WHO guidelines

on sexual and reproductive health

Heli Bathija

GFMER on-line course

28 May 2010

(thanks to the many colleagues in various departments - mostly of Reproductive Health and Research and Making Pregnancy Safer - whose presentations I have used in preparing this one)

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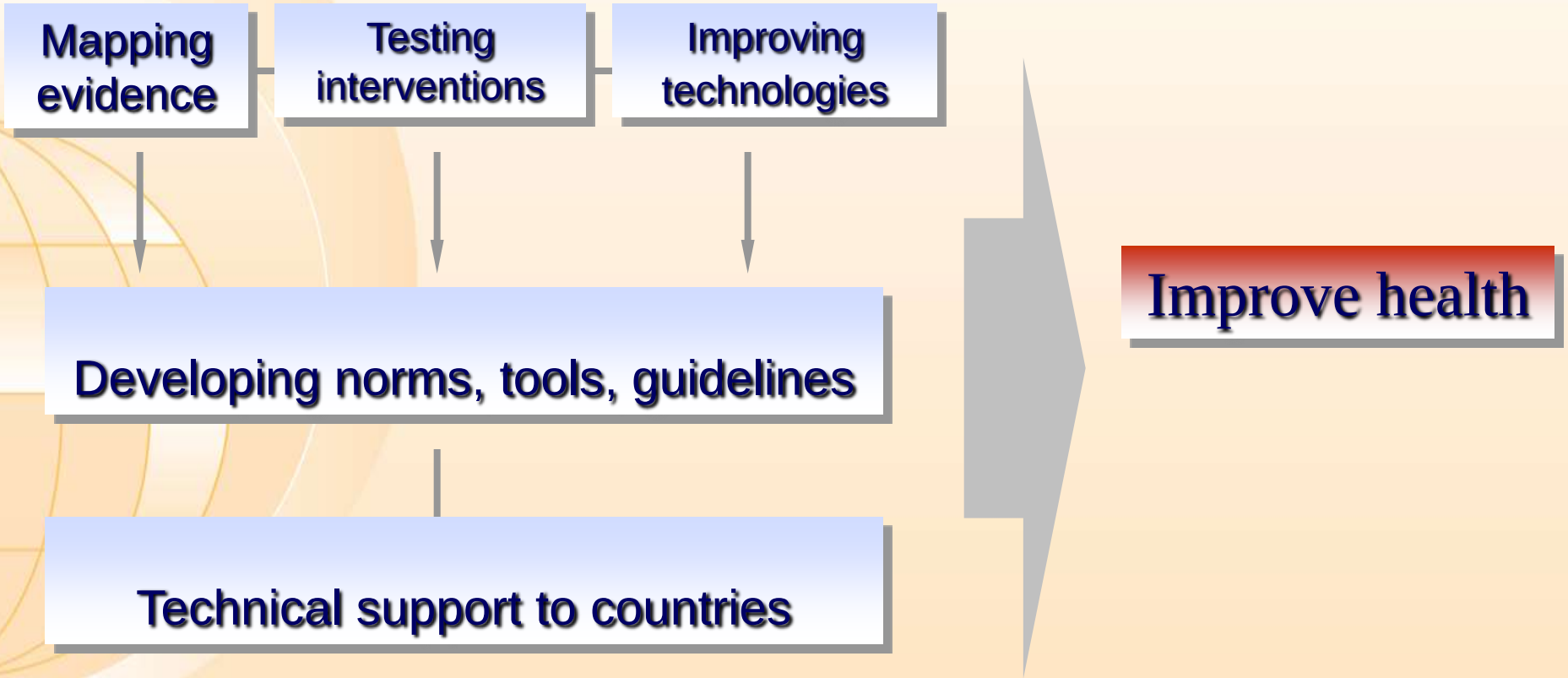
WHO's work

WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.



What is a WHO guideline?

"Guidelines are **recommendations** intended to assist providers and recipients of health care and other stakeholders to make **informed decisions.** Recommendations may relate to **clinical interventions, public health activities, or government policies."**
WHO 2003, 2007

Difficulties…

- **Some claim**

WHO guidelines: not transparent, not evidence based

↓ Systematic reviews

↓ Transparency about judgements

↑ Expert opinion

↓ Adaptation of global guidelines to end users' needs

↔ Tension between time taken and when advice needed

↓ Resources

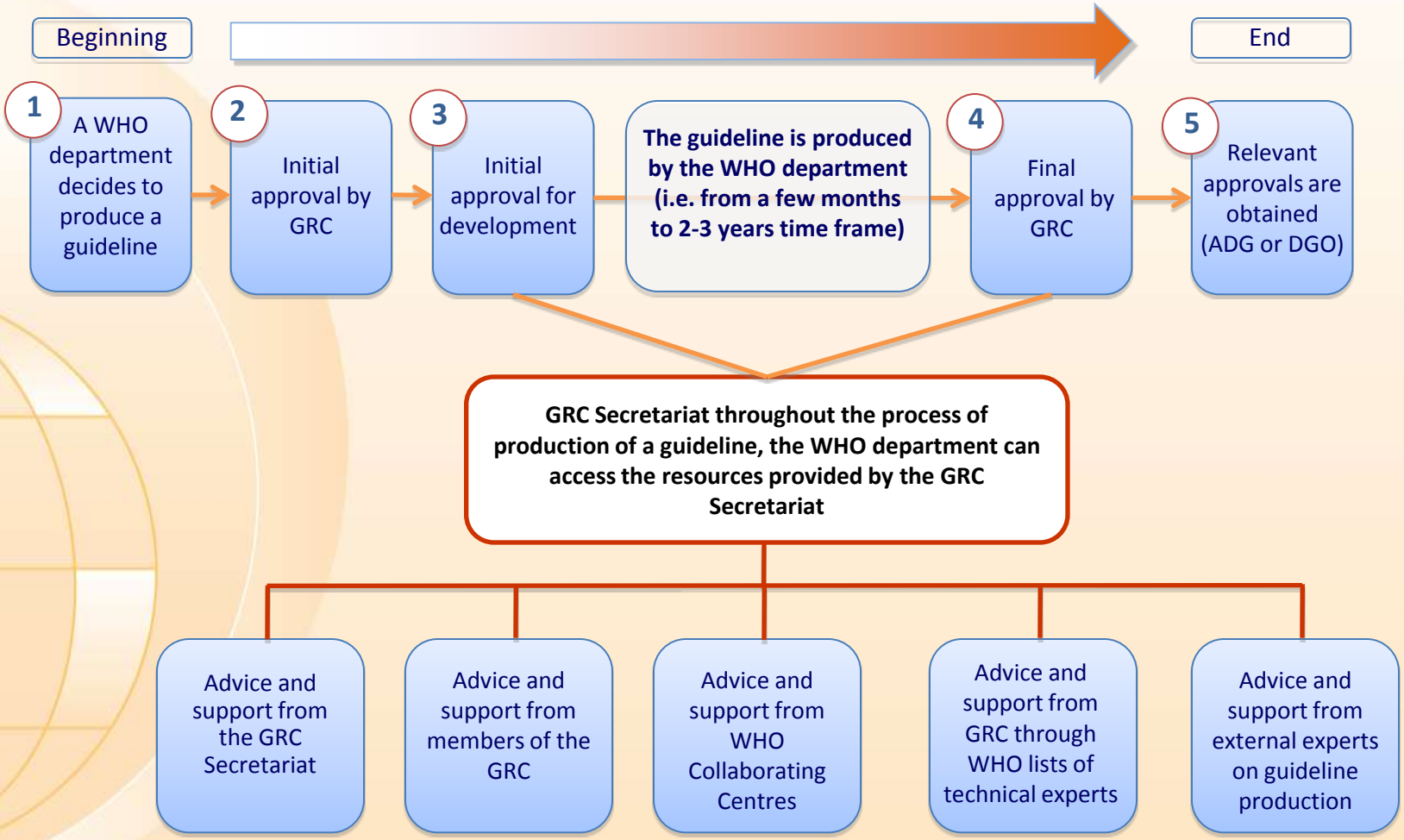
- ***Oxman et al, Lancet 2007;369:1883-9***

Solutions…

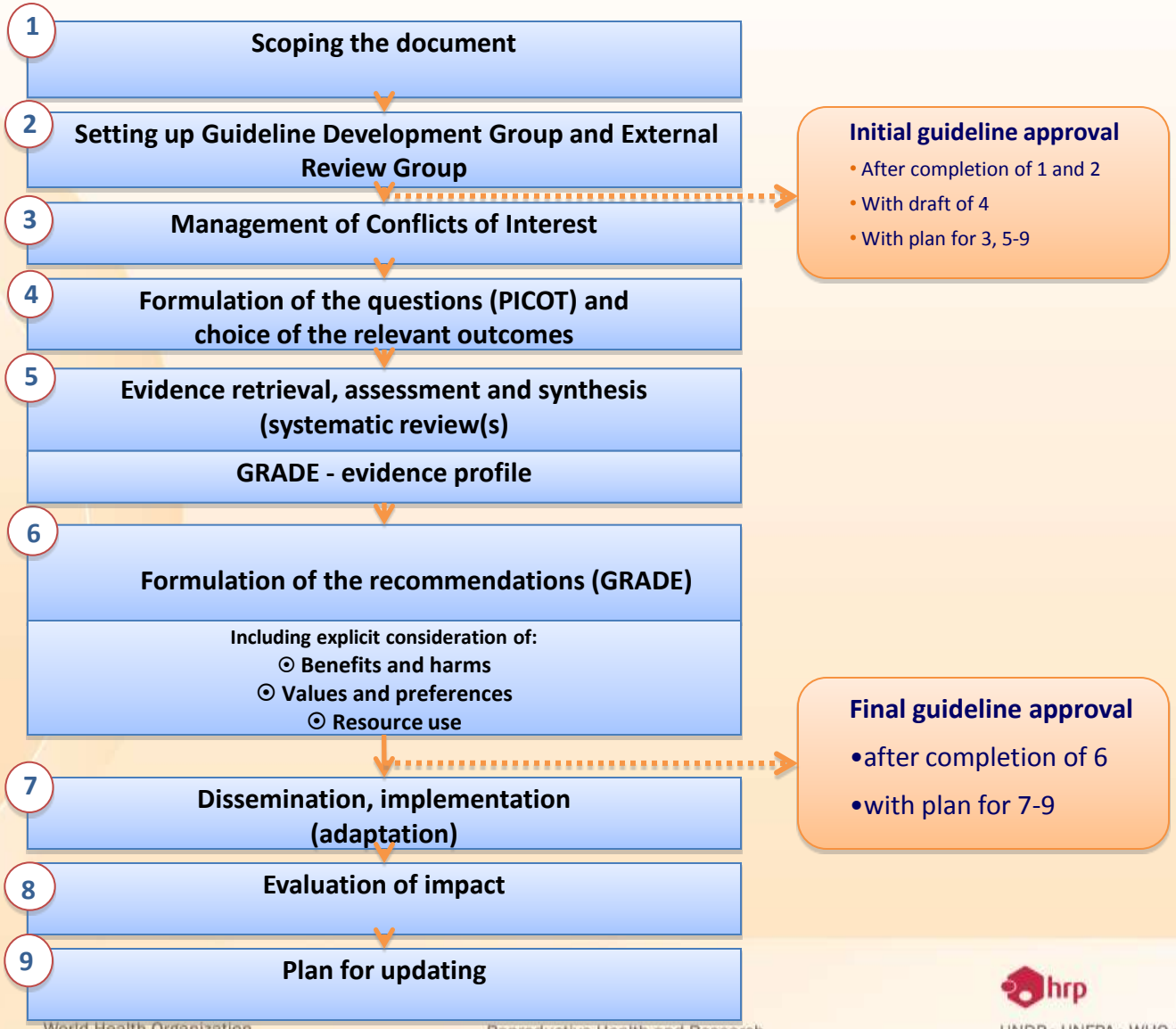
WHO response

- Guidelines Review Committee (**GRC)**
- **Standards for:**
  - **Reporting**
  - **Processes**
  - **Use of evidence**
- **Revised WHO handbook for guidelines**
- **Different types of documents for different purposes**

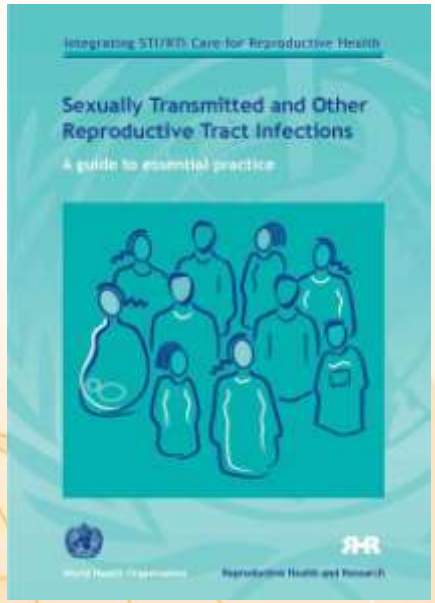
WHO Guidelines Production Process

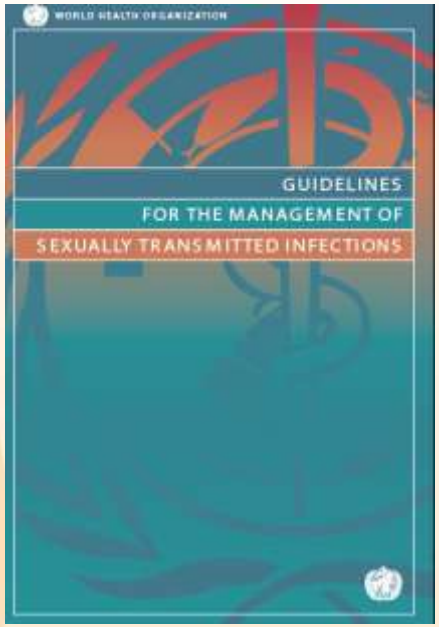


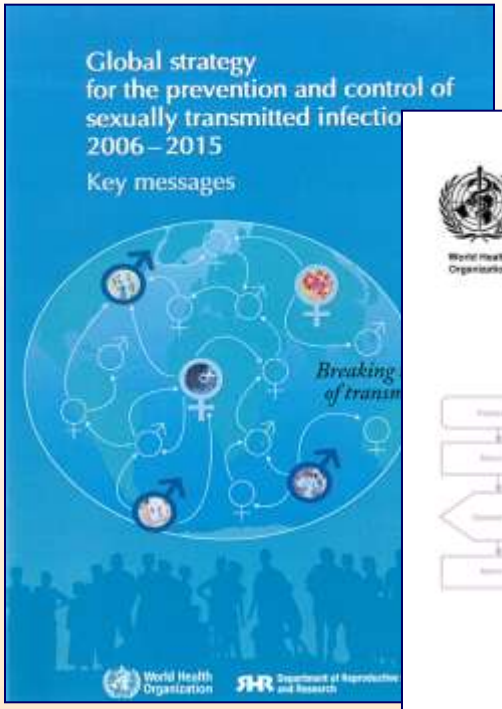
Guideline Development Process

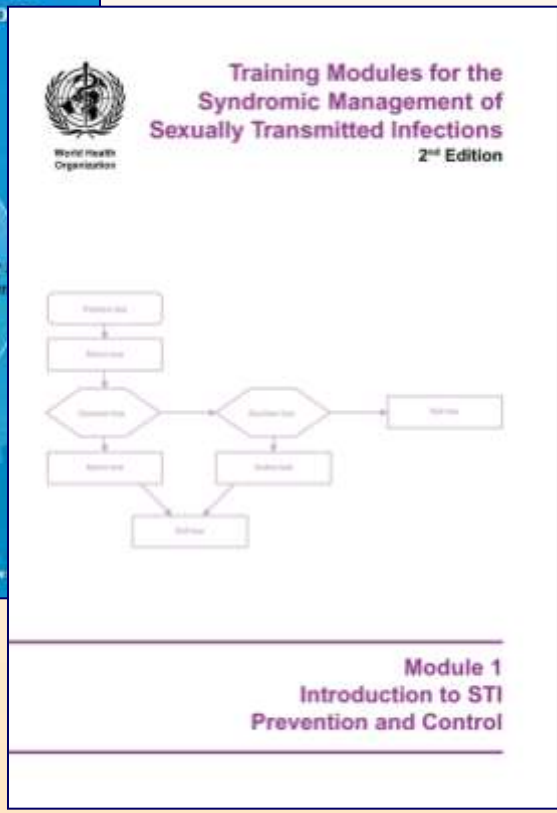


STI Guidelines









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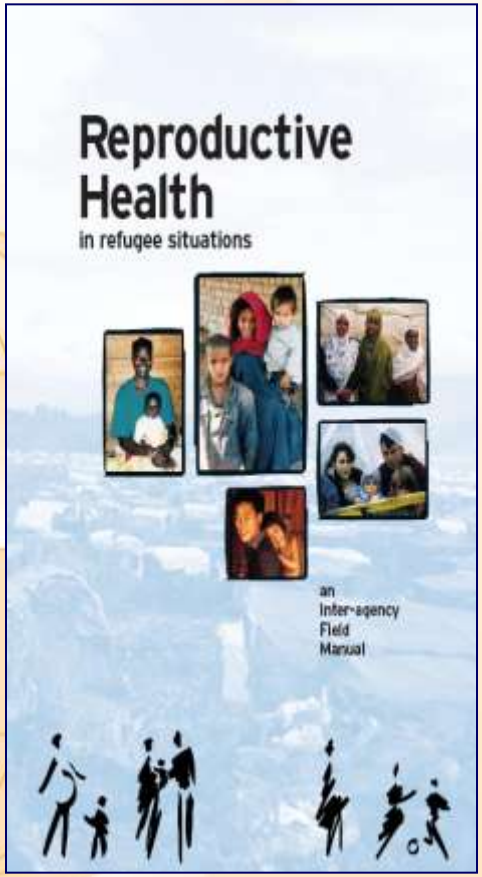
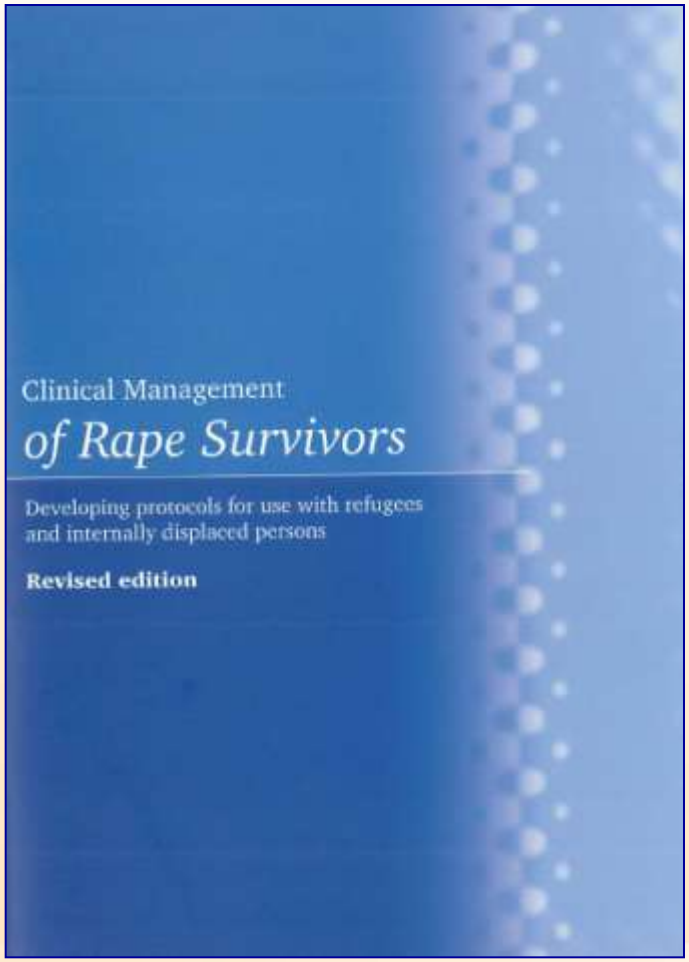
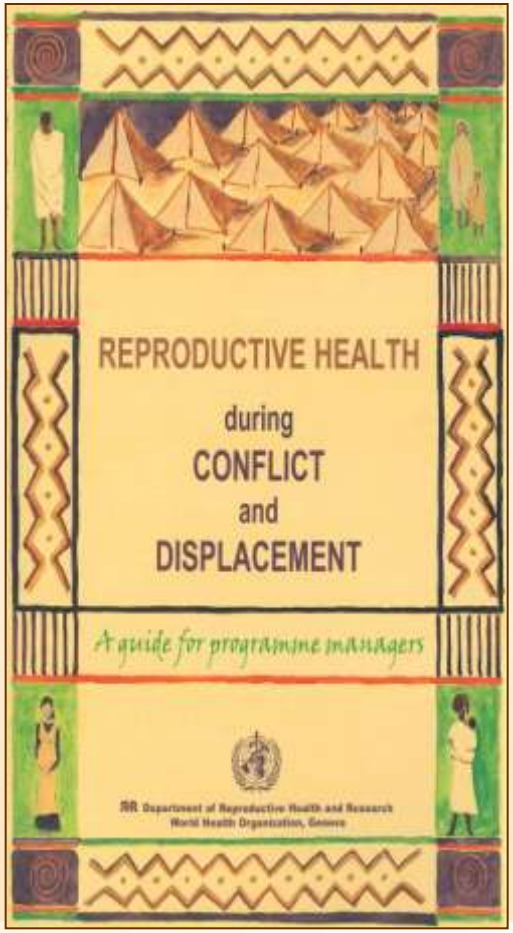
Guidelines relating to SRH in Crisis situations



World Health Organization



Reproductive Health and Research



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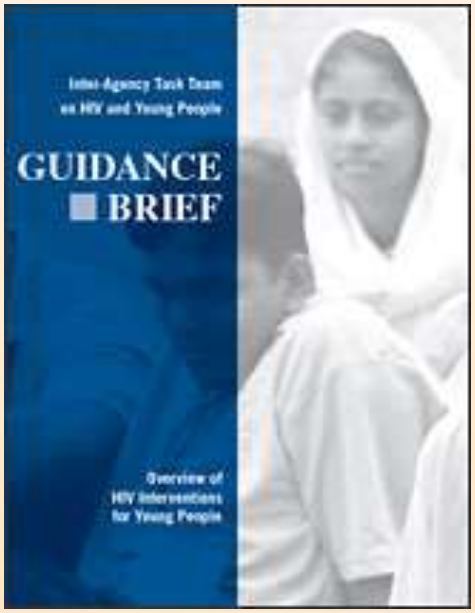
Adolescent Health

- http://www.who.int/child_adolescent_health/documents/adolescent/en/index.html



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Family planning guidelines and tools

1. Continuous update of the four cornerstones

Medical eligibility criteria

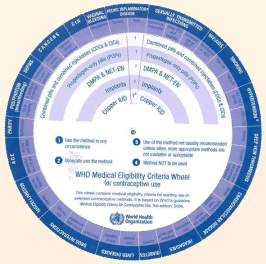
Selected practice recommendations

CIRE

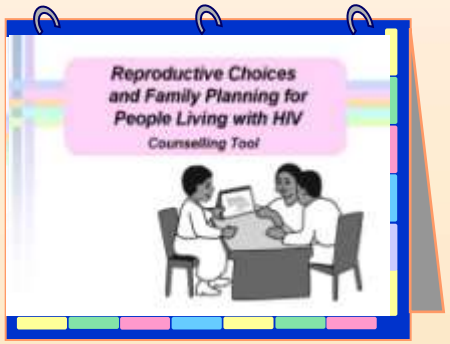
Decision-making tool

Manual

2. New tools for service providers



The Medical Eligibility Criteria Wheel



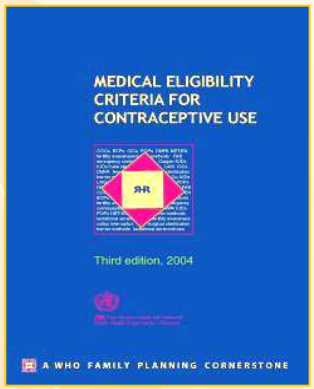
Reproductive Choices and Family Planning for People with HIV

The need for evidence-based guidance

- To base family planning practices on the best available evidence
- To address misconceptions regarding who can safely use contraception
- To reduce medical barriers
- To improve access and quality of care in family planning

The Four Cornerstones of Evidence-Based Guidance for Family Planning

Medical Eligibility Criteria for Contraceptive Use



Selected Practice Recommendations for Contraceptive Use

Guidance for guides

Guidance for providers and clients

System for keeping the guidance up-to-date

Decision-Making Tool for Family Planning Clients and Providers

Family Planning: A Global Handbook for Providers

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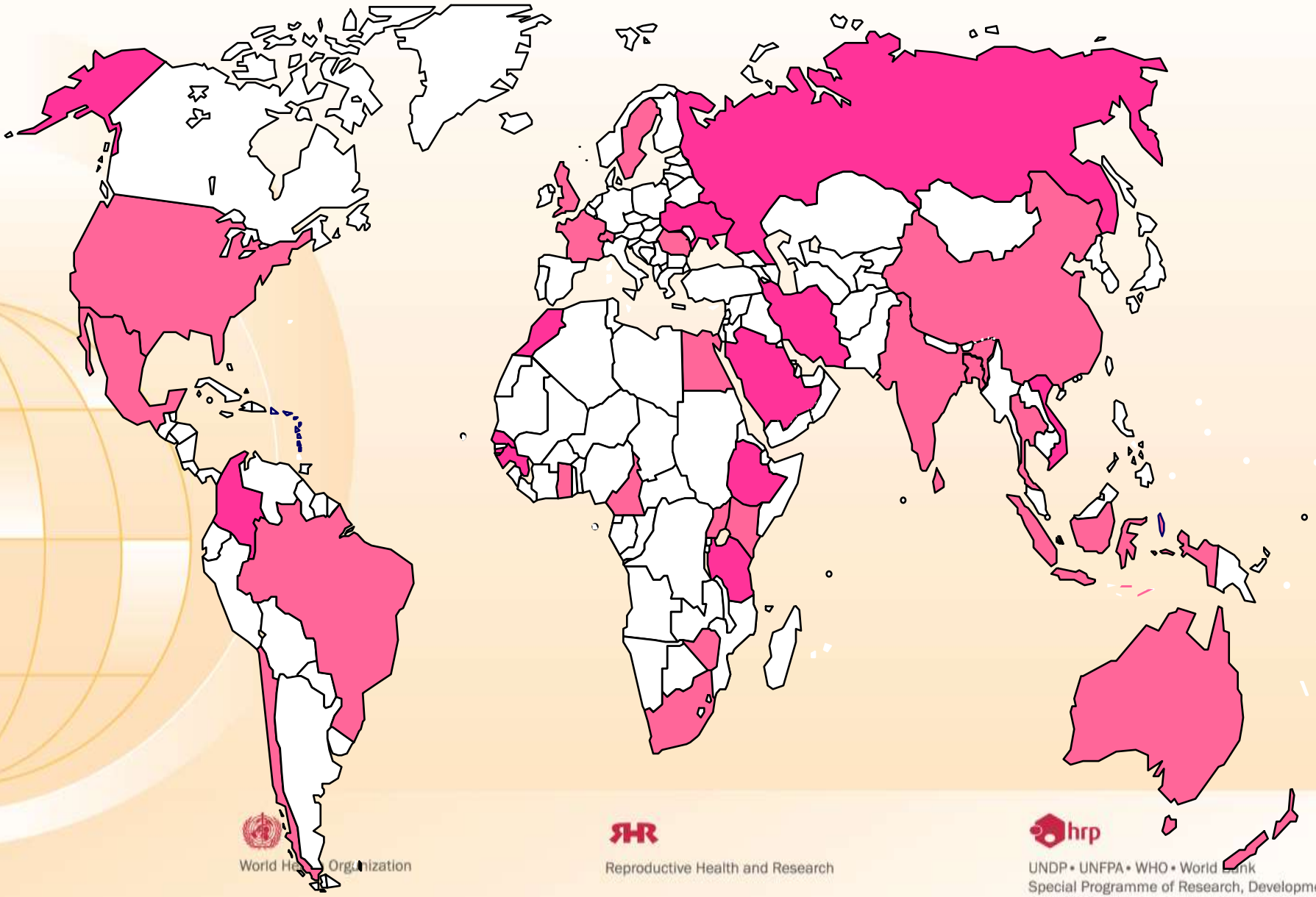
Guidance developed through consensus

Academy for Educational Development
Addis Ababa University
AIDS Alliance
All India Institute of Medical Sciences
AWARE-RH (Ghana)
California Family Health Council
Catalyst Consortium
CEMICAMP (Brazil)
Central Board of Health (Zambia)
Centre for Development and Population Activities (CEDPA)
Centers for Disease Control and Prevention
Chilean Institute of Reproductive Medicine
Cidade Universitaria (Brazil)
CTC, Inc.
East European Institute for Reproductive Health
Emory University School of Medicine
EngenderHealth
Family Health International
Family Planning Association (Bangladesh)
Family Planning and Well Woman Services
Georgetown University Institute for Reproductive Health
International Centre for Diarrhoeal Disease Research, Bangladesh
International Federation of Gynecology and Obstetrics (FIGO)
International Planned Parenthood Federation
IntraHealth
Johns Hopkins Bloomberg School of Public Health
Johns Hopkins School of Medicine
JHPIEGO
Karolinksa Institute (Sweden)
King Khalid National Guard Hospital
Khon Kaen University (Thailand)
Management Sciences for Health (MSH)
Marie Stopes Clinic Society (Bangladesh)
Ministry of Health (Morocco)
Ministry of Health (Russian Federation)
Ministry of Health (Senegal)
Ministry of Health (Vietnam)
Ministry of Health and Medical Education (Iran)
Ministry of Health and Social Welfare (Tanzania)
National Institute of Nutrition (Mexico)
National Egyptian Fertility Care Foundation
National Research Institute for Family Planning (China)
United States National Institutes of Health
Odessa Oblast Clinical Hospital (Ukraine)
PATH
Planned Parenthood Federation of America
Population Council
Princeton University
Project HOPE

And more partners….

Royal Pharmaceutical Society of Great Britain
Sydney Centre for Reproductive Health
St Bartholomew's Hospital, London
UK Family Planning Association
Universidad Nacional de Colombia
University College, London
Université de Conakry, Guinée
University of Aberdeen, Scotland
University of Liverpool
University of North Carolina Chapel Hill School of Public Health
University Research Co., LLC
University of the Witwatersrand, Reproductive Health Research Unit
University of Zimbabwe
US Agency for International Development
World Health Organization

Country experts



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Keeping up with the evidence...

Guidance based on evidence and kept up-to-date

Monitoring all new evidence

CIRE

Systematic review on selected issues

Expert Working Groups

Electronic updates

http://www.who.int/reproductivehealth/topics/family_planning/en/index.html

Key Elements of CIRE:

- **Identification of potentially relevant new evidence, as it becomes available**
- **Critical appraisal of relevant new evidence**
- **Preparation of systematic reviews**
- **Evaluation of impact of new evidence on guidance**

Step 1: **Identify new evidence pertaining to contraceptive safety and efficacy**

Step 2: **Post records on CIRE database**

Step 3: **Screen for relevance to MEC & SPR**

Step 4: 

Update or conduct systematic review

Step 5: 

Send for peer review

Step 6: 

Evaluate need to update guidance in MEC/SPR

Step 7:

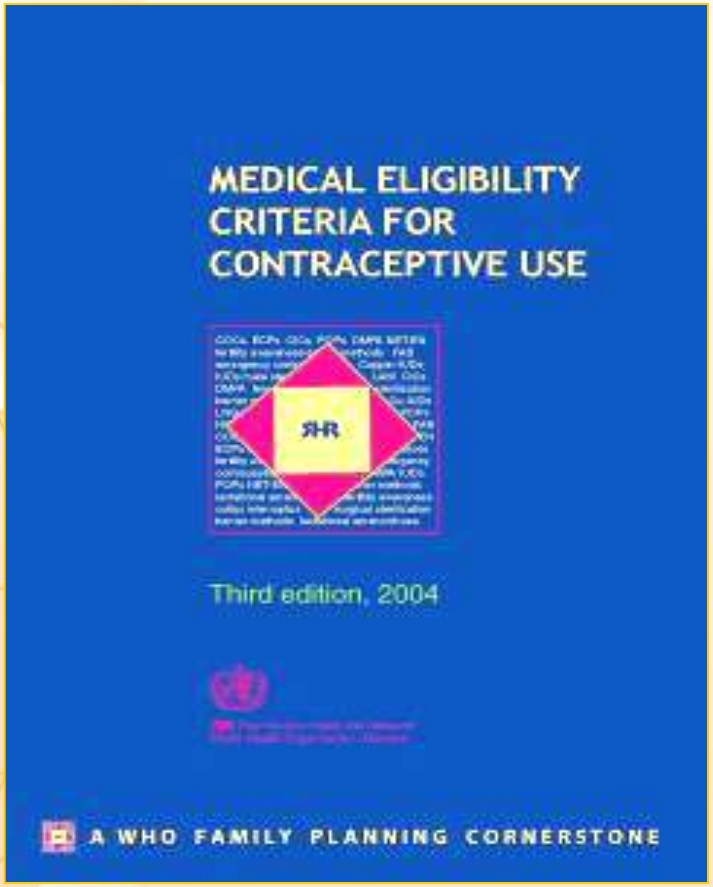
If consistent with current guidance or not urgent:

Review at next Expert Working Group

If inconsistent & urgent:

Consult Guideline Steering Group and post guidance updates on web

Medical eligibility criteria for contraceptive use



Purpose:

Who can safely use contraceptive methods?

- First published in 1996; revised in 2000, 2004, latest 4th edition approved for printing.
- 4th edition will be published on WHO website and bound copies will be printed.
- Layout and design will address suggestions from the survey of country, regional, and providers.

Medical eligibility criteria for contraceptive use – 2008 update

- Briefly summarizes 86 new and 165 updated recommendations across 11 contraceptive methods.
- Describes recommendation changes for female sterilization and barrier methods.
- Highlights newly defined medical conditions.
- Available on WHO website (http://www.who.int/reproductive-health/family_planning/updates.htm) in English, French, Spanish.
- Changes will appear in 4th edition.


MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE

2008 update

EXECUTIVE SUMMARY

The *Medical eligibility criteria for contraceptive use* – one of the four cornerstones of the World Health Organization's (WHO) evidence-based family planning guidance – provides evidence-based recommendations on whether an individual can safely use a contraceptive method. This guideline is intended for use by policy-makers, programme managers, and the scientific community in the preparation of national family planning/sexual and reproductive health programmes for delivery of contraceptives. The first edition of the *Medical eligibility criteria for contraceptive use* was published in 1996; subsequent editions were published in 2000 and 2004.

On 1–4 April 2008, WHO convened an expert Working Group in Geneva, Switzerland to revise the third edition in response to newly published evidence as well as to provide recommendations for additional medical conditions. The meeting brought together 43 participants from 23 countries, including nine agency representatives. The expert Working Group was comprised of: international family planning experts, including clinicians, epidemiologists, policy makers, programme managers; experts in evidence identification and synthesis; experts in pharmacology; and users of the guideline. All members of the expert Working Group were asked to declare any conflict of interest; three of the experts declared a conflict of interest relevant to the subject matter of the meeting. They were not asked to withdraw from recommendation formulation.

METHOD OF WORK

Using a system that identifies new evidence on an ongoing basis (the Continuous Identification of Research Evidence, or CIRE system, www.infoforhealth.org/cire/cire_pub.pl),[1] WHO identified recommendations from the third edition for which new evidence was available. Systematic reviews were then conducted to appraise the complete body of evidence for those recommendations. To conduct the systematic reviews, studies were identified using the CIRE system as well as through searches of PubMed and *The Cochrane Library* from 1966 to January 2008. The search also included reviews of reference lists in articles identified by the literature search and contact with experts in the field. The systematic reviews were provided to the expert Working Group prior to the meeting and served as the basis for the Group's deliberations during the meeting. The Group arrived at its recommendations through consensus.

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Classifications

1 = No restriction

2 = Advantages generally outweigh theoretical or proven risks

3 = Theoretical or proven risks usually outweigh the advantages

4 = Unacceptable health risk

Where resources for clinical judgement are limited,

1 & 2 = Medically eligible

3 & 4 = Not medically eligible

Hypertension and contraceptive use

	COC/ P/R	CIC	POP	DMPA/ NET-EN	LNG/ ETG Implants	Cu-IUD	LNG-IUD
Hypertension							
History, where BP can not be evaluated	3	3	2	2	2	1	2
Adequately controlled where BP can be evaluated	3	3	1	2	1	1	1
Elevated BP levels							
i) Systolic 140-159 or diastolic 90-99	3	3	1	2	1	1	1
ii) Systolic ≥160 or diastolic ≥100	4	4	2	3	2	1	2
Vascular disease	4	4	2	3	2	1	2

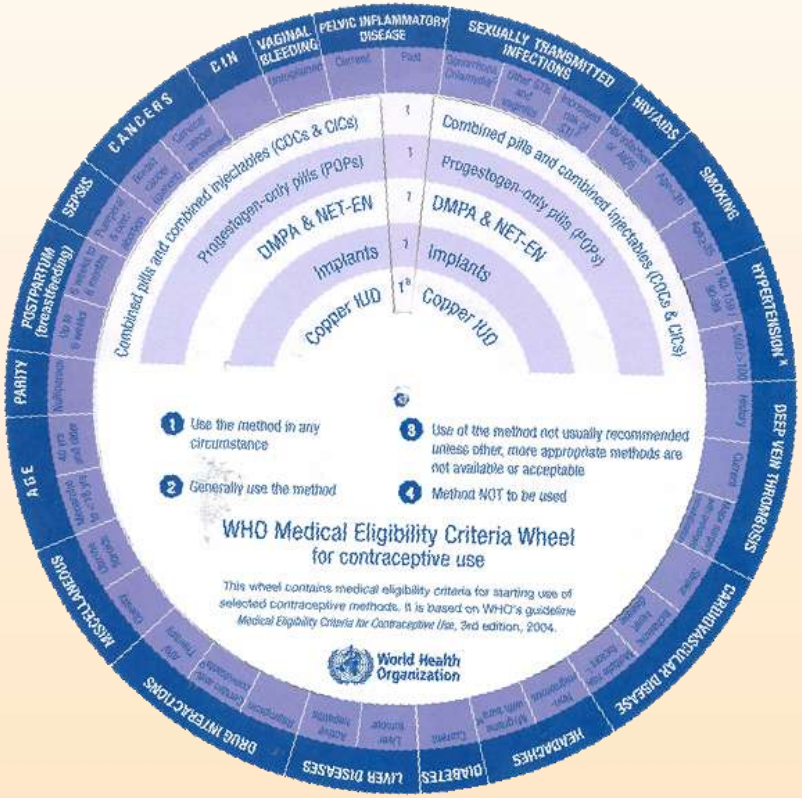
Materials derived from the guidelines
The MEC wheel

- A job aid, developed in collaboration with John Hopkins University, Communication Partnership for Family Health (Jordan), and University of Ghana Medical School.

- Available in English, French, Spanish on WHO website. Arabic, Russian translations underway.

- Country translations: Chinese, Mongolian, Myanmar, Pacific Island Countries, Armenian.

- Adapted by many countries



WHO statement and provider briefs

Statement

July 2005

Department of Reproductive Health and Research

Hormonal contraception and bone health

Steroid hormonal contraceptives, including oral contraceptives, injectables and implants, are highly effective and widely used. These contraceptives have important health benefits, including contraceptive and non-contraceptive benefits, and some health risks. For most women, the health benefits of use clearly exceed the health risks. Questions have been raised regarding the association between use of one particular hormonal contraceptive, depot medroxyprogesterone acetate (DMPA), and the risk of bone loss. In response, WHO convened a consultation in Geneva, on 20-21 June 2005, to assess current evidence on the relationship between the use of steroid hormonal contraceptives and bone health.

Bone health may be influenced by many factors including pregnancy, breastfeeding and use of hormonal contraceptives. The principal clinical outcome of interest with regard to bone health is the occurrence of fracture. Bone mineral density (BMD) measurements are commonly used to assess fracture risk, but the accuracy of measurements can be influenced by changes in body composition, including changes in lean body mass and fat. Furthermore, fracture risk is related to many factors, BMD being only one of them. The relationship between decrease in BMD and increase in fracture risk has been best studied in postmenopausal women, among whom the risk of any fracture increases approximately 1.5 fold for each standard deviation (SD) decrease in BMD. There is little information on the impact of BMD changes in young age groups on fracture risk later in life.

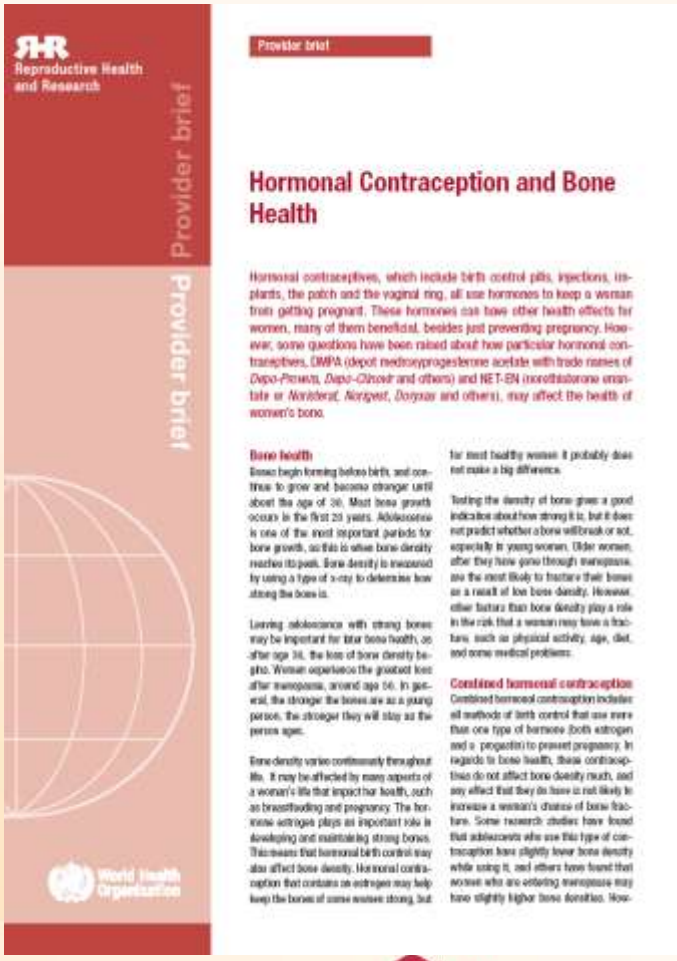
Combined methods of contraception

The use of current formulations of combined oral contraceptives (COCs) may have some small effects on BMD that are unlikely to be of clinical significance. Adolescent COC users may gain less BMD compared with adolescent non-users while perimenopausal users generally have increased BMD compared with perimenopausal non-users. A number of studies have investigated the risk of fracture among postmenopausal women in relation to past use of COCs, but the findings are inconsistent. Data for other combined hormonal contraceptives, such as combined injectables, vaginal rings and skin patches, are scarce or non-existent.

Progestogen-only methods of contraception

With regard to progestogen-only methods, data on levonorgestrel implants suggest no adverse effect on BMD. Other low-dose progestogen-only contraceptives such as pills, other implants and the levonorgestrel-releasing intrauterine device do not appear to have an effect on BMD, although data for these methods are limited.

The use of DMPA for contraception produces a hypo-estrogenic state in women; some studies have shown that this is associated with a decrease in BMD. The weight of data indicates that DMPA use reduces BMD in women who have attained peak bone mass, and impairs the acquisition of bone mineral among those who have not yet attained peak bone mass. The magnitude of effect on BMD is similar across a



Reproductive Health and Research

Provider brief

Provider brief

Hormonal Contraception and Bone Health

Hormonal contraceptives, which include birth control pills, injections, implants, the patch and the vaginal ring, all use hormones to keep a woman from getting pregnant. These hormones can have other health effects for women, many of them beneficial, besides just preventing pregnancy. However, some questions have been raised about how particular hormonal contraceptives, DMPA (depot medroxyprogesterone acetate with trade names of *Depo-Provera, Depo-Clinovir* and others) and NET-EN (norethisterone enanthate or *Noristerat, Norigest, Doryxas* and others), may affect the health of women's bone.

Bone health

Bones begin forming before birth, and continue to grow and become stronger until about the age of 30. Most bone growth occurs in the first 20 years. Adolescence is one of the most important periods for bone growth, as this is when bone density reaches its peak. Bone density is measured by using a type of x-ray to determine how strong the bone is.

Leaving adolescence with strong bones may be important for later bone health, as after age 30, the loss of bone density begins. Women experience the greatest loss after menopause, around age 50. In general, the stronger the bones are as a young person, the stronger they will stay as the person ages.

Bone density varies continuously throughout life. It may be affected by many aspects of a woman's life that impact her health, such as breastfeeding and pregnancy. The hormone estrogen plays an important role in developing and maintaining strong bones. This means that hormonal birth control may also affect bone density. Hormonal contraception that contains an estrogen may help keep the bones of some women strong, but for most healthy women it probably does not make a big difference.

Testing the density of bone gives a good indication about how strong it is, but it does not predict whether a bone will break or not, especially in young women. Older women, after they have gone through menopause, are the most likely to fracture their bones as a result of low bone density. However, other factors than bone density play a role in the risk that a woman may have a fracture, such as physical activity, age, diet, and some medical problems.

Combined hormonal contraception

Combined hormonal contraception includes all methods of birth control that use more than one type of hormone (both estrogen and a progestin) to prevent pregnancy. In regards to bone health, these contraceptives do not affect bone density much, and any effect that they do have is not likely to increase a woman's chance of bone fracture. Some research studies have found that adolescents who use this type of contraception have slightly lower bone density while using it, and others have found that women who are entering menopause may have slightly higher bone densities. How-

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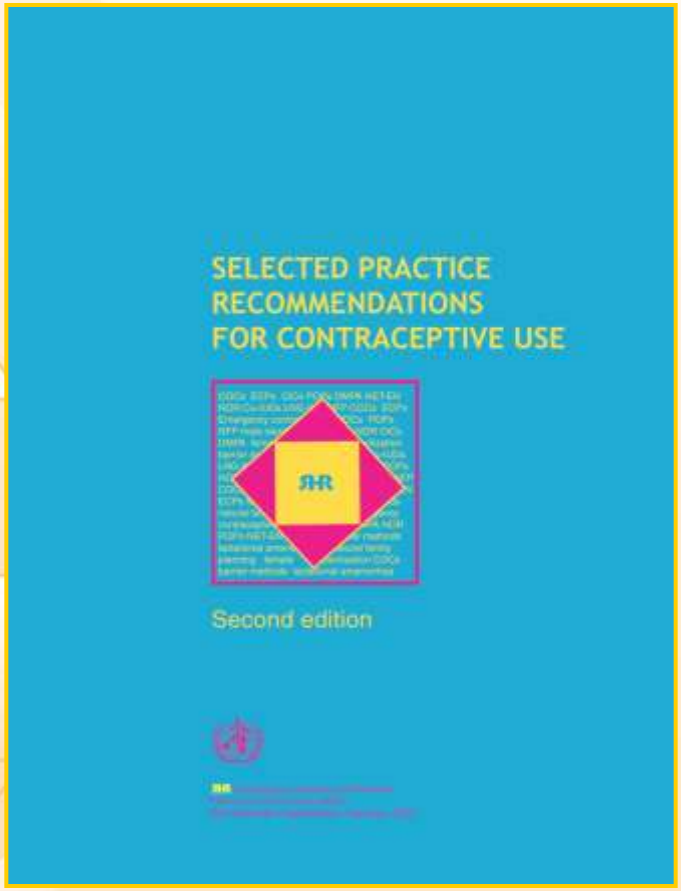
Selected practice recommendations for contraceptive use



Purpose:

How to use contraceptive methods

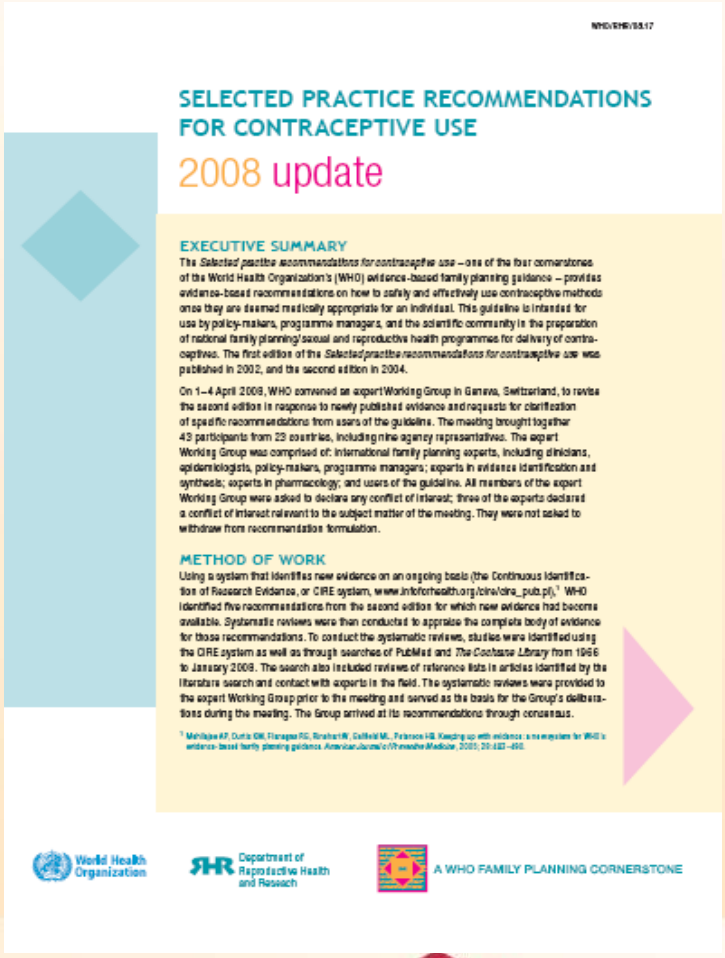
First published in 2002, 2nd edition in 2005. 3rd edition revision underway.

33 questions related to when to start & re-administer methods, how to manage problems

Updated recommendations published on the web

Selected practice recommendations for contraceptive use – 2008 update

- Summarizes changes for five recommendations (questions 6, 9, 11, 18, 22) and clarifies wording for question 17.
- Can be inserted into current 2nd edition.
- Consult 2nd edition for complete wording of each recommendation.
- Currently available on WHO website in English, French, and Spanish (http://www.who.int/reproductive-health/family_planning/updates.htm).
- Changes will appear in revised, 3rd edition of guidance; preparation underway.



WHO/RHR/08.17

SELECTED PRACTICE RECOMMENDATIONS FOR CONTRACEPTIVE USE

2008 update

EXECUTIVE SUMMARY

The *Selected practice recommendations for contraceptive use* – one of the four cornerstones of the World Health Organization's (WHO) evidence-based family planning guidance – provides evidence-based recommendations on how to safely and effectively use contraceptive methods once they are deemed medically appropriate for an individual. This guideline is intended for use by policy-makers, programme managers, and the scientific community in the preparation of national family planning/ sexual and reproductive health programmes for delivery of contraceptives. The first edition of the *Selected practice recommendations for contraceptive use* was published in 2002, and the second edition in 2004.

On 1–4 April 2008, WHO convened an expert Working Group in Geneva, Switzerland, to revise the second edition in response to newly published evidence and requests for clarification of specific recommendations from users of the guideline. The meeting brought together 43 participants from 23 countries, including nine agency representatives. The expert Working Group was comprised of: international family planning experts, including clinicians, epidemiologists, policy-makers, programme managers; experts in evidence identification and synthesis; experts in pharmacology; and users of the guideline. All members of the expert Working Group were asked to declare any conflict of interest; three of the experts declared a conflict of interest relevant to the subject matter of the meeting. They were not asked to withdraw from recommendation formulation.

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[1] Mehlsipe AF, Curtis KM, Flanagan RC, Rinehart W, Gaffield ML, Peterson HB. Keeping up with evidence: a new system for WHO's evidence-based family planning guidance. American Journal of Preventive Medicine. 2008; 35:482–490.

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Decision-making tool

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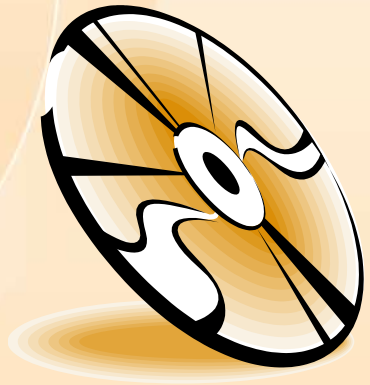
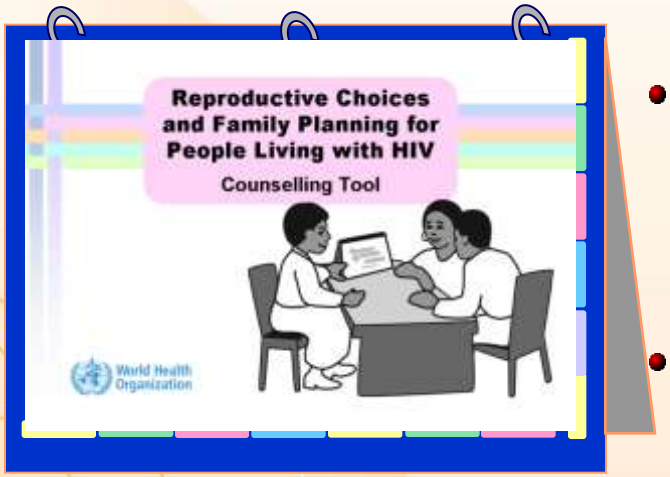
Implementation CD



PowerPoint files with:

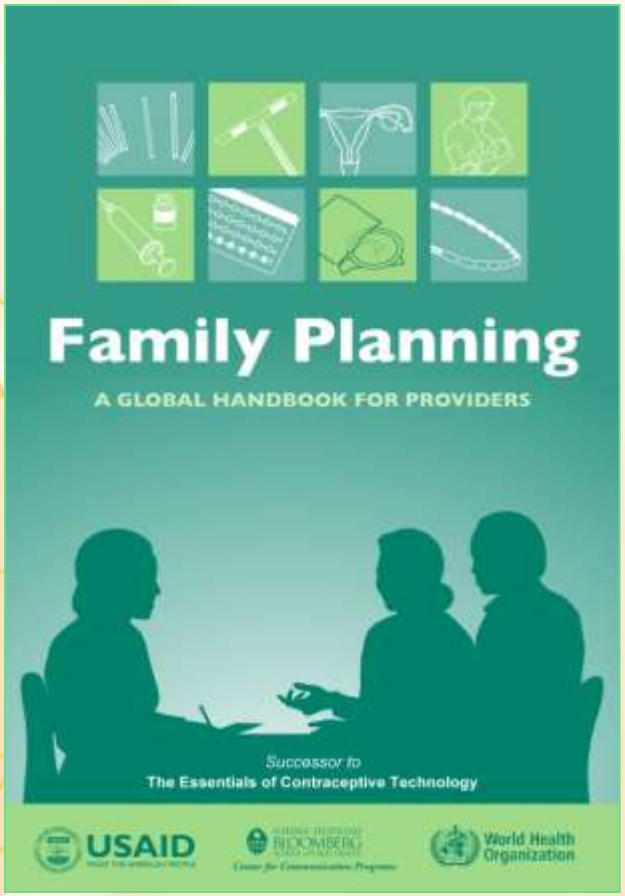
- **Adaptation materials**
- **Advocacy Materials**
- **Training Materials**
- **Reference Materials**

Reproductive Choices and Family Planning for People with HIV



- Two-day training and job aid – an adaptation of the Decision-Making Tool for Family Planning Clients and Providers
- Developed as part of Integrated Management of Adolescent and Adult Illness (IMAI) series, in collaboration with the INFO Project at Johns Hopkins Bloomberg School of Public Health
- Field tested in Uganda and Lesotho
- Published in 2006; available on WHO website

Family Planning: A Global Handbook for Providers



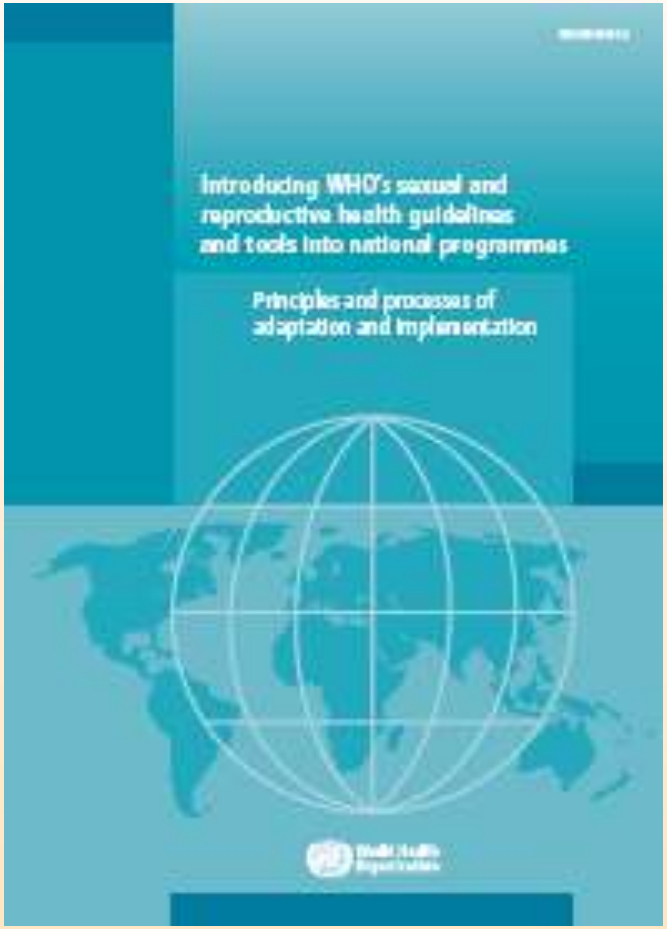
- **Successor to** *The Essentials of Contraceptive Technology*
- **Over 100,000 copies distributed since 2007**
- **English version updated with latest guidance (2008)**
- **Translated into Arabic, English, French, Hindi, Portuguese, Romanian, Russian, Spanish, Swahili**
- **Available on WHO website or can be ordered from Johns Hopkins University**

Other materials derived from the guidelines

Developed by Johns Hopkins University

Adaptation of guidelines for sexual and reproductive health

- Generic guide on how to adapt SRH guidelines and tools into national programmes.
- Published in 2007
- Available from WHO website or publication centre



World Health Organization

Reproductive Health and Research

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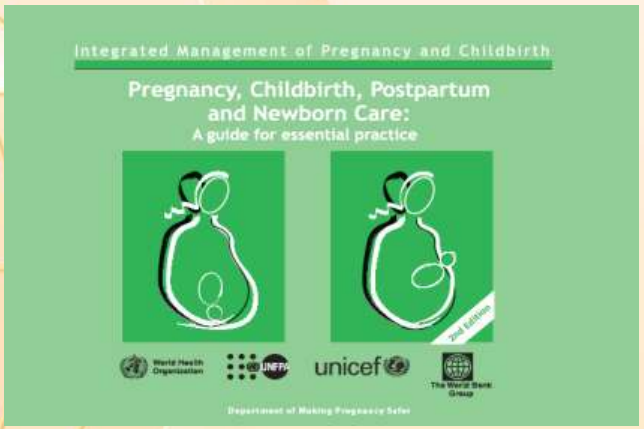
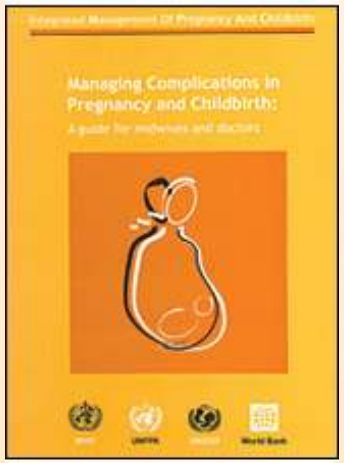
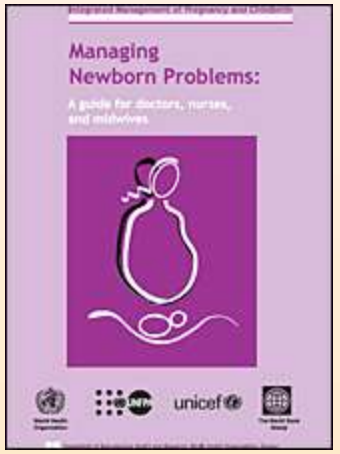
Special Programme of Research, Development and Research Training in Human Reproduction

Integrated Management of Pregnancy and Childbirth (IMPAC)







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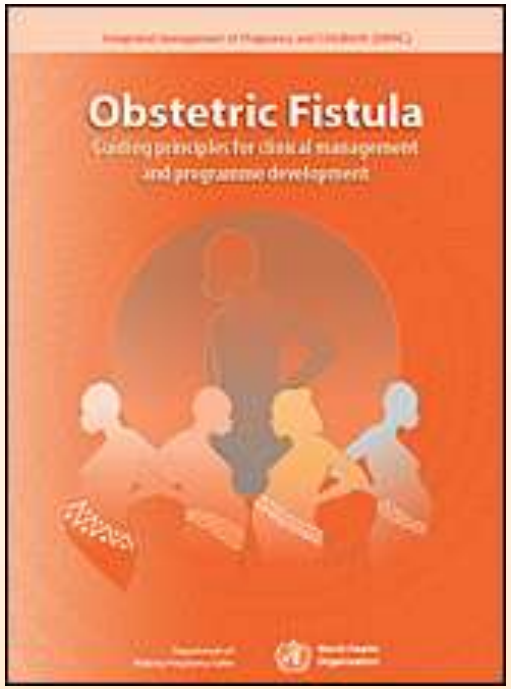
Obstetric fistula
Guiding principles for clinical management and programme development



- This is a practical guide intended for health-care professionals and planners, policy-makers and community leaders. It strives to draw attention to the urgent issue of obstetric fistula and advocates for change. It provides essential, factual background information along with principles for developing fistula prevention and treatment strategies and programmes.
- The guide can also be used to implement and scale up effective programmes for the elimination of obstetric fistula.

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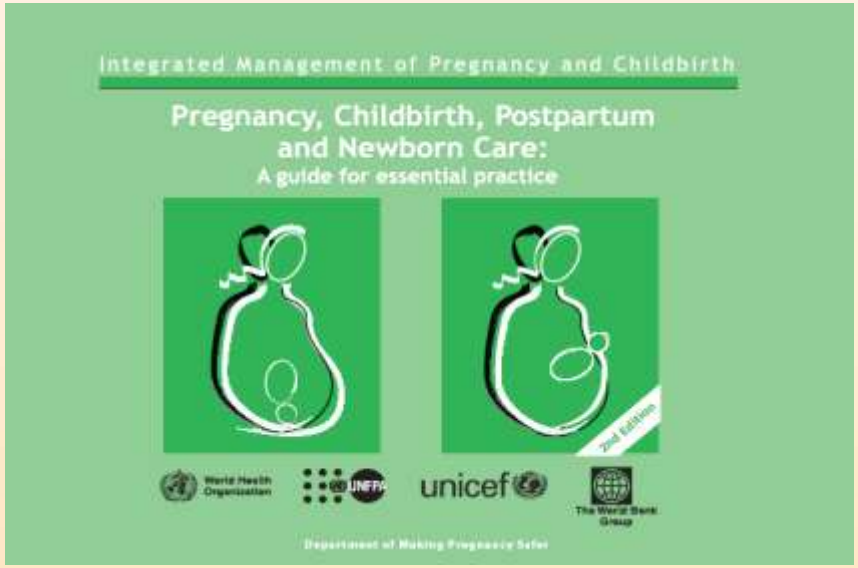
Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC)

A guide for essential practice



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What is PCPNC ?

- Antenatal care
- Childbirth (labour, delivery and immediate postpartum care)
- Postnatal care for the mother and the newborn
- Normal care + initial care for complications
- Prevention and control of endemic conditions (tetanus, malaria, STI, TB, anaemia – nutritional, parasitic) and nutrition
- Prevention of mother-to-child transmission of HIV
- Post-abortion care
- Total >50 interventions

What is PCPNC ?

- Essential clinical practice
- Low and medium resource settings
- All pregnant women and newborn infants
- Continuum from pregnancy to postpartum, mother and baby
- At primary health care level
  - care at the facility (health center, hospital)
  - at home
- Referral – mother, baby (both) to a higher level
  - Elective – planned
  - Emergency
- Role of the partner, family, community

What is its content?

- Introduction,
  how to use the guide
- Principles of good care (A)
- Quick check and rapid assessment and management (B)
- Antenatal care (C)
- Childbirth: labour, delivery, immediate postpartum (D)
- Postpartum mother (E)
- Preventive measures (F)
- Inform and counsel on HIV/AIDS (G)
- Woman with special needs (H)
- Community support for maternal and newborn health (I)
- Newborn (J, K)
- Equipment and supplies (L)
- Information and counseling sheets (M)
- Records and forms (N)

How is it structured ?

- Alfa-numerical page numbering
- Coloured pages for easier cross-referencing and navigation:
  - Warm colours: care
  - Cold colours: additional information
- Various formats for of information

How is it structured ?

- Decision making charts
- Key sequential steps for normal and abnormal deliveries
- Treatment and information pages
- Information and counselling sheets
- Equipment supplies and drug lists
- Rapid laboratory tests
- Details of treatments
- Examples of selected records

Principles of good practice

PRINCIPLES OF GOOD CARE

A2 COMMUNICATION

A3 WORKPLACE AND ADMINISTRATIVE PROCEDURES

A4 STANDARD PRECAUTIONS AND CLEANLINESS

A5 ORGANIZING A VISIT

Principles of good care

PRINCIPLES OF GOOD CARE

Standard precautions and cleanliness

A4

STANDARD 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
- Drawing blood.

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.

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 process disinfected gloves. They are not sterile.

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

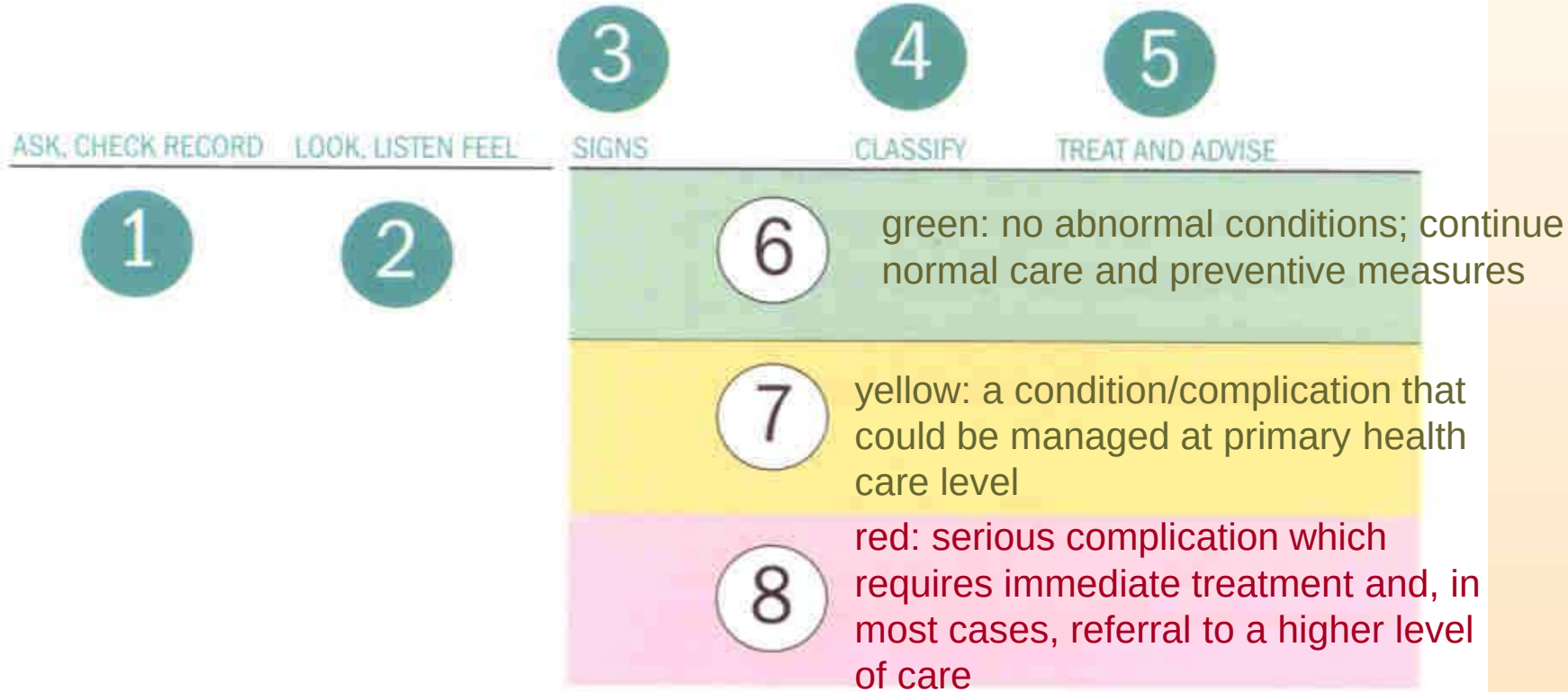
Sterilize gloves

- Sterilize by autoclaving or highly disinfect by steaming or boiling.

Decision-making charts

- Assessment, classification and management
- Colour coding

Traffic lights



Decision-making Quick Check

VAGINAL BLEEDING

- Assess pregnancy status
- Assess amount of bleeding

PREGNANCY STATUS	BLEEDING	TREATMENT	
EARLY PREGNANCY not aware of pregnancy, or not pregnant (uterus NOT above umbilicus)	HEAVY BLEEDING Pad or cloth soaked in < 5 minutes.	■ Insert an IV line B8. ■ 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.	This may be abortion, miscarriage, ectopic pregnancy.
	LIGHT BLEEDING	■ Examine woman as on B18. ■ 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 B8. ■ Give fluids rapidly if heavy bleeding or shock B9. ■ Refer woman urgently to hospital* B17.	This may be placenta previa, abruptio placentae, ruptured uterus.
DURING LABOUR before delivery of baby	BLEEDING MORE THAN 100 ML SINCE LABOUR BEGAN	DO NOT do vaginal examination, but: ■ Insert an IV line B8. ■ Give fluids rapidly if heavy bleeding or shock B9. ■ Refer woman urgently to hospital* B17.	This may be placenta previa, abruptio placentae, ruptured uterus.

* But if birth is imminent (bulging, thin perineum during contractions, visible fetal head), transfer woman to labour room and proceed as on B1-B20.

NEXT: Vaginal bleeding in postpartum

velopment
production

Antenatal care
Detection and management of pre-eclampsia

ANTENATAL CARE

CHECK FOR PRE-ECLAMPSIA

Screen all pregnant women at every visit.

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
■ Blood pressure at the last visit?	■ Measure blood pressure in sitting position. ■ If diastolic blood pressure is ≥90 mmHg, repeat after 1 hour rest. ■ If diastolic blood pressure is still ≥90 mmHg, ask the woman if she has: → severe headache → blurred vision → epigastric pain and → check protein in urine.	■ Diastolic blood pressure ≥110 mmHg and 3+ proteinuria, or ■ Diastolic blood pressure ≥90 mmHg on two readings and 2+ proteinuria, and any of: → severe headache → blurred vision → epigastric pain.	SEVERE PRE-ECLAMPSIA	■ Give magnesium sulphate C19. ■ Give appropriate anti-hypertensives C14. ■ Revise the birth plan C2. ■ Refer urgently to hospital C17.
		■ Diastolic blood pressure 90–110 mmHg on two readings and 2+ proteinuria.	PRE-ECLAMPSIA	■ Revise the birth plan C2. ■ Refer to hospital.
		■ Diastolic blood pressure ≥90 mmHg on 2 readings.	HYPERTENSION	■ Advise to reduce workload and to rest. ■ 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.
		■ None of the above.	NO HYPERTENSION	No treatment required.

▼ NEXT: Check for anaemia

Childbirth - birth planning

Respond to obstetrical problems on admission

RESPOND TO OBSTETRICAL PROBLEMS ON ADMISSION

Use this chart if abnormal findings on assessing pregnancy and fetal status D2-D3.

	SIGNS	CLASSIFY	TREAT AND ADVISE
	■ Transverse lie. ■ Continuous contractions. ■ Constant pain between contractions. ■ Sudden and severe abdominal pain. ■ Horizontal ridge across lower abdomen. ■ Labour >24 hours.	OBSTRUCTED LABOUR	■ If distressed, insert an IV line and give fluids D9. ■ If in labour >24 hours, give appropriate IM/IV antibiotics D15. ■ Refer urgently to hospital D17.
FOR ALL SITUATIONS IN RED BELOW, REFER URGENTLY TO HOSPITAL IF IN EARLY LABOUR, MANAGE ONLY IF IN LATE LABOUR			
	■ Rupture of membranes and any of: → Fever >38°C → Foul-smelling vaginal discharge.	UTERINE AND FETAL INFECTION	■ Give appropriate IM/IV antibiotics D15. ■ If in late labour, deliver and refer to hospital after delivery D17. ■ Plan to treat newborn J5.
	■ Rupture of membranes at <8 months of pregnancy.	RISK OF UTERINE AND FETAL INFECTION	■ Give appropriate IM/IV antibiotics D15. ■ If in late labour, deliver D18-D20. ■ Discontinue antibiotic for mother after delivery if no signs of infection. ■ Plan to treat newborn J5.
	■ Diastolic blood pressure >90 mmHg.	PRE-ECLAMPSIA	■ Assess further and manage as on D22.
	■ Severe palmar and conjunctival pallor and/or haemoglobin <7 g/dl.	SEVERE ANAEMIA	■ Manage as on D25.
	■ Breech or other malpresentation D18. ■ Multiple pregnancy D19. ■ Fetal distress D14. ■ Prolapsed cord D13.	OBSTETRICAL COMPLICATION	■ Follow specific instructions (see page numbers in left column).

Childbirth
Decision making – key sequential steps

CHILDBIRTH: LABOUR, DELIVERY AND IMMEDIATE POSTPARTUM CARE

First stage of labour (1): when the woman is not in active labour

D8

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

MONITOR EVERY 4 HOURS:

- Cervical dilatation D9 D15
  Unless indicated, **DO NOT** do vaginal examination more frequently than every 4 hours.
- Temperature
- Pulse B3
- Blood pressure D23

- Record findings regularly in Labour record and Partograph D4-N5
- Record time of rupture of membranes and colour of amniotic fluid.
- Give Supportive care D6-D7
- **Never leave the woman alone.**

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** B12

- 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

Childbirth - Responding to problems

Respond to problems immediately postpartum (3) — D24

CHILDBIRTH: LABOUR, DELIVERY AND IMMEDIATE POSTPARTUM CARE

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
IF PALLOR ON SCREENING, CHECK FOR ANAEMIA				
■ Bleeding during labour, delivery or postpartum.	■ Measure haemoglobin, if possible. ■ Look for conjunctival pallor. ■ Look for palmar pallor. If pallor: → Is it severe pallor? → Some pallor? → Count number of breaths in 1-minute	■ Haemoglobin <7 g/dl. AND/OR ■ Severe palmar and conjunctival pallor or ■ Any pallor with >30 breaths per minute.	SEVERE ANAEMIA	■ If early labour or postpartum, refer urgently to hospital R17. ■ If late labour: → monitor intensively → minimize blood loss → refer urgently to hospital after delivery R17.
		■ Any bleeding. ■ Haemoglobin 7-11 g/dl. ■ Palmar or conjunctival pallor.	MODERATE ANAEMIA	■ DO NOT discharge before 24 hours. ■ Check haemoglobin after 3 days. ■ Give double dose of iron for 3 months P2. ■ Follow up in 4 weeks.
		■ Haemoglobin >11 g/dl ■ No pallor	NO ANAEMIA	■ Give iron/folate for 3 months P2.
IF MOTHER SEVERELY ILL OR SEPARATED FROM THE BABY				
				■ Teach mother to express breast milk every 3 hours R3. ■ Help her to express breast milk if necessary. Ensure baby receives mother's milk R3. ■ Help her to establish or re-establish breastfeeding as soon as possible. See R3-R7.
IF BABY STILLBORN OR DEAD				
				■ Give supportive care: → Inform the parents as soon as possible after the baby's death. → Show the baby to the mother, give the baby to the mother to hold, where culturally appropriate. → Offer the parents and family to be with the dead baby in privacy as long as they need. → Discuss with them the events before the death and the possible causes of death. ■ Advise the mother on breast care R3. ■ Counsel on appropriate family planning method R27.

▼ NEXT: Give preventive measures

Family planning counselling before discharge

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).
- Council on safer sex including 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 02.
- For HIV-positive women, see 04 for family planning considerations
- Her partner can decide to have a vasectomy (male sterilization) at any time.

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 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) copper IUD (immediately following expulsion of placenta or within 48 hours)
Delay 3 weeks	Combined oral contraceptives Combined injectables Fertility awareness methods

Method options for the breastfeeding woman

Can be used immediately postpartum	Lactational amenorrhoea method (LAM) Condoms Spermicide Female sterilization (within 7 days or delay 6 weeks) copper 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

Newborn resuscitation
Key steps and decision making

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 M1.

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 D19
  - → monitor every 15 minutes for breathing and warmth
  - → tell the mother that the baby will probably be well.

DO NOT leave the baby alone

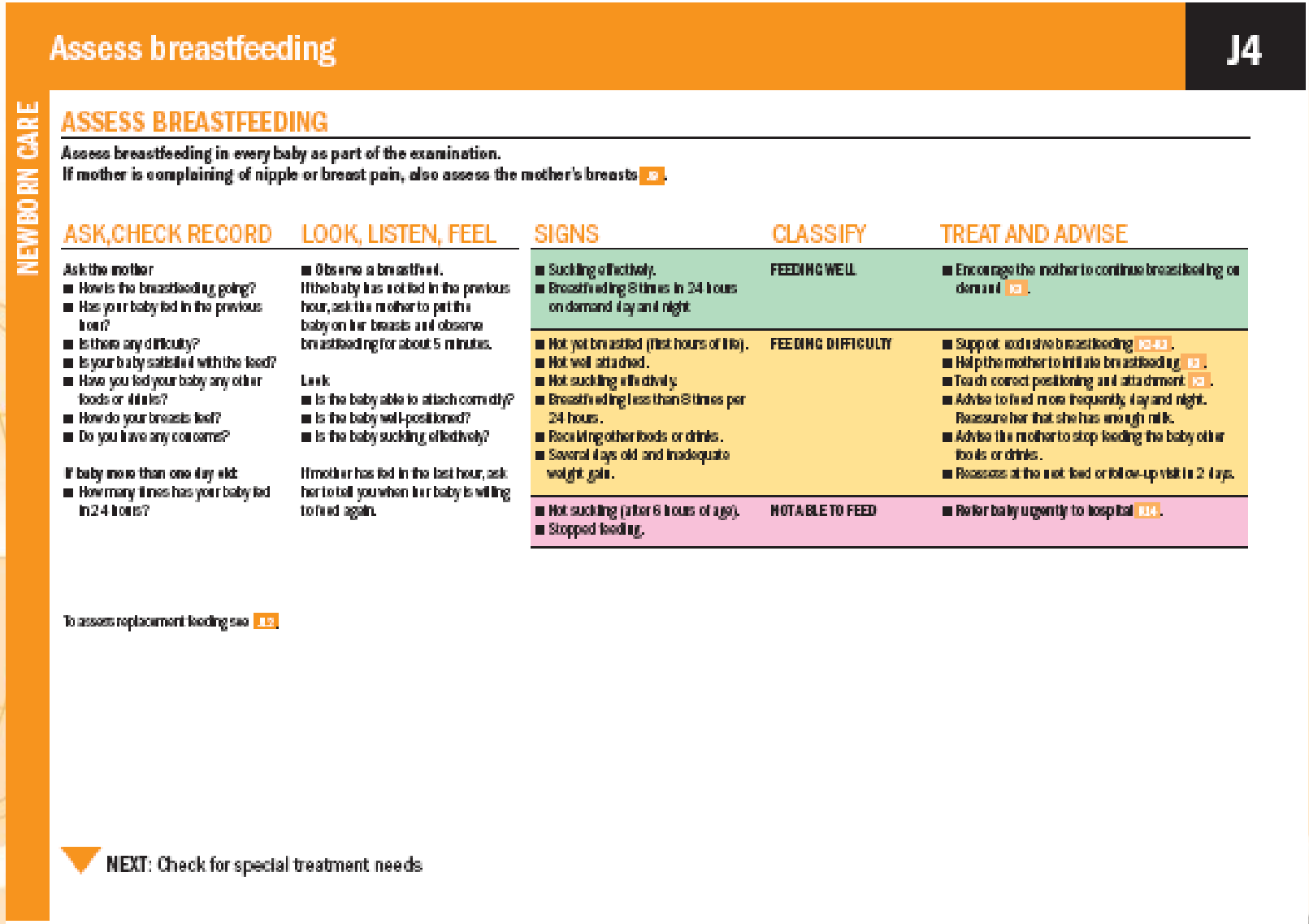
If breathing less than 30 breaths per minute or severe chest in-drawing:

- 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 D24.
- Record the event.

Newborn – assess breastfeeding



Assess breastfeeding

J4

NEWBORN CARE

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 J2.

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
Ask the mother ■ How is the breastfeeding going? ■ Has your baby fed in the previous hour? ■ Is there any difficulty? ■ Is your baby satisfied with the feed? ■ Have you fed your baby any other foods or drinks? ■ How do your breasts feel? ■ Do you have any concerns? If baby more than one day old: ■ How many times has your baby fed in 24 hours?	■ Observe a breastfeed. 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. Look: ■ Is the baby able to attach correctly? ■ Is the baby well-positioned? ■ Is the baby sucking effectively? If mother has fed in the last hour, ask her to tell you when her baby is willing to feed again.	■ Sucking effectively. ■ Breastfeeding 8 times in 24 hours on demand day and night.	FEEDING WELL	■ Encourage the mother to continue breastfeeding on demand K2.
		■ Not yet breastfed (first hours of life). ■ Not well attached. ■ Not sucking effectively. ■ Breastfeeding less than 8 times per 24 hours. ■ Receiving other foods or drinks. ■ Several days old and inadequate weight gain.	FEEDING DIFFICULTY	■ Support and advise breastfeeding K2-K3. ■ Help the mother to initiate breastfeeding K3. ■ Teach correct positioning and attachment K4. ■ Advise to feed more frequently, day and night. Reassure her that she has enough milk. ■ Advise the mother to stop feeding the baby other foods or drinks. ■ Reassess at the next feed or follow-up visit in 2 days.
		■ Not sucking (after 6 hours of age). ■ Stopped feeding.	NOT ABLE TO FEED	■ Refer baby urgently to hospital J14.

To assess replacement feeding see K8.

NEXT: Check for special treatment needs

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Breastfeeding counselling

Counsel on breastfeeding (3) — K4

BREASTFEEDING, CARE, PREVENTIVE MEASURES AND TREATMENT FOR THE NEWBORN

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 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 suckling 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 K3.
  - → Let the mother express breast milk and feed baby by cup K4. 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 K7.

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.

Mothers breasts

NEWBORN CARE

ASSESS THE MOTHER'S BREASTS IF COMPLAINING OF NIPPLE OR BREAST PAIN

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
■ 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 breastfeed if not yet done J4.	■ No swelling, redness or tenderness. ■ Normal body temperature. ■ Nipple not sore and no fissure visible. ■ Baby well attached.	BREASTS HEALTHY	■ Reassure the mother.
		■ Nipple sore or fissured. ■ Baby not well attached.	NIPPLE SORENESS OR FISSURE	■ Encourage the mother to continue breastfeeding. ■ Teach correct positioning and attachment J3. ■ Reassess after 2 feeds (or 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.
		■ Both breasts are swollen, shiny and patchy red. ■ Temperature <38°C. ■ Baby not well attached. ■ Not yet breastfeeding.	BREAST ENGORGEMENT	■ Encourage the mother to continue breastfeeding. ■ Teach correct positioning and attachment J3. ■ Advise to feed more frequently. ■ Reassess after 2 feeds (1 day). If not better, teach mother how to express enough breast milk before the feed to relieve discomfort J5.
		■ Part of breast is painful, swollen and red. ■ Temperature >38°C. ■ Feels ill.	MASTITIS	■ Encourage mother to continue breastfeeding. ■ Teach correct positioning and attachment J3. ■ Give cloxacillin for 10 days P2. ■ 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 J5. ■ If severe pain, give paracetamol P4.

NEXT: Care of the newborn

Newborn – care of a small baby

NEWBORN CARE

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) J4:
  - → Encourage the mother to breastfeed every 2-3 hours.
  - → Assess breastfeeding daily: attachment, suckling, duration and frequency of feeds, and baby satisfaction with the feed J4 J5.
  - → If alternative feeding method is used, assess the total daily amount of milk given.
  - → Weigh daily and assess weight gain J7.

- Ensure additional warmth for the small baby J6:
  - → Ensure the room is very warm (25°-28°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 J10.

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 36.5° and 37.5°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 J5-J8.
  - → Teach the mother how to hand express breast milk directly into the baby's mouth J5
  - → Teach the mother to express breast milk and cup feed the baby J5-J8
  - → Determine appropriate amount for daily feeds by age J8.
- 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 (36.5°C to 37.5°C):
  - → Keep the baby in skin-to-skin contact with the mother as much as possible
  - → If body temperature below 36.5°C persists for 2 hours despite skin-to-skin contact with mother, assess the baby J2-J6.
- If breathing difficulty, assess the baby J2-J6.
- If jaundice, refer the baby for phototherapy.
- If any maternal concern, assess the baby and respond to the mother J2-J6.

- If the mother and baby are not able to stay, ensure daily (home) visits or send to hospital.

Additional care of a small baby (twin)

J11

Information and counselling

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 K8-11.
- 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.

Sleeping

- Use the bednet day and night for a sleeping baby.
- Let the baby sleep on her/his back or on the side.
- Keep the baby away from smoke or people smoking.
- Keep the baby, especially a small baby, away from sick children or adults.

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, and arms 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:

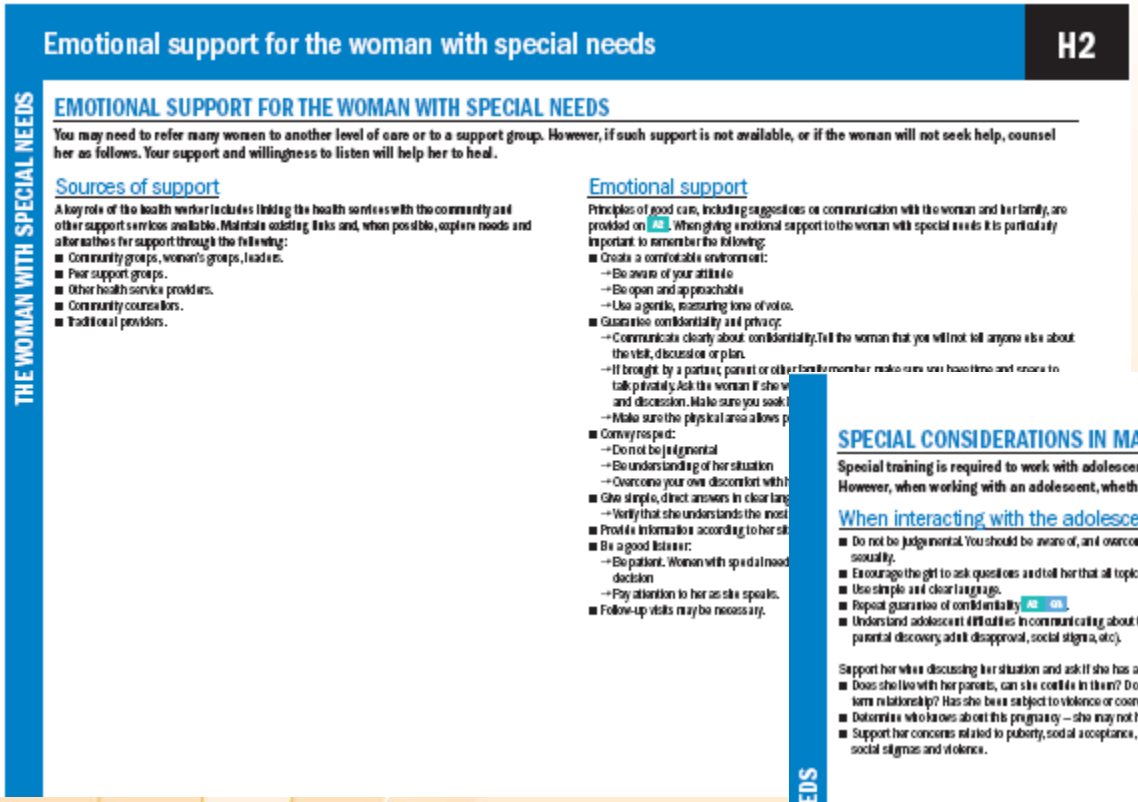
- Use cloth on baby's bottom to collect stool. Dispose of the stool as for woman's pads. Wash hands.

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.

Reaching out for all women and newborns



Emotional support for the woman with special needs H2

THE WOMAN WITH SPECIAL NEEDS

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

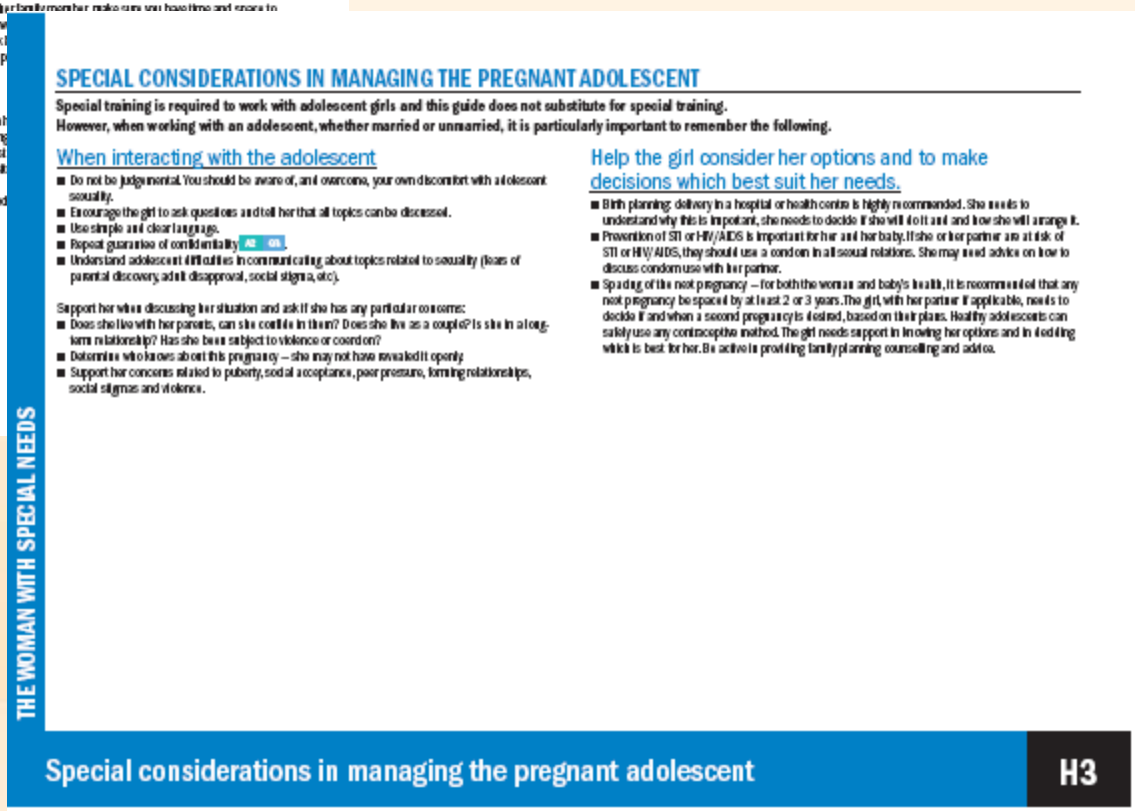
A key role of the health worker includes linking the health services with the community and other support services available. Maintain existing links and, when possible, explore needs and alternatives for support through the following:

- 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 A2. 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 w… and discussion. Make sure you seek …
  - → Make sure the physical area allows p…
- Convey respect:
  - → Do not be judgmental
  - → Be understanding of her situation
  - → Overcome your own discomfort with h…
- Give simple, direct answers in clear lang…
  - → Verify that she understands the most…
- Provide information according to her sit…
- Be a good listener:
  - → Be patient. Women with special need… decision
  - → Pay attention to her as she speaks.
- Follow-up visits may be necessary.



THE WOMAN WITH SPECIAL NEEDS

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 judgmental. 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 G1.
- 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 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.

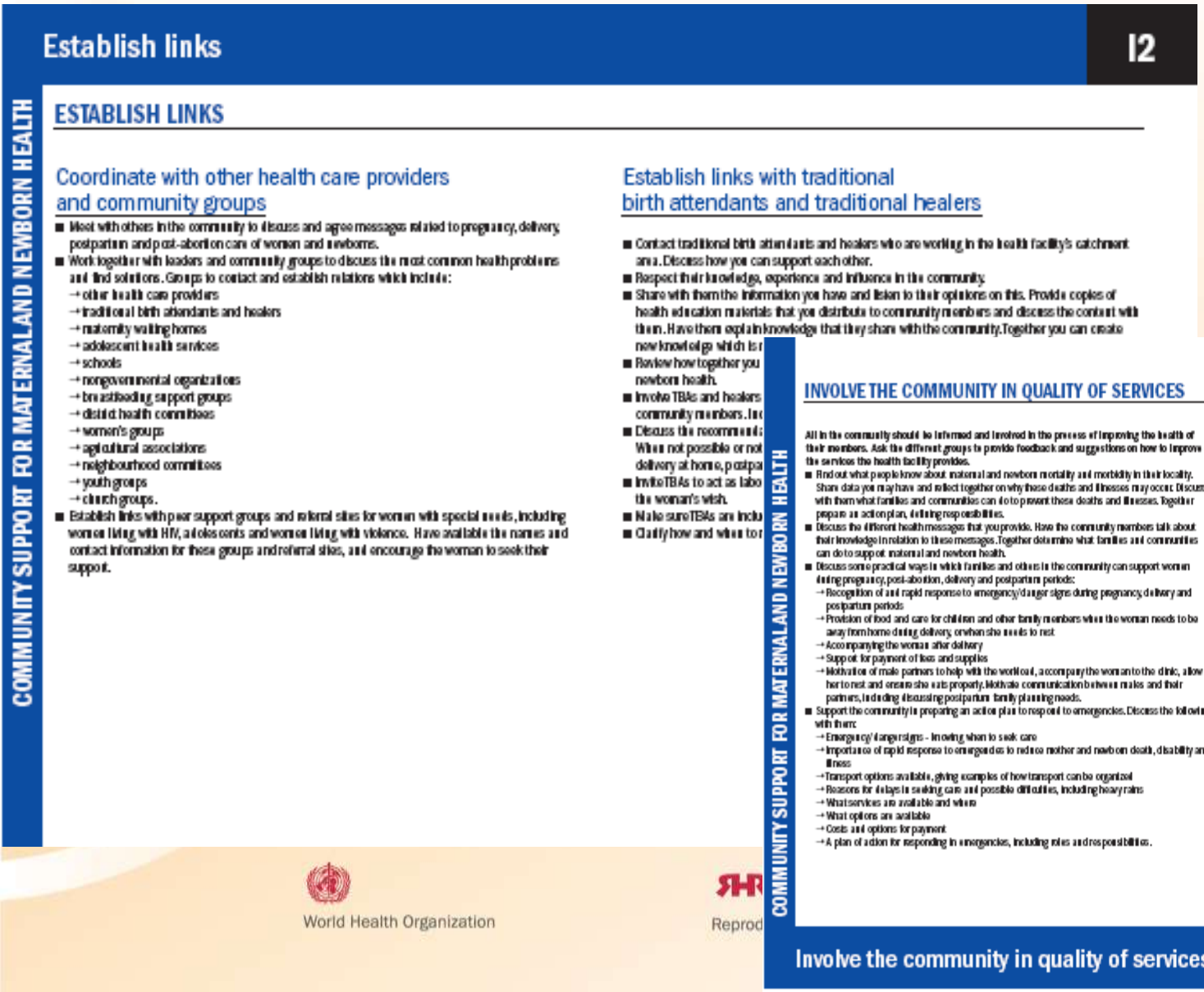
Special considerations in managing the pregnant adolescent H3

Women living

- with violence
- HIV
- After abortion

World Health Organization

Working with women, families and communities



Labour record

Labour record

N4

LABOUR RECORD

USE THIS RECORD FOR MONITORING DURING LABOUR, DELIVERY AND POSTPARTUM — RECORD NUMBER

NAME — AGE — PARITY

ADDRESS

DURING LABOUR	AT OR AFTER BIRTH – MOTHER	AT OR AFTER BIRTH – NEW BORN	PLANNED NEWBORN TREATMENT
ADMISSION DATE	BIRTH TIME	LIVEBIRTH_ STILLBIRTH: FRESH_ MACERATED_	
ADMISSION TIME	OXYTOCIN – TIME GIVEN	RESUSCITATION NO YES	
TIME ACTIVE LABOUR STARTED	PLACENTA COMPLETE NO YES	BIRTH WEIGHT	
TIME MEMBRANES RUPTURED	TIME DELIVERED	GEST. AGE --------OR PRETERM NO_ YES_	
TIME SECOND STAGE STARTS	ESTIMATED BLOOD LOSS	SECOND BABY	
ENTRY EXAMINATION			
STAGE OF LABOUR NOT IN ACTIVE LABOUR_ ACTIVE LABOUR_			

NOT IN ACTIVE LABOUR													PLANNED MATERNAL TREATMENT
HOURS SINCE ARRIVAL	1	2	3	4	5	6	7	8	9	10	11	12	
HOURS SINCE RUPTURED MEMBRANES													
VAGINAL BLEEDING (0 + ++)													
STRONG CONTRACTIONS IN 10 MINUTES													
FETAL HEART RATE (BEATS PER MINUTE)													
T (AXILLARY)													
PULSE (BEATS/MINUTE)													
BLOOD PRESSURE (SYSTOLIC/DIASTOLIC)													
URINE VOIDED													
CERVICAL DILATATION (CM)													

PROBLEM	TIME ONSET	TREATMENTS OTHER THAN NORMAL SUPPORTIVE CARE

IF MOTHER REFERRED DURING LABOUR OR DELIVERY, RECORD TIME AND EXPLAIN

Sample form to be adapted. Revised on 13 June 2003.

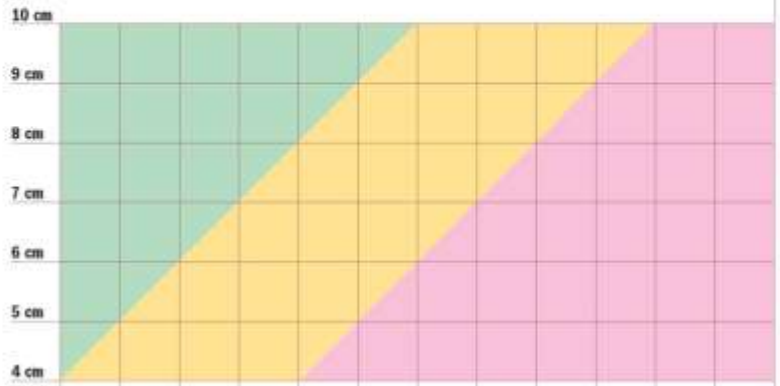
RECORDS AND FORMS

Simplified partograph

RECORDS AND FORMS

PARTOGRAPH

USE THIS FORM FOR MONITORING ACTIVE LABOUR



FINDINGS	TIME											
Hours in active labour		1	2	3	4	5	6	7	8	9	10	11	12
Hours since ruptured membranes													
Rapid assessment (0-4)													
Vaginal bleeding (0 + ++)													
Amniotic fluid (meconium stained)													
Contractions in 10 minutes													
Fetal heart rate (beats/minute)													
Urine voided													
T (axillary)													
Pulse (beats/minute)													
Blood pressure (systolic/diastolic)													
Cervical dilatation (cm)													
Delivery of placenta (time)													
Oxytocin (time/given)													
Problem-note onset/describe below													

Safe4All hints to be adapted. Revised on 13 June 2003.

Partograph

N5

Referral record

Referral record

N2

REFERRAL RECORD

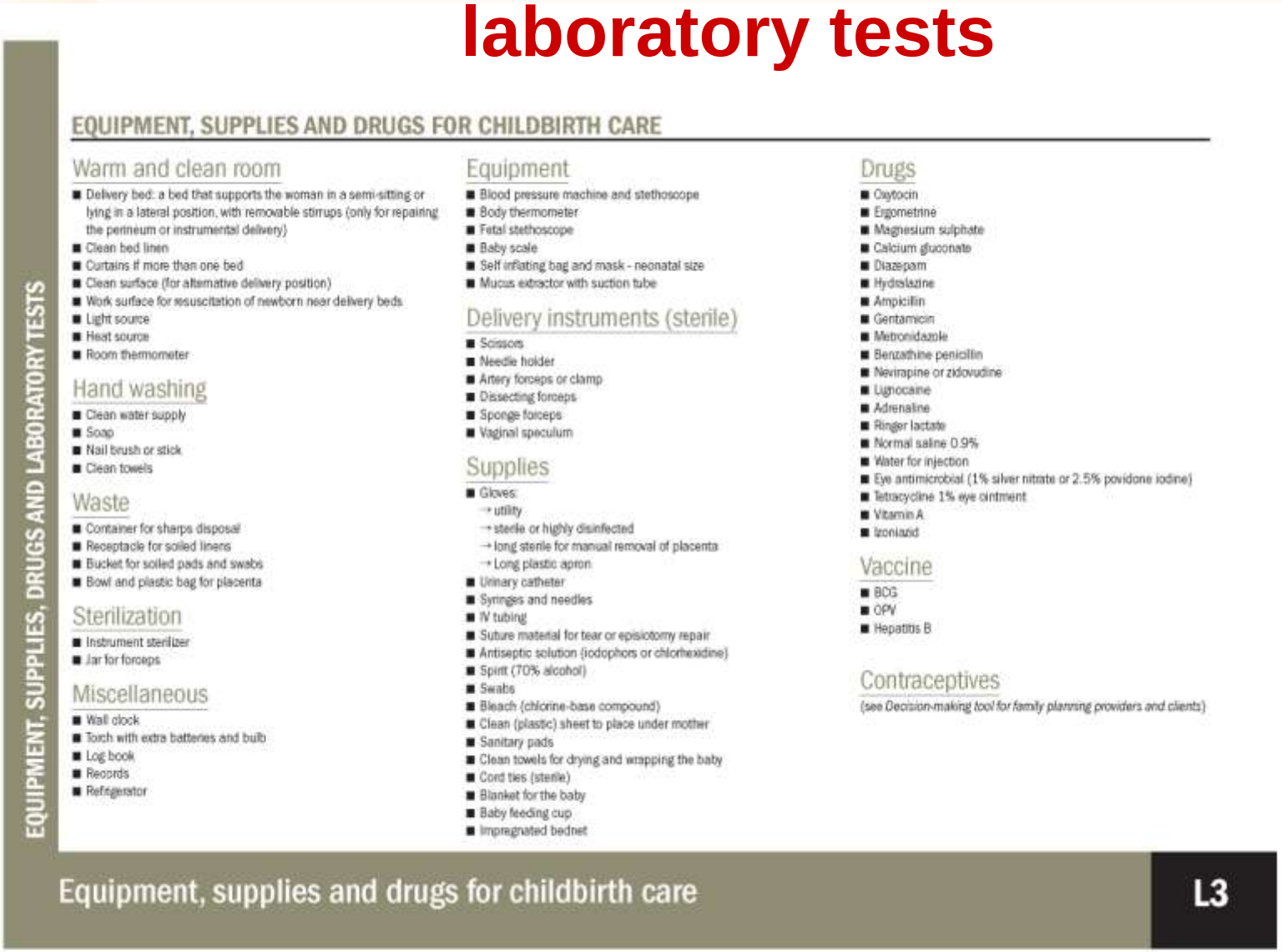
WHO IS REFERRING	RECORD NUMBER	REFERRED DATE	TIME
NAME		ARRIVAL DATE	TIME
FACILITY			
ACCOMPANIED BY THE HEALTH WORKER			

WOMAN	BABY
NAME AGE	NAME DATE AND HOUR OF BIRTH
ADDRESS	BIRTH WEIGHT GESTATIONAL AGE
MAIN REASONS FOR REFERRAL ☐ Emergency ☐ Non-emergency ☐ To accompany the baby	MAIN REASONS FOR REFERRAL ☐ Emergency ☐ Non-emergency ☐ To accompany the mother
MAJOR FINDINGS (CLINICAL AND BIRTHEND, LAB.)	MAJOR FINDINGS (CLINICAL AND TEMP.) LAST BREASTFEED (TIME)
TREATMENTS GIVEN AND TIME	TREATMENTS GIVEN AND TIME
BEFORE REFERRAL	BEFORE REFERRAL
DURING TRANSPORT	DURING TRANSPORT
INFORMATION GIVEN TO THE WOMAN AND COMPANION ABOUT THE REASONS FOR REFERRAL	INFORMATION GIVEN TO THE WOMAN AND COMPANION ABOUT THE REASONS FOR REFERRAL

Sample form to be adapted. Revised on 13 June 2003.

Lists

Equipment, supplies, drugs and laboratory tests



EQUIPMENT, SUPPLIES, DRUGS AND LABORATORY TESTS

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
- Izoniazid

Vaccine

- BCG
- OPV
- Hepatitis B

Contraceptives

(see Decision-making tool for family planning providers and clients)

Equipment, supplies and drugs for childbirth care

L3

HIV in pregnancy and prevention of mother-to-child transmission of HIV

ANTENATAL CARE

CHECK FOR HIV STATUS

Test and counsel all pregnant women for HIV at the first antenatal visit. Check status at every visit.
Inform the woman that HIV test will be done routinely and that she may refuse the HIV test.

ASK, CHECK RECORD

Provide key information on HIV C2
- What is HIV and how is HIV transmitted C2?
- Advantage of knowing the HIV status in pregnancy C2.
- Explain about HIV testing and counselling including confidentiality of the result C3.

Ask the woman:
- Have you been tested for HIV?
  - → If not: tell her that she will be tested for HIV, unless she refuses.
  - → If yes: Check result. (Explain to her that she has a right not to disclose the result.)
  - → Are you taking any ARV?
  - → Check ARV treatment plan.
- Has the partner been tested?

LOOK, LISTEN, FEEL

- Perform the Rapid HIV test if not performed in this pregnancy L8.

SIGNS	CLASSIFY	TREAT AND ADVISE
■ Positive HIV test.	HIV-POSITIVE	■ Counsel on implications of a positive test C3. If HIV services available: ■ Refer the woman to HIV services for further assessment. ■ Ask her to return in 2 weeks with her documents. If HIV services are not available: ■ Determine the severity of the disease and assess eligibility for ARVs C19. ■ Give her appropriate ARV C6, C9. For all women: ■ Support adherence to ARV C8. ■ Counsel on infant feeding options C7. ■ Provide additional care for HIV-positive woman C4. ■ Counsel on family planning C4. ■ Counsel on safer sex including use of condoms C2. ■ Counsel on benefits of disclosure (involving) and testing her partner C2. ■ Provide support to the HIV-positive woman C5.
■ Negative HIV test.	HIV-NEGATIVE	■ Counsel on implications of a negative test C3. ■ Counsel on the importance of staying negative by practising safer sex, including use of condoms C2. ■ Counsel on benefits of involving and testing the partner C2.
■ She refuses the test or is not willing to disclose the result of previous test or no test results available.	UNKNOWN HIV STATUS	■ Counsel on safer sex including use of condoms C2. ■ Counsel on benefits of involving and testing the partner C2.

▼ NEXT: Respond to observed signs or volunteered problems
If no problem, go to page C12.

Maternal HIV

Respond to observed signs or volunteered problems (4)

C10

ANTENATAL CARE

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
IF SIGNS SUGGESTING HIV INFECTION				
(HIV status unknown) ■ 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 high risk group: ■ Occupational exposure? ■ Multiple sexual partner? ■ Intravenous drug abuse? ■ History of blood transfusion? ■ Illness or death from AIDS in a sexual partner? ■ History of forced sex?	■ 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 on HIV testing and counselling C3-C3. ■ Counsel on the benefits of testing the partner C3. ■ Counsel on safer sex including use of condoms C2. ■ Refer to TB control if cough.
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

Maternal HIV infection

INFORM AND COUNSEL ON HIV

CARE AND COUNSELLING FOR THE HIV-POSITIVE WOMAN

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 her additional support G1.
- Advise on the importance of good nutrition G12 D06.
- Use standard precautions as for all women A4.
- 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
  - → no weight gain
  - → skin infections
  - → foul-smelling lochia.

DURING PREGNANCY:

- Revise the birth plan G2 G12.
  - → Advise her to deliver in a facility
  - → Advise her to go to a facility as soon as her membranes rupture or labour starts.
  - → Tell her to take ARV medicine at the onset of labour as instructed G3.
- Discuss the infant feeding options G8–G9.
- Modify preventive treatment for malaria, according to national strategy C4.

DURING CHILDBIRTH:

- Check if nevirapine is taken at onset of labour.
- Give ARV medicines as prescribed G3 G5.
- Adhere to standard practice for labour and delivery.
- Respect confidentiality when giving ARV to the mother and baby.
- Record all ARV medicines given on labour record, postpartum record and on referral record, if woman is referred.

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).
- Counsel her on family planning G4.
- If not breastfeeding, advise her on breast care H3.
- Visit HIV services 2 weeks after delivery for further assessment.

Counsel the HIV-positive woman on family planning

- Use the advice and counselling sections on G18 during antenatal care and D07 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.
  - → Discuss her options for preventing both pregnancy and infection with other sexually transmitted infections or HIV reinfection.
- Condoms may be the best option for the woman with HIV. Counsel the woman on safer sex including the use of condoms G3.
- If the woman think that her partner will not use condoms, she may wish to use an additional method for pregnancy protection. However, not all methods are appropriate for the HIV-positive woman:
  - → Given the woman's HIV status, she may not choose to breastfeed and lactational amenorrhoea method (LAM) may not be a suitable method.
  - → Spermicides are not recommended for HIV-positive women.
  - → Intrauterine device (IUD) use is not recommended for women with AIDS who are not on ARV therapy.
  - → Due to changes in the menstrual cycle and elevated temperatures fertility awareness methods may be difficult if the woman has AIDS or is on treatment for HIV infections.
  - → 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.

On site tests

PERFORM RAPID HIV TEST (TYPE OF TEST USE DEPENDS ON THE NATIONAL POLICY)

- Explain the procedure and seek consent according to the national policy
- Use test kits recommended by the national and/or international bodies and follow the instructions of the HIV rapid test selected.
- Prepare your worksheet, label the test, and indicate the test batch number and expiry date. Check that expiry time has not lapsed.
- Wear gloves when drawing blood and follow standard safety precautions for waste disposal.
- Inform the women when to return to the clinic for their test results (same day or they will have to come again).
- Draw blood for all tests at the same time (tests for Hb, syphilis and HIV can often be coupled at the same time).
  - → Use a sterile needle and syringe when drawing blood from a vein.
  - → Use a lancet when doing a finger prick.
- Perform the test following manufacturer's instructions.
- Interpret the results as per the instructions of the HIV rapid test selected.
  - → If the first test result is negative, no further testing is done. Record the result as – Negative for HIV.
  - → If the first test result is positive, perform a second HIV rapid test using a different test kit.
  - → If the second test is also positive, record the result as – Positive for HIV.
  - → If the first test result is positive and second test result is negative, record the result as Inconclusive. Repeat the test after 6 weeks or refer the woman to hospital for a confirmatory test.
  - → Send the results to the health worker. Respect confidentiality A21.
- Record all results in the logbook.

Treatment details – ARV for HIV

INFORM AND COUNSEL ON HIV

ANTIRETROVIRALS FOR HIV-POSITIVE WOMAN AND HER INFANT

Below are examples of ARV regimens. Use national guidelines for local protocols.
For longer regimens to further reduce the risk of transmission follow national guidelines.
Record the ARV medicine prescribed and given in the appropriate records – facility and home-based. DO NOT write HIV-positive.

		Woman					Newborn infant				
		Pregnancy		Labour, delivery		Postpartum**					
	ARVs	Before 28 weeks	Starting at 28 weeks	At onset of labour*	Until birth of the baby	After birth of the baby	ARVs	Dose (syrup)	Give first dose	Then give	Duration
HIV-positive with HIV-AIDS related signs and symptoms	Triple therapy	Continue the ARV treatment prescribed before pregnancy. In the first trimester replace Efavirenz with Nevirapine (200 mg once daily for 2 weeks, then every 12 hours)					Zidovudine	4 mg/kg	8–12 hours after birth	every 12 hours	7 days***
HIV-positive without HIV- related signs and symptoms	3TC			150 mg	every 12 hours	7 days					
	Zidovudine		300 mg every 12 hours	300 mg	every 3 hours	ev 12 h					
	Nevirapine			200 mg once							
ARVs during labour	Zidovudine			300 mg	every 3 hours						
				Or 600 mg							
	Nevirapine			200 mg once							
Only minimal range of ARV treatment	Nevirapine			200 mg once							

* At onset of contractions or rupture of membranes, regardless of the previous schedule
** Arrange follow-up for further assessment and treatment within 2 weeks after delivery
*** Treat the newborn infant with Zidovudine for 4 weeks if mother received Zidovudine for less than 4 weeks durin

Antiretrovirals for HIV-positive woman and her in

World Health Organization

INFORM AND COUNSEL ON HIV

Give antiretroviral (ARV) medicine(s) to treat HIV infection — G6

GIVE ANTIRETROVIRAL (ARV) MEDICINE(S) TO TREAT HIV INFECTION

Use these charts when starting ARV medicine(s) and to support adherence to ARV

Support the initiation of ARV

- If the woman is already on ARV treatment continue the treatment during pregnancy, as prescribed. If she is in the first trimester of pregnancy and treatment includes efavirenz, replace it with nevirapine.
- If the woman is not on ARV treatment and is tested HIV-positive, choose appropriate ARV regimens C29 C27 according to the stage of the disease.
- If treatment with Zidovudine (AZT) is planned: measure haemoglobin; if less than 8 g/dL refer to hospital C4.
- Write the treatment plan in the Home Based Maternal Record.
- Give written instructions to the woman on how to take the medicines.
- Give prophylaxis for opportunistic infections according to national guidelines.
- Modify preventive treatment for malaria according to national guidelines P3.

Explore local perceptions about ARVs

Explain to the woman and family that:

- ARV treatment will improve the woman's health and will greatly reduce the risk of infection to her baby. The treatment will not cure the disease.
- The choice of regimen depends on the stage of the disease C29.
  - → If she is in early stage of HIV infection, she will need to take medicines during pregnancy, childbirth and only for a short period after delivery to prevent mother-to-child transmission of HIV infection (PMTCT). Progress of disease will be monitored to determine if she needs additional treatment.
  - → If she has mild-severe HIV disease she will need to continue the treatment even after childbirth and postpartum period.
- She may have some side effects but not all women have them. Common side effects like nausea, diarrhoea, headache or fever often occur in the beginning but they usually disappear within 2–3 weeks. Other side effects like yellow eyes, pallor, severe abdominal pain, shortness of breath, skin rash, painful feet, legs or hands may appear at any time. If these signs persist, she should come to the clinic.
- Give her enough ARV tablets for 2 weeks or till her next ANC visit.
- Ask the woman if she has any concerns. Discuss any incorrect perceptions.

Support adherence to ARV

For ARV medicine to be effective:

- Advise woman on:
  - → which tablets she needs to take during pregnancy, when labour begins (painful abdominal contractions and/or membranes rupture) and after childbirth.
  - → taking the medicine regularly, every day, at the right time. If she chooses to stop taking medicines during pregnancy, her HIV disease could get worse and she may pass the infection to her child.
  - → If she forgets to take a dose, she should not double the next dose.
  - → continue the treatment during and after the childbirth (if prescribed), even if she is breastfeeding.
  - → taking the medicine(s) with meals in order to minimize side effects.
- For newborn:
  - → Give the first dose of medicine to the newborn 8–12 hours after birth.
  - → Teach the mother how to give treatment to the newborn.
  - → Tell the mother that the baby must complete the full course of treatment and will need regular visits throughout the infancy.
  - → If the mother received less than 4 weeks of Zidovudine (AZT) during pregnancy, give the treatment to the newborn for 4 weeks.
- Record all treatment given. If the mother or baby is referred, write the treatment given and the regimen prescribed on the referral card.

- DO NOT label records as HIV-Positive
- DO NOT share drugs with family or friends.

Counselling on infant feeding options

COUNSEL ON INFANT FEEDING OPTIONS

Explain the risks of HIV transmission through breastfeeding and not breastfeeding

- Four 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 lesions 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 increases the risk of diarrhoea. It may also increase the risk of HIV transmission.

If a woman does not know her HIV status

- Counsel on the importance of exclusive breastfeeding P4.
- Encourage exclusive breastfeeding.
- Counsel on the need to know the HIV status and where to go for HIV testing and counselling P9.
- Explain to her the risks of HIV transmission:
  - → even in areas where 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 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.

Home delivery

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 D17, records, and the delivery kit.
- Ensure that the family prepares, as on D16.

Delivery care

- Follow the labour and delivery procedures D23-D30 D31.
- Observe universal precautions A6.
- Give supportive care. Involve the companion in care and support D26-D27.
- Maintain the partograph and labour record M4-M6.
- Provide newborn care D35-40.
- Refer to facility as soon as possible if any abnormal finding in mother or baby D17 R14.

Immediate postpartum care of mother

- Stay with the woman for first two hours after delivery of placenta D32 D33-D34.
- Examine the mother before leaving her D31.
- Advise on postpartum care, nutrition and family planning D35-D37.
- 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 D32.
- Advise on breastfeeding and breast care D1.
- Examine the baby before leaving N2-N3.
- Immunize the baby if possible D12.
- Advise on newborn care D35-D39.
- Advise the family about danger signs and when and where to seek care D14.
- 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 D14.

Home delivery

ANTENATAL CARE

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 burry).

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.

How is it different from other guidelines?

- Entry point: pregnant woman/newly born infant (routine or for complications)
- Care described "as provided"
- Emphasis on clinical decision-making
- Care described as provided
- Simple, consistent standards of care
- Balance between clarity, simplicity and detail
- Integration
- (Resources: limited)
- Assumptions

What are the assumptions?

- About services organization, resources and alternatives, for example:
  - Single healthcare worker at primary health care level (skilled attendant) able to provide all services for the woman and her baby
  - For emergency care available 24/24, 7/7
  - Secondary (Referral) healthcare distant (all pre-referral treatments needed)

What are the assumptions?

- About endemic diseases - prevalent
  - High prevalence of anaemia due to
    - iron deficiency
    - hookworm infestation
    - malaria
      - high transmission area
      - Falciparum
  - Maternal syphilis and gonorrhoea

- About support groups
  - available

Assumptions

Assumptions underlying the Guide

HOW TO READ THE GUIDE

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 neighborhood.
- A single skilled attendant is providing care. She may work at the health care centre, a maternity unit of a hospital or she may go to the woman's home, if necessary. However there may be other health workers who receive the woman or support the skilled attendant when emergency complications occur.
- 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 maternal and newborn health issues.
- Other programme activities, such as management of malaria, tuberculosis and other lung diseases, treatment 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.
- All pregnant women are routinely offered HIV testing and counselling at the first contact with the health worker, which could be during the antenatal visits, in early labour or in the postpartum period.
  Women who are first seen by the health worker in late labour are offered the test after the childbirth.
  Health workers are trained to provide HIV testing and counselling.
  HIV testing kits and ARV medicines are available at the Primary health-care

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.

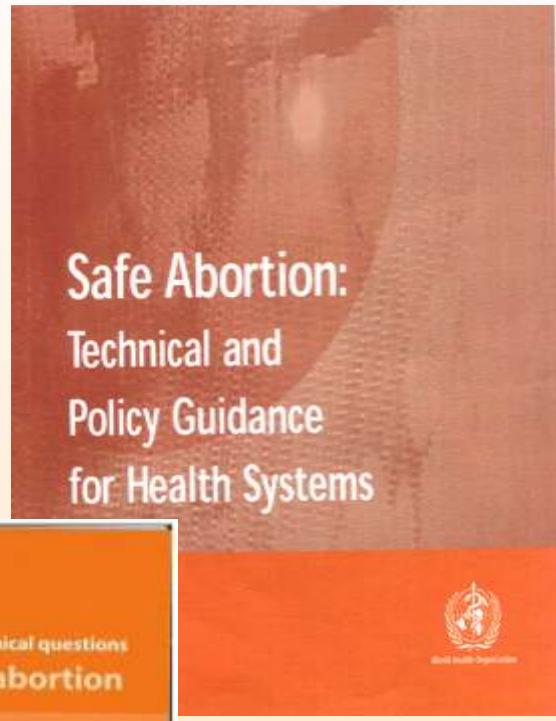
An adaptation guide is available to assist national experts in modifying the Guide according to national needs, for different demographic and epidemiological conditions, resources and settings. The adaptation guide offers some alternatives. It includes guidance on developing information and counselling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

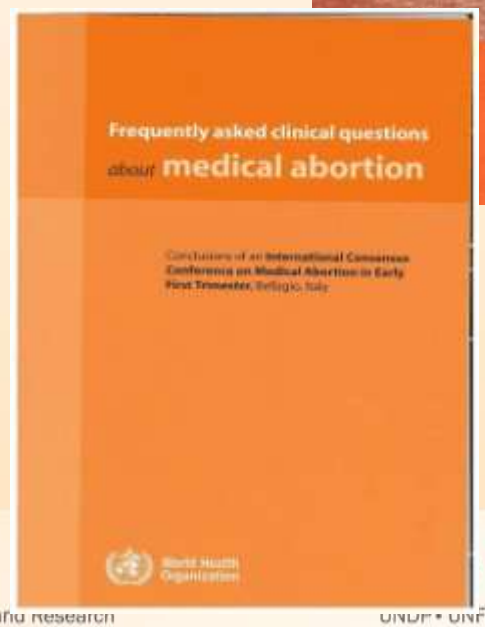
Update of the Guidelines for Safe Abortion

World Health Organization
Reproductive Health and Research
UNDP • UNFPA • WHO • World Bank
Special Programme of Research, Development and Research Training in Human Reproduction

Purpose of the update

- First evidence-based, global guidance on the provision of safe abortion, published 2003
- *Frequently asked clinical questions about medical abortion* published in 2006
- More than 30,000 copies of both documents distributed
  - English, French, Russian, Spanish, and others





Overview for recommendations

- Scoping of the guidelines
  - Identified priority topics internally from input from key external experts and organizations
    - Identified 35 issues and narrowed down to the top 18
  - Outcomes for each of the priority topics ranked by level of importance by external guidelines group and other external experts and organizations

18 priority questions

- 3 are questions already addressed by our department:
  - Competencies to provide safe abortion services
  - Indicators of safe abortion services
  - Postabortion contraception

- 16 are clinical questions addressing the following issues:
  - Recommended methods for treatment of incomplete abortion
  - Recommended methods for induced surgical and medical abortion
  - Antibiotic use
  - Pain control
  - Ultrasound
  - Cervical preparation
  - Follow-up care

Overview for recommendations

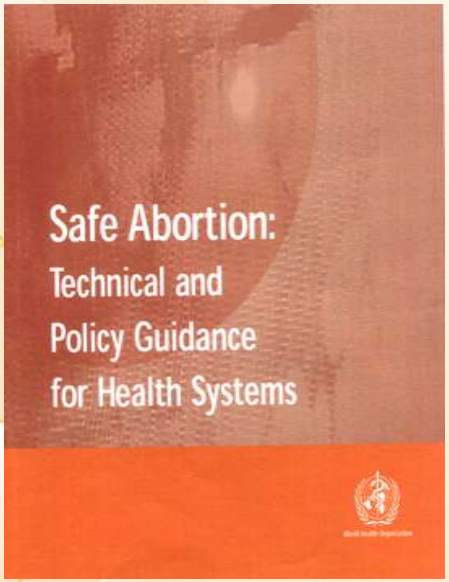
- Each priority topic was addressed with a systematic review of the evidence
  - Exception of three topics for which WHO has developed guidance separately
  - Focus of the Technical Consultation will be the evidence from these systematic reviews
    - Focus on the evidence for the outcomes with high (critical) ranking

Purpose of the Technical Consultation 9-12 August 2010

- Considerable amount of new data available since 2003
  - Need for updated guidance
- Bring together global group of experts in the field, human rights lawyers and representatives/ users of the guidelines
  - Comment on the evidence used to inform the guideline
  - Advise on the interpretation of the evidence, with explicit consideration of the overall balance of risks and benefits
  - Formulate recommendations, taking into account diverse values and preferences

Outcome of the meeting:
Evidence-based guidance for safe abortion care

Safe abortion: Technical and policy guidance for health systems



Guidance for policy-makers and programme managers

Clinical practice guidelines for comprehensive abortion care

Guidance for health-care providers

Outcome: Clinical practice guidelines for comprehensive abortion care

- Companion document for clinical staff involved in abortion care
  - Not a training document
- Technical information to help the health provider effectively deliver appropriate abortion care
  - Practical step-by-step format
- Reflects evidence-based abortion guidance extrapolated from chapter 2

The WHO Reproductive Health Library (RHL)

http://www.who.int/rhl

http://www.who.int/rhl

RHL is an electronic review journal published by the Department of Reproductive Health and Research at WHO Headquarters in Geneva, Switzerland, since 1997.

Translations: Chinese, French, Spanish, Vietnamese, Russian, Arabic

RHL is used in a training course on "Evidence-based decision making"

RHL takes the best available evidence, on sexual and reproductive health, mainly from Cochrane systematic reviews and presents it as practical actions for clinicians (and policy-makers) to improve health outcomes, especially in developing countries.

Contents

- Full text of selected *Cochrane systematic reviews* in English and Spanish;
- *RHL commentaries* each Cochrane review is supplemented by at least one independent "expert commentary";
- *RHL practical guides* give advice on implementation of findings of each Cochrane review;
- *Effectiveness summaries* a complete list of interventions evaluated in RHL, classified by the degree of their effectiveness (beneficial to harmful);
- *Videos* demonstrating evidence-based techniques in real life settings;
- A set of other *EBM resources*

Systematic review or Overview

Comprehensively

- **locates**
- **evaluates**
- **synthesizes**

all the available literature on a given topic **using a strict scientific design which must itself be reported in the review**

A ‘systematic review’, therefore, aims to be:

- **Systematic** (e.g. in its identification of literature);
- **Explicit** (e.g. in its statement of objectives, materials and methods);
- **Reproducible** (e.g. in its methodology and conclusions.

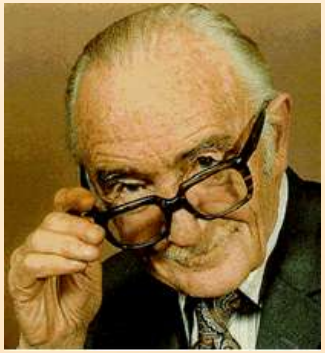
The ‘systematic’ part of systematic reviews is all about

minimizing bias in the way the review is carried out

The Cochrane Collaboration

International organization that aims to help professionals make well-informed decisions about the effects of health care interventions.

The Cochrane Collaboration was founded in 1993 and *named* for the British epidemiologist, Archie Cochrane.



- Cochrane Library includes systematic reviews in all areas of health care with an annual rate of 300.

- 12-16 new reviews are selected every year for inclusion in RHL. Currently 137 reviews.

- RHL offers full access to reviews in developing countries, in English and Spanish. Other language versions provide translations of abstracts and full access in English.