POCKET GUIDE ON SELECTED TOPICS ON MATERNAL AND NEWBORN HEALTH CARE

Private Health Sector Project (PHSP)

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Acronyms

ANC	Antenatal care
BEmONC	Basic Emergency Obstetrics and Newborn Care
CRC	Compassionate and Respectful Care
FMoH	Federal Ministry of health
FP	Family Planning
GP	General Practitioner
HO	Health officer
HDP	Hypertensive Disease in Pregnancy
IEC/BCC	Information Education Counselling/ Behavioral Change Communication
IUCD	Intra Uterine Contraceptive Device
LBW	Low Birth Weight
MPDSR	Maternal and Perinatal Death Surveillance and Response
NICU	Neonatal Intensive Care Unit
PHSP	Private Health Sector Project
PPM	Private Public Mix
RHB	Regional health Bureau
RMNCH	Reproductive maternal Newborn and Child Health
USAID	United States Aid for International Development
WHO	World Health Organization

Preface

This pocket guide on selected topics in maternal and newborn care is the first of its kind in RMNCH program, which is customized from the national BEmONC training module and the PNC 2018 implementation guidelines of FMoH. It is intended to be used by midwifes, HO's, GP's and Obstetricians who are engaged in care of mothers and newborns at ANC, Labor and delivery and PNC. The pocket guide is expected to serve as a quick reference for the busy health care providers working at medium clinics, Ob/Gyn specialty clinics, MCH centers and hospitals. Generally, it is believed that using the pocket guide improves the maternal and newborn health care practices in the health facilities in the country.

This pocket guide is comprised of basic and cross cutting topics as compassionate and respectful care, rapid initial assessment in case of obstetric emergency, emergency management principles, referring the mother for care and post-delivery/postnatal care (PNC) for mothers and newborns. While this guide could be used as a quick reference, it is by no means a replacement for standard guidelines, recommendations and other reference materials issued nationally on broader topics of maternal and newborn health care.

We believe this pocket guide will be of benefit to health care workers engaged in the clinical care of mothers and newborns and their clients or patients alike.

Acknowledgements

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Introduction

The Private Health Sector Project (PHSP) in Ethiopia is USAID funded project and implemented by Abt Associates. PHSP operates in ten regions in Ethiopia supporting FMoH and RHB's to increase access to quality and affordable clinical services in TB, HIV/AIDS, Malaria, RMNCH and STI through the private health facilities.

The RMNCH program, in year two of the project (2015/2016), PHSP conducted a rapid assessment of the potential for providing RMNCH/FP services in 90 selected private health facilities (both PHSP and non-PHSP supported sites) from selected towns in the eight regional states and two city administrations. The study found that all levels of private sector facilities have the potential to deliver various RMNCH services although there are major gaps in the quality of ANC, labor and delivery, postnatal care, FP, child health care, and immunization services.

The findings of this study was disseminated to all stakeholders. Based on the findings of the assessment, PHSP recommended that comprehensive services, covering the full continuum of care (ANC, labor and delivery, postnatal care, and child health) can and should be delivered by Midlevel clinics, Obstetric/Gynecologic clinics, MCH centers, hospitals.

Hence engagement of these facilities using a PPM approach would help ensure services are compliant with national guidelines, capture and report data to the RHB and FMoH, and are delivered at an affordable price.

Accordingly, PHSP started providing Technical assistance (TA) to 61 providing maternal health care services on top of the 118 facilities providing FP largely by integrating service with HIV care and treatment. Additionally, PHSP has started pilot implementation of maternal, perinatal, death, surveillance and Reporting (MPDSR) at 18 facilities in collaboration with AA RHB. PHSP has enabled these facilities to access Magnesium sulfate, vitamin A and K, vaccines and FP commodities which had helped to improve service provision per national standards and protocol. Also the program has customized or adopted various IEC/BCC materials to increase service uptake and Job aids /provider support tools to improve the quality of care one example of the latter being this pock guide for quick reference on selected maternal and newborn health care topics. Moreover, the project has had a series of policy dialogues with FMoH and RHBs to seek consensus on initiating PPM in RMNCH.

Therefore, we sincerely hope that this would be of service to a busy health care workers who are engaged in the day to day care of mothers and newborns in the private facilities across the country.

I. COMPASSINATE AND RESPECTFUL CARE (CRC) / WOMEN FRIENDLY CARE:

CRC is a care which is life-saving as studies have shown that women may refuse to seek care from a provider who "abuses" them or does not treat them well, even if the provider is skilled in preventing and managing of complications.

CRC is a care that:-

- **Provides services that are acceptable to the woman:**
  - ✓ Respects beliefs, traditions, and culture
  - ✓ Includes family, partner, or other support person in care
  - ✓ Provides relevant and feasible advice
- **Empowers woman and her family to become active participants in care**
- **Considers the rights of the woman:**
  - ✓ Right to information about her health
  - ✓ Right to be informed about what to expect during visit
  - ✓ Obtains permission/consent prior to exams and procedures
- **Ensures that all healthcare staff use good interpersonal communication skills**
- **Considers the emotional, psychological, and social well-being of the woman**

  Some examples of care that is compassionate and respectful/ women friendly:-

  - ✓ Individualizes care to woman's needs
  - ✓ Recognizes the richness and spiritual significance of community and culture
  - ✓ Aware of traditional beliefs regarding pregnancy and childbirth
  - ✓ Cooperates and liaises with traditional healthcare system when possible
  - ✓ Provides culturally sensitive care

- **Respects and supports the mother-newborn dyad:**
    - ✓ Encourages bonding
    - ✓ Keeps newborn with mother
    - ✓ Places newborn on mother's abdomen (at breast) immediately after birth
- **Speaks to the woman in her own language whenever possible**
- **Observes rules and norms of her culture as appropriate**
- **Is aware of who makes decisions in her life and involves that person in discussions and decisions**
- **Learns about traditional practices:**
    - ✓ Promotes/builds on positive traditional practices
    - ✓ Offers alternatives to those that are harmful

Some examples of care that is not women-friendly:-

- **Does not respect woman or her culture or background**
- **Rude, offensive, demeaning language by health personnel**
- **Physically restrains, pushes or hits the woman**
- **Insists on routine procedures that are convenient for the healthcare provider but may be shameful or disgusting to the woman**, eg. lithotomy position only, routine episiotomy, frequent vaginal exams, assembly-line fashion of care
- **Excludes partner or companion from care**
- **Separates mother and newborn**

II. RAPID INITIAL ASSESSMENT IN CASE OF OBSTETRIC EMERGENCY

QUICK CHECK

- **Look** at the woman:
    - ➢ Did someone carry her into the health institution? (possible sign of shock)
    - ➢ Is there blood on her clothing or on the floor beneath her? (sign of bleeding in pregnancy.)
    - ➢ Is she grunting, moaning, or bearing down? (possible signs of advance labor)

- **Ask the woman or someone who is with her whether she has now or has recently had:**
  - Vaginal bleeding
  - Severe headache/blurred vision
  - Convulsions or loss of consciousness
  - Difficulty breathing
  - Fever
  - Severe abdominal pain
  - Labor pains

- **If the woman has or recently had ANY of these danger signs, or signs and symptoms of advanced labor, immediately:**
  - Shout for help.
  - Stay calm. Focus on the woman.
  - Do not leave the woman alone.
  - Notify the skilled provider.

TABLE 1:- Rapid initial assessment

Assess	Danger Signs	Consider
Airway and breathing	**LOOK FOR**: cyanosis (blueness) respiratory distress **EXAMINE**: skin: pallor lungs: wheezing or rales	severe anemia heart failure pneumonia asthma
Circulation (signs of shock)	**EXAMINE**: skin: cool and clammy pulse: 110 or more and weak BP: low (systolic less than 90)	**Shock,**

Vaginal bleeding (early or late pregnancy or after childbirth)	**ASK IF**: pregnant, length of gestation recently given birth placenta delivered **EXAMINE**: vulva: amount of bleeding placenta retained obvious tears uterus: atony bladder: full **DO NOT DO A VAGINAL EXAM AT THIS STAGE**	abortion ectopic pregnancy molar pregnancy abruption placentae ruptured uterus placenta previa atonic uterus tears of cervix and vagina retained placenta nverted uterus
Unconscious or convulsing	**ASK IF**: pregnant, length of gestation **EXAMINE**: blood pressure: high (diastolic 90 mm Hg or More) temperature: 38°C or more	eclampsia malaria epilepsy tetanus

TABLE 1:- Cont. Rapid initial assessment

Assess	Danger Signs	Consider
Dangerous fever	**ASK IF**: weak, lethargic frequent, painful urination **EXAMINE**: temperature: 38°C or more unconscious neck: stiffness lungs: shallow breathing, consolidation abdomen: severe tenderness vulva: purulent discharge breasts: tender	urinary tract infection malaria metritis pelvic abscess peritonitis breast infection complications of abortion pneumonia
Abdominal pain	**ASK IF**: pregnant, length of gestation **EXAMINE**: blood pressure: below 90 mm Hg pulse: fast (110 or more) temperature: 38°C or more uterus: state of pregnancy	ovarian cyst appendicitis ectopic pregnancy possible term or preterm labor amnionitis abruptio placentae ruptured uterus

Note; This list does not include all the possible problems that a woman may face in a pregnancy or the puerperal period. The list is only meant to identify those problems that put the woman at greater risk of maternal morbidity and mortality.

The woman also needs prompt attention if she has any of the following signs: blood-stained mucus discharge (show) with palpable contractions; ruptured membranes; pallor; weakness; fainting; severe headaches; blurred vision; vomiting; fever or respiratory distress. The woman should be sent to the front of the queue and promptly treated.

III. EMERGENCY MANAGEMENT PRINCIPLES

Emergencies can happen suddenly, as with a convulsion, or they can develop as a result of a complication that is not properly managed or monitored.

PREVENTING EMERGENCIES

Most emergencies can be prevented by:

- Careful planning
- Following clinical guidelines;
- Close monitoring of the woman.

RESPONDING TO AN EMERGENCY

Responding to an emergency promptly and effectively requires that members of the clinical team know their roles and how the team should function to respond most effectively to emergencies. Team members should also know:

- Clinical situations and their diagnoses and treatments;
- Drugs and their use, administration and side effects;
- Emergency equipment and how it functions.

INITIAL MANAGEMENT

In managing an emergency:

- Stay calm. Think logically and focus on the needs of the woman.
- Do not leave the woman unattended.
- Take charge. Avoid confusion by having one person in charge.
- **SHOUT FOR HELP.** Have one person go for help and have another person gather emergency equipment and supplies (e.g. oxygen cylinder, emergency kit).
- If the **woman is unconscious**, assess the airway, breathing and circulation.
- If **shock is suspected**, immediately begin treatment. Even if signs of shock are not present, keep shock in mind as you evaluate the woman further because her status may worsen rapidly. If **shock develops**, it is important to begin treatment immediately.

- Position the woman lying down on her left side with her feet elevated. Loosen tight clothing.
- Talk to the woman and help her to stay calm. Ask what happened and what symptoms she is experiencing.
- Perform a quick examination including vital signs (blood pressure, pulse, respiration, temperature) and skin color. Estimate the amount of blood lost and assess symptoms and signs.

IV. REFERRING THE MOTHER FOR CARE

- After emergency management, discuss decision to refer with woman and family.
- Quickly organize transport and possible financial aid.
- Inform the referral center by phone.
- Give the woman a referral slip containing the following information:
  - ✓ Name, age, address
  - ✓ Obstetric history (parity, gestational age, antenatal complications)
  - ✓ Relevant past obstetric complications
  - ✓ Specific problem for which she is referred
  - ✓ Treatment applied thus far and results
- Send with the woman:
  - A health worker trained in childbirth care
  - Essential emergency drugs and supplies
  - A family member who can support and attend her
- If there is a newborn, send with the mother if there is a family member who can go with the mother to care for the neonate.
- During journey:
  - Maintain IV infusion.
  - Keep the woman (and newborn, if born) warm but do not overheat.
  - If journey is long, give appropriate treatment on the way.
  - Keep record of all IV fluids, medications given, time of administration, and woman's condition.

V. POST-DELIVERY CARE/POST NATAL CARE (PNC) FOR MOTHERS AND NEWBORNS

It is now mandatory to keep the mother and newborn for 24 hrs after delivery following uncomplicated delivery, it is recommended to have at least three additional PNC contacts for all mothers and the newborns. The timing of the recommended PNC visits/contacts are:

- **First visit** should be within 72 hours after delivery.
- **Second visit** should be between 73 hours up to 7th day after delivery.
- **Third visit** between 7th day and 6th week**.**

Rationale to stay for the first 24 hrs at the facility

Maternal and neonatal morbidity and mortality are still high despite an increase in facility-based deliveries. As most morbidities and mortalities in both the mother and newborn occur during the postnatal period with 50% of maternal and 39% of neonatal deaths occurring in the first 24 hours after delivery, it is essential to strengthen the quality of postnatal care provided in facilities.

The current practice of discharging delivered women and neonates within 6 hours of delivery is believed to compromise the quality of postnatal care provided. Thus, in line with global recommendations, it's crucial to apply 24 hours postnatal stay.

The Ministry of Health has developed an national implementation guideline (adopting from the 2013 WHO updated guidelines) which recommend for 24hours facility stay after birth. On the basis of these, 24 hours postnatal care services will be implemented within existing health systems with a goal of improving maternal and newborn health outcomes.

Objectives:

a) To ensure all mothers and newborns get quality PNC in the critical 24hours after birth.

b) To use missed opportunities including integration of services such as PPFP.

Content of PNC for the Mother and Newborn in PNC

A. Management of the mother

When the ANC record is available, it should be thoroughly reviewed prior to delivery in order to extract any preexisting condition of the mother or newborn or history of previous deliveries that can put the woman as well as the newborn at increased risk during the postpartum period.

All postpartum women should have regular assessment of:

1. Vaginal bleeding
2. Uterine contraction
3. Fundal height
4. Temperature and heart rate (pulse)
5. Blood Pressure
6. Urine void
7. Breastfeeding status
8. Pain
9. Emotional wellbeing and bonding with the newborn

Important: Assessments of the mother should be done immediately after birth, at one hour, then every four hours and at discharge.

Minimizing the risk of Complications during the Postpartum Period

The major complications during the postpartum period are hemorrhage, hypertensive disorders of pregnancy and infection. Health care providers should keep these in mind during care provision as well as during patient education and counseling.

Postpartum Hemorrhage (PPH):

PPH is the number one cause of morbidity and mortality in Ethiopia. Although certain women are at higher risk of PPH, majority of women that experience PPH do not have any risk factor.

Hypertensive Disorder of Pregnancy (HDP):

HDP is a complication that can happen during pregnancy or the postpartum period and can potentially be deadly. In order to identify HDP early, all women should have:

- ❖ Blood pressure measured and documented at least once during the first hour after delivery.

- Postpartum women should be routinely assessed for headache, visual disturbance, and epigastric pain.

All women that are diagnosed with HDP should receive prompt treatment.

Infection:

Puerperal infection contributes to maternal morbidity and Women that experience fever, complain of shivering, or foul smelling vaginal discharge should be given special attention to determine if they have infection and receive appropriate treatment.

Initiation of Family Planning

All postpartum women and their partners should receive counseling on family planning as soon as stable after delivery. The counseling should focus on initiation of long-term family planning methods such as IUCD's and Implants. Women that are interested in initiating a family planning method should receive the appropriate method of their choice before discharge.

Initiation and support for Breastfeeding

The immediate postpartum period is a crucial period to establish breastfeeding. The mother needs to be educated and supported to establish in the first hour after delivery. Education needs to be supported with proper demonstration of techniques. Mothers should also be educated about common issues related to breastfeeding and how to manage them at home.

Respectful and Compassionate Maternity Care

Although pregnancy and birth are time of joy and celebration, it is also a time that can make women feel physically and emotionally vulnerable. Provision of care at each and every contact that respects the woman's dignity regardless of her situation and choices is the responsibility of every healthcare provider.

Special consideration for women who experience perinatal loss

Perinatal loss is not uncommon. Dealing with the loss have an increased risk of postpartum blue and depression. It is therefore very important that women receive appropriate care and receive bereavement counseling in the immediate postnatal period and beyond.

The mother also needs to receive education on how to manage breast engorgement.

Important: Mothers that experience perinatal loss are at increased risk for postpartum depression and need to receive appropriate care and counseling.

B. Management of the Newborn

Assessment of the baby

The following danger signs should be assessed immediately at birth, at one hour after birth, and every four hours thereafter as well as at discharge. If any of the danger signs are present, the newborn should receive pre-referral treatment and promptly referred to a health facility with NICU for further evaluation:

- Stopped feeding well
- Convulsions
- Fast breathing (breathing rate ≥60 per minute)
- Severe chest in-drawing
- Movement only when stimulated or no movement even when stimulated
- Fever (temperature ≥37.5 °C)
- Low body temperature (temperature <35.5 °C)
- Any jaundice in first 24 hours of life, or yellow palms and soles at any age.

Important: Assessment of the newborn should be done immediately at birth, at one hour, and every four hours and at discharge. And newborn with any of the above danger signs should receive a pre-referral treatment and promptly referred to a health facility with NICU.

Exclusive Breastfeeding:

- All babies should be exclusively breastfed from birth until 6 months of age.

Cord care:

- Daily chlorhexidine Gel (7.1% chlorhexidine digluconate, delivering 4% chlorhexidine) should be applied to the umbilical cord stump during the first week of life. **Appropriate education should be given so the medicine is not mistakenly applied to the eye.**

Bathing:

- Bathing should **be delayed until after the first 24 hours** of birth.

Additional instructions for newborn care:

- Appropriate clothing of the baby for ambient temperature is important. This means one to two layers of clothes more than adults and use of hats/caps at all times.
- The mother and baby should not be separated and should stay in the same room 24 hours a day to establish bonding unless medically contraindicated.
- Communication and play with the newborn should be encouraged. Simple actions such as **looking at the baby, cuddling, making eye contact, smiling, and singing** are important for bonding and the baby's growth and development.
- Immunizations should be given per the national EPI protocol.
- Preterm and low-birth-weight (LBW) babies should be identified immediately after birth and should receive special care and referred to NICU. Special care for all preterm and LBW babies should include:
  - ✓ Kangaroo Mother Care
  - ✓ Special support for breastfeeding
  - ✓ Do not discharge before feeding is well established, infant is gaining weight and body temperature is stable.

C. Key discharge Instructions for the Mother and Newborn

After an uncomplicated vaginal birth at a health facility, healthy mothers and newborns should receive care in the facility for at least 24 hours after birth. Discharge only if mother's **bleeding is normal, mothers and baby's vital signs are stable without any sign of infection or other diseases and the baby is breast-feeding well.**

- The mother should receive counseling on danger signs for herself as well as the baby.
- The discharge counseling should be provided in a private set up to allow the mother to ask questions and express concerns.
- The father of the baby or any close family member should be part of the discharge education, if the mother wishes so.

- The mother should be informed on follow up visits for herself as well as the newborn.
- Immunization card filled with all relevant information should be given to the mother if birth doses are given before discharge, with instruction to bring it to every clinic visit with the newborn.
- Instruct the mother to have the newborn registered with Vital Registration within **30 days of birth.**

Before the mother is discharged home:

- Ask the mother about her wellbeing, including her **mental and physical readiness to care for herself and her newborn**.
- Provide iron folate tablets and teach her about the need to continue for 3 months.
- Advice on avoiding harmful traditional practices
- Newborn's exposure to sunlight
- Immunize against tetanus toxoid (subsequent dose).
- Provide chlorhexidine Gel (7.1% chlorhexidine digluconate) to be applied for six consecutive days for umbilical cord care.

In addition to counseling on the danger signs, the mother should receive appropriate education on:

- Breastfeeding
- Personal hygiene
- Emotional wellbeing
- Pain control
- Physical activity
- Family planning
- Sexual intercourse
- HIV prevention
- Maternal Diet
- Malaria control if in malaria endemic region
- Advise on follow up care.

The discharge instruction to the mother should also include teaching about **danger signs of the newborn i**ncluding:

- Poor feeding or sucking
- Fast breathing >60 breaths /min
- Slow breathing <30 breaths /min
- Skin pustules or bullae > 10mm
- Fever or hypothermia (> 380C or <350C)
- Eyes swollen, sticky or draining pus
- Lethargy
- Cord red, bleeding or draining pus
- Jaundice (yellow skin)
- Persistent vomiting
- Vomiting with a swollen abdomen
- Eye discharge
- Watery or dark green stools with mucus or blood

Important: If the mother or newborn manifest any signs or symptoms of complications, discharge should be postponed, and if needed, referred for a higher level of care. And the mother should be advised to take the newborn to a health facility if it shows any of the above danger signs after discharged home.