WHO guidelines on sexual and reproductive health

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GFMER on-line course
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(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)
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

1. A WHO department decides to produce a guideline
2. Initial approval by GRC
3. Initial approval for development
4. The guideline is produced by the WHO department (i.e. from a few months to 2-3 years time frame)
5. Final approval by GRC

GRC Secretariat throughout the process of production of a guideline, the WHO department can access the resources provided by the GRC Secretariat

- Advice and support from the GRC Secretariat
- Advice and support from members of the GRC
- Advice and support from WHO Collaborating Centres
- Advice and support from GRC through WHO lists of technical experts
- Advice and support from external experts on guideline production
Guideline Development Process

1. Scoping the document
2. Setting up Guideline Development Group and External Review Group
3. Management of Conflicts of Interest
4. Formulation of the questions (PICOT) and choice of the relevant outcomes
5. Evidence retrieval, assessment and synthesis (systematic review(s))
   - GRADE - evidence profile
6. Formulation of the recommendations (GRADE)
   - Including explicit consideration of:
     - Benefits and harms
     - Values and preferences
     - Resource use
7. Dissemination, implementation (adaptation)
8. Evaluation of impact
9. Plan for updating

Initial guideline approval
- After completion of 1 and 2
- With draft of 4
- With plan for 3, 5-9

Final guideline approval
- After completion of 6
- With plan for 7-9
STI Guidelines
Guidelines relating to SRH in Crisis situations
Adolescent Health

Family planning guidelines and tools

1. Continuous update of the four cornerstones

- Medical eligibility criteria
- Selected practice recommendations

2. New tools for service providers

- The Medical Eligibility Criteria Wheel
- Reproductive Choices and Family Planning for People Living with HIV

Decision-making tool
Manual
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**
- **Decision-Making Tool for Family Planning Clients and Providers**
- **Family Planning: A Global Handbook for Providers**

System for keeping the guidance up-to-date

Guidance for guides

Guidance for providers and clients
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
Karolinska 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
Keeping up with the evidence...
Guidance based on evidence and kept up-to-date

- Monitoring all new evidence
- 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?

- 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.

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

<table>
<thead>
<tr>
<th>Hypertension</th>
<th>COC/P/R</th>
<th>CIC</th>
<th>POP</th>
<th>DMPA/NET-EN</th>
<th>LNG/ETG Implants</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>History, where BP can not be evaluated</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Adequately controlled where BP can be evaluated</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Elevated BP levels</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Systolic 140-159 or diastolic 90-99</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>ii) Systolic ≥160 or diastolic ≥100</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Vascular disease</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
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
Selected practice recommendations for contraceptive use

Purpose:
How to use contraceptive methods


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.
Decision-making tool

DECISION-MAKING TOOL
for Family Planning Clients and Providers

World Health Organization
Reproductive Health and Research

UNDP • UNFPA • WHO • World Bank
Special Programme of Research, Development
and Research Training in Human Reproduction
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
In recent decades, tremendous advances have been made in the development of safer and more effective contraceptives, and in the provision of affordable and accessible family planning services. Yet, still millions of individuals and couples around the world are unable to plan their families as they wish.

It is estimated that over 137 million couples do not use contraceptives, despite wanting to space or limit their childbearing. In addition, many women who use contraceptives nevertheless become pregnant. At the same time, many couples who want to have children are unable to conceive.
Integrated Management of Pregnancy and Childbirth (IMPAC)
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.
Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC)

A guide for essential practice
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 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**

**A3 Communication**

**A4 Workplace and administrative procedures**

**A5 Standard precautions and cleanliness**

**Standard precautions and cleanliness**

**Principles of good care**

**A6 Communication**

**A7 Workplace and administrative procedures**

**A8 Standard precautions and cleanliness**

**Standard precautions and cleanliness**

**Protect yourself from blood and other body fluids during deliveries**

- Wear gloves; cover any cuts, abrasions, or broken skin with a barrier cream, bandage, 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 readily available.
- Use each needle and syringe only once.
- Do not recap, bend, or break needles after giving an injection.
- Dispose of used (disposable) needles, and plastic syringes and blades directly into the sharps container, without making contact with skin or other body fluids.
- Empty or send for incineration when the container is three-quarters full.

**Practice safe waste disposal**

- Dispose of potentially blood- or body-fluid-contaminated items, in leak-proof containers.
- Store or bury contaminated solid waste.
- Wash hands, gloves, and containers after disposal of infectious waste.
- Pour liquid waste down a drain or flush it into the toilet.
- Wash hands after disposal of infectious waste.

**Clean and disinfect gloves**

- Wash the gloves in soap and water.
- Check for damage: Blow gloves full of air, twist the cuff closed, hold under running 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 1.6 litres bleach containing 5% available chlorine).
- Dry away from direct sunlight.
- Dust inside with talcum powder or starch.

**Stirilize gloves**

- Sterilize by autoclaving or highly by distilling by steaming or boiling.
Decision-making charts

- Assessment, classification and management
- Colour coding

**Traffic lights**

1. Ask, check record
2. Look, listen feel

3. Signs
4. Classify
5. Treat and advise

6. Green: no abnormal conditions; continue normal care and preventive measures
7. Yellow: a condition/complication that could be managed at primary health care level
8. Red: serious complication which requires immediate treatment and, in most cases, referral to a higher level of care
# Decision-making Quick Check

**Rapid assessment and management (RAM) ▶ Vaginal bleeding**

<table>
<thead>
<tr>
<th>PREGNANCY STATUS</th>
<th>BLEEDING</th>
<th>TREATMENT</th>
</tr>
</thead>
</table>
| EARLY PREGNANCY           | HEAVY BLEEDING            | • Insert an IV line
• Give fluids rapidly
• Give 0.2 mg ergometrine IV
• Repeat 0.2 mg ergometrine IM
• If bleeding continues, suspect possible complicated abortion, give appropriate IM/IV antibiotics
• Refer woman urgently to hospital

| LATE PREGNANCY            | LIGHT BLEEDING            | • Examine woman as above
• If pregnancy not likely, refer to other clinical guidelines |

| DURING LABOUR             | ANY BLEEDING IS DANGEROUS | • Do NOT do vaginal examination, but:
• Insert an IV line
• Give fluids rapidly if heavy bleeding or shock
• Refer woman urgently to hospital |

| BLEEDING                  | MORE THAN 100 ml          | • Do NOT do vaginal examination, but:
• Insert an IV line
• Give fluids rapidly if heavy bleeding or shock
• Refer woman urgently to hospital |

*But if birth is imminent (bulging, thin perineum during contractions, visible fetal head), transfer woman to labour room and proceed as on 114.*
## Antenatal care

### Detection and management of pre-eclampsia

**CHECK FOR PRE-ECLAMPSIA**

Screen all pregnant women at every visit.

<table>
<thead>
<tr>
<th>ASK, CHECK RECORD</th>
<th>LOOK, LISTEN, FEEL</th>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure at the last visit?</td>
<td>- Measure blood pressure in sitting position.</td>
<td>Diastolic blood pressure &lt;110 mmHg and 3+ proteinuria, or</td>
<td>SEVERE PRE-ECLAMPSIA</td>
<td>- Give magnesium sulphate.</td>
</tr>
<tr>
<td></td>
<td>- If diastolic blood pressure is ≤90 mmHg, repeat after 1 hour rest.</td>
<td>Diastolic blood pressure &lt;90 mmHg on two readings and 2+ proteinuria, and any of:</td>
<td>PRE-ECLAMPSIA</td>
<td>- Give appropriate anti-hypertensives.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- severe headache</td>
<td></td>
<td>- Review the birth plan.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- blurred vision</td>
<td></td>
<td>- Refer urgently to hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- epigastric pain and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- check protein in urine.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HYPERTENSION**

- Blood pressure ≥140/90 mmHg or 2 readings 135/85 mmHg.

- Advise to reduce workload and to rest.

- Advise on dietary modification.

- Reassess at the next antenatal visit or in 1 week if ≥5 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.

**Hypertension**

- None of the above.

**NO HYPERTENSION**

No treatment required.

NEXT: Check for anaemia

Assess the pregnant woman → Check for pre-eclampsia C3
### 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.

<table>
<thead>
<tr>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
</table>
| • Transverse lie.  
• Continuous contractions.  
• Constant pain between contractions.  
• Sudden and severe abdominal pain.  
• Horizontal ridge across lower abdomen.  
• Labor >24 hours. | OBSTRUCTED LABOUR | • Hidemeth, insert an IV line and give fluid.  
• If labor >24 hours, give appropriate IV/N antibiotics.  
• Refer urgently to hospital. |

**FOR ALL SITUATIONS IN RED BELOW, REFER URGENTLY TO HOSPITAL IF IN EARLY LABOUR, MANAGE ONLY IF IN LATE LABOUR**

<table>
<thead>
<tr>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
</table>
| • Rupture of membranes and any or  
• Fever >38°C  
• Foet-al-smelling vaginal discharge. | UTERINE AND FETAL INFECTION | • Give appropriate IV/N antibiotics.  
• Hidemeth, labor, deliver and refer to hospital after delivery.  
• Plan to treat newborn. |
| • Rupture of membranes at  
<8 months of pregnancy. | RISK OF UTERINE AND FETAL INFECTION | • Give appropriate IV/N antibiotics.  
• Hidemeth, labor, deliver and refer to hospital.  
• Give continuous antibiotic for mother after delivery if no signs of infection.  
• Plan to treat newborn. |
| • Diastolic blood pressure >60 mmHg. | PRE-ECLAMPSIA | • Assess further and manage as on page 123. |
| • Severe palmar and conjunctival pallor and/or haemoglobin <7 g/dL. | SEVERE ANAEMIA | • Manage as on page 124. |
| • Breach or other malpresentation  
• Multiple pregnancy  
• Multiple gestations  
• Fetal distress  
• Prolapse cord. | OBSTETRICAL COMPLICATIONS | • Follow specific instructions  
(see page numbers in left column). |
Childbirth
Decision making – key sequential steps

<table>
<thead>
<tr>
<th>First stage of labour (1): when the woman is not in active labour</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FIRST STAGE OF LABOUR: NOT IN ACTIVE LABOUR</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

**MONITOR EVERY HOUR:**
- For emergency signs, using rapid assessment (RAM) 03 04 05
- Frequency, intensity and duration of contractions
- Fetal heart rate 04 05
- Mood and behaviour (distressed, anxious) 04
- Cervical dilatation 03 04 05
- Record findings regularly in Labour record and Partograph 03 04 05
- Record time of rupture of membranes and colour of amniotic fluid
- Give Supportive care 03 04 05
- Never leave the woman alone

**MONITOR EVERY 4 HOURS:**
- Temperature
- Pulse 03
- Blood pressure 03

**ASSESS PROGRESS OF LABOUR**
- After 8 hours if:
  - Contraction stronger and more frequent but
  - No progress in cervical dilatation with or without membranes ruptured

**TREAT AND ADVISE, IF REQUIRED**
- Refer the woman urgently to hospital 03
- Discharge the woman and advise her to return if:
  - Pain/discomfort increases
  - Vaginal bleeding
  - Membranes rupture
- Cervical dilatation 4 cm or greater
  - Begin plotting the partograph 03 04 and manage the woman as in Active labour 03
**Childbirth - Responding to problems**

### Respond to problems immediately postpartum (3)

<table>
<thead>
<tr>
<th>ASK, CHECK RECORD</th>
<th>LOOK, LISTEN, FEEL</th>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IF PALLOR ON SCREENING, CHECK FOR ANAEMIA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding during labour, delivery or postpartum.</td>
<td>Measure haemoglobin, if possible.</td>
<td>Haemoglobin &lt;7 g/dl. AND OR</td>
<td>Severe anaemia</td>
<td></td>
</tr>
<tr>
<td>Look for conjunctival pallor.</td>
<td>Severe palmar and conjunctival pallor or Any pallor with &gt;30 breaths per minute.</td>
<td></td>
<td>If early labour or postpartum, refer urgently to hospital [17]</td>
<td></td>
</tr>
<tr>
<td>Look for palmar pallor.</td>
<td>Any bleeding.</td>
<td>Moderate anaemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hb: low or normal?</td>
<td>Haemoglobin 7-11 g/dl.</td>
<td></td>
<td>DO NOT discharge before 2-4 hours.</td>
<td></td>
</tr>
<tr>
<td>Palmar or conjunctival pallor</td>
<td>Palmar palor</td>
<td>Check haemoglobin after 3 days.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count number of breaths in 1 min.</td>
<td>Haemoglobin &gt;11 g/dl.</td>
<td>Give double dose of iron for 3 months [7].</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No pallor.</td>
<td>No pallor</td>
<td>Follow up in 4 weeks.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IF MOTHER SEVERELY ILL OR SEPARATED FROM THE BABY**

- Teach mother to express breast milk every 3 hours [8].
- Help her to express breast milk if necessary. Ensure baby receives mother’s milk [8].
- Help her to establish or re-establish breastfeeding as soon as possible. See [2].

**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 want.
  - Discuss with them the events before the death and the possible causes of death.
  - Advise the mother on breast care [9].
  - Counsel on appropriate family planning methods [18].

> 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 she 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).
- Counsel 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.
- For HIV-positive women, see HIV for family planning considerations.
- Her partner can decide to have a vasectomy (male sterilization) at any time.

Method options for the non-breastfeeding woman
- Can be used immediately postpartum
  - Condoms
  - Progestogen-only oral contraceptives
  - Progestogen-only injectables
  - Implants
  - Spacerside
  - 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

Lactational amenorrhoea method (LAM)
- A breastfeeding woman is protected from pregnancy only:
  - if she is no more than 6 months postpartum, and
  - she is breastfeeding exclusively (8 or more times a day, including at least once at night; no daytime feedings more than 4 hours apart and no night feedings more than 6 hours apart; no complementary foods or fluids), and
  - her menstrual cycle has not returned.
- A breastfeeding woman can also choose any other family planning method, either to use alone or together with LAM.

Method options for the breastfeeding woman
- Can be used immediately postpartum
  - Lactational amenorrhoea method (LAM)
    - Condoms
    - Spacerside
    - Female sterilisation (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
    - Spacerside
  - 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 [1].

**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 [2]
  - 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 [3]
- Record the event.
Newborn – assess breastfeeding

**Assess breastfeeding**

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

### ASSESS BREASTFEEDING

#### ASK, CHECK, RECORD
- 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?

#### LOOK, LISTEN, FEEL
- 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.

#### SIGNs
- Suckling effectively.
- Breastfeeding ≥ 8 times in 24 hours on demand if you and night.

#### CLASSIFY
- FEEDING WELL
  - Encourage the mother to continue breastfeeding on demand.

- FEEDING DIFFICULTY
  - Stop all exclusive breastfeeding.
  - Help the mother to initiate breastfeeding.
  - Teach correct positioning and attachment.
  - Advise to feed more frequently if you 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.

#### TREAT AND ADVISE
- STOPABLE TO FEED
  - Refer baby urgently to hospital.

To assess replacement feeding see [12].

**Next:** Check for special treatment needs.
Counsel on breastfeeding (3)

COUNSEL ON BREASTFEEDING

Give special support to breastfeed the small baby (preterm and/or low birth weight)

COUNSEL THE MOTHER:
- Reassure the mother that she can breastfeed her small baby and she has enough milk.
- Explain that her milk is the best food for such a small baby. Feeding for her/him is 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 need as well as a big baby in the first days:
  - may take easily and suckle well at first
  - may suckle for shorter periods before resting
  - may fall asleep during feeding
  - may have longer pauses between sucking and may feed longer
  - it does not always wake up for feeds.
- Explain that breastfeeding will become easier if she/baby suckles and stimulates the breast/herself and when the baby becomes bigger.
- Encourage skin-to-skin contact as 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 nursing.
- If the baby is not yet sucking well and long enough, do whatever works best in your setting:
  - Let the mother express breast milk into baby’s mouth (milk syringe).
  - Let the mother express breast milk and feed baby by cup (optional). On the first day express breast milk into, and feed colostrum by spoon.
- Teach the mother to observe swallow, if giving expressed breast milk.
- Weigh the baby daily (if accurate and precise scales available), record and assess weight gain.

Give special support to breastfeed twins

COUNSEL THE MOTHER:
- Reassure the mother that she has enough breast milk for two babies.
- Encourage her that twins may take longer to establish breastfeeding since they are frequently born premature 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 position to feed the twins:
  - If one is weaker, encourage him 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.

Bank Republic of Korea.

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# Assess the Mother's Breasts if Complaining of Nipple or Breast Pain

## Ask, Check Record
- How do your breasts feel?
- Look at the nipple for fissure.
- Look at the breasts for:
  - swelling
  - unevenness
  - redness.
- Feel gently for painful part of the breast.
- Measure temperature.
- Observe breastfeeding if not yet done.

## Look, Listen, Feel
- Look at the nipple for fissure.
- Look at the breasts for:
  - swelling
  - unevenness
  - redness.
- Feel gently for painful part of the breast.
- Measure temperature.
- Observe breastfeeding if not yet done.

## Signs
- **Breasts Healthy**
  - No swelling, redness, or tenderness.
  - Normal body temperature.
  - Nipple not sore and no fissure visible.
  - Baby well attached.

- **Nipple Soreness or Fissure**
  - Nipple sore or fissured.
  - Baby not well attached.

- **Breast Engagement**
  - Both breasts are swollen, shiny and patchy red.
  - Temperature <38°C.
  - Baby not well attached.
  - Not yet breastfeeding.

- ** mastitis**
  - Part of breast is painful, swollen and red.
  - Temperature >38°C.
  - Feels ill.

## Classify

<table>
<thead>
<tr>
<th>Signs</th>
<th>Treat and Advise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breasts Healthy</td>
<td>Reassure mother.</td>
</tr>
</tbody>
</table>
| Nipple Soreness or Fissure   | Encourage mother to continue breastfeeding.
| Breast Engagement            | Teach correct positioning and attachment. |
| Mastitis                     | Give PARACETAMOL for 1-2 days. |

## Treat and Advise
- Reassure mother.
- Teach correct positioning and attachment.
- Advise to feed more frequently.
- Reassess after 2 feeds (1-4 day). If not better, teach mother how to express breast milk from the affected breast and feed baby by cup, and continue breastfeeding on the healthy side.
- Encourage mother to express enough breast milk before the feed to relieve discomfort.
- Encourage breastfeeding.
- Teach correct positioning and attachment.
- Give PARACETAMOL for 1-2 days.
- Reassess in 2-4 days. If no improvement or worse, refer to hospital.
- If mother is HA+ let her breastfeed on the healthy breast. Express milk from the affected breast and discard until no fever.
- If severe pain, give PARACETAMOL.
Newborn – care of a small baby

**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 breast feeding the small baby (or twins)**
  - 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.
  - If alternative feeding method is used, assess the total daily amount of milk given.
  - Weigh daily and assess weight gain.

- **Ensure additional warmth for the small baby**
  - Ensure the room is very warm (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.

- **Assess the small baby daily**
  - Measure temperature
  - Assess breathing (baby must be quiet, not crying)
  - Listen for grunting; count breaths per minute, expect at least 40-60 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 where**
  - Breastfeeding well
  - Gaining weight adequately on 3 consecutive days
  - Body temperature between 36.5°C and 37.5°C Co 3 consecutive days
  - Mother able and confident in caring for the baby
  - No maternal concerns
  - Assess the baby for 48 change.

**RESPONSE TO ABNORMAL FINDINGS**

- If the small baby is not sucking effectively and does not have other danger signs, consider alternative feeding methods.
  - Teach the mother how to hand express breast milk directly into the baby’s mouth.
  - Teach the mother to express breast milk and cup feed the baby.
  - Determine appropriate amount for daily feeds by age.

- If feeding difficulties persist 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.

- If breathing difficulty assess the baby.

- If jaundice, refer the baby for phototherapy.

- If any maternal concern, assess the baby and respond to the mother.

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

**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 not draining pus or blood, examine the baby and manage accordingly [12-17].
- Explain to the mother that she should seek care if the umbilicus is not 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 mucus.

DO NOT remove vernix.
DO NOT bathe the baby until at least 6 hours of age.

**LATER AND AT HOME:**
- Wash the face, neck, umbilicus daily.
- Wash the buttocks when soiled. Dry thoroughly.
- Bathe when necessary:
  - Ensure the room is warm, no drafts.
  - 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 to the baby's eyes except an anti-microbial 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

**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, assess needs and alternatives for support through the following:

- Community groups, women's groups, hosts, etc.
- Formal support groups.
- Formal health service providers.
- Community counsellors.
- Traditional providers.

**Emotional support**

Principles of good care, including suggestions or communication with the woman and her family, are provided on H2. 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 but tell the woman that you will not tell anyone else about the visit, discussion or plan.
  - In a separate, private setting, for example family planning the woman will now come to talk privately with the woman if she wishes and discuss her options. Make sure you understand:
  - Convey respect.
  - Do not be judgmental.
  - Be understanding of her situation.
  - Overcome your own discomfort with:
    - One simple, clear answer in clear terms.
    - Verify that she understands the instructions.
  - Provide information according to her skill level.
  - Be a good listener.
  - Be patient. Women with special needs may take longer.
  - Pay attention to her non-verbal cues.
  - Follow-up visits may be necessary.

**Special considerations in managing the pregnant adolescent**

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

**When interacting with the adolescent**

- Do not be judgemental. You should be aware of, and overcome, your own discomfort with a adolescent sexuality.
- Encourage the girl to ask questions and tell her that all topics can be discussed.
- Use simple and clear language.
- Respect guarantees of confidentiality.
- Understand adolescent difficulties in communicating about topics related to sexuality (fear of parental discovery, adult discomfort, social stigma, etc.).
- Support her when discussing her situation and ask if she has any particular concerns:
  - Does she love her partner? Can she confide in him?
  - Does she see herself as a couple? Is she in a long-term relationship?
  - Has she been subjected to violence or coercion?
  - Someone who knows about this pregnancy — she may not have received support.
- Support her concerns relating to puberty, social acceptance, peer pressure, forming relationships, social stigma and violence.

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

- **Birth control:** delivery in a hospital or health centre is highly recommended. She needs to understand why this is important, she needs to decide if she will do it and how she will arrange it.
- **Prevention of HIV/AIDS:** is important for her and her baby. If she or her partner are at risk of HIV/AIDS, they should use a condom in all sexual relations. She may need advice on how to discuss condom use with her partner.
- **Spaying 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. She needs advice planning family planning, counselling and advice.

Women living

- with violence
- with HIV
- After abortion
Labour record

<table>
<thead>
<tr>
<th>LABOUR RECORD</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME:</td>
</tr>
<tr>
<td>ADDRESS:</td>
</tr>
<tr>
<td>DURING LABOUR</td>
</tr>
<tr>
<td>BIRTH DATE:</td>
</tr>
<tr>
<td>OXYTOCID TIME</td>
</tr>
<tr>
<td>PLACENTA COMPLETE</td>
</tr>
<tr>
<td>TIME ACTIVE LABOUR STARTED</td>
</tr>
<tr>
<td>TIME EMBRYO FRAGMENT RUPTURED</td>
</tr>
<tr>
<td>TIME SECOND STAGE STARTS</td>
</tr>
<tr>
<td>ENTRY EXAMINATION</td>
</tr>
<tr>
<td>STAGE OF LABOUR: NOT IN ACTIVE LABOUR</td>
</tr>
<tr>
<td>NOT INACTIVE LABOUR</td>
</tr>
<tr>
<td>HOURS SINCE ARRIVAL</td>
</tr>
<tr>
<td>HOURS SINCE RUPTURED MEMBRANES</td>
</tr>
<tr>
<td>VAGINAL BLEEDING (0-+++)</td>
</tr>
<tr>
<td>STRONG CONTRACTIONS IN 10 MINUTES</td>
</tr>
<tr>
<td>FETAL HEART RATE</td>
</tr>
<tr>
<td>T (AUXILIARY)</td>
</tr>
<tr>
<td>PULSE (BEATS/MINUTE)</td>
</tr>
<tr>
<td>BLOOD PRESSURE (SYSTOLIC/DIASTOLIC)</td>
</tr>
<tr>
<td>URINE EXAMED</td>
</tr>
<tr>
<td>CERVICAL DILATATION (CM)</td>
</tr>
<tr>
<td>PROBLEM</td>
</tr>
<tr>
<td>IF MOTHER REFERRED DURING LABOUR OR DELIVERY, RECORD TIME AND EXPLAN</td>
</tr>
</tbody>
</table>

Sample forms to be adapted. Revised on 13 June 2003.
RECORDS AND FORMS
Simplified partograph

PARTOGRAPH
USE THIS FORM FOR MONITORING ACTIVE LABOUR

<table>
<thead>
<tr>
<th>FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours in active labour</td>
</tr>
<tr>
<td>Hours since ruptured membranes</td>
</tr>
<tr>
<td>Rapid assessment: XX</td>
</tr>
<tr>
<td>Vaginal bleeding (0, ++, ++)</td>
</tr>
<tr>
<td>Amniotic fluid (meconium stained)</td>
</tr>
<tr>
<td>Contractions in 10 minutes</td>
</tr>
<tr>
<td>Fetal heart rate (beats/minute)</td>
</tr>
<tr>
<td>Urine voided</td>
</tr>
<tr>
<td>T (auxiliary)</td>
</tr>
<tr>
<td>Pulse (beats/minute)</td>
</tr>
<tr>
<td>Blood pressure (systolic/diastolic)</td>
</tr>
<tr>
<td>Cervical dilatation (cm)</td>
</tr>
<tr>
<td>Delivery of placenta (time)</td>
</tr>
<tr>
<td>Oxytocin (time/given)</td>
</tr>
<tr>
<td>Problem noted: onset/describe below</td>
</tr>
</tbody>
</table>

Sample form to be filled. Printed on 13 June 2003

World Bank
Research, Development
and Research Training in Human Reproduction
# Referral record

## Referral Record

<table>
<thead>
<tr>
<th>WHO IS REFERRING</th>
<th>RECORD NUMBER</th>
<th>REFERRED DATE</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FACILITY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACCOMPANYED BY THE HEALTH WORKER</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Woman

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Baby

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE AND HOUR OF BIRTH</th>
<th>BIRTH WEIGHT</th>
<th>GESTATIONAL AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Main Reasons for Referral

- Urgency
- Non-urgent
- To accompany the baby

### Minor Reasons for Referral

- Urgency
- Non-urgent
- To accompany the mother

### Major Findings (Clinical and Temp)

<table>
<thead>
<tr>
<th>LAST BREASTFEED (TIME)</th>
<th>TREATMENTS GIVEN AND TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Treatments Given and Time

<table>
<thead>
<tr>
<th>BEFORE REFERRAL</th>
<th>DURING TRANSPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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 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
- Muras 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 (iodophor 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
- Cephalothin
- Ergometrine
- Magnesium sulphate
- Calcium gluconate
- Diazepam
- Hydralazine
- Ampicillin
- Gentamicin
- Metronidazole
- Benzathine penicillin
- Nalorphine or zidovudine
- Lidocaine
- Adrenalin
- Ringer lactate
- Normal saline 0.9%
- Water for injection
- Eye antimicrobial (1% silver nitrate or 2.5% povidone iodine)
- Tetracycline 1% eye ointment
- Vitamin A
- Isoniazid

### Vaccine
- BCG
- OPV
- Hepatitis B

### Contraceptives
(see Decision-making tool for family planning providers and clients)
HIV in pregnancy and prevention of mother-to-child transmission of HIV

### CHECK FOR HIV STATUS

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

<table>
<thead>
<tr>
<th>CHECK FOR HIV STATUS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASK, CHECK RECORD</strong></td>
<td><strong>SIGNS</strong></td>
<td><strong>HIV-POSITIVE</strong></td>
</tr>
<tr>
<td>- Advantages of knowing the HIV status in pregnancy.</td>
<td>- Positive HIV test.</td>
<td>- Counsel on implications of a positive test.</td>
</tr>
<tr>
<td>- Explain about HIV testing and counselling including confidentiality of the result.</td>
<td></td>
<td>- Refer the woman to HIV services for further assessment.</td>
</tr>
<tr>
<td>- Ask the woman:</td>
<td></td>
<td>- Ask her to return in 2 weeks with her documents.</td>
</tr>
<tr>
<td>- Have you been tested for HIV?</td>
<td></td>
<td>- Determine the severity of the disease and assess eligibility for ARVs.</td>
</tr>
<tr>
<td>→ If not: tell her that she will be tested for HIV, unless she refuses.</td>
<td></td>
<td>- Give her appropriate ARVs.</td>
</tr>
<tr>
<td>→ If yes: Check result.</td>
<td></td>
<td>For all women:</td>
</tr>
<tr>
<td>(Explain to her that she has a right not to disclose the result.)</td>
<td></td>
<td>- Support adherence to ARVs.</td>
</tr>
<tr>
<td>→ Are you taking any ARVs?</td>
<td></td>
<td>- Counsel on infant feeding options.</td>
</tr>
<tr>
<td>→ Check ARV treatment plan.</td>
<td></td>
<td>- Provide additional care for HIV-positive women.</td>
</tr>
<tr>
<td>- Has the partner been tested?</td>
<td></td>
<td>- Counsel on family planning.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Counsel on risk of acquiring HIV from a discordant couple.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Counsel on benefits of disclosure (involving) and testing her partner.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Provide support to the HIV-positive woman.</td>
</tr>
<tr>
<td><strong>LOOK, LISTEN, FEEL</strong></td>
<td><strong>NEGATIVE</strong></td>
<td><strong>HIV-NEGATIVE</strong></td>
</tr>
<tr>
<td>- She refuses the test or is not willing to disclose the result of previous test or no test results available.</td>
<td></td>
<td>- Counsel on implications of a negative test.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Counsel on the importance of staying negative by practicing safer sex, including use of condoms.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Counsel on benefits of involving and testing the partner.</td>
</tr>
</tbody>
</table>

**NEXT:** Respond to observed signs or volunteered problems. If no problem, go to page 212.
Maternal HIV

Respond to observed signs or volunteered problems (4)

<table>
<thead>
<tr>
<th>ASK, CHECK RECORD</th>
<th>LOOK, LISTEN, FEEL</th>
<th>SIGNs</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF SIGNS SUGGESTING HIV INFECTION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(HIV status unknown)*

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

Assess if 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 recent sex?

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

- Two of these signs:
  - Weight loss
  - Fever >1 month
  - Diarrhea >1 month
  - OR
- One of the above signs and
  - One or more other signs or
  - From a high group.

STRONG LIKELIHOOD OF HIV INFECTION

- Reinforce the need to know HIV status and advise on HIV testing and counseling.
- Counsel on the benefits of testing the partner.
- Counsel on safer sex including use of condoms.
- Refer to TB centre if cough.

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

- Counsel on stopping smoking.
- For alcohol/drug abuse, refer to specialist care providers.
- For counselling on violence, see.

NEXT: If cough or breathing difficulty
Maternal HIV infection

Care and counselling for the HIV-positive woman

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.
- Advise on the importance of good nutrition.
- Use standard precautions as for all women.
- Advise her that she is more prone to infections and should seek medical help as soon as possible if she has:
  - Fever
  - Persistent diarrhoea
  - Cold and cough — respiratory infections
  - Burning urination
  - Vaginal itching/foul-smelling discharge
  - No weight gain
  - Skin infections
  - Foul-smelling lochia.

DURING PREGNANCY:

- Revise the birth plan.
  - Advise her to deliver in a facility.
  - Advise her to go to a facility as soon as her membranes rupture or labour starts.
  - Tell her to take ARV medicine at the onset of labour as instructed.
- Discuss the infant feeding options.
- Modify preventative treatment for malaria according to national strategy.

DURING CHILDBIRTH:

- Check if meconium is taken at onset of labour.
- Give ARV medicines as prescribed.
- 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 antenatal record, if woman is married.

DURING THE POSTPARTUM PERIOD:

- Tell her that fevers can cause infections in other people and therefore she should dispose of blood-stained sanitary pads safely (list local options).
- Counsel her on family planning.
- If not breastfeeding, advise her to breast care.
- 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 antenatal care and delivery 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), anencephaly, preterm labour, stillbirth, low birth weight, toxoplasmosis, and other complications.
  - If she wants more children, advise her that 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 infection.
- Condoms may be the best option for the woman with HIV. Counsel the woman on safer sex including the use of condoms.
- If the woman thinks 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:
  - Give the woman’s HIV status, she may not choose to breastfeed and accidental amniocentesis (LAM) may not be a suitable method.
  - Spontaneous deliveries 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.
Perform Rapid HIV Test

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 works list, 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 HBs, 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 task 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.
- Record all results in the logbook.
## Treatment details – ARV for 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.

<table>
<thead>
<tr>
<th>ARVs</th>
<th>Woman</th>
<th>Newborn Infant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pregnancy</td>
<td>Labour, delivery</td>
</tr>
<tr>
<td></td>
<td>Before 24 weeks</td>
<td>Starting at 24 weeks</td>
</tr>
<tr>
<td>HIV-positive with HIV- AIDS related signs and symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triple therapy</td>
<td>Continuous ARV treatment prescribed before pregnancy. In the first trimester replace Emtriva with Nevirapine (200 mg once daily for 2 weeks, then every 12 hours) 23d cildavine</td>
<td>4 mg/kg</td>
</tr>
<tr>
<td>HIV-positive without HIV-related signs and symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3TC</td>
<td>150 mg</td>
<td>every 12 hours</td>
</tr>
<tr>
<td>zidovudine</td>
<td>300 mg every 12 hours</td>
<td>300 mg</td>
</tr>
<tr>
<td>Nevirapine</td>
<td>100 mg</td>
<td>every 3 hours</td>
</tr>
<tr>
<td>ARVs during labour</td>
<td>23d cildavine</td>
<td>300 mg</td>
</tr>
<tr>
<td>zidovudine</td>
<td>100 mg</td>
<td>every 3 hours</td>
</tr>
<tr>
<td>Nevirapine</td>
<td>200 mg</td>
<td>every 3 hours</td>
</tr>
<tr>
<td>Only minimal ARV treatment</td>
<td>Nevirapine</td>
<td>200 mg</td>
</tr>
</tbody>
</table>

*At onset of contractions or rupture of membranes, regardless of the previous schedule.

**Arrange follow-up for her assessment and treatment within 2 weeks after delivery.

***Treat the newborn infant with 23d cildavine for 4 weeks if mother received 23d cildavine for less than 4 weeks during pregnancy.

---

### Give antiretroviral (ARV) medicine(s) to treat HIV infection

#### GIVE ANTIRETROVIAL (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 is indicated, replace it with nevirapine.
- If the woman is not on ARV treatment and is found HIV-positive, choose appropriate ARV regimen.
- According to the stage of the disease.
- Treatment with 23d cildavine (AZT) is planned measures haemoglobin, less than 6 g/dl, refer to hospital.
- While 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 prevent treatment for malaria according to national guidelines.

### Explore local perceptions about ARVs

Explain to the woman and identify that:

- ARV treatment will not harm the woman’s health and will greatly reduce the risk of transmission to her baby.
- Treatment will not cause the baby to be born prematurely.
- The choice of therapy depends on the stage of the disease.
- If she is in early-stage of HIV infection, she will need to take medicines during pregnancy, childhood and only for a short period after delivery to prevent mother-to-child transmission of HIV infection (MTCT). Progress of disease will be monitored to determine if she needs additional treatment.
- If she has mild-moderate HIV disease, she will need to continue the treatment even after childbirth and postpartum period.
- She may have some side-effects but not serious adverse effects. Common side effects include nausea, diarrhoea, headache or taste changes, i.e., they usually disappear within 2–3 weeks.
- Other side-effects like yellow skin, pale skin, sore mouth, pain and irregular bleeding, shortness of breath, skin rash, painful feet, legs or hands may appear at any time. If these side-effects, 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:
    - Following the schedule, which includes both before and during pregnancy
  - Taking the medicine regularly, every day, at the same time, if she chooses to stop taking medicines during pregnancy, but HIV disease could worsen and she may pass the infection to her child.
  - If the baby is to take a dose, she should not double the next dose.
  - Continue the treatment during and after the childbirths (as prescribed), even if she is breastfeeding.
  - Taking the medicines, with meals in order to minimize side effects.
- For neonatal:
  - Give the full 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 comply the full course of treatment and will need regular visits throughout the infancy.
  - If the mother received less than 4 weeks of 23d cildavine (AZT) during pregnancy, give the treatment to the newborn for 4 weeks.
  - Record all treatment given. If the mother or baby is relapsed, write the treatment given and the regimen prescribed in the referral card.
  - Do HIV lab results at 2 months.
  - Do HIV 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 modification. These 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.
- Maternal and multiple illnesses 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.
- Encourage exclusive breastfeeding.
- Counsel on the need to know the HIV status and when to go for HIV testing and counselling.
- Explain to her the risks of HIV transmission:
  - 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 continuing breastfeeding plus complementary feeding until 6 months of age, as recommended for HIV-negative women and women who do not know their status.

In some situations additional possibilities are:

- Supplementation and in-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 needs enrichment complementary feeding up to 2 years.
- If this cannot be assured, 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 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, inocents, and the delivery kit.
- Ensure that the family prepares, as on p. 116.

Delivery care
- Follow the labour and delivery procedures on p. 120.
- Observe universal precautions.
- Give supportive care: involve the companion in care and support.
- Maintain the partograph and labour record.
- Provide newborn care.
- Refer to facility as soon as possible if any abnormal finding in mother or baby.

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

Postpartum care of newborn
- Stay until baby has had the first breastfeeding and help the mother good positioning and attachment.
- Advise on breastfeeding and breast care.
- Examine the baby before leaving.
- Immunise the baby if possible.
- Advise on newborn care.
- Advise the family about danger signs and when and where to seek care.
- 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.
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 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 clean, safe and culturally appropriate manner (burn or bury).

Advise to avoid harmful practices

For example:
- NOT to use local medications to hasten labour.
- NOT to wait for waters to stop before going to the 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 best practices:

Advise on danger signs

If the mother or baby has any of these signs, she/he 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 healthcare 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 underlying 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 child mortality
- Many adolescent pregnancies
- High prevalence of endemic conditions:
  - Anaemia
  - Stable transmission of filariasis in malaria
  - Hookworm ( Necator americanus and Ancylostoma duodenale)
  - Sexually transmitted infections, including HIV/AIDS
- Vitamin A and iron/iodine deficiencies.

Health care system
The Guide assumes that:
- Routine and emergency pregnancy, delivery and postnatal care are provided at the primary level of the health care system, 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 an 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 lines, supplies, gloves and essential equipment are available.
- A health worker with higher levels of skill (at the facility or a referral hospital) is providing pregnancy, childbirth and postnatal care to women other than those referred, she follows the recommendations described in this Guide.
- Routine visits and follow-up visits are scheduled during normal 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 filariasis in Bolivia and other lung diseases, treatment for HIV, and antenatal and postnatal care, that require specific referral, are delivered by a different provider at the same facility or at the referral hospital. Referral of women and inpatient 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, or 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.

Adaptation of the Guide
It is essential that the guide is adapted to national and local situations, not only with the context of existing health priorities and resources, but also in terms of access to health for the majority of the population. Therefore, the guide has been adapted for use in different settings and contexts. These adaptations have been made in order to ensure that the guide is relevant and applicable to the local situation.

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.
Update of the Guidelines for Safe Abortion
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

Clinical practice guidelines for comprehensive abortion care

Guidance for policy-makers and programme managers

Guidance for health-care providers

World Health Organization

Reproductive Health and Research

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