN RESUSCITATION
Start resuscitation within 1 minute of birth if baby is not breathing or is gasping for breath.
Observe universal precautions to prevent infection.

Keep the baby warm
- Clamp and cut the cord if necessary.
- Transfer the baby to a dry, clean and warm surface.
- Inform the mother that the baby has difficulty initiating breathing and that you will help the baby to breathe.
- Keep the baby wrapped and under a radiant heater if possible.

Open the airway
- Position the head so it is slightly extended.
- Suction first the mouth and then the nose.
- Introduce the suction tube into the newborn's mouth 5 cm from lips and suck while withdrawing.
- Introduce the suction tube 3 cm into each nostril and suck while withdrawing until no mucus.
- Repeat each suction if necessary but no more than twice and no more than 20 seconds in total.

If still no breathing, VENTILATE:
- Place mask to cover chin, mouth, and nose.
- Form seal.
- Squeeze bag attached to the mask with 2 fingers or whole hand, according to bag size, 2 or 3 times.
- Observe rise of chest. If chest is not rising:
  - reposition head
  - check mask seal.
- Squeeze bag harder with whole hand.
- Once good seal and chest rising, ventilate at 40 squeezes per minute until newborn starts crying or breathing spontaneously.

If breathing or crying, stop ventilating
- Look at the chest for in-drawing.
- Count breaths per minute.
- If breathing more than 30 breaths per minute and no severe chest in-drawing:
  - do not ventilate any more
  - put the baby in skin-to-skin contact on mother's chest and continue care as on
  - monitor every 15 minutes for breathing and warmth
  - tell the mother that the baby will probably be well.

DO NOT leave the baby alone

If breathing less than 30 breaths per minute or severe chest in-drawing:
- continue ventilating
- arrange for immediate referral
- explain to the mother what happened, what you are doing and why
- ventilate during referral
- record the event on the referral form and labour record.

If no breathing or gasping at all after 20 minutes of ventilation:
- Stop ventilating. The baby is dead.
- Explain to the mother and give supportive care.
- Record the event.
TREAT THE BABY

Treat the baby

■ Determine appropriate drugs and dosage for the baby's weight.
■ Tell the mother the reasons for giving the drug to the baby.
■ Give intramuscular antibiotics in thigh. Use a new syringe and needle for each antibiotic.

TEACH THE MOTHER TO GIVE TREATMENT TO THE BABY AT HOME

■ Explain carefully how to give the treatment. Label and package each drug separately.
■ Check mother's understanding before she leaves the clinic.
■ Demonstrate how to measure a dose.
■ Watch the mother practice measuring a dose by herself.
■ Watch the mother give the first dose to the baby.

Give 2 IM antibiotics (first week of life)

■ Give first dose of both ampicillin and gentamicin IM in thigh before referral for possible serious illness, severe umbilical infection or severe skin infection.
■ Give both ampicillin and gentamicin IM for 5 days in asymptomatic babies classified at risk of infection.
■ Give intramuscular antibiotics in thigh. Use a new syringe and needle for each antibiotic.

### Give IM benzathine penicillin to baby (single dose) if mother tested RPR-positive

<table>
<thead>
<tr>
<th>Weight</th>
<th>Dose: 50 000 units/kg once</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 - 1.4 kg</td>
<td>0.35 ml</td>
</tr>
<tr>
<td>1.5 - 1.9 kg</td>
<td>0.5 ml</td>
</tr>
<tr>
<td>2.0 - 2.4 kg</td>
<td>0.6 ml</td>
</tr>
<tr>
<td>2.5 - 2.9 kg</td>
<td>0.75 ml</td>
</tr>
<tr>
<td>3.0 - 3.4 kg</td>
<td>0.85 ml</td>
</tr>
<tr>
<td>3.5 - 3.9 kg</td>
<td>1 ml</td>
</tr>
<tr>
<td>4.0 - 4.4 kg</td>
<td>1.1 ml</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weight</th>
<th>Dose: 5 mg per kg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 - 1.4 kg</td>
<td>0.5 ml</td>
</tr>
<tr>
<td>1.5 - 1.9 kg</td>
<td>0.7 ml</td>
</tr>
<tr>
<td>2.0 - 2.4 kg</td>
<td>0.85 ml</td>
</tr>
<tr>
<td>2.5 - 2.9 kg</td>
<td>1.35 ml</td>
</tr>
<tr>
<td>3.0 - 3.4 kg</td>
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<tr>
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<td>1.85 ml</td>
</tr>
<tr>
<td>4.0 - 4.4 kg</td>
<td>2.1 ml</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weight</th>
<th>Dose: 50 mg per kg once</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 - 1.4 kg</td>
<td>1 ml</td>
</tr>
<tr>
<td>1.5 - 1.9 kg</td>
<td>1.5 ml</td>
</tr>
<tr>
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<td>2 ml</td>
</tr>
<tr>
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<tr>
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<td>3 ml</td>
</tr>
<tr>
<td>3.5 - 3.9 kg</td>
<td>3.5 ml</td>
</tr>
<tr>
<td>4.0 - 4.4 kg</td>
<td>4 ml</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weight</th>
<th>Dose: 25 mg per kg once, max. 75 mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 - 1.4 kg</td>
<td>0.7 ml</td>
</tr>
<tr>
<td>1.5 - 1.9 kg</td>
<td>1 ml</td>
</tr>
<tr>
<td>2.0 - 2.4 kg</td>
<td>1.3 ml</td>
</tr>
<tr>
<td>2.5 - 2.9 kg</td>
<td>1.7 ml</td>
</tr>
<tr>
<td>3.0 - 3.4 kg</td>
<td>2 ml</td>
</tr>
<tr>
<td>3.5 - 3.9 kg</td>
<td>2 ml</td>
</tr>
<tr>
<td>4.0 - 4.4 kg</td>
<td>2 ml</td>
</tr>
</tbody>
</table>

### Give IM antibiotic for possible gonococcal eye infection (single dose)

<table>
<thead>
<tr>
<th>Weight</th>
<th>Dose: 50 mg per kg every 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 - 1.4 kg</td>
<td>0.35 ml</td>
</tr>
<tr>
<td>1.5 - 1.9 kg</td>
<td>0.5 ml</td>
</tr>
<tr>
<td>2.0 - 2.4 kg</td>
<td>0.6 ml</td>
</tr>
<tr>
<td>2.5 - 2.9 kg</td>
<td>0.75 ml</td>
</tr>
<tr>
<td>3.0 - 3.4 kg</td>
<td>0.85 ml</td>
</tr>
<tr>
<td>3.5 - 3.9 kg</td>
<td>1 ml</td>
</tr>
<tr>
<td>4.0 - 4.4 kg</td>
<td>1.1 ml</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weight</th>
<th>Dose: 5 mg per kg every 24 hours if term; 4 mg per kg every 24 hours if preterm</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 - 1.4 kg</td>
<td>0.5 ml</td>
</tr>
<tr>
<td>1.5 - 1.9 kg</td>
<td>0.7 ml</td>
</tr>
<tr>
<td>2.0 - 2.4 kg</td>
<td>0.85 ml</td>
</tr>
<tr>
<td>2.5 - 2.9 kg</td>
<td>1.35 ml</td>
</tr>
<tr>
<td>3.0 - 3.4 kg</td>
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<td>1.85 ml</td>
</tr>
<tr>
<td>4.0 - 4.4 kg</td>
<td>2.1 ml</td>
</tr>
</tbody>
</table>
Treat and immunize the baby (2)

**Treat local infection**

**TEACH MOTHER TO TREAT LOCAL INFECTION**

- Explain and show how the treatment is given.
- Watch her as she carries out the first treatment.
- Ask her to let you know if the local infection gets worse and to return to the clinic if possible.
- Treat for 5 days.

**TREAT SKIN PUSTULES OR UMBILICAL INFECTION**

Do the following 3 times daily:

- Wash hands with clean water and soap.
- Gently wash off pus and crusts with boiled and cooled water and soap.
- Dry the area with clean cloth.
- Paint with gentian violet.
- Wash hands.

**TREAT EYE INFECTION**

Do the following 6-8 times daily:

- Wash hands with clean water and soap.
- Wet clean cloth with boiled and cooled water.
- Use the wet cloth to gently wash off pus from the baby’s eyes.
- Apply 1% tetracycline eye ointment in each eye 3 times daily.
- Wash hands.

**REASSESS IN 2 DAYS:**

- Assess the skin, umbilicus or eyes.
- If pus or redness remains or is worse, refer to hospital.
- If pus and redness have improved, tell the mother to continue treating local infection at home.

**Give isoniazid (INH) prophylaxis to newborn**

If the mother is diagnosed as having tuberculosis and started treatment less than 2 months before delivery:

- Give 5 mg/kg isoniazid (INH) orally once a day for 6 months (1 tablet = 200 mg).
- Delay BCG vaccination until INH treatment completed, or repeat BCG.
- Reassure the mother that it is safe to breastfeed the baby.
- Follow up the baby every 2 weeks, or according to national guidelines, to assess weight gain.

**Immunize the newborn**

- Give BCG, OPV-0, Hepatitis B (HB-1) vaccine in the first week of life, preferably before discharge.
- If un-immunized newborn first seen 1-4 weeks of age, give BCG only.
- Record on immunization card and child record.
- Advise when to return for next immunization.

<table>
<thead>
<tr>
<th>Age</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth &lt; 1 week</td>
<td>BCG OPV-0 HB-1</td>
</tr>
<tr>
<td>6 weeks</td>
<td>DPT OPV-1 HB-2</td>
</tr>
</tbody>
</table>

**Immunize the newborn**

**Age Vaccine**

- Birth < 1 week BCG OPV-0 HB-1
- 6 weeks DPT OPV-1 HB-2
Advise when to return with the baby

**ADVISE WHEN TO RETURN WITH THE BABY**

For maternal visits see schedule on [D28].

### Routine visits

<table>
<thead>
<tr>
<th>Postnatal visit</th>
<th>Return</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Within the first week, preferably within 2-3 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immunization visit</th>
<th>Return</th>
</tr>
</thead>
<tbody>
<tr>
<td>(If BCG, OPV-0 and HB-1 given in the first week of life)</td>
<td>At age 6 weeks</td>
</tr>
</tbody>
</table>

### Follow-up visits

<table>
<thead>
<tr>
<th>If the problem was:</th>
<th>Return in</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding difficulty</td>
<td>2 days</td>
</tr>
<tr>
<td>Red umbilicus</td>
<td>2 days</td>
</tr>
<tr>
<td>Skin infection</td>
<td>2 days</td>
</tr>
<tr>
<td>Eye infection</td>
<td>2 days</td>
</tr>
<tr>
<td>Thrush</td>
<td>2 days</td>
</tr>
<tr>
<td>Mother has either:</td>
<td>2 days</td>
</tr>
<tr>
<td>→ breast engorgement or</td>
<td>2 days</td>
</tr>
<tr>
<td>→ mastitis</td>
<td>2 days</td>
</tr>
<tr>
<td>Low birth weight, and either</td>
<td>2 days</td>
</tr>
<tr>
<td>→ first week of life or</td>
<td></td>
</tr>
<tr>
<td>→ not adequately gaining weight</td>
<td></td>
</tr>
<tr>
<td>Low birth weight, and either</td>
<td>2 days</td>
</tr>
<tr>
<td>→ older than 1 week or</td>
<td>7 days</td>
</tr>
<tr>
<td>→ gaining weight adequately</td>
<td>7 days</td>
</tr>
<tr>
<td>Orphan baby</td>
<td>14 days</td>
</tr>
<tr>
<td>INH prophylaxis</td>
<td>14 days</td>
</tr>
<tr>
<td>Treated for possible congenital syphilis</td>
<td>14 days</td>
</tr>
<tr>
<td>Mother HIV-positive</td>
<td>14 days</td>
</tr>
</tbody>
</table>

Advise the mother to seek care for the baby

Use the counselling sheet to advise the mother when to seek care, or when to return, if the baby has any of these danger signs:

**RETURN OR GO TO THE HOSPITAL IMMEDIATELY IF THE BABY HAS**

- difficulty breathing.
- convulsions.
- fever or feels cold.
- bleeding.
- diarrhoea.
- very small, just born.
- not feeding at all.

**GO TO HEALTH CENTRE AS QUICKLY AS POSSIBLE IF THE BABY HAS**

- difficulty feeding.
- pus from eyes.
- skin pustules.
- yellow skin.
- a cord stump which is red or draining pus.
- feeds <5 times in 24 hours.

Refer baby urgently to hospital

- After emergency treatment, explain the need for referral to the mother/father.
- Organize safe transportation.
- Always send the mother with the baby, if possible.
- Send referral note with the baby.
- Inform the referral centre if possible by radio or telephone.

**DURING TRANSPORTATION**

- Keep the baby warm by skin-to-skin contact with mother or someone else.
- Cover the baby with a blanket and cover her/his head with a cap.
- Protect the baby from direct sunshine.
- Encourage breastfeeding during the journey.
- If the baby does not breastfeed and journey is more than 3 hours, consider giving expressed breast milk by cup [K6].
Check urine for protein
Check haemoglobin

Perform rapid plasmeagin (RPR) test for syphilis
**Equipment, supplies, drugs and tests for routine and emergency pregnancy and postpartum care**

### Warm and clean room
- Examination table or bed with clean linen
- Light source
- Heat source

### Hand washing
- Clean water supply
- Soap
- Nail brush or stick
- Clean towels

### Waste
- Bucket for soiled pads and swabs
- Receptacle for soiled linens
- Container for sharps disposal

### Sterilization
- Instrument sterilizer
- Jar for forceps

### Miscellaneous
- Wall clock
- Torch with extra batteries and bulb
- Log book
- Records
- Refrigerator

### Equipment
- Blood pressure machine and stethoscope
- Body thermometer
- Fetal stethoscope
- Baby scale

### Supplies
- Gloves:
  - utility
  - sterile or highly disinfected
  - long sterile for manual removal of placenta
- Urinary catheter
- Syringes and needles
- IV tubing
- Suture material for tear or episiotomy repair
- Antiseptic solution (iodophors or chlorhexidine)
- Spirit (70% alcohol)
- Swabs
- Bleach (chlorine base compound)
- Impregnated bednet
- Condoms

### Tests
- RPR testing kit
- Proteinuria sticks
- Container for catching urine

### Disposable delivery kit
- Plastic sheet to place under mother
- Cord ties (sterile)
- Sterile blade

### Drugs
- Oxytocin
- Ergometrine
- Magnesium sulphate
- Calcium gluconate
- Diazepam
- Hyaluronic acid
- Ampicillin
- Gentamicin
- Metronidazole
- Benzathine penicillin
- Cloxacillin
- Amoxycillin
- Ceftriaxone
- Trimethoprim + sulfamethoxazole
- Clotrimazole vaginal pessary
- Erythromycin
- Ciprofloxacin
- Tetracycline or doxycycline
- Artemether or quinine
- Chloroquine tablet
- Nevirapine or zidovudine
- Lignocaine
- Adrenaline
- Ringer lactate
- Normal saline 0.9%
- Glucose 50% solution
- Water for injection
- Paracetamol
- Gentian violet
- Iron folic acid tablet
- Mebendazole
- Sulphadoxine-pyrimethamine

### Vaccine
- Tétanos toxoid
## Equipment, Supplies and Drugs for Childbirth Care

### Warm and clean room
- Delivery bed: a bed that supports the woman in a semi-sitting or lying in a lateral position, with removable stirrups (only for repairing the perineum or instrumental delivery)
- Clean bed linen
- Curtains if more than one bed
- Clean surface (for alternative delivery position)
- Work surface for resuscitation of newborn near delivery beds
- Light source
- Heat source
- Room thermometer

### Hand washing
- Clean water supply
- Soap
- Nail brush or stick
- Clean towels

### Waste
- Container for sharps disposal
- Receptacle for soiled linens
- Bucket for soiled pads and swabs
- Bowl and plastic bag for placenta

### Sterilization
- Instrument sterilizer
- Jar for forceps

### Miscellaneous
- Wall clock
- Torch with extra batteries and bulb
- Log book
- Records
- Refrigerator

### Equipment
- Blood pressure machine and stethoscope
- Body thermometer
- Fetal stethoscope
- Baby scale
- Self inflating bag and mask - neonatal size
- Mucus extractor with suction tube

### Delivery instruments (sterile)
- Scissors
- Needle holder
- Artery forceps or clamp
- Dissecting forceps
- Sponge forceps
- Vaginal speculum

### Supplies
- Gloves:
  - Utility
  - Sterile or highly disinfected
  - Long sterile for manual removal of placenta
  - Long plastic apron
- Urinary catheter
- Syringes and needles
- IV tubing
- Suture material for tear or episiotomy repair
- Antiseptic solution (iodophors or chlorhexidine)
- Spirit (70% alcohol)
- Swabs
- Bleach (chlorine-base compound)
- Clean (plastic) sheet to place under mother
- Sanitary pads
- Clean towels for drying and wrapping the baby
- Cord ties (sterile)
- Blanket for the baby
- Baby feeding cup
- Impregnated bednet

### Drugs
- Oxytocin
- Ergometrine
- Magnesium sulphate
- Calcium gluconate
- Diazepam
- Hydralazine
- Ampicillin
- Gentamicin
- Metronidazole
- Benzathine penicillin
- Nevirapine or zidovudine
- Lignocaine
- Adrenaline
- Ringer lactate
- Normal saline 0.9%
- Water for injection
- Eye antimicrobial (1% silver nitrate or 2.5% povidone iodine)
- Tetracycline 1% eye ointment
- Vitamin A
- Isoniazid

### Vaccine
- BCG
- OPV
- Hepatitis B

### Contraceptives
(see Decision-making tool for family planning providers and clients)
LABORATORY TESTS

Check urine for protein

- Label a clean container.
- Give woman the clean container and explain where she can urinate.
- Teach woman how to collect a clean-catch urine sample. Ask her to:
  - Clean vulva with water
  - Spread labia with fingers
  - Urinate freely (urine should not dribble over vulva; this will ruin sample)
  - Catch the middle part of the stream of urine in the cup. Remove container before urine stops.
- Analyse urine for protein using either dipstick or boiling method.

DIPSTICK METHOD

- Dip coated end of paper dipstick in urine sample.
- Shake off excess by tapping against side of container.
- Wait specified time (see dipstick instructions).
- Compare with colour chart on label. Colours range from yellow (negative) through yellow-green and green-blue for positive.

BOILING METHOD

- Put urine in test tube and boil top half. Boiled part may become cloudy. After boiling allow the test tube to stand. A thick precipitate at the bottom of the tube indicates protein.
- Add 2-3 drops of 2-3% acetic acid after boiling the urine (even if urine is not cloudy)
  - If the urine remains cloudy, protein is present in the urine.
  - If cloudy urine becomes clear, protein is not present.
  - If boiled urine was not cloudy to begin with, but becomes cloudy when acetic acid is added, protein is present.

Check haemoglobin

- Draw blood with syringe and needle or a sterile lancet.
- Insert below instructions for method used locally.
PERFORM RAPID PLASMAREAGIN (RPR) TEST FOR SYPHILIS

Perform rapid plasmareagin (RPR) test for syphilis

- Seek consent.
- Explain procedure.
- Use a sterile needle and syringe. Draw up 5 ml blood from a vein. Put in a clear test tube.
- Let test tube sit 20 minutes to allow serum to separate (or centrifuge 3-5 minutes at 2000–3000 rpm). In the separated sample, serum will be on top.
- Use sampling pipette to withdraw some of the serum.
  Take care not to include any red blood cells from the lower part of the separated sample.
- Hold pipette vertically over a test card circle. Squeeze teat to allow one drop (50 µl) of serum to fall onto a circle. Spread the drop to fill the circle using a toothpick or other clean spreader.

Important: Several samples may be tested on one card. Be careful not to contaminate the remaining test circles. Use a clean spreader for every sample. Carefully label each sample with a patient's name or number.
- Attach dispensing needle to a syringe. Shake antigen.*
  Draw up enough antigen for the number of tests to be done (one drop per test).
- Holding the syringe vertically, allow exactly one drop of antigen (20 µl) to fall onto each test sample.
  DO NOT stir.
- Rotate the test card smoothly on the palm of the hand for 8 minutes.**
  (Or rotate on a mechanical rotator.)

Interpreting results

- After 8 minutes rotation, inspect the card in good light. Turn or tilt the card to see whether there is clumping (reactive result). Most test cards include negative and positive control circles for comparison.
  1. Non-reactive (no clumping or only slight roughness) – Negative for syphilis
  2. Reactive (highly visible clumping) – Positive for syphilis
  3. Weakly reactive (minimal clumping) – Positive for syphilis

NOTE: Weakly reactive can also be more finely granulated and difficult to see than in this illustration.

EXAMPLE OF A TEST CARD

* Make sure antigen was refrigerated (not frozen) and has not expired.
** Room temperature should be 73º - 85º F (22.8º - 29.3º C).
INFORMATION AND COUNSELLING SHEETS

CARE DURING PREGNANCY
Visit the health worker during pregnancy
Care for yourself during pregnancy
Routine visits to the health centre
Know the signs of labour
When to seek care on danger signs

PREPARING A BIRTH AND EMERGENCY PLAN
Preparing a birth plan
Planning for delivery at home
Preparing an emergency plan
Planning for delivery at the hospital or health centre

CARE FOR THE MOTHER AFTER BIRTH
Care of the mother
Family planning
Routine visits to the health centre
When to seek care for danger signs

CARE AFTER AN ABORTION
Self-care
Family planning
Know these DANGER signs
Additional support

CARE FOR THE BABY AFTER BIRTH
Care of the newborn
Routine visits to the health centre
When to seek care for danger signs

BREASTFEEDING
Breastfeeding has many advantages for the baby and the mother
Suggestions for successful breastfeeding
Health worker support
Breastfeeding and family planning

CLEAN HOME DELIVERY (1)
Delivery at home with an attendant
Instructions to mother and family for a clean and safer delivery at home

CLEAN HOME DELIVERY (2)
Avoid harmful practices
Encourage helpful traditional practices
Danger signs during delivery
Routine visits to the health centre

These individual sheets have key information for the mother, her partner and family on care during pregnancy, preparing a birth and emergency plan, clean home delivery, care for the mother and baby after delivery, breastfeeding and care after an abortion.

Individual sheets are used so that the woman can be given the relevant sheet at the appropriate stage of pregnancy and childbirth.
Visit the health worker during pregnancy

- Go to the health centre if you think you are pregnant. It is important to begin care as early in your pregnancy as possible.
- Visit the health centre at least 4 times during your pregnancy, even if you do not have any problems. The health worker will tell you when to return.
- If at any time you have any concerns about your or your baby's health, go to the health centre.
- During your visits to the health centre, the health worker will:
  - Check your health and the progress of the pregnancy
  - Help you make a birth plan
  - Answer questions or concerns you may have
  - Provide treatment for malaria and anaemia
  - Give you a tetanus toxoid immunization
  - Advise and counsel on:
    - breastfeeding
    - birthspacing after delivery
    - nutrition
    - HIV counselling and testing
    - correct and consistent condom use
    - laboratory tests
    - other matters related to your and your baby's health.
- Bring your home-based maternal record to every visit.

Care for yourself during pregnancy

- Eat more and healthier foods, including more fruits and vegetables, beans, meat, fish, eggs, cheese, milk.
- Take iron tablets every day as explained by the health worker.
- Rest when you can. Avoid lifting heavy objects.
- Sleep under a bednet treated with insecticide.
- Do not take medication unless prescribed at the health centre.
- Do not drink alcohol or smoke.
- Use a condom correctly in every sexual relation to prevent sexually transmitted infection (STI) or HIV/AIDS if you or your companion are at risk of infection.

**PREGNANCY IS A SPECIAL TIME. CARE FOR YOURSELF AND YOUR BABY.**

Routine visits to the health centre

<table>
<thead>
<tr>
<th>Visit</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st visit</td>
<td>Before 4 months</td>
</tr>
<tr>
<td>2nd visit</td>
<td>6-7 months</td>
</tr>
<tr>
<td>3rd visit</td>
<td>8 months</td>
</tr>
<tr>
<td>4th visit</td>
<td>9 months</td>
</tr>
</tbody>
</table>

Know the signs of labour

If you have any of these signs, go to the health centre as soon as you can.

**If these signs continue for 12 hours or more, you need to go immediately.**

- Painful contractions every 20 minutes or less.
- Bag of water breaks.
- Bloody sticky discharge.

When to seek care on danger signs

Go to the hospital or health centre immediately, day or night, DO NOT wait, if any of the following signs:

- vaginal bleeding
- convulsions/ fits
- severe headaches with blurred vision
- fever and too weak to get out of bed
- severe abdominal pain
- fast or difficult breathing.

Go to the health centre as soon as possible if any of the following signs:

- fever
- abdominal pain
- water breaks and not in labour after 6 hours
- feel ill
- swollen fingers, face and legs.
Preparing a birth plan

The health worker will provide you with information to help you prepare a birth plan. Based on your health condition, the health worker can make suggestions as to where it would be best to deliver. Whether in a hospital, health centre or at home, it is important to deliver with a skilled attendant.

At every visit to the health centre, review and discuss your birth plan. The plan can change if complications develop.

Planning for delivery at home

- Who do you choose to be the skilled attendant for delivery?
- Who will support you during labour and delivery?
- Who will be close by for at least 24 hours after delivery?
- Who will help you to care for your home and other children?
- Organize the following:
  - A clean and warm room or corner of a room.
  - Home-based maternal record.
  - A clean delivery kit which includes soap, a stick to clean under the nails, a new razor blade to cut the baby's cord, 3 pieces of string (about 20 cm. each) to tie the cord.
  - Clean cloths of different sizes: for the bed, for drying and wrapping the baby, and for cleaning the baby's eyes, and for you to use as sanitary pads.
  - Warm covers for you and the baby.
  - Warm spot for the birth with a clean surface or clean cloth.
  - Bowls: two for washing and one for the placenta.
  - Buckets of clean water and some way to heat this water.
  - For handwashing, water, soap and a towel or cloth for drying hands of the birth attendant.
  - Fresh drinking water, fluids and food for the mother.

Preparing an emergency plan

To plan for an emergency, consider:
- Where should you go?
- How will you get there?
- Will you have to pay for transport to get there? How much will it cost?
- What costs will you have to pay at the health centre? How will you pay for this?
- Can you start saving for these possible costs now?
- Who will go with you to the health centre?
- Who will help you while you are away and care for your home and other children?

Planning for delivery at the hospital or health centre

- How will you get there? Will you have to pay for transport to get there?
- How much will it cost to deliver at the facility? How will you pay for this?
- Can you start saving for these costs now?
- Who will go with you and support you during labour and delivery?
- Who will help you while you are away and care for your home and other children?
- Bring the following:
  - Home-based maternal record.
  - Clean clothes of different sizes: for the bed, for drying and wrapping the baby, and for you to use as sanitary pads.
  - Clean clothes for you and the baby.
  - Food and water for you and the support person.
Care for the mother after birth

CARE FOR THE MOTHER AFTER BIRTH

Care of the mother

■ Eat more and healthier foods, including more meat, fish, oils, coconut, nuts, cereals, beans, vegetables, fruits, cheese and milk.
■ Take iron tablets as explained by the health worker.
■ Rest when you can.
■ Drink plenty of clean, safe water.
■ Sleep under a bednet treated with insecticide.
■ Do not take medication unless prescribed at the health centre.
■ Do not drink alcohol or smoke.
■ Use a condom in every sexual relation, if you or your companion are at risk of sexually transmitted infections (STI) or HIV/AIDS.
■ Wash all over daily, particularly the perineum.
■ Change pad every 4 to 6 hours. Wash pad or dispose of it safely.

Family planning

■ You can become pregnant within several weeks after delivery if you have sexual relations and are not breastfeeding exclusively.
■ Talk to the health worker about choosing a family planning method which best meets your and your partner’s needs.

Routine visits to the health centre

First week after birth:

6 weeks after birth:

When to seek care for danger signs

Go to hospital or health centre immediately, day or night, DO NOT wait, if any of the following signs:
■ Vaginal bleeding has increased.
■ Fits.
■ Fast or difficult breathing.
■ Fever and too weak to get out of bed.
■ Severe headaches with blurred vision.

Go to health centre as soon as possible if any of the following signs:
■ Swollen, red or tender breasts or nipples.
■ Problems urinating, or leaking.
■ Increased pain or infection in the perineum.
■ Infection in the area of the wound.
■ Smelly vaginal discharge.
CARE AFTER AN ABORTION

Self-care
- Rest for a few days, especially if you feel tired.
- Change pads every 4 to 6 hours. Wash used pad or dispose of it safely. Wash perineum.
- Do not have sexual intercourse until bleeding stops.
- You and your partner should use a condom correctly in every act of sexual intercourse if at risk of STI or HIV.
- Return to the health worker as indicated.

Family planning
- Remember you can become pregnant as soon as you have sexual relations.
  Use a family planning method to prevent an unwanted pregnancy.
- Talk to the health worker about choosing a family planning method which best meets your and your partner's needs.

Know these danger signs
If you have any of these signs, go to the health centre immediately, day or night. DO NOT wait:
- Increased bleeding or continued bleeding for 2 days.
- Fever, feeling ill.
- Dizziness or fainting.
- Abdominal pain.
- Backache.
- Nausea, vomiting.
- Foul-smelling vaginal discharge.

Additional support
- The health worker can help you identify persons or groups who can provide you with additional support if you should need it.
Care for the baby after birth

CARE FOR THE BABY AFTER BIRTH

Care of the newborn

KEEP YOUR NEWBORN CLEAN
- Wash your baby's face and neck daily. Bathe her/him when necessary. After bathing, thoroughly dry your baby and then dress and keep her/him warm.
- Wash baby's bottom when soiled and dry it thoroughly.
- Wash your hands with soap and water before and after handling your baby, especially after touching her/his bottom.

CARE FOR THE NEWBORN'S UMBILICAL CORD
- Keep cord stump loosely covered with a clean cloth. Fold diaper and clothes below stump.
- Do not put anything on the stump.
- If stump area is soiled, wash with clean water and soap. Then dry completely with clean cloth.
- Wash your hands with soap and water before and after care.

KEEP YOUR NEWBORN WARM
- In cold climates, keep at least an area of the room warm.
- Newborns need more clothing than other children or adults.
- If cold, put a hat on the baby's head. During cold nights, cover the baby with an extra blanket.

OTHER ADVICE
- Let the baby sleep on her/his back or side.
- Keep the baby away from smoke.

Routine visits to the health centre

First week after birth:

At 6 weeks:

At these visits your baby will be vaccinated. Have your baby immunized.

When to seek care for danger signs

Go to the hospital or health centre immediately, day or night, DO NOT wait, if your baby has any of the following signs:
- Difficulty breathing
- Fits
- Fever
- Feels cold
- Bleeding
- Stops feeding
- Diarrhoea.

Go to the health centre as soon as possible if your baby has any of the following signs:
- Difficulty feeding.
- Feeds less than every 5 hours.
- Pus coming from the eyes.
- Irritated cord with pus or blood.
- Yellow eyes or skin.
Breastfeeding has many advantages

FOR THE BABY
- During the first 6 months of life, the baby needs nothing more than breast milk — not water, not other milk, not cereals, not teas, not juices.
- Breast milk contains exactly the water and nutrients that a baby's body needs. It is easily digested and efficiently used by the baby's body. It helps protect against infections and allergies and helps the baby's growth and development.

FOR THE MOTHER
- Postpartum bleeding can be reduced due to uterine contractions caused by the baby's sucking.
- Breastfeeding can help delay a new pregnancy.

FOR THE FIRST 6 MONTHS OF LIFE, GIVE ONLY BREAST MILK TO YOUR BABY, DAY AND NIGHT AS OFTEN AND AS LONG AS SHE/HE WANTS.

Suggestions for successful breastfeeding
- Immediately after birth, keep your baby in the bed with you, or within easy reach.
- Start breastfeeding within 1 hour of birth.
- The baby's suck stimulates your milk production. The more the baby feeds, the more milk you will produce.
- At each feeding, let the baby feed and release your breast, and then offer your second breast. At the next feeding, alternate and begin with the second breast.
- Give your baby the first milk (colostrum). It is nutritious and has antibodies to help keep your baby healthy.
- At night, let your baby sleep with you, within easy reach.
- While breastfeeding, you should drink plenty of clean, safe water. You should eat more and healthier foods and rest when you can.

The health worker can support you in starting and maintaining breastfeeding
- The health worker can help you to correctly position the baby and ensure she/he attaches to the breast. This will reduce breast problems for the mother.
- The health worker can show you how to express milk from your breast with your hands. If you should need to leave the baby with another caretaker for short periods, you can leave your milk and it can be given to the baby in a cup.
- The health worker can put you in contact with a breastfeeding support group.

If you have any difficulties with breastfeeding, see the health worker immediately.

Breastfeeding and family planning
- During the first 6 months after birth, if you breastfeed exclusively day and night, and your menstruation has not returned, you are protected against another pregnancy.
- If you do not meet these requirements, or if you wish to use another family planning method while breastfeeding, discuss the different options available with the health worker.
Regardless of the site of delivery, it is strongly recommended that all women deliver with a skilled attendant. For a woman who prefers to deliver at home the following recommendations are provided for a clean home delivery to be reviewed during antenatal care visits.

**CLEAN HOME DELIVERY**

**Delivery at home with an attendant**

- Ensure the attendant and other family members know the emergency plan and are aware of danger signs for yourself and your baby.
- Arrange for a support person to assist the attendant and to stay with you during labour and after delivery.
- Have these supplies organized for a clean delivery: new razor blade, 3 pieces of string about 20 cm each to tie the cord, and clean cloths to cover the birth place.
- Prepare the home and the supplies indicated for a safe birth:
  - Clean, warm birth place with fresh air and a source of light
  - Clean warm blanket to cover you
  - Clean clothes:
    - for drying and wrapping the baby
    - for cleaning the baby’s eyes
    - to use as sanitary pads after birth
    - to dry your body after washing
    - for birth attendant to dry her hands.
  - Clean clothes for you to wear after delivery
  - Fresh drinking water, fluids and food for you
  - Buckets of clean water and soap for washing, for you and the skilled attendant
  - Means to heat water
  - Three bowls, two for washing and one for the placenta
  - Plastic for wrapping the placenta
  - Bucket for you to urinate in.

**Instructions to mother and family for a clean and safer delivery at home**

- Make sure there is a clean delivery surface for the birth of the baby
- Ask the attendant to wash her hands before touching you or the baby. The nails of the attendant should be short and clean.
- When the baby is born, place her/him on your abdomen/chest where it is warm and clean. Dry the baby thoroughly and wipe the face with a clean cloth. Then cover with a clean dry cloth.
- Cut the cord when it stops pulsating, using the disposable delivery kit, according to instructions.
- Wait for the placenta to deliver on its own.
- Make sure you and your baby are warm. Have the baby near you, dressed or wrapped and with head covered with a cap.
- Start breastfeeding when the baby shows signs of readiness, within the first hour of birth.
- Dispose of placenta ____________________________
  (describe correct, safe culturally accepted way to dispose of placenta)

**DO NOT**
- be alone for the 24 hours after delivery.
- bath the baby on the first day.
Avoid harmful practices

FOR EXAMPLE:
DO NOT use local medications to hasten labour.
DO NOT wait for waters to stop before going to health facility.
DO NOT insert any substances into the vagina during labour or after delivery.
DO NOT push on the abdomen during labour or delivery.
DO NOT pull on the cord to deliver the placenta.
DO NOT put ashes, cow dung or other substance on umbilical cord/stump.

Encourage helpful traditional practices:

Danger signs during delivery

If you or your baby has any of these signs, go to the hospital or health centre immediately, day or night, DO NOT wait.

MOTHER
- If waters break and not in labour after 6 hours.
- Labour pains (contractions) continue for more than 12 hours.
- Heavy bleeding (soaks more than 2-3 pads in 15 minutes).
- Placenta not expelled 1 hour after birth of baby.

BABY
- Very small.
- Difficulty in breathing.
- Fits.
- Fever.
- Feels cold.
- Bleeding.
- Not able to feed.

Routine visits to the health centre

- Go to the health centre or arrange a home visit by a skilled attendant as soon as possible after delivery preferably within the first days, for the examination of you and your baby and to receive preventive measures.
- Go for a routine postpartum visit at 6 weeks.
Records and forms

RECORDS AND FORMS

- Records are suggested not so much for the format as for the content. The content of the records is adjusted to the content of the Guide.
- Modify national or local records to include all the relevant sections needed to record important information for the provider, the woman and her family, for the purposes of monitoring and surveillance and official reporting.
- Fill out other required records such as immunization cards for the mother and baby.
### Referral Record

<table>
<thead>
<tr>
<th>WOMAN</th>
<th>BABY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NAME</strong></td>
<td><strong>NAME</strong></td>
</tr>
<tr>
<td><strong>ADDRESS</strong></td>
<td><strong>DATE AND HOUR OF BIRTH</strong></td>
</tr>
<tr>
<td><strong>MAIN REASONS FOR REFERRAL</strong></td>
<td><strong>MAIN REASONS FOR REFERRAL</strong></td>
</tr>
<tr>
<td>- Emergency</td>
<td>- Emergency</td>
</tr>
<tr>
<td>- Non-emergency</td>
<td>- Non-emergency</td>
</tr>
<tr>
<td>- To accompany the baby</td>
<td>- To accompany the mother</td>
</tr>
<tr>
<td><strong>MAJOR FINDINGS (CLINICA AND BP, TEMP., LAB.)</strong></td>
<td><strong>MAJOR FINDINGS (CLINICA AND TEMP.)</strong></td>
</tr>
<tr>
<td><strong>LAST (BREAST) FEED (TIME)</strong></td>
<td><strong>LAST (BREAST) FEED (TIME)</strong></td>
</tr>
<tr>
<td><strong>TREATMENTS GIVEN AND TIME BEFORE REFERRAL</strong></td>
<td><strong>TREATMENTS GIVEN AND TIME BEFORE REFERRAL</strong></td>
</tr>
<tr>
<td><strong>DURING TRANSPORT</strong></td>
<td><strong>DURING TRANSPORT</strong></td>
</tr>
<tr>
<td><strong>INFORMATION GIVEN TO THE WOMAN AND COMPANION ABOUT THE REASONS FOR REFERRAL</strong></td>
<td><strong>INFORMATION GIVEN TO THE WOMAN AND COMPANION ABOUT THE REASONS FOR REFERRAL</strong></td>
</tr>
</tbody>
</table>

---

Sample form to be adapted. Revised on 13 June 2003.
### FEEDBACK RECORD

<table>
<thead>
<tr>
<th>WHO IS REFERRING</th>
<th>RECORD NUMBER</th>
<th>ADMISSION DATE</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
<td>DISCHARGE DATE</td>
<td>TIME</td>
<td></td>
</tr>
<tr>
<td>FACILITY</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### WOMAN

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>ADDRESS</th>
<th>MAIN REASONS FOR REFERRAL</th>
<th>□ Emergency □ Non-emergency □ To accompany the baby</th>
</tr>
</thead>
</table>

### BABY

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>BIRTH WEIGHT</th>
<th>AGE AT DISCHARGE (DAYS)</th>
<th>MAIN REASONS FOR REFERRAL</th>
<th>□ Emergency □ Non-emergency □ To accompany the mother</th>
</tr>
</thead>
</table>

### DIAGNOSES

### TREATMENTS GIVEN AND TIME

### TREATMENTS AND RECOMMENDATIONS ON FURTHER CARE

### FOLLOW-UP VISIT

<table>
<thead>
<tr>
<th>WHEN</th>
<th>WHERE</th>
</tr>
</thead>
</table>

### PREVENTIVE MEASURES

### IF DEATH:

<table>
<thead>
<tr>
<th>DATE</th>
<th>CAUSES</th>
</tr>
</thead>
</table>

Sample form to be adapted. Revised on 25 August 2003.
# Labour Record

**Labour Record**

**Use this record for monitoring during labour, delivery and postpartum**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>During Labour</th>
<th>At or After Birth – Mother</th>
<th>At or After Birth – Newborn</th>
<th>Planned Newborn Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date</td>
<td>Birth Time</td>
<td>Livebirth □</td>
<td>Stillbirth: Fresh □</td>
</tr>
<tr>
<td>Admission Time</td>
<td>Oxytocin – Time Given</td>
<td>Resuscitation No □</td>
<td>MACERATED □</td>
</tr>
<tr>
<td>Time Active Labour Started</td>
<td>Placenta Complete No □ Yes □</td>
<td>Birth Weight</td>
<td></td>
</tr>
<tr>
<td>Time Membranes Ruptured</td>
<td>Time Delivered</td>
<td>Gest. Age</td>
<td>Or Preterm No □ Yes □</td>
</tr>
<tr>
<td>Time Second Stage Starts</td>
<td>Estimated Blood Loss</td>
<td>Second Baby</td>
<td></td>
</tr>
</tbody>
</table>

### Entry Examination

#### Stage of Labour
- Not in Active Labour □
- Active Labour □

#### Not in Active Labour

<table>
<thead>
<tr>
<th>Hours Since Arrival</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
</table>

#### Planned Maternal Treatment

<table>
<thead>
<tr>
<th>Hours Since Ruptured Membranes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal Bleeding (0 +++)</td>
</tr>
<tr>
<td>Strong Contractions in 10 Minutes</td>
</tr>
<tr>
<td>Fetal Heart Rate (Beats Per Minute)</td>
</tr>
<tr>
<td>T (Axillary)</td>
</tr>
<tr>
<td>Pulse (Beats/Minute)</td>
</tr>
<tr>
<td>Blood Pressure (Systolic/Diastolic)</td>
</tr>
<tr>
<td>Urine Voided</td>
</tr>
<tr>
<td>Cervical Dilatation (CM)</td>
</tr>
</tbody>
</table>

### Problem

<table>
<thead>
<tr>
<th>Time Onset</th>
<th>Treatments Other Than Normal Supportive Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### If Mother Referred during Labour or Delivery, Record Time and Explain

---

Sample form to be adapted. Revised on 13 June 2003.
## Findings

<table>
<thead>
<tr>
<th>FINDINGS</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours in active labour</td>
<td>1-12</td>
</tr>
<tr>
<td>Hours since ruptured membranes</td>
<td></td>
</tr>
<tr>
<td>Rapid assessment</td>
<td>B3-B7</td>
</tr>
<tr>
<td>Vaginal bleeding (0 + ++)</td>
<td></td>
</tr>
<tr>
<td>Amniotic fluid (meconium stained)</td>
<td></td>
</tr>
<tr>
<td>Contractions in 10 minutes</td>
<td></td>
</tr>
<tr>
<td>Fetal heart rate (beats/minute)</td>
<td></td>
</tr>
<tr>
<td>Urine voided</td>
<td></td>
</tr>
<tr>
<td>T (axillary)</td>
<td></td>
</tr>
<tr>
<td>Pulse (beats/minute)</td>
<td></td>
</tr>
<tr>
<td>Blood pressure (systolic/diastolic)</td>
<td></td>
</tr>
<tr>
<td>Cervical dilatation (cm)</td>
<td></td>
</tr>
<tr>
<td>Delivery of placenta (time)</td>
<td></td>
</tr>
<tr>
<td>Oxytocin (time/given)</td>
<td></td>
</tr>
<tr>
<td>Problem-note onset/describe below</td>
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</tbody>
</table>

**Partograph**

USE THIS FORM FOR MONITORING ACTIVE LABOUR.
### POSTPARTUM RECORD

<table>
<thead>
<tr>
<th>MONITORING AFTER BIRTH</th>
<th>TIME</th>
<th>2 HR</th>
<th>3 HR</th>
<th>4 HR</th>
<th>8 HR</th>
<th>16 HR</th>
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</tr>
<tr>
<td>BLEEDING (0 + ++)</td>
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<td></td>
<td></td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>UTERUS HARD/ROUND?</td>
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<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>MATERNAL: BLOOD PRESSURE</td>
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<td></td>
<td></td>
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<td></td>
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<td>URINE VOIDED</td>
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<tr>
<td>VULVA</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEWBORN: BREATHING</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WARMTH</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>NEWBORN ABNORMAL SIGNS (LIST)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TIME FEEDING OBSERVED</td>
<td>□ FEEDING WELL □ DIFFICULTY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMMENTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TIME TREATMENT GIVEN

<table>
<thead>
<tr>
<th>PLANNED TREATMENT</th>
<th>TIME</th>
<th>TREATMENT GIVEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOTHER</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| NEWBORN |      |               |

#### ADVISE AND COUNSEL

##### MOTHER
- Postpartum care and hygiene
- Nutrition
- Birth spacing and family planning
- Danger signs
- Follow-up visits

##### BABY
- Exclusive breastfeeding
- Hygiene, cord care and warmth
- Special advice if low birth weight
- Danger signs
- Follow-up visits

#### PREVENTIVE MEASURES

##### FOR MOTHER
- Iron/folate
- Vitamin A
- Mebendazole
- Sulphadoxine-pyrimethamine
- Tetanus toxoid immunization
- RPR test result and treatment
- ARV

##### FOR BABY
- Risk of bacterial infection and treatment
- BCG, OPV-0, Hep-0
- RPR result and treatment
- TB test result and prophylaxis
- ARV

Sample form to be adapted. Revised on 25 August 2003.
## INTERNATIONAL FORM OF MEDICAL CERTIFICATE OF CAUSE OF DEATH

<table>
<thead>
<tr>
<th>CAUSE OF DEATH</th>
<th>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I</strong></td>
<td></td>
</tr>
<tr>
<td>Disease or condition directly leading to death*</td>
<td>(a) .......................................</td>
</tr>
<tr>
<td></td>
<td>Due to (or as consequence of) ...............</td>
</tr>
<tr>
<td></td>
<td>(b) .......................................</td>
</tr>
<tr>
<td><strong>Antecedent causes</strong></td>
<td>Due to (or as consequence of) ...............</td>
</tr>
<tr>
<td>Morbid conditions, if any, giving rise to the above cause, stating</td>
<td>(C) .......................................</td>
</tr>
<tr>
<td></td>
<td>Due to (or as consequence of) ...............</td>
</tr>
<tr>
<td></td>
<td>(d) .......................................</td>
</tr>
<tr>
<td><strong>II</strong></td>
<td></td>
</tr>
<tr>
<td>Other significant conditions contributing to the death, but not related to the disease or condition causing it.</td>
<td>.......................................</td>
</tr>
</tbody>
</table>

* This does not mean the mode of dying, e.g. heart failure, respiratory failure. It means the disease, injury or complication that caused death.

### CONSIDER COLLECTING THE FOLLOWING INFORMATION

#### III
If the deceased is a female, was she
- [ ] Not pregnant
- [ ] Not pregnant, but pregnant within 42 days of death
- [ ] Pregnant at the time of death
- [ ] Unknown if pregnant or was pregnant within 42 days of death

#### IV
If the deceased is an infant and less than one month old
- What was the birth weight: ........... g
- If exact birth weight not known, was baby weighing:
  - [ ] 2500 g or more
  - [ ] less than 2500 g
GLOSSARY AND ACRONYMS

ABORTION
Termination of pregnancy from whatever cause before the fetus is capable of extrauterine life.

ADOLESCENT
Young person 10-19 years old.

ADVISE
To give information and suggest to someone a course of action.

ANTENATAL CARE
Care for the woman and fetus during pregnancy.

ASSES
To consider the relevant information and make a judgement. As used in this guide, to examine a woman or baby and identify signs of illness.

BABY
A very young boy or girl in the first week(s) of life.

BIRTH
Expulsion or extraction of the baby (regardless of whether the cord has been cut).

BIRTH AND EMERGENCY PLAN
A plan for safe childbirth developed in antenatal care visit which considers the woman’s condition, preferences and available resources. A plan to seek care for danger signs during pregnancy, childbirth and postpartum period, for the woman and newborn.

BIRTH WEIGHT
The first of the fetus or newborn obtained after birth.

For live births, birth weight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred, recorded to the degree of accuracy to which it is measured.

CHART
As used in this guide, a sheet presenting information in the form of a table.

CHILDBIRTH
Giving birth to a baby or babies and placenta.

CLASSIFY
To select a category of illness and severity based on a woman’s or baby’s signs and symptoms.

CLINIC
As used in this guide, any first-level outpatient health facility such as a dispensary, rural health post, health centre or outpatient department of a hospital.

COMMUNITY
As used in this guide, a group of people sometimes living in a defined geographical area, who share common culture, values and norms. Economic and social differences need to be taken into account when determining needs and establishing links within a given community.

CONFIDENCE
A feeling of being able to succeed.

CONTRAINICATION
A condition occurring during another disease or aggravating it. This classification includes conditions such as obstructed labour or bleeding.

COUNSELLING
As used in this guide, interaction with a woman to support her in solving actual or anticipated problems, reviewing options, and making decisions. It places emphasis on provider support for helping the woman make decisions.

DANGER SIGNS
Terminology used to explain to the woman the signs of life-threatening and other serious conditions which require immediate intervention.

DANGERS
Signs of life-threatening conditions which require immediate intervention.

ESSENTIAL
Basic, indispensable, necessary.

CONCERN
A worry or an anxiety that the woman may have about herself or the baby(ies).

FACILITY
A place where organized care is provided: a health post, health centre, hospital maternity or emergency unit, or ward.

FAMILY
Includes relationships based on blood, marriage, sexual partnership, and adoption, and a broad range of groups whose bonds are based on feelings of trust mutual support, and a shared destiny.

FOLLOW-UP VISIT
A return visit requested by a health worker to see if further treatment or referral is needed.

GESTATIONAL AGE
Duration of pregnancy from the last menstrual period. In this guide, duration of pregnancy (gestational age) is expressed in 3 different ways:

<table>
<thead>
<tr>
<th>Trimester</th>
<th>Months</th>
<th>Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>less than 4 months</td>
<td>less than 16 weeks</td>
</tr>
<tr>
<td>Second</td>
<td>4-6 months</td>
<td>16-28 weeks</td>
</tr>
<tr>
<td>Third</td>
<td>7-9+ months</td>
<td>29-40+ weeks</td>
</tr>
</tbody>
</table>

GRUNTING
Soft short sounds that a baby makes when breathing out. Grunting occurs when a baby is having difficulty breathing.
<table>
<thead>
<tr>
<th>GLOSSARY AND ACRONYMS</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOME DELIVERY</td>
<td>Delivery at home (with a skilled attendant, a traditional birth attendant, a family member, or by the woman herself).</td>
</tr>
<tr>
<td>HOSPITAL</td>
<td>As used in this guide, any health facility with inpatient beds, supplies and expertise to treat a woman or newborn with complications.</td>
</tr>
<tr>
<td>INTEGRATED MANAGEMENT</td>
<td>A process of caring for the woman in pregnancy, during and after childbirth, and for her newborn, that includes considering all necessary elements: care to ensure they remain healthy, and prevention, detection and management of complications in the context of her environment and according to her wishes.</td>
</tr>
<tr>
<td>LABOUR</td>
<td>As used in this guide, a period from the onset of regular contractions to complete delivery of the placenta.</td>
</tr>
<tr>
<td>LOW BIRTH WEIGHT BABY</td>
<td>Weighing less than 2500 g at birth.</td>
</tr>
<tr>
<td>MATERNITY CLINIC</td>
<td>Health centre with beds or a hospital where women and their newborns receive care during childbirth and delivery, and emergency first aid.</td>
</tr>
<tr>
<td>MISCARRIAGE</td>
<td>Premature expulsion of a non-viable fetus from the uterus.</td>
</tr>
<tr>
<td>MONITORING</td>
<td>Frequently repeated measurements of vital signs or observations of danger signs.</td>
</tr>
<tr>
<td>NEWBORN</td>
<td>Recently born infant. In this guide used interchangeable with baby.</td>
</tr>
<tr>
<td>PARTNER</td>
<td>As used in this guide, the male companion of the pregnant woman (husband, “free union”) who is the father of the baby or the actual sexual partner.</td>
</tr>
<tr>
<td>POSTNATAL CARE</td>
<td>Care for the baby after birth. For the purposes of this guide, up to two weeks.</td>
</tr>
<tr>
<td>POSTPARTUM CARE</td>
<td>Care for the woman provided in the postpartum period, e.g. from complete delivery of the placenta to 42 days after delivery.</td>
</tr>
<tr>
<td>PRE-REFERRAL</td>
<td>Before referral to a hospital.</td>
</tr>
<tr>
<td>PREGNANCY</td>
<td>Period from when the woman misses her menstrual period or the uterus can be felt, to the onset of labour/ elective caesarian section or abortion.</td>
</tr>
<tr>
<td>PREMATURE</td>
<td>Before 37 completed weeks of pregnancy.</td>
</tr>
<tr>
<td>PRETERM BABY</td>
<td>Born early, before 37 completed weeks of pregnancy. If number of weeks not known, 1 month early.</td>
</tr>
<tr>
<td>PRIMARY HEALTH CARE*</td>
<td>Essential health care accessible at a cost the country and community can afford, with methods that are practical, scientifically sound and socially acceptable. (Among the essential activities are maternal and child health care, including family planning; immunization; appropriate treatment of common diseases and injuries; and the provision of essential drugs).</td>
</tr>
<tr>
<td>PRIMARY HEALTH CARE LEVEL</td>
<td>Health post, health centre or maternity clinic, a hospital providing care for normal pregnancy and childbirth.</td>
</tr>
<tr>
<td>PRIORITY SIGNS</td>
<td>Signs of serious conditions which require interventions as soon as possible, before they become life-threatening.</td>
</tr>
<tr>
<td>RAPID ASSESSMENT AND MANAGEMENT</td>
<td>Systematic assessment of vital functions of the woman and the most severe presenting signs and symptoms; immediate initial management of the life-threatening conditions; and urgent and safe referral to the next level of care.</td>
</tr>
<tr>
<td>REASSSESSMENT</td>
<td>As used in this guide, to examine the woman or baby again for signs of a specific illness or condition to see if she or the newborn are improving.</td>
</tr>
<tr>
<td>RECOMMENDATION</td>
<td>Advice. Instruction that should be followed.</td>
</tr>
<tr>
<td>REFERRAL, URGENT</td>
<td>As used in this guide, sending a woman or baby or both, for further assessment and care to a higher level of care; including arranging for transport and care during transport, preparing written information (referral form), and communicating with the referral institution.</td>
</tr>
<tr>
<td>REPLACEMENT FEEDING</td>
<td>The process of feeding a baby who is not receiving breast milk with a diet that provides all the nutrients she/he needs until able to feed entirely on family foods.</td>
</tr>
<tr>
<td>SECONDARY HEALTH CARE</td>
<td>More specialized care offered at the most peripheral level, for example radiographic diagnostic, general surgery, care of women with complications of pregnancy and childbirth, and diagnosis and treatment of uncommon and severe diseases. (This kind of care is provided by trained staff at such institutions as district or provincial hospitals).</td>
</tr>
<tr>
<td>SHOCK</td>
<td>A dangerous condition with severe weakness, lethargy, or unconsciousness, cold extremeties, and fast, weak pulse. It is caused by severe bleeding, severe infection, or obstructed labour.</td>
</tr>
<tr>
<td>SIGN</td>
<td>As used in this guide, physical evidence of a health problem which the health worker observes by looking, listening, feeling or measuring. Examples of signs: bleeding, convulsions, hypertension, anaemia, fast breathing.</td>
</tr>
</tbody>
</table>
**SKILLED ATTENDANT**
Refers exclusively to people with midwifery skills (for example, midwives, doctors and nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose or refer obstetric complications.

For the purposes of this guide, a person with midwifery skills who:

- has acquired the requisite qualifications to be registered and/or legally licensed to practice training and licensing requirements are country-specific;
- may practice in hospitals, clinics, health units, in the home, or in any other service setting;
- is able to do the following:
  - give necessary care and advice to women during pregnancy and postpartum and for their newborn infants;
  - conduct deliveries on her/his own and care for the mother and newborn; this includes provision of preventive care, and detection and appropriate referral of abnormal conditions.
  - provide emergency care for the woman and newborn; perform selected obstetrical procedures such as manual removal of placenta and newborn resuscitation; prescribe and give drugs (IM/IV) and infusions to the mother and baby as needed, including for post-abortion care.

**SMALL BABY**
A newly born infant born preterm and/or with low birth weight.

**STABLE**
Staying the same rather than getting worse.

**STILLBIRTH**
Birth of a baby that shows no signs of life at birth (no gasping, breathing or heart beat).

**SURVEILLANCE, PERMANENT**
Continuous presence and observation of a woman in labour.

**SYMPTOM**
As used in this guide, a health problem reported by a woman, such as pain or headache.

**TERM, FULL-TERM**
Word used to describe a baby born after 37 completed weeks of pregnancy.

**TRIMESTER OF PREGNANCY**
See Gestational age.

**VERY SMALL BABY**
Baby with birth weight less than 1500g or gestational age less than 32 weeks.

WHO definitions have been used where possible but, for the purposes of this guide, have been modified where necessary to be more appropriate to clinical care (reasons for modification are given). For conditions where there are no official WHO definitions, operational terms are proposed, again only for the purposes of this guide.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome, caused by infection with human immunodeficiency virus (HIV). AIDS is the final and most severe phase of HIV infection.</td>
</tr>
<tr>
<td>ANC</td>
<td>Care for the woman and fetus during pregnancy.</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral drug, a drug to treat HIV infection. As used in this guide, a drug used to prevent mother-to-child transmission of HIV.</td>
</tr>
<tr>
<td>BCG</td>
<td>An immunization to prevent tuberculosis, given at birth.</td>
</tr>
<tr>
<td>BP</td>
<td>Blood pressure.</td>
</tr>
<tr>
<td>BPM</td>
<td>Beats per minute.</td>
</tr>
<tr>
<td>FHR</td>
<td>Fetal heart rate.</td>
</tr>
<tr>
<td>Hb</td>
<td>Haemoglobin.</td>
</tr>
<tr>
<td>HB-1</td>
<td>Vaccine given at birth to prevent hepatitis B.</td>
</tr>
<tr>
<td>HMBR</td>
<td>Home-based maternal record: pregnancy, delivery and inter-pregnancy record for the woman and some information about the newborn.</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus. HIV is the virus that causes AIDS.</td>
</tr>
<tr>
<td>INH</td>
<td>Isoniazid, a drug to treat tuberculosis.</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous (injection or infusion).</td>
</tr>
<tr>
<td>IM</td>
<td>Intramuscular injection.</td>
</tr>
<tr>
<td>IU</td>
<td>International unit.</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine device.</td>
</tr>
<tr>
<td>LAM</td>
<td>Lactation amenorrhea.</td>
</tr>
<tr>
<td>LBW</td>
<td>Low birth weight: birth weight less than 2500 g.</td>
</tr>
<tr>
<td>LMP</td>
<td>Last menstrual period: a date from which the date of delivery is estimated.</td>
</tr>
<tr>
<td>MTCT</td>
<td>Mother-to-child transmission of HIV.</td>
</tr>
<tr>
<td>NG</td>
<td>Naso-gastric tube, a feeding tube put into the stomach through the nose.</td>
</tr>
<tr>
<td>ORS</td>
<td>Oral rehydration solution.</td>
</tr>
<tr>
<td>OPV-0</td>
<td>Oral polio vaccine. To prevent poliomyelitis, OPV-0 is given at birth.</td>
</tr>
<tr>
<td>QC</td>
<td>A quick check assessment of the health status of the woman or her baby at the first contact with the health provider or services in order to assess if emergency care is required.</td>
</tr>
<tr>
<td>PAL</td>
<td>Practical approach to lung health guidelines.</td>
</tr>
<tr>
<td>RAM</td>
<td>Systematic assessment of vital functions of the woman and the most severe presenting signs and symptoms; immediate initial management of the life-threatening conditions; and urgent and safe referral to the next level of care.</td>
</tr>
<tr>
<td>RPR</td>
<td>Rapid plasma reagin, a rapid test for syphilis. It can be performed in the clinic.</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection.</td>
</tr>
<tr>
<td>TBA</td>
<td>A person who assists the mother during childbirth. In general, a TBA would initially acquire skills by delivering babies herself or through apprenticeship to other TBAs.</td>
</tr>
<tr>
<td>TT</td>
<td>An immunization against tetanus.</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary counselling and testing for HIV.</td>
</tr>
</tbody>
</table>

**More than** ≥
**Equal or more than** ≥
**Less than** <
**Equal or less than** ≤
For more information, please contact:
Department of Reproductive Health and Research
Family and Community Health, World Health Organization
Avenue Appia 20, CH-1211 Geneva 27, Switzerland
Fax: +41 22 791 4189 / 4171
E-mail: reproductivehealth@who.int

For updates to this publication, please visit the
maternal and newborn health section of
WHO's reproductive health web site at:
www.who.int/reproductive-health