WHO guidelines
on sexual and reproductive health

Heli Bathija
Training Course in Sexual and Reproductive Health Research
Geneva 2012
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.

- Mapping evidence
- Testing interventions
- Improving technologies

- Developing norms, tools, guidelines
- Technical support to countries

Improve health
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
A WHO department decides to produce a guideline

Initial approval by GRC

Initial approval for development

The guideline is produced by the WHO department (i.e. from a few months to 2-3 years time frame)

Final approval by GRC

Relevant approvals are obtained (ADG or DGO)

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

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World Health Organization
Reproductive Health and Research
UNDP • UNFPA • WHO • World Bank Special Programme of Research, Development and Research Training in Human Reproduction
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 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
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
WHO statement and provider briefs
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
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
Promoting family planning

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.

SOCIAL SCIENCE AND OPERATIONS RESEARCH

EVIDENCE-BASED GUIDANCE

RELATED LINKS

ADVOCACY

Repositioning family planning: guidelines for advocacy action

UPDATES

Medical eligibility criteria for contraceptive use

Guidelines & provider tools

Related publications

Latin America Symposium

Contraceptive Technology

World Health Organization

Reproductive Health and Research
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

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

  - **Wear gloves**
    - Sterile or highly disinfected gloves when performing physical examination, delivery, cord cutting, repair of episiotomy, or blood drawing.
    - Wear long gloves 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 a good lime); 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 a single-use 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 the container, without soaking, and without passing to another person.
  - Empty or send for destruction 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.
  - Discard 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.

- **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 cold 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 liter bleach containing 5% available chlorine).
  - Dry away from direct sunlight.
  - Dust inside with talcum powder or starch.

  - This produces 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.

- **Organizing a visit**

  - **Communication**
  - **Workplace and administrative procedures**
  - **Standard precautions and cleanliness**
  - **Principles of good care**
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**<br>not aware of pregnancy, or not pregnant (uterus NOT above umbilicus) | HEAVY BLEEDING<br>Pad or cloth soaked in < 5 minutes. | - Insert an IV line
- Give fluids rapidly
- Give 0.2 mg ergometrine IV RAPID
- Repeat 0.2 mg ergometrine IV if bleeding continues,
- If suspect possible complicated abortion, give appropriate IM/IV antibiotics RAPID
- Refer woman urgently to hospital RAPID
- This may be abortion, miscarriage, or ectopic pregnancy. |

| **LIGHT BLEEDING** | | |
|-------------------| | |
| Examine woman as on GB4 | If pregnancy not likely, refer to other clinical guidelines. |

<table>
<thead>
<tr>
<th><strong>LATE PREGNANCY</strong>&lt;br&gt;(uterus above umbilicus)</th>
<th>ANY BLEEDING IS DANGEROUS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DO NOT do vaginal examination, but:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Insert an IV line</td>
<td>RAPID</td>
</tr>
<tr>
<td></td>
<td>- Give fluids rapidly if heavy bleeding or shock</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Refer woman urgently to hospital** RAPID</td>
<td></td>
</tr>
<tr>
<td></td>
<td>This may be placenta previa, abruptio placentae, ruptured aorta.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DURING LABOUR</strong>&lt;br&gt;before delivery of baby</th>
<th>BLEEDING</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MORE THAN 100 ML&lt;br&gt;SINCE LABOUR BEGAN</td>
<td>DO NOT do vaginal examination, but:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Insert an IV line RAPID</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Give fluids rapidly if heavy bleeding or shock RAPID</td>
</tr>
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<td>This may be placenta previa, abruptio placentae, ruptured aorta.</td>
</tr>
</tbody>
</table>

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*But if birth is imminent (bulging, thin parabened during contractions, visible fetal head), transfer woman to labour room and proceed as on GB4.*

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**NEXT:** Vaginal bleeding in postpartum
**Antenatal care**

Detection and management of pre-eclampsia

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### CHECK FOR PRE-ECLAMPSIA

Screen all pregnant women at every visit.

#### ASK, CHECK RECORD

- Blood pressure at the last visit?
- Urine: check proteinuria.
- Ask about: headache, blurring of vision, epigastric pain.

#### LOOK, LISTEN, FEEL

- Blood pressure: sitting position.
- If blood pressure is ≥50 mmHg, repeat after 1 hour rest.
- If blood pressure is still ≥50 mmHg, ask the woman if she has:
  - Severe headache
  - Blurring of vision
  - Epigastric pain
  - Check proteinuria in urine.

#### SIGNS

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Classify</th>
<th>Treat and Advise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diastolic blood pressure</td>
<td>SEVERE PRE-ECLAMPSIA</td>
<td></td>
</tr>
<tr>
<td>≥110 mmHg, and ≥3+ proteinuria, or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diastolic blood pressure</td>
<td>PRE-ECLAMPSIA</td>
<td></td>
</tr>
<tr>
<td>≥90-110 mmHg, or two readings and ≥2+ proteinuria, and any of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Severe headache</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Blurred vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Epigastric pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Check proteinuria in urine.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### TREAT AND ADVISE

- Give magnesium sulphate (MgSO4)
- Give antihypertensive (ASA)
- Revise the birth plan
- Refer urgently to hospital

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

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[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.

<table>
<thead>
<tr>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transverse lie.</td>
<td>OBSTRUCTED LABOUR</td>
<td><strong>Hydramnios. Insert an IV line and give fluids.</strong></td>
</tr>
<tr>
<td>Continuous contractions.</td>
<td></td>
<td><strong>Null labour &gt; 24 hours, give appropriate IN/N antibiotics.</strong></td>
</tr>
<tr>
<td>Constant pain behaves contractions.</td>
<td></td>
<td><strong>Refer urgently to hospital.</strong></td>
</tr>
<tr>
<td>Sudden and severe abdominal pain.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Horizontal ridge across lower abdomen.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labour &gt; 24 hours.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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>
<tbody>
<tr>
<td>Rupture of membranes and any of Fever &gt; 38°C</td>
<td>UTERINE AND FETAL INFECTION</td>
<td><strong>Give appropriate IN/N antibiotics.</strong></td>
</tr>
<tr>
<td>Rupture of membranes at &lt; 8 months of pregnancy</td>
<td>RISK OF UTERINE AND FETAL INFECTION</td>
<td><strong>Give appropriate IN/N antibiotics.</strong></td>
</tr>
<tr>
<td>Diastolic blood pressure &gt; 60 mmHg.</td>
<td>PRE ECLAMPSIA</td>
<td><strong>Assess further and manage as O 128.</strong></td>
</tr>
<tr>
<td>Severe palmar and conjunctival pallor and/or haemoglobin &lt; 7 g/dL.</td>
<td>SEVERE ANAEMIA</td>
<td><strong>Manage as O 128.</strong></td>
</tr>
<tr>
<td>Breach or other malpresentation</td>
<td>OSTEOTRICAL COMPLICATION</td>
<td><strong>Follow specific instructions (see page numbers in left column).</strong></td>
</tr>
</tbody>
</table>
**First stage of labour (1): when the woman is not in active labour**

### 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.

<table>
<thead>
<tr>
<th>Monitor Every Hour:</th>
<th>Monitor Every 4 Hours:</th>
</tr>
</thead>
<tbody>
<tr>
<td>For emergency signs, using rapid assessment (RAM) 03 67</td>
<td></td>
</tr>
<tr>
<td>Frequency, intensity and duration of contractions.</td>
<td></td>
</tr>
<tr>
<td>Fetal heart rate 04.</td>
<td></td>
</tr>
<tr>
<td>Mood and behaviour (distressed, anxious) 06.</td>
<td></td>
</tr>
<tr>
<td>Cervical dilatation 08. 015.</td>
<td></td>
</tr>
<tr>
<td>Record time of rupture of membranes and colour of amniotic fluid.</td>
<td></td>
</tr>
<tr>
<td>Give Supportive care 06 32</td>
<td></td>
</tr>
<tr>
<td>Never leave the woman alone.</td>
<td></td>
</tr>
<tr>
<td>Temperature</td>
<td></td>
</tr>
<tr>
<td>Pulse 08.</td>
<td></td>
</tr>
<tr>
<td>Blood pressure 02.</td>
<td></td>
</tr>
</tbody>
</table>

### Assess Progress of Labour

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

- **Cervical dilatation 4 cm or greater.**

### Treat and Advise, if Required

- **Refer the woman urgently to hospital 09.**

- **Discharge the woman and advise her to return if:**
  - Pain/discomfort increases.
  - Vaginal bleeding.
  - Membranes rupture.

- **Begin plotting the partograph 82.** and manage the woman as in Active labour 09.
### 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>
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</tr>
<tr>
<td>Bleeding during labour, delivery or postpartum.</td>
<td>Measure haemoglobin, if possible.</td>
<td>Haemoglobin &lt; 7 g/dl.</td>
<td>SEVERE ANAEMIA</td>
<td>If early labour or postpartum, refer urgently to hospital.</td>
</tr>
<tr>
<td>Look for conjunctival pallor.</td>
<td>Look for palmar pallor.</td>
<td></td>
<td></td>
<td>If late labour:</td>
</tr>
<tr>
<td>Palmar or conjunctival pallor or</td>
<td>Any pallor?</td>
<td></td>
<td></td>
<td>+ monitor intensively</td>
</tr>
<tr>
<td>Any pallor or &gt; 30 breaths per minute.</td>
<td>Count number of breaths in 1 minute.</td>
<td></td>
<td></td>
<td>+ minimize blood loss</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+ refer urgently to hospital after delivery.</td>
</tr>
<tr>
<td><strong>IF MOTHER SEVERELY ILL OR SEPARATED FROM THE BABY</strong></td>
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<tr>
<td>Teach mother to express breast milk every 3 hours.</td>
<td>Help her to express breast milk if necessary. Ensure baby receives mother’s milk.</td>
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<tr>
<td>Help her to establish or re-establish breastfeeding as soon as possible. See 12-13.</td>
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<tr>
<td><strong>IF BABY STILLBORN OR DEAD</strong></td>
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<tr>
<td>Give supportive care:</td>
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<tr>
<td>+ Inform the parents as soon as possible after the baby’s death.</td>
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<tr>
<td>+ Give the baby to the mother if the mother wants to hold, where culturally appropriate.</td>
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<tr>
<td>+ Offer the parents and family to be with the dead baby in privacy as long as they want.</td>
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<tr>
<td>+ Discuss with them the events before the death and the possible causes of death.</td>
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<tr>
<td>+ Advise the mother on breast care.</td>
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<tr>
<td>+ Counsel on appropriate family planning method.</td>
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</tbody>
</table>

**NEXT: Give preventive measures**
**Counsel on birth spacing and family planning**

<table>
<thead>
<tr>
<th>Option</th>
<th>Immediate Postpartum</th>
<th>Delay 6 weeks</th>
<th>Delay 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Methods</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condoms</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Progestogen-only oral contraceptives</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Progestogen-only injectables</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Implant</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Spacemaker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female sterilisation (within 7 days or delay 6 weeks)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copper IUD (within 48 hours)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delay 3 weeks</td>
<td>Combined oral contraceptives</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Combined injectables</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Fertility awareness methods</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Lactational amenorrhoea method (LAM)**

- A breastfeeding woman is protected from pregnancy only:
  - 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 complimentary 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.
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.

---

**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 page 99.
  - 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 you ventilate during referral.
- Record the event on the referral form and labour record.

**If no breathing or gasping at all after 20 minutes of ventilation**

- Stop ventilating. The baby is dead.
- Explain to the mother and give supportive care.
- Record the event.
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.

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 contented with the food?
  - 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?

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 breast 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.

SIGNs

- Suckling effectively.
- Breastfeeding 8 times in 24 hours on demand if any at night.
- Not yet breastfed (first few hours of life).
- Not well attached.
- Not sucking effectively.
- Breastfeeding less than 8 times per 24 hours.
- Receiving other foods or drinks.
- Several 48s and inadequate weight gain.
- Hot sucking for more than 6 hours of age.
- Stoped feeding.

CLASSIFY

- Feeding well
- Feeding difficulty
- Not able to feed

TREAT AND ADVISE

- Encourage the mother to continue breastfeeding on demand.
- Support exclusive breastfeeding.
- Help the mother to initiate breastfeeding.
- Teach correct positioning and attachment.
- Advise to feed more frequently if any at 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.
- Refer baby urgently to hospital.

To assess replacement feeding see

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 baby is even more important than for a big baby.
- Explain how her milk’s appearance changes: milk in the first days is thick and yellow, then it becomes thinner and whitish. Both are good for the baby.
- A small baby does not live as well as a big baby in the first days:
  - may tire easily and suck weakly at first
  - may suckle for shorter periods before settling
  - 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 sucks and stimulates the breast 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 he/she does not wake up alone, 2 hours after the last feed.
- Always start the feed with breastfeeding before offering any 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 crying.
- 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.
  - Let the mother express breast milk and feed baby by cup.
- Teach the mother to observe swallowing if giving expressed breast milk.
- Weigh the baby daily (if accurate and precise scales are available), record and assess weight gain.

Give special support to breastfeed twins

COUNSEL THE MOTHER:
- Reassure the mother that she has enough breast milk for two babies.
- Encourage her that twins may take longer to establish breastfeeding since they are frequently born preterm and with low birth weight.

HELP THE MOTHER:
- Start feeding one baby at a time until breastfeeding is well established.
- Help the mother find the best position 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.
# Assess the Mother’s Breasts if Complaining of Nipple or Breast Pain

<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>How do your breasts feel?</td>
<td></td>
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<tr>
<td>Look at the nipple for laceration</td>
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<tr>
<td>Look at the breasts for:</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>+ Swelling</td>
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<td></td>
</tr>
<tr>
<td>+ Skinliness</td>
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<td></td>
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<tr>
<td>+ Redness</td>
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<tr>
<td>Feel gently for painful part of the breast.</td>
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<tr>
<td>Measure temperature.</td>
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<tr>
<td>Observe a breastfeeding infant yet done.</td>
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<tr>
<td>No swelling, redness, or tenderness.</td>
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<tr>
<td>Normal body temperature.</td>
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<tr>
<td>Nipple not sore and no fissure visible.</td>
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<tr>
<td>Baby well attached.</td>
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<tr>
<td><strong>Breasts Healthy</strong></td>
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<tr>
<td>Nipple sore or fissured.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Baby not well attached.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nipple Soreness or Fissure</strong></td>
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<tr>
<td>Both breasts are swollen, shiny, and patchy red.</td>
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<tr>
<td>Temperature &lt;38°C.</td>
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<td></td>
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</tr>
<tr>
<td>Baby not well attached.</td>
<td></td>
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<tr>
<td>Not yet breastfeeding.</td>
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<tr>
<td><strong>Breast Engorgement</strong></td>
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<tr>
<td>Part of breast is painful, swollen and red.</td>
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<tr>
<td>Temperature &gt;38°C.</td>
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<tr>
<td>Feels ill.</td>
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<tr>
<td><strong>Mastitis</strong></td>
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<tr>
<td>Encourage mother to continue breastfeeding.</td>
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<tr>
<td>Teach correct positioning and attachment.</td>
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<tr>
<td>Give codeine for 10 days.</td>
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<tr>
<td>Reassess in 2 days. If no improvement or worse, refer to hospital.</td>
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</tr>
<tr>
<td>If mother is HA* let her breastfeed on the healthy breast. Express milk from the affected breast and discard until no fever.</td>
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<tr>
<td>If severe pain, give paracetamol.</td>
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</tr>
</tbody>
</table>

*HA* indicates healthy arm.
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 if a very small baby: >2 months early, weighing <1500g.**

#### CARE AND MONITORING

| Plan to keep the baby for 1 more day before discharging. |
| Allow visits to the mother and baby. |

- Give special support for breastfeeding the small baby (or twins):
  - Encourage the mother to breastfeed every 2-3 hours.
  - Assess breastfeeding daily: attachment, sucking, duration and frequency of feeds, and baby satisfaction with the feed.
  - If alternative feeding method is used, assess the total daily amount of milk given.
  - Weigh daily and assess weight gain.

- Ensure additional warmth for the small baby:
  - Ensure the room is very warm (25°C - 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, inspect the count if 60 or < 30; look for chest in-drawing).
  - Look for jaundice (first 10 days of life): first 24 hours of the abdomen, then on palpiation.

- Plan to discharge where:
  - Breastfeeding well.
  - Gaining weight adequately on 3 consecutive days.
  - Temperature between 36.5°C and 37.5°C on 3 consecutive days.
  - Mother able and confident in caring for the baby.
  - No medical concerns.

| 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 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.

- 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

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 cloths.
- If stump is soiled, wash it with clean water and soap. Dry it thoroughly with clean cloth.
- If umbilical cord is not or draining pus or blood, examine the baby and manage accordingly.
- Explain to the mother that she should seek care if the umbilical cord is not healing.

DO NOT bandage the stump or abdomen.
DO NOT apply any substances or medicines to stump.
Avoid touching the stump unnecessarily.

Sleeping
- Use the bed at day and night for a sleeping baby.
- Let the baby sleep on 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, umbilicus, and hands.
- Wash the buttocks when soiled. Dry thoroughly.
- Bath when necessary:
  - Ensure the room is warm, no draft.
  - 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 if the baby is cold.
DO NOT apply anything in the baby’s eyes except an antibiotic ointment at birth.

SMALL BABIES REQUIRE MORE CAREFUL ATTENTION:
- The room must be warmer when changing, washing, bathing, and examining a small baby.
Women living
- with violence
- HIV
- After abortion
Working with women, families and communities

### Establish links

**COORDINATE WITH OTHER HEALTH CARE PROVIDERS AND COMMUNITY GROUPS**
- Meet with others in the community to discuss and agree messages related to pregnancy, delivery, postpartum, and post-abortion care of women and newborns.
- Work together with leaders and community groups to discuss the most common health problems and find solutions. Groups can contact and establish relations which include:
  - Other health care providers
  - Traditional birth attendants and healers
  - Maternity waiting homes
  - Adolescent health services
  - Schools
  - Non-governmental organizations
  - Community-based support groups
  - Local health committees
  - Women's groups
  - Agricultural associations
  - Neighborhood committees
  - Youth groups
  - Church groups.

**Establish links with traditional birth attendants and traditional healers**
- Contact traditional birth attendants and healers who are working in the health facility's catchment area. Discuss how you can support their work.
- Respect their knowledge, experience, and influence in the community.
- Share with them the information you have and listen to their experience. Provide copies of health education materials that you distribute to community members and discuss the content with them. Have them explain in knowledge that they share with the community. Together you can create new knowledge with them.
- Review how to gather and share information.
- Include TBAs and traditional healers in community committees.
- Discuss the recommendations.
- When not possible or not necessary, review the woman's wish.
- Involve TBAs to take part in the woman's wish.
- Make sure that TBAs are included.
- Qualify how and when to involve the community in quality of services.

### Involve the community in quality of services

All in the community should be informed and involved in the process of improving the health of their members. Ask the different groups to provide feedback and suggestions on how to improve the services the health facility provides:
- Find out what people know about maternal and newborn mortality and morbidity in their locality.
- Share data you may have, select together on these deaths and illnesses and discuss. Discuss with them what families and communities can do to prevent these deaths and illnesses, together as a group, defining responsibilities.
- Discuss the different health messages that are provided. Have the community members talk about their knowledge related to these messages. Together determine what families and communities can do to support national and local health.
- Discuss some practical ways in which families and other in the community can support women during pregnancy, postpartum, and postpartum:
  - Recognition and rapid response to emergency/danger signs during pregnancy, delivery, and postpartum periods.
  - Preparation of food and care for children and other family members when the woman needs to be away from home during delivery, when she needs rest.
  - Accompanying the woman after delivery.
  - Support for payment of fees and supplies.
  - Introduction of male partners to help with the workload, accompany the woman to the clinic, and how to breastfeed and ensure she does it properly. Share communication between nurses and their partners, including how to prepare family planning needs.
- Support the community in preparing an action plan to respond to emergencies. Discuss the following with them:
  - Early warning system: learning when to seek care.
  - Importance of rapid response to emergencies to reduce mother and newborn deaths, disability and illness.
  - Transport options available, giving examples of how transport can be organized.
  - Reasons for delays in seeking care and possible difficulties, including money.
  - What services are available and when.
  - What options are available.
  - Cost and options for payment.
  - A plan of action for responding to emergencies, including roles and responsibilities.

---

**World Health Organization**

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# Labour record

**Labour Record**

Use this record for monitoring during labour, delivery, and postpartum.

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

**Labouring Labour**

<table>
<thead>
<tr>
<th>DURATION</th>
<th>AT OR AFTER BIRTH - MOTHER</th>
<th>AT OR AFTER BIRTH - NEWBORN</th>
<th>PLANNED NEWBORN TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADMISSION DATE</td>
<td>BIRTH TIME</td>
<td>STILLBIRTH</td>
<td>FRESH</td>
</tr>
<tr>
<td>ADMISSION TIME</td>
<td>OXYTOCIN TIME GIVEN</td>
<td>RESUSCITATION NO YES</td>
<td></td>
</tr>
</tbody>
</table>

**Time Active Labour Started**

<table>
<thead>
<tr>
<th>TIME</th>
<th>PLACENTAL COMPLETE</th>
<th>YES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TIME MENTAL Ruptured</td>
<td>TIME DELIVERED</td>
<td>GEST, AGE</td>
<td>OR PERTINENT NO YES J</td>
</tr>
</tbody>
</table>

**Stage 2 Stage Starts**

<table>
<thead>
<tr>
<th>TIME</th>
<th>ESTIMATED BLOOD LOSS</th>
<th>SECOND BIRTH</th>
</tr>
</thead>
</table>

**Entry Examination**

<table>
<thead>
<tr>
<th>STAGE OF LABOUR NOT IN ACTIVE LABOUR</th>
<th>ACTIVE LABOUR</th>
<th>PLANNED MATERNAL TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOT INACTIVE LABOUR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOURS SINCE ARRIVAL</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>HOURS SINCE Ruptured membranes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VAGINAL BLEEDING</td>
<td>0</td>
<td>+</td>
</tr>
<tr>
<td>STRONG CONTRACTIONS</td>
<td>1 0 MINUTES</td>
<td></td>
</tr>
<tr>
<td>FETAL HEART RATE</td>
<td>BEATS MINUTE</td>
<td></td>
</tr>
<tr>
<td>T (AUXILIARY)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PULSE</td>
<td>BEATS MINUTE</td>
<td></td>
</tr>
<tr>
<td>BLOOD PRESSURE</td>
<td>SYSTOLIC</td>
<td>DIASTOLIC</td>
</tr>
<tr>
<td>UNIFIED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CERVICAL DILATATION</td>
<td>CM</td>
<td></td>
</tr>
</tbody>
</table>

**Problem**

<table>
<thead>
<tr>
<th>TIME ONSET</th>
<th>TREATMENTS OTHER THAN MINIMAL SUPPORTIVE CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If mother referred during labour or delivery, record time and explain.

Sample form to be adapted. Revised on 12 June 2003.
**Simplified partograph**

### Partograph

**Use this form for monitoring active labour.**

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

Sample form to be filled. Revised on 13 June 2003.
# 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>MEAL TIME</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FACILITY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACCOMPANIED BY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEALTH WORKER</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Woman

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

- Emergency
- Non-emergency
- To accompany the baby

## Major Findings (Clinical and Temp)

## Last Breastfeed (Time)

## Treatments Given and Time

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

## Referral record

- Information 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

<table>
<thead>
<tr>
<th>Equipment, supplies and drugs for childbirth care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Warm and clean room</strong></td>
</tr>
<tr>
<td>- 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)</td>
</tr>
<tr>
<td>- Clean bed linen</td>
</tr>
<tr>
<td>- Curtains if more than one bed</td>
</tr>
<tr>
<td>- Clean surface (for alternative delivery position)</td>
</tr>
<tr>
<td>- Work surface for resuscitation of newborn near delivery beds</td>
</tr>
<tr>
<td>- Light source</td>
</tr>
<tr>
<td>- Heat source</td>
</tr>
<tr>
<td>- Room thermometer</td>
</tr>
<tr>
<td><strong>Hand washing</strong></td>
</tr>
<tr>
<td>- Clean water supply</td>
</tr>
<tr>
<td>- Soap</td>
</tr>
<tr>
<td>- Nail brush or stick</td>
</tr>
<tr>
<td>- Clean towels</td>
</tr>
<tr>
<td><strong>Waste</strong></td>
</tr>
<tr>
<td>- Container for sharps disposal</td>
</tr>
<tr>
<td>- Receptacle for soiled linens</td>
</tr>
<tr>
<td>- Bucket for soiled pads and swabs</td>
</tr>
<tr>
<td>- Bowl and plastic bag for placenta</td>
</tr>
<tr>
<td><strong>Sterilization</strong></td>
</tr>
<tr>
<td>- Instrument sterilizer</td>
</tr>
<tr>
<td>- Jar for forceps</td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
</tr>
<tr>
<td>- Wall clock</td>
</tr>
<tr>
<td>- Torch with extra batteries and bulb</td>
</tr>
<tr>
<td>- Log book</td>
</tr>
<tr>
<td>- Records</td>
</tr>
<tr>
<td>- Refrigerator</td>
</tr>
</tbody>
</table>

| 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 bedet                                |

| Drugs                                              |
| - Cephalosporin                                   |
| - Ergometrine                                     |
| - Magnesium sulphate                              |
| - Calcium gluconate                                |
| - Danazol                                          |
| - Hydralazine                                     |
| - Ampicillin                                       |
| - Gentamicin                                       |
| - Metronidazole                                    |
| - Benzathine penicillin                            |
| - Naloxone zinc or zidovudine                      |
| - Lignocaine                                       |
| - Adrenaline                                       |
| - Ringer lactate                                   |
| - Normal saline 0.9%                               |
| - Water for injection                              |
| - Eye antinfectial (1% silver nitrate or 2.5% povidone iodine) |
| - Tetacycline 1% eye ointment                      |
| - Vitamin A                                        |
| - Isoniazid                                        |

| Vaccine                                            |
| - DPT                                             |
| - 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

<table>
<thead>
<tr>
<th>SIGN</th>
<th>CLASSIFY</th>
<th>TREAT AND ADVISE</th>
</tr>
</thead>
</table>
| Positive HIV test. | HIV-POSITIVE | - Counselling on implications of a positive test [31].  
- Refer the woman to HIV services for further assessment.  
- Ask her to return in 2 weeks with her documents.  
- Determine the severity of the disease and eligibility for ARTs. |  
|  |  | - Give her an appropriate ART [30], [38].  
- For all women:  
  - Support adherence to ART [44].  
  - Counsel on infant feeding options [47].  
  - Provide additional care for HIV-positive women [44].  
  - Counsel on family planning [44].  
  - Counsel on safer sex including use of condoms [62].  
  - Counsel on benefits of disclosure (involving) and testing her partner [63].  
  - Provide support to the HIV-positive woman [65]. |
| Negative HIV test | HIV-NEGATIVE | - Counselling on implications of a negative test [31].  
- Counselling on the importance of staying negative by practicing safer sex, including use of condoms [62].  
- Counselling on benefits of involving and testing the partner [63]. |
| She refuses the test or is not willing to disclose the result of previous test or no test results available | UNKNOWN HIV STATUS | - Counselling on safer sex including use of condoms [62].  
- Counselling on benefits of involving and testing the partner [63]. |

ASSESS THE PREGNANT WOMAN > CHECK FOR HIV STATUS

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.

ASK, CHECK RECORD  LOOK, LISTEN, FEEL

Provide key information on HIV [62].  
- What is HIV and how is HIV transmitted? [62].  
- Advantage of knowing the HIV status in pregnancy [62].  
- Explain about HIV testing and counselling including confidentiality of the result [62].

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.

Perform the Rapid HIV test. If not performed in this pregnancy [68].  
- Has the partner been tested?
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><strong>IF SIGNS SUGGESTING HIV INFECTION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(HIV status unknown)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Have you lost weight?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Do you have fever?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- How long (&gt;1 month)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Have you had diarrhea (continuous or intermittent)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- How long, &gt; 1 month?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Have you had cough?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- How long, &gt; 1 month?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Look to reliable wasting.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Look for ulcers and white patches in the mouth (thrush).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Look at the skin:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Is there a rash?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Are there blisters along the toes on one side of the body?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Two of these signs:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ weight loss</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ fever &gt; 1 month</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ diarrhea &gt; 1 month.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- One of the above signs and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ one or more other signs or</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ from a high risk group.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STRONG LIKELIHOOD OF HIV INFECTION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Reinforce the need to know HIV status and advise on HIV testing and counselling.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Counsel on the benefits of testing the partner.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Counsel on safer sex including use of condoms.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Refer to TB centre if cough.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 104.

▶ 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 she should seek medical help as soon as possible if she has:
  - fever
  - persistent diarrhoea
  - cough and cold
  - respiratory infections
  - burning urination
  - vaginal itching
discharge
  - weight loss
  - skin infections
  - foul-smelling lochia.

DURING PREGNANCY:
- Review 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 medicines at the onset of labour as instructed.
- Discuss the infant feeding options.
- Modify preventive 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 medical record, if woman is infected.

DURING THE POSTPARTUM PERIOD:
- Tell her that tetanus can cause infection in other people and therefore she should dispose of blood-stained sanitary pads safely (local options).
- Counsel her on family planning.
- If not breastfeeding, advise her on 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 breastfeeding 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, epistaxis, 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.
  - Deter 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:
  - Given the woman's HIV status, she may not choose to breastfeed and lactational amenorrhoea method (LAM) may not be a suitable method.
  - Contraception devices (IUD) use is not recommended for women with HIV who are not on ART therapy.
  - Due to changes in the menstrual cycle and elevated temperatures, fertility awareness methods may be difficult if the woman has HIV 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 worklist, 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 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.
- 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.

### Antiretrovirals for HIV-positive woman and her infant

<table>
<thead>
<tr>
<th></th>
<th>Woman</th>
<th>Newborn Infant</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ARVs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before 28 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting at 28 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At onset of labour**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Until birth of the baby</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After birth of the baby</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dosage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Give first dose</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Then give</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV-positive with HIV-ADHS related signs and symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triple therapy</td>
<td>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)</td>
<td>2D: 300 mg</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>2D: 300 mg</td>
<td>every 12 hours</td>
<td>7 days***</td>
</tr>
<tr>
<td>Nevirapine</td>
<td>200 mg once</td>
<td></td>
</tr>
<tr>
<td>ARVs during labour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2D: 300 mg</td>
<td>every 3 hours</td>
<td>7 days***</td>
</tr>
<tr>
<td>200 mg once</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nevirapine</td>
<td>200 mg once</td>
<td></td>
</tr>
<tr>
<td>Only minimal ARV treatment</td>
<td>Nevirapine</td>
<td>200 mg once</td>
</tr>
</tbody>
</table>

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

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

**Give the newborn infant 2D: 300 mg during the 3rd dose for 4 weeks if mother received 2D: 300 mg for less than 4 weeks during pregnancy.**

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

**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 found HIV-positive, choose appropriate ARV regimen(s) according to the stage of the disease.
- Treatment with 3TC (TDF) is planned because it is highly effective. Choose it as the second-line ARV.
- With the treatment plan in the Health Education Manual, ensure that it is both efficacious and safe.
- Give written instructions to the woman on how to take the medicines.
- Give pharmacists an opportunity to discuss ARVs, according to national guidelines.
- Modify preventive treatment for malaria according to national guidelines.

### 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 transmission to her baby. The treatment will not cause the illness.
- The choice of treatment depends on the stage of the disease.
- In the early stage of the disease, the woman will need ARVs during pregnancy, childbirth, and 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.
- In the late stage of HIV disease the woman will need to continue the treatment even after childbirth and postpartum period.
- Shingles have some side effects but not all women have them. Common side effects include nausea, diarrhea, headache or fever (which is nothing to worry about). They usually disappear within 2-3 weeks, although side effects like yellow eyes, palmar plantar erythema, perianal pain, soreness of mouth, skin rash, painful feet, legs or hands may appear at times. If these signs persist, she should come to the clinic.
- Give her enough ARV tablets for 2 weeks until her next ANC visit.
- Ask the woman if she has any concerns. Discuss any incorrect perceptions.

### Support adherence to ARV

- Advise woman on:
  - Which tablets she needs to take during pregnancy, labour and breast feeding (if applicable) and after childbirth.
  - Taking the medication regularly every day at the right time. If she chooses to stop taking medicines during pregnancy, both HIV disease could worsen and she may pass the infection to her child.
  - At the first stage to take a dose, she should not double the next dose.
  - Continue treatment during and after childbirth (as prescriber). Women who are breastfeeding:
    - Take the medicines, if instructed by the prescriber.
  - For newborns:
    - Give the newborn the first dose of medicine to be taken 3-12 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 3TC (TDF) 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 regimen prescribed on the refill card.

**RHT label records HIV-positive**

**RHT share drugs with nearby 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 every infant born to a known HIV-positive mother will be infected during pregnancy and delivery without any intervention. Those born may be infected by breastfeeding.
- The risk may be reduced if the baby is breastfed exclusively using good technique, so that the baby is always healthy.
- Maternal and infant 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, 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 knows that she is HIV-positive

- Inform her about the options for feeding, the advantages and risks:
  - It 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 initiated 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:
  - Supplementation and introducing 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 she chooses breastfeeding, give her special advice.
- Make sure the mother understands that if she chooses replacement feeding, this has to be done before introducing complementary feeding, at 6 months of age.
- 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.

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 where to go for HIV testing and counselling.
- Explain to her the risks of HIV transmission:
  - In many areas where many women have HIV, most women are negative.
  - The risk of infecting the baby is highest if the mother is newly infected.
  - Explain that it is very important to avoid infection during pregnancy and the breastfeeding period.
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, instruments, and the delivery kit.
- Ensure that the family prepares, as on p. 166.

Delivery care
- Follow the labour and delivery procedures on p. 166.
- Observe universal precautions.
- Give supportive care, involve the companion in care and support.
- Maintain the partograph and labour record.
- Provide the newborn care.
- Refer the 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 breastfeed and helped the mother to 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 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 baby/there:

- 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 pulsing.
- 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 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 instead traditional practices:

Advises 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 eat.

Advise on danger signs
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 underlying the Guide

Assumptions Underlying the Guide

Recommendations in the Guide are generic, made on the assumption 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 Ankylostoma duodenale)
  - Sexually transmitted infections, including HIV/AIDS
  - Vitamin A and iron/riboflavin 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, i.e. at the facility near the woman's home. 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. It is necessary for there to 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, gauze 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 office hours.
- Emergency services ("unscheduled" visits) for labour and delivery complications, or severe illness or dehydration 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 programmes, such as management of fevers, tuberculosis, and other infections, immunisation, health education, and infant feeding counselling, that require specific training, are delivered by different providers, at the same facility or at the referral hospital. Delegation, 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, at 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 ART medicines are available at the primary health care.

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 hospitability and sensitivity to the needs of women, newborns and the communities 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 follows some alignment rules. 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.

Knowledge and skills of care providers:

This guide assumes that programme users using it have the knowledge and skills in providing care. It describes the training material that 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.