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ANTENATAL AND POSTNATAL CARE GUIDELINE

IN PRIMARY HEALTH CAR CENTERS IN IRAQ

DISCLAIMER
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List of abbreviations:

ANC ----------Ante Natal Care

MMR----------Maternal Mortality Rate

IMMS ---------Iraqi Maternal Mortality Surveillance

MD ----------Maternal death

MDG ----------Millennium Developmental goals

MOH----------Ministry of Health

RAM---------- Rapid Assessment and Management

VDRL----------Venereal Disease Research Laboratory test

TBA----------Traditional Birth Attendants

GDM---------- Gestational Diabetes Mellitus

TB ----------Tuberculosis

STI----------Sexual Transmitted Infection

PHC----------Primary Health Care

LAM----------Lactational Amenorrhea method

IUD----------Intra Uterine Device

Introduction

Antenatal care is a preventive obstetric health care program aimed at optimizing maternal-fetal outcome through regular monitoring of pregnancy. Antenatal and postnatal care indicators, still it has been a challenge, that health providers need to maintain for this reproductive age group which has been especially vulnerable due to a number of negative factors operating over many decades(wars & sanction).These factors have affected the health status of many Iraqis with serious results and impacts.

Iraq has significantly improved the national health quality of services. Efforts are being made to strengthen various aspects of antenatal care which most likely will have an effect on the outcome of pregnancy. It is important for the pregnant woman to receive high quality antenatal and post natal care from a skilled health care providers who provide all elements of this service which include the following:

1) Assessment of pregnancy and purperum
2) Check for diseases.
3) Respond to problems
4) Give preventive measures
5) Education and counseling about

- Routine and follow up visits
    - Self-care and nutrition.
    - Alarming symptoms and signs.
    - Birth and emergency plan.
    - Breast-feeding.
    - Family planning and birth spacing.

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Updated changes:

The ANC guideline adopted from WHO/UNICEF-2009 guideline according to the needs and resources in Iraq. The guideline covers the most serious prevalent conditions that the health providers are able to manage and made consistent with the national treatment guidelines and other policies aiming to be helpful for the training programs. The changes are:

1. The sequences of the boxes of checking the pregnant woman according to the priorities in Iraq
2. Changes in the contents of the boxes according to the MOH policies
3. Check for Diabetes during pregnancy was added
4. Check for Toxoplasmosis during pregnancy was added.
5. Check for Hepatitis during pregnancy was added
6. Check for thromboebolic risk factors was added in antenatal and postnatal care
7. Check for Small for gestational age was added in antenatal and postnatal care
8. Respond to primary hypertention during pregnancy was added
9. Respond to obesity during pregnancy and purperium was added
10. Indications for referral to the hospital was added
11. Registration and data analysis of ANC and PPC was added
12. Essential drugs list for ANC and PPC services, supplies and equipment
13. Referral form was added

The Current Situation in Iraq

The Millennium Development Goal (MDG) #5 set for Iraq a MMR to reach 29 by the year 2015. The MOH has undertaken a number of steps to reduce Maternal Mortality one of them is quality antenatal and postnatalcare.

The 1st ANC visit was about 78% and the 4th was about 50% according to MICS 4(2011) this might be due to the lack of awareness about the importance of antenatal visits or lack of confidence in PHC services .

General principles of good care

1-*Communication:* Communicating with the woman(and her companion)	Privacy and Confidentiality	Prescribing and commending treatments and preventive measures for the woman	
• Make the woman (and her companion) feel welcome. • Be friendly, respectful and non- judgmental at all times. • Use simple and clear language. • Encourage her to ask questions. • Ask and provide information related to her needs. • Support her in understanding her options and making decisions. • At any examination or before any procedure: → Seek her permission and → Inform her of what you are doing. • Summarize the most important information, including the information on routine laboratory tests and treatments. *Verify that she understands emergency signs, treatment instructions ,and when And where to return .Check for understanding by asking her to explain or demonstrate treatment instructions	• In all contacts with the woman and her husband: -Ensure a private place for the examination and counseling. -Ensure, when discussing, sensitive subjects that you cannot be overheard. -Make sure you have the woman's consent before discussing with her husband or family. -Never discuss confidential information about clients with other providers, or outside the health facility. -Organize the examination area so that, during examination, the woman is protected from the view of other people (curtain, screen, or wall). -Ensure all records are confidential and kept locked away. -Limit access to logbooks and registers to responsible providers only.	• When giving a treatment (drug, vaccine, condom) at the clinic, or prescribing measures to be followed at home: -Explain to the woman what the treatment is and why it should be given. -Explain to her that the treatment will not harm her or her baby, and that not taking it may be more dangerous. -Give clear and helpful advice on how to take the drug regularly: → For example: take 2 tablets 3 times a day, thus every 8 hours, in the morning, afternoon, and evening with some water and after a meal, for 5 days. -Demonstrate the procedure. -Explain the side-effects to her. Explain that they are not serious	Tell her how to mange them -Advise her to return if she has any problems or concerns about taking the drugs. -Explore any barriers she or her family may have, or have heard from others, about using the treatment, where possible: → Has she or any one she knows used the Treatment or preventive measure before? → Were there problems? → Reinforce the correct information that she has, and try to clarify the incorrect information. -Discuss with her the importance of taking the prescribed amount.

2-*Work Place and Administrative Procedures*

Workplace	Daily and occasional administrative activities	Record keeping	International conventions
• Service hours should be clearly posted. • Be on time with appointments or inform the woman/women if she/they need to wait. • Before beginning the services, check that equipment is clean and functioning and that supplies and drugs are in place. • Keep the facility clean by regular cleaning. • At the end of the service: → Discard litter and sharps safely → Prepare for disinfection; clean and disinfect equipment and supplies → Replace linen, prepare for washing → Replenish supplies and drugs → Ensure outline cleaning of all areas. • Handover essential information to the colleague who follows on duty	• Keep records of equipment,supplies,drugs and vaccines. • Check availability and functioning of essential equipment (orders of supplies,drugs, vaccines, and contraceptives before they run out). • Establish staffing lists and schedules. • Complete periodic reports on births,deaths and the indicators as required ,according to instructions.	• Always record findings on clinical record(maternal card).Record treatments, reasons for referral, and follow-up recommendations at the time the observation is made. • Do not record confidential information on the maternal card if the woman is unwilling. • Maintain and file appropriately: → All clinical records • → All other documentation.	• The health facility should not allow distribution of free or low-cost supplies or products within the scope of the International Code of Marketing of Breast Milk Substitutes. It should also be tobacco free and support a tobacco-free environment.

3- *Organizing a Visit*

Receive and respond immediately	**Begin each routine visit (for the woman)**	
Receive every woman seeking care immediately after arrival (or organize reception by another provider). Perform Quick Check on all new incoming women and those in the waiting room, especially if no-one is receiving them. . At the first emergency sign on Quick Check, begin rapid assessment and management (RAM) , If she is in labor, refer to hospital If she has priority signs (bleeding, fever ….ect), examine her immediately . If no emergency or priority sign on RAM or not in labor, invite her to wait in the waiting room. **<u>Begin each emergency care visit</u>** Introduce yourself. Ask the name of the woman. Encourage the companion to stay with the woman. Explain all procedures, ask permission, and keep the woman informed as much as you can about what you are doing. If she is unconscious, talk to the companion. Ensure and respect privacy during examination and discussion.	Greet the woman and offer her a seat. Introduce yourself Ask her name . Ask her: * Why did you come? * For a scheduled (routine) visit? * For specific complaints? * First or follow-up visit? * Do you want to include your companion or other family member in the examination and discussion? If antenatal care, always revise the birth plan at the end of the visit . Unless the condition of the woman require urgent referral to hospital, give preventive measures If follow-up visit is within a week, and if no other complaints: * Assess the woman for the specific condition requiring follow-up only * Compare with earlier assessment and re-classify. If a follow-up visit is more than a week after the initial examination (but not the next scheduled visit)	*Repeat the whole assessment as required for an antenatal, postpartum visit according to the schedule * If antenatal visit, revise the birth plan. **<u>During the visit</u>** Explain all procedures, Ask permission before undertaking an examination or test. Keep the woman informed throughout. Discuss findings with her (and her husband). Ensure privacy during the examination and discussion **<u>At the end of the visit:</u>** Ask the woman if she has any questions. Summarize the most important messages with her. Encourage her to return for a routine visit (tell her when) and if she has any concerns. Fill the card. Ask her if there are any points which need to be discussed and would she like support for this

4-Quick Check

- Assess the general condition of the care seeker(s) immediately on arrival
- Periodically repeat this procedure if the waiting time is long.

If a woman is very sick, talk to her companion

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ASK, CHECK RECO	LOOK, LISTEN, FEEL	SIGNS	classify	TREAT
• Why did you come? • What is the concern?	• Is the woman being wheeled or • carried in or: • bleeding vaginally • convulsing • looking very ill • unconscious • in severe pain • in labor	If the woman is or has: • unconscious (does not answer) • convulsing • bleeding • severe abdominal pain or looks very ill • headache and visual disturbance • severe difficulty breathing • fever • severe vomiting.	Emergency	• Reassure the woman that she will be taken care of immediately. • Ask her companion to stay. • Transfer the woman to hospital
		• Imminent delivery or • Labor	Labor	• Transfer the woman to the hospital
		• Pregnant woman, or after delivery, • with no danger signs	Routine care	• Keep the woman in the waiting room

Antenatal Care

Assess the Pregnancy Status and check for diseases

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

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	INDICATIONS	PLACE OF DILIVER Y	ADVISE
All visits -Check duration of pregnancy. -Where do you plan to deliver? -Any vaginal bleeding since last visit? -Is the baby moving? (after 4 months) -Check record for previous complications and treatments received during this pregnancy. -Do you have any concerns? continue	Feel for trimester of pregnancy	-Age less than 18 years. -First birth -Prior delivery by caesarean. -Obvious multiple pregnancy. -Transverse lie or other obvious malpresentation within one month of expected delivery. -Tubal ligation indicated immediately after delivery -Documented third degree tear. -Last baby born dead or died in first day. -More than 4 previous births. -Prior delivery with heavy bleeding. -Prior delivery with convulsions. -Prior delivery by forceps or vacuum. -HIV and hepatitis positive woman -History of or current vaginal bleeding or other complication during this pregnancy.	Referral level	-Explain why delivery needs to be at referral level. -Develop the birth and emergency plan.

First visit: • How many months pregnant are you? • When was your last period? • When do you expect to deliver? • How old are you? • Have you had a baby before? If yes: • Check record for prior pregnancies or if there is no record ask about: -Number of prior pregnancies/deliveries -Prior caesarean section, forceps, or vacuum -Prior third degree tear -Heavy bleeding during or after delivery - Convulsions -Stillbirth or death in first day. -Do you smoke or use any drugs? -HIV risk group -contact with infectious diseases(T.B Hepatitis, Rubella….ect)	Look for caesarean scar	More than 18 years old without risk problem para 2 up to para 4	Primary health care	-Explain why delivery needs to be at primary health care level. -Develop the birth and emergency plan.
		None of the above.	ccording to woman's preferences	-Explain why delivery needs to be with a skilled birth attendant, preferably at a facility. -Develop the birth and emergency plan.
Third trimester Has she been counseled on family planning?	Feel for obvious multiple pregnancy. Feel for transverse lie. Listen to fetal heart.			

2-Check for anemia (do hemoglobin to all pregnant women in each trimester)

3-Check for hypertensive disorder in all pregnant women at every visit

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
-Do you tire easily? -Are you breathless (short of breath) during routine household work?	-In each trimester: Measure hemoglobin -On subsequent visits: Look for -conjunctival pallor. -palmer pallor. If pallor: →Is it -severe pallor? →Some pallor? →Count number of breaths in1 minute.	• Hemoglobin<7-g/dl. And/or • Severe palmer and conjunctival pallor or • Any pallor with any of →>30 breaths per minute →tires easily →breathlessness at rest	severe Anemia	• DO film for malaria • Refer urgently to hospital after: -Revise birth plan so as to deliver in facility with blood transfusion services. -Give double dose of iron(1 tablet twice daily) for 3 months -Counsel on compliance with treatment • Follow up in 2 weeks to check clinical progress, test results ,and compliance with treatment.
		• Haemoglobin 7-11-g/dl.or Palmer or conjunctival pallor.	Moderate Anemia	• DO film for malaria • Give double dose of iron(1 tablet twice daily) for 3 months • Counsel on compliance with treatment • Reassess at next antenatal visit(4-6weeks).If anemia persists, refer to hospital.
		• Hemoglobin equel to or >11-g/dl. • No pallor.	No clinical anemia	• Give iron 1 tablet once daily for 3 months • Counsel on compliance with treatment

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
-Blood pressure at the last visit?	-Measure blood pressure in sitting position. -If diastolic blood pressure is ≥90 mmHg, repeat after rest. -If diastolic blood pressure is still ≥90 mmHg, ask the woman if she has: severe headache blurred vision →epigastric pain and →check protein in urine.	Diastolic blood pressure ≥110 mmHg and 3+ proteinuria, or Diastolic blood pressure ≥90-mmHg on two readings and 2+ proteinuria, and any of: →severe headache →blurred vision →epigastric pain.	Severe pre-eclampsia	Give adalat capsule 10mg orally. give oxygen and insert I.V line Revise the birth plan. Refer urgently to hospital
		Diastolic blood pressure 90-110-mmHg on two readings and 2+ proteinuria.	Preeclampsia	Revise the birth plan Refer to hospital.
		Diastolic blood pressure ≥90 mmHg on 2 readings.	Hypertension	Advise to reduce workload and to rest Advise on danger signs Reassess at the next antenatal visit or in 1 week if>8 months pregnant. If hypertension persists after 1 week or at next visit, refer to hospital
		None of the above.	No Hypertention	No treatment required.

4-check for thromboembolism (to be assessed at booking and repeated if admitted)

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
if there is one of the following -Single previous venous thromboembolism(VTE+) -Thrombophilia or family history -Unprovoked/estrogen-related Previous recurrent VTE			High risk	Refer to hospital
if there is one of the following -Single previous VTE with no family history or thrombophilia -Thrombophilia + no VTE -MEDICAL COMORBITIES, e.g. heart or lung disease, SLE, cancer, inflammatory conditions, nephrotic syndrome, sickle cell disease, -intravenous drug user -Surgical procedure, e.g. appendicectomy			Intermediate risk	Refer to hospital
-Age > 35 years -Parity ≥< 3 - Smoker -long-distance travel= > 4hr -Immobility ≥ 3 days,, e.g. paraplegia,	-Gross varicose veins symptomatic, above the knee or associated with phlebitis/oedema/skin changes -Current systemic infection -symphysis pubis dysfunction with reduced mobility(SPD),-Multiple pregnancy -Pre-eclampsia	-Obesity (BMI > 30kg/m2)Dehydration/hyperemesis	<3 Low risk. (three or more risk or 2 and admission intermediate risk)	Mobilization and avoidance of dehydration in low risk

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
at Booking -Maternal age 35-40 year -Nilliparous -Smoker 1-10/day -Low fruit intake -Pregnancy interval< 6month - Pregnancy interval ≥ 30 months -Paternal SGA	-BMI<20 -BMI 25-29.9 -Preeclampsia		Minor risk factors for (SGA)	3 Minor risk factors Refer to hospital for Doppler at 20-24w of gestation if normal repeated at 3rd trimester
-Maternal age >40year -Smoker ≥11/day - daily vigorous exercise -previous small gestational age baby -previous still birth -Chronic hypertension -maternal SGA	-Unexplained APH -Preclamsia -Diabetes and vascular disease -Severe pregnancy induced hypertension -Low maternal weight		Major risk factors for (SGA)	one major risk factors Refer to hospital for serial Doppler at 26-28 w of gestation repeated at 3rd trimester - refer before 16w gestation if risk factor for pre eclamsia (aspirin will be considerd)
	After 12 ws gestation examine SFH(symphysis fundal hight) if less than expected gestation		Probable SGA	Refer to hospital for US examination for AC & /OR EFW(abdominal circumference or estimated fetal weight)
	fibroid and BMI 35 or polyhdraminos		not suitable for monitoring	Refer to hospital for serial Doppler at 26-28 w of gestation repeated at 3rd trimester

5- check for Small–for–Gestational–Age (SGA) Fetus

6- Check for diabetes mellitus (Screen all pregnant women between 24th-28th weeks of gestation and the high risk groups at booking)

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	TEST RESULT	CLASSIFY	TREAT AND ADVISE
High risk groups: Older than 25 years of age. Family history of DM. Obesity Special minority groups. History of birth of macrosomic baby congenital anomaly, IUDand preterm birth.	Screening protocol of GDM 50 grams 1-hour oral glucose challenge (no need for fasting-at any time of the day)	Plasma glucose < 140 mg/dl < 7.8 mmol/LPlasma glucose	No GDM	
		≥140 mg/dl ≥7.8 mmol/dl give 100 gram 3-hours oral GTT (After 8-12h overnight fast) If ≥2 are abnormal (according to 4thinternational workshop for diagnosis of GDM) FPG ≥95 mg/dl (5.3 mmol/L) 1 hours –plasma glucose ≥180 (10 mmol/L) 2 hours –plasma glucose ≥155 (8.6 mmol/L) 3 hours- plasma glucose ≥140 (7.8 mmol/L)	GDM	Refer to hospital always for Diet, moniter glucose and fetus

Diabetes affect 1-12% of pregnancies.15% may progress to permanent DM. (Glycemic targets)

Fasting plasma glucose < 100mg/dl 1- hour postprandial plasma glucose <140mg/dl 2-hours postprandial plasma glucose <120mg/dl

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	TEST RESULT	CLASSIFY	REAT AND ADVISE
• Have you been tested for syphilis during this pregnancy →If not, perform the (VDRL test) • If test was positive, have you and your husband been treated for syphilis? →If not, and test is positive, ask "Are you allergic to penicillin?"		• VDRL test positive.	Possible syphilis	• Give benzathine benzyl penicillin) If allergy, give erythromycin, tetracycline or Doxycline • Plan to treat the newborn. • Encourage woman to bring her husband for treatment. • Counsel on safer sex including use Of Condoms To Prevent new infection
		• VDRL test negative.	no syphilis	• Counsel onsafter sex including use of condoms to prevent infection

7- Check for Hepatitis. Test and counsel all pregnant women for HbsAg and AntiHCV at the first antenatal visit.

8-check for syphilis (test all pregnant women at first visit)

Indication	Antibiotic	Dose	Frequency	Duration	Comments
Syphilis VDRL test positive	Benzathine Penicillin (2.4millioncunits in5ml)	2.4million units IM injection	once only	Once only	Give as two IM injections Plan to treat new born . Counsel on correct and consistent use of condoms
If woman has allergy to penicillin	Erythromycin (1tablet=250mg)	500mg (2tablets)	every 6 hours	15days	
If husband has allergy to penicillin	Tetracycline (1tablet=250mg) OR Doxycline (1tablet=100mg)	500mg (2tablets) 100mg	every 6 hours every12hours	15days 15days	Not safe for pregnant or lactating woman.

A

HIV is a virus that destroys parts of the body's immune system. A person infected with HIV may not feel sick at first, but slowly the body's immune system is destroyed. The person becomes ill and unable to fight infection. Once a person is infected with HIV, she or he can give the virus to others.
HIV can be transmitted through:
-Exchange of HIV-infected body fluids such as semen, vaginal fluid or blood during unprotected sexual intercourse.
-HIV-infected blood transfusions or contaminated needles.
-From an infected mother to her child (MTCT) during (pregnancy, labor and delivery and postpartum through breastfeeding
-HIV cannot be transmitted through hugging or mosquito bites.
-A blood test is done to find out if the person is infected with HIV.
-All pregnant risky women are offered this test. They can refuse the test.

9-Check for HIV Use this chart testing and counseling during pregnancy for all risk group woman

What Is HIV (Human Immune Deficiency Virus)? Counsel
on safer sex including use of condoms

Safer sex is any sexual practice that reduces the risk of transmitting HIV and sexually transmitted infections (STIs) from one person to another the best protection is obtained by:

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
-Provide key information on HIV What is HIV and how is HIV transmitted? -Advantage of knowing the HIV status in pregnancy -Explain about HIV testing and counseling including confidentiality of the result -Ask the risky woman: Have you been tested for HIV? -If not: tell her that she will be tested for HIV, unless she refuses. -If yes: . (Explain to her that she has a right not to disclose the result.) -Has the husband been tested?	< Perform HIV test if not performed in this pregnancy	< Positive HIV test.	HIV POSITIVE	HIV positive women will get care at facilities assigned for them.
		< Negative HIV test.	HIV NEGATIVE	< Counsel on implications of a negative test. < Counsel on the importance of staying negative by practicing safer sex, including use of condoms. < Counsel on benefits of involving and testing the husband.
		< She refuses the test or is not willing to disclose the result of previous test or no test results available	UNKNOWN HIV STATUS	< Counsel on safer sex including use of condoms. < Counsel on benefits of involving and testing the husband.

Correct and consistent use of condoms during every sexual act.
Choosing sexual activities that do not allow semen, fluid from the vagina, or blood to enter the mouth, anus or vagina of the husband.
If the woman is HIV-negative explain to her that she is at risk of HIV infection and that it is important to remain negative during pregnancy and breastfeeding. The risk of infecting the baby is higher if the mother is newly infected.
Make sure the husband knows how to use condoms and where to get them.

HIV testing and counseling services

Explain about HIV testing:

- HIV test is used to determine if the woman is infected with HIV.
- It includes blood testing and counseling.
- Result is available on the same day
- inform the woman about:
- Where to go.
- How the test is performed.
- How confidentiality is maintained
- When and how results are given.
- When she should come back to the clinic with the test result
- Provide the address of HIV testing in your area's nearest site :
- Ask her if she has any questions or concerns

10-Check for Toxoplasmosis

Test for toxoplasmosis women with history of abortion (but not habitual abortion), congenital anomaly or stillbirth

Ask, Check Record	Look, Listen and feel	Signs	Classify	Treat and Advise
Have you had a: • fever • fatigue • malaise • generalized weakness • abdominal pain • contact with cats • occupation(Farmer) • immunosuppressive drugs or HIV +	Exam for: • Fever • Lymphadenopathy • Hepato-splenomegaly	-Asymptomatic - fever and lymphadenopathy (flue like illness) fever,fatigue,weakness, malaise> The lymphadenitis may wax and wane for months and finally resolve spontaneously Rarely: Fulminating disease with an erythematous rash, fever, malaise, myositis, dyspnea, acute myocarditis and encephalitis. Outcome can be fatal.	Inapparent (90%) Apparent (10%)	• Ensure that meat is cooked thoroughly 66c orfreeze to -20 for 24 hr. • Thoroughly wash fruits and vegetables before eating. • Wash cutting boards, dishes, counters, utensils and hands with hot, soapy water after they have come in contact with raw foods. • Wear gloves when gardening and during any contact with soil or sand because it might contain cat feces. • Wash hands thoroughly after coming in contact with soil or sand. • Do not handle stray cats. • Do not feed your cat raw or undercooked meats. • Refer pregnant women (those with both IGM and IGG - converted to + or both of them are +) to DOH /PHCD/communicable disease section for treatment.

InToxoplasmosis

- The risk of the baby's infection depend partly upon the timing of the mother's infection, when mothers are infected in the first trimester, 15 percent of fetuses become infected, as compared to 30 percent in the second trimester and 65 percent in the third trimester.
- Primary infection during early pregnancy may lead to fetal infection with death of the fetus or anomalies while in late pregnancy lead to mild or subclinical fetal disease
- With rare exception, woman who has been infected at least 6-9 months before conception develop immunity to toxoplasmosis and do not pass it on to their fetus in the pregnancy.
- Test serum for the presence of TOXOPLASMA specific IgG Antibody if negative mean no infection if positive mean infected woman AND to determine a proximate time of infection test serum for presence of TOXOPLASMA specific IgM Antibody if positive mean recent infection and has to be confirmed in the central health lab through either ALYZA or IFAT

Respond to observed signs or volunteers problems

4- pregnant woman with obesity:			
	Booking visit	**through out pregnancy**	**third trimester**
Care for women with body mass index ≥30	-Measure weight and height to calculate BMI -Use appropriate size BL.Pr cuff -ConΘnue 5mg folic acid daily up to 12W gestaΘon -Assess for thromboembolism risk -Glucose tolerance test -Give information about risk of obesity and pregnancy and how to minimize it	-Assess for thromboembolism risk -Use appropriate size blood pressure cuff	-Glucose tolerance test at 24-28w Give advice on benefit of breast feeding initiation and maintenance

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
1-If woman had history of primary hypertension				
Check blood pressure	Kidney function, ,electrolyte full bl count transaminase and bilirubin	160/110 or higher	Severe	**Refer to hospital**
Check blood pressure twice per week	Kidney function, ,electrolyte full bl count transaminase and bilirubin	150/100-159/109	Moderate	**Aldomet tablet 250mg *3 increase to 2g/d**
Check blood pressure once per week	Routine ANC test	140/90 to 149/99mHg	Mild	**no**
2-If No Fetal Movement				
• When did the baby last move? • If no movement felt, ask woman to move around for some time, reassess fetal movement	• Feel for fetal movements. • Listen for fetal heart after 6 months of pregnancy by fetoscope or sonic aid (if< 100lm or > 180lm turn woman on her left side and count again . • If no heart beat, repeat after 1 hour	• No fetal movement. • No fetal heart beat	probably dead baby	-Inform the woman and husband about the possibility of dead baby. -Refer to hospital .
		• No fetal movement but fetal heart beat present.	well baby	Inform the woman that baby is fine and likely to be well but to return if problem persists.(If she do not feel more than 10 movements in 2 hours, contact maternity unit).

3-threatened premature birth means the presence of uterine activity (contractions) from 24 - 37 weeks gestation				
a-No rupture membrane				
- No history of premature labor -History of premature labor				-Bed rest counseling -Treat cause -Follow up after 10 days if persist refer to hospital Refer to hospital
b-If Ruptured Membranes And No Labor				
• When did the membranes rupture? • When is your baby due?	-Measure temperature -Look at pad or under wear for evidence of: • amniotic fluid • foul-smelling vaginal discharge • If no evidence, examine her with a sterile speculum .	• Fever 38ºC. • Foul-smelling vaginal discharge.	uterine and fetal infection	• Give ampicilline 2 gm iv or im+metranidazol100 ml infusion and gentamycine 80gm iv or im. • Refer ergently to hospital. .
		• Rupture of membranes at <=8months of pregnancy.	risk of uterine and fetal infection	• give ampicilline 2 gm iv or im • Refer ergently to hospital.
		• Rupture of membranes at >8 months of pregnancy	rupture of membranes	• Refer urgently to hospital to Manage as Woman in childbirth

	-Refer to consultant to discuss birth plan- and Consider 75 mg aspirin if there is additional moderate risk for preeclampsia		
Care for women with body mass index ≥35	As above plus Refer if one or more additional risk factors for preclamsia(first pregnancy, previous pre-eclampsia, _10 years since last baby, _40 years old pregnant woman, family history of pre-eclampsia, booking diastolic BP_80mmHg, booking proteinuria _1+ on more than one occasion, multiple pregnancy, and certain underlying medical conditions such as pre-existing hypertension, renal disease or diabetes.	As above plus Monitor for preclamsia 3 times/w between 24-32w and 2 times/w between 32 and delivery	As above
Care for women with body mass index ≥40	As above plus Refer	As above plus Monitor for preclamsia 3 times/w between 24-32w and 2 times/w between 32 and delivery	As above

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
6-If vaginal discharge				
< Have you noticed changes in your vaginal discharge? < Do you have itching at the vulva? < Has your husband had a urinary problem? If husband is present in the clinic, ask the woman if she feels comfortable if you ask him similar	< Separate the labia and look for abnormal vaginal discharge: -- amount -- color -- odor/smell. < If no discharge is seen, examine with a gloved finger and look at the discharge on the glove.	< Abnormal vaginal discharge. husband has urethral discharge or burning on passing urine.	possible gonorrhoea or chlamydia infection	< Give cefitriaxon 250mg im injection once to woman < Treat husband with ciprofluxacine 500mg once orally < Counsel on safer sex including use of condoms.
			possible candida infection	

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	EAT AND ADVISE
5-IF FEVER OR BURNING ON URINATION				
• Have you had fever? • Do you have burning on urination?	• If history of fever or feels hot: • Measure axillary temperature. • Look or feel for stiff neck. • Look for lethargy. • Percuss flanks for tenderness	• Fever >38°C and any of: • very fast breathing or • stiff neck • lethargy • very weak/not able to stand	very severe febrile disease	• Insert IV line • Give ampicilline 2 gm iv or im +metranidazol 100 ml infusion and gentamycine 80gm iv or im. • Do blood film for malaria • Refer urgently to hospital
		• Fever >38°C and any of: • Flank pain • Burning on urination.	upper urinary tract infection	• Give ampicilline 2 gm iv or im and gentamycine 80gm iv or im. • Do blood film for malaria • Refer urgently to hospital
		• Burning on urination.	lower urinary tract infection	• Give amoxycilline capsule 500 mg l 8hr for three days after send to GUE(General urine examination). • Encourage her to drink more water • Refer to hospital if no response in 2days or she get worse.

questions. If yes, ask him if he has: < urethral discharge or pus. < burning on passing urine. If husband could not be approached, explain importance of husband assessment and treatment to avoid reinjection. Schedule follow-up appointment for woman and husband (if possible).		< Curd like vaginal discharge. < Intense vulvae itching. < Abnormal vaginal discharge	possible bacterial or trichomonas infection	< Give 200 mg clotrimazole one pessary every night for three days(teach the woman to wash her hands before and after application) < Counsel on safer sex including use of condoms . < Give 2gm metronidazole once to woman or 500mg every 12 hours for 7 days < Counsel on safer sex including use of condoms .
7- If signs suggesting HIV Infection				
< Have you lost weight؟ < Do you have fever ؟ How long (>1 month) Have you got diarrhoea (continuous or intermittent؟) How long, >1 month؟ < Have you had cough ؟ How long, >1 month ؟ Assess if in high risk group: < Occupational exposure؟	< Look for visible wasting. < Look for ulcers and white patchs in the mouth (thrush.(< Look at the skin: -Is there a rash؟ -Are there blisters along the ribs on one side of the body?	< Two of these signs: --weight loss --fever >1 month --diarrhea>1month. OR < One of the above signs and --one or more other signs or -- from a risk group.	Strong likelihood of HIV infection	< Reinforce the need to know HIV status and advise on HIV testing and counseling . < Counsel on the benefits of testing the husband < Counsel on safer sex including use of condoms

< Multiple sexual partner؟ < Intravenous drug use؟ < History of blood transfusion؟ < llness or died husband from AIDS ؟ < History of forced sex?				< Refer to voluntary counseling and testing center < Refer to TB centre if cough.
8-IF SMOKING OR DRUG ABUSE, OR HISTORY OF VIOLENCE				
				-Counsel on stopping smoking -For drug abuse, refer to specialized care providers. -counsel on violence if found.

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
9- if cough or breathing difficulty, chest pain and arrhythmia				
< How long have you been coughing? < How long have you had difficulty in breathing? < Do you have chest pain? < Do you have any blood in sputum? < Do you smoke?	< Look for breathlessness. < Listen for wheezing. < Measure temperature. < Measure pulse rate and regularity	At least 2 of the following signs: < Fever >38ºC. < Breathlessness. < Chest pain.	POSSIBLE PNEUMONIA	< Give ampicilline 2 gm iv or im and gentamycine 80gm iv or im.. < Refer urgently to hospital
		At least 1 of the following signs: < Cough or breathing difficulty for >3 weeks < Blood in sputum < Wheezing	POSSIBLE CHRONIC LUNG DISEASE	< Refer to hospital for assessment. < If severe wheezing, refer urgently to hospital.
		< Fever <38ºC, and < Cough <3 weeks.	UPPER RESPIRATORY TRACT INFECTION	< Advise safe, soothing remedy. < If smoking counsel to stop smoking
		If any of the following signs - Breathlessness. - Chest pain. -arrhythmia -cyanosis	POSSIBLE HEART DISEASE	Refer to hospital for further assessment

ASK, CHECK RECORD	SIGNS	CLASSIFY	TREAT AND ADVISE
10-If Taking Anti-Tuberculosis Drugs			
• Are you taking anti-tuberculosis drugs? If yes, since when? • Does the treatment include injection(streptomycin)?	• Taking anti-tuberculosis drugs. • Receiving injectable anti tuberculosis drugs	Tuberculosis	• If anti-tubercular treatment includes streptomycin(injection), refer the woman to district TB focal point for revision of treatment as streptomycin is ototoxic to the fetus. • If treatment does not include streptomycin, assure the woman that the drugs are not harmful to her baby, and urge her to continue treatment for a successful outcome of pregnancy. • If her sputum is TB positive within 2 months of delivery, plan to give INH prophylaxis to the newborn • Reinforce advice on HIV testing and counseling • If smoking, counsel to stop smoking. • Advise to screen immediate family members and close contacts for tuberculosis.

- If the mother is diagnosed as having tuberculosis and started treatment less than 2 months before delivery:
  -Tell mother that INH prophylaxis for newborn is needed for 6 months
  -Delay BCG vaccination until INH treatment completed, or repeat BCG.
  -Reassure the mother that it is safe to breastfeed the baby.
  -Follow up the baby every 2 weeks, or according to national guidelines, to assess weight gain.

Postnatal Care

assessment of the mother status and check for diseases

1-Assessment of mother within 6 weeks after delivery

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
• When and where did you deliver? • How are you feeling? • Have you had **any pain or fever** or • Bleeding since delivery? • Do you have any problem with **Passing urine?** • Have you decided on any **Contraception?** • How do your **breasts feel**? • Do you have any other **concerns?** • Check records: **-Any complications during Delivery?** **- Receiving any treatments?** **-HIV status if she is in the risk group**	• Measure blood pressure and temperature. • Feel uterus. Is it hard and round? • Look at vulva and perineum for: • tear • swelling • Pus. • Look at pad for bleeding and lochia. • Does it smell? • Is it profuse? • Look for pallor.	• Mother feeling well. • Did not bleed >250 ml. • Uterus well contracted and hard. • No perineal swelling. • Blood pressure, pulse and temperature normal. • No pallor. • No breast problem, • is breastfeeding well. • No fever or pain or concern. • No problem with urination	NORMAL PURPERUM	• Make sure woman and family know what to watch for and when to seek care • Advise on Postpartum care and hygiene, and counsel on nutrition • Counsel on the importance of birth spacing and family planning • Refer for PHCS with family planning if not available in your center • Dispense 3 months iron supply and counsel on compliance. • Give any treatment or prophylaxis due: • Tetanus immunization if she has not had full course. • Promote use of impregnated Bed net for the mother and baby in endemic area. • Record on the mother's card . • Advise to return to health center within 4-6 weeks if she came earlier • Vitamin A Capsule 200000 I U

2-Check for the following diseases as in ANC:

-Anemia and send for HB test on need.

-Hypertensive disorder.

-Diabetes mellitus if she had gestational diabetes

-Hepatitis B if she is from the risk group (unknown or test result negative during pregnancy).

- HIV Status in risky group use the same chart for HIV testing and counseling during pregnancy (if the woman is not previously tested)

3-check for thromboembolism in purperum

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
-Any previous VTE+ -Anyone requiring antenatal LMWH			High risk	Refer to hospital
Caesarean section in labour Asymptomatic thrombophilia (inherited or acquired) BMI > 40 kg/m2 Prolonged hospital admission MEDICAL COMORBIDITIES, e.g. heart or lung disease, SLE, cancer, imflammatory conditions, nephrotic syndrome, sickle cell disease, intravenous drug user			Intermediate risk	Refer to hospital
Age > 35 years Obesity (BMI > 30kg/m2) Parity ≥ 3 Smoker Elective caesarian section Any surgical procedure in the puerperium Gross varicose veins Current systemic infection Immobility, e.g. paraplegia, long distance travel Pre-eclampsia Prolonged labour (> 24 hours) PPH > 1 litre or blood transfusion	-		low risk if < 2 risk factors Intermediate risk if 2 or more risk factors	Mobilization and avoidance of dehydration in low risk

Respond to observed signs or volunteered problems during purperum

1-IF HEAVY VAGINAL BLEEDING	SIGNS	CLASSIFY	
	More than 1 pad soaked in 5 minutes	postpartum bleeding	• Insert an IV line • Refer urgently to hospital -Drugs given according to PPH protocol
2-if pallor, respond to anemia- follow the same chart of ANC 3-if elevated diastolic blood pressure -follow the same chart of ANC 4-if vaginal discharge or signs suggesting HIV infection follow the same chart of ANC 5-if cough or breathing difficulty follow the same chart of ANC 6-if taking anti-tuberculosis drugs 7-if signs suggesting HIV infection follow the same chart of ANC			

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
8-IF FEVER OR FOUL-SMELLING LOCHIA				
Have you had: • Heavy bleeding? • Foul-smelling lochia? • Burning on urination?	• Feel lower abdomen and flanks for • tenderness. • Look for abnormal lochia. • Measure temperature. • Look or feel for stiff neck. • Look for lethargy.	Temperature >38°C and any of: • very weak • abdominal tenderness • foul-smelling lochia • profuse lochia • uterus not well contracted • lower abdominal pain • history of heavy vaginal bleeding	uterine infection	Insert an IV line Give ampicillin 2g Gentamycin 80 mg IM or • IV ,Metronidazole 500mg IV Send blood film for malaria Refer urgently to hospital
		Fever >38ºC and any of: • burning on urination • flank pain.	Upper Urinary Tract Infection	Give ampicillin vial 2 gram and Gentamycin • 80 mg IM/IV. Send blood film for malaria Refer urgently to • hospital.
		Burning on urination	Lower urinary tract infection	Give amoxicillin one tab500 mg /8 hr for • three days Send for general urine examination Encourage her to drink more fluids. Follow up in 2 days. If no improvement, refer to hospital
		Temperature >38°C and any of: • stiff neck • Lethargy.	VERY SEVERE FEBRILE DISEASE	Insert an IV line . Give ampicillin 2gm iv or im, • gentamicin80mg and metronidazole 500mg iv Send blood film for malaria Refer urgently to hospital

9-If Dribbling Urine		Dribbling or leaking urine	Urine incontinenc	Give :Amoxicillin 500 mg every 8 hourly If conditions persist more than one week refer the women to hospital.
		Fever >37.2ºC	Suspected malaria	Do blood film for malaria
10-If pus or perineal pain		Excessive swelling ofvulva or perineum	Perineal trauma	Refer the woman to hospital
11-If feeling unhappy or crying easily		Pus in perineum Pain in perineum	Perineal infection episiotomy wound) or pain	Remove suture if present Clean the wound. Counsel on care and hygiene Give paracetamol for pain One to two tab every four to six hours Follow up in two days if no improvement refer to hospital
How have you been feeling recently? • Have you been in low spirits? • Have you been able to enjoy the • things you usually enjoy?		Two or more of the following symptoms during the same 2 week period representing a change from normal: • Inappropriate guilt or negative feeling towards self. • Cries easily.	postpartum depression (usually after first week)	Provide emotional support. Refer urgently the woman to hospital

• Have you had your usual level of • energy, or have you been feeling tired? • How has your sleep been? • Have you been able to concentrate (for example on newspaper articles or your favorite radio programs)?		• Decreased interest or pleasure. • Feels tired, agitated all the time. • Disturbed sleep (sleeping too much or too little, waking early). • Diminished ability to think or concentrate. • Marked loss of appetite.		
		Any of the above, for less than 2 weeks	postpartum blues (usually in first week	Assure the woman that this is very common. • Listen to her concerns. Give emotional Encouragement and support. • Counsel husband and family to provide assistance to the woman. • Follow up in 2 weeks, and refer if no improvement.
12- IF complaining of nipple or breast pain				
How do your breasts feel?	Look at the nipple for fissure • Look at the breasts for: • swelling • shininess • redness. • Feel gently for painful part of thebreast.	No swelling, redness or tenderness. • Normal body temperature. • Nipple not sore and no fissure • visible.	breasts healthy	Reassure the mother.

	• Measure temperature. • Observe a breastfeed if not yet done .	• Baby well attached.		
		• Nipple sore or fissured. • Baby not well attached	nipple soreness or fissure	Encourage the mother to continue breastfeeding. • Teach correct positioning and attachment. • Reassess after 2 feeds (or 1 day). If not better, teach the mother how to express breast milk from the affected breast and feed baby by cup, and Continue breastfeeding on the healthy side.
Both breasts are swollen, shiny and patchy red. • Temperature <38ºC. • Baby not well attached. • Not yet breastfeeding.		breast engorgement		Encourage the mother to continue breastfeeding. • Teach correct positioning and attachment . • Advise to feed more frequently. • Reassess after 2 feeds (1 day). If not better, teach • mother how to express enough breast milk before • the feed to relieve discomfort .
Part of breast is painful, swollen and red. • Temperature >38ºC • Feels ill.		mastitis		Encourage mother to continue breastfeeding. • Teach correct positioning and attachment • Give cloxacillin for 10 days . • Reassess in 2 days. If no improvement or worse, refer to hospital. • If mother is HIV+ let her breastfeed on the healthy breast. Express milk from the affected breast and discard until no fever. • If severe pain, give paracetamol

13-woman with obesity	
body mass index	**Treatment and advice**
≥30 **OR** **≥35**	- Encourage mobilize as early as possible -Provide compression stocking if 2 or more risk factors for thromboembolism -Give advice on benefit of breast feeding initiation and maintenance -Glucose tolerance test at 6 w aŌer delivery -refer to dietician
≥40	As above and refer for thromboprophylaxis

Preventive Measures

1-Tetanus toxoid in ANC and PNC

Assess, Check Record	Treat And Advise
• Check tetanus toxoid (TT) immunization status.	Give tetanus toxoid if due < If TT1, plan to give TT2 at next visit. According to the schedule
• When was TT last given?	Tetanus schedule
• Which dose of TT was this?	at first antenatal care visit, as early as possible. TT1
• If immunization status unknown, give TT1. And Plan to give TT2 in 4 w.	At least 4 weeks after TT1 (at next antenatal care visit). TT2
2- Give vitamin A after delivery • Give 200-000-IU vitamin A capsules after delivery or within 6 weeks of delivery: • Explain to the woman that the capsule with vitamin A will help her to recover better, and that the • baby will receive the vitamin through her breast milk. • Ask her to swallow the capsule in your presence. • Explain to her that if she feels nauseated or has a headache, it should pass in a couple of days. • DO NOT give capsules with high dose of vitamin A during pregnancy .Vitamin A1 capsule 200-000 IU 1 capsule after delivery or within 6 weeks of delivery	At least 6 months after TT2. TT3
	At least 1 year after TT3. TT4
	At least 1 year after TT4. TT5
	Explain to the woman that the vaccine is safe to be given in pregnancy; it will not harm the baby.
	The injection site may become a little swollen, red and painful, but this will go away in a few days.
	If she has heard that the injection has contraceptive effects, assure her it does not, that it only protect her from disease< Give 0.5 ml TT IM, upper arm.
	Advise woman when next dose is due.< Record on mother's card.

3- Ferofolic tablet in ANC and PNC :Check woman's supply of iron and folic acid at each visit and dispense 1 months' supply.

- Advise to store iron safely Where children cannot get it In a dry place.
- Iron and folate (1 tablet = 60-mg iron, folic acid = 400-µg)
- Give iron and folic acidto all pregnant, postpartum and post-abortion women as follow:

All women		Women with anemia
1 tablet		2 tablets
In pregnancy	Throughout the pregnancy	3 months
Postpartum and post-abortion	3 months	3 months

-Motivate on compliance with iron treatment:

- Explore local perceptions about iron treatment (examples of incorrect perceptions: making more blood will make bleeding worse, iron will cause too large a baby).
- Explain to mother and her family: Iron is essential for her health during pregnancy and after delivery< The danger of anemia and need for supplementation.
- Discuss any incorrect perceptions.
- Explore the mother's concerns about the medication: Has she used the tablets before? Were there problems? Any other concerns? Advise on how to take the tablets
- With meals or, if once daily, at night Iron tablets may help the patient feel less tired. Do not stop treatment if this occurs Do not worry about black stool. This is normal.
- Give advice on how to manage side-effects: If constipated, drink more water

- Take tablets after food or at night to avoid nausea
- Explain that these side effects are not serious
- Advise her to return if she has problems taking the iron tablets.
- If necessary, discuss with family member, TBA, other community-based health workers or other women, how to help in promoting the use of iron and folate tablets.
- Counsel on eating iron-rich foods
- Counsel on nutrition :Advise the woman to eat a greater amount and variety of healthy foods, such as meat, fish, oils, nuts, seeds, cereals, beans, vegetables, cheese, milk, to help her feel well and strong (give examples of types of food and how much to eat).
- Reassure the mother that she can eat any normal foods – these will not harm the breastfeeding baby.
- Spend more time on nutrition counseling with very thin women and adolescents.
- Determine if there are important taboos about foods which are nutritionally healthy. Advise the woman against these taboos.
- Talk to family members such as husband and mother-in-law, to encourage them to help ensure the woman eats enough and avoids hard physical work.

Advice and Counsel

Advice and counsel on:

- Nutrition and self care
- Routine and follow up visits
- Develop a birth and emergency plan
- Danger signs during pregnancy labor and purperum
- Labor sign
- importance of exclusive breastfeeding
- family planning

1-Advise and counsel on nutrition and self-care :

a-Counsel on nutrition

< Advise the woman to eat a greater amount and variety of healthy foods, such as meat, fish, oils, nuts, seeds, cereals, beans, vegetables, cheese, milk, to help her feel well and strong (give examples of types of food and how much to eat).

< Spend more time on nutrition counselling with very thin, adolescent and HIV-positive woman.

< Determine if there are important taboos about foods which are nutritionally important for good health. Advise the woman against these taboos.

< Talk to family members such as the partner and mother-in-law, to encourage them to help ensure the woman eats enough and avoids hard physical work.

b- counsel on self-care

- Eat more and healthier foods, including more meat, fish, oils, coconut, nuts, cereals, beans, vegetables, fruits, cheese and milk
- Drink plenty of clean, safe water.
- Take iron and folic tablets
- Rest .
- Sleep under an insecticide impregnated bed net in northern area.
- Counsel on safer sex including use of condoms, if at risk for STI or HIV
- Avoid smoking .
- NOT to take medication unless prescribed by doctors.
- After delivery wash all over daily, particularly the perineum. And Change pad every 4 to 6 hours. Wash pad or dispose it safely

2-Advise and counsel on routine and follow up visits :

- **ANC visits :**

a-Routine Visits:

are monthly during the first 6th month of pregnancy , twice weekly in the 7th and 8th months of pregnancy and weekly in the 9th month of pregnancy the lowest number of visits are 4 through out pregnancy as follow:

1st visit Before 4 months Before 16 weeks

2nd visit 6 months 24-28 weeks

3rd visit 8 months 30-32 weeks

4th visit 9 months 36-38 weeks

< First antenatal contact should be as early in pregnancy as possible.

< During the last visit, inform the woman to return if she does not deliver within 2 weeks after the expected date of delivery.

< If women is HIV-positive ensure a visit between 26-28 weeks.

b- Follow-up visits if there is problems

-Hypertension Return in: 1 week if >8 months pregnant

-Severe anemia Return in: 2 weeks

- postnatal care visits:

a- Routine:

FIRST VISIT	Within the first week, as early as possible
SECOND VISIT	4-6 weeks preferably on 4th week

b - Follow-up visits if there is problem

-Fever	2 days
-Lower urinary tract infection	2 days
- Perineal infection or pain	2 days
-Hypertension	1 week
-Urinary incontinence	1 week
-Severe anemia	2 weeks
-Postpartum blues	2 weeks
-Moderate anemia	4 weeks
-If treated in hospital for any complication	According to doctors instructions or according to national guidelines, but no later than in 2 weeks

3-DEVELOP A BIRTH AND EMERGENCY PLAN

a-DEVELOP A BIRTH PLAN

Facility delivery

Explain why birth in a facility is recommended

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

Advise how to prepare

Review the arrangements for delivery:

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

Advise when to go

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

Advise what to bring

- Maternal card.
- Clean clothes for washing, drying and wrapping the baby.
- Additional clean clothes to use as sanitary pads after birth.
- Clothes for mother and baby.

-Instructions to mother and family for if choose delivery at home:

- **Choose a skilled and trained birth attendant**
- Make sure there is a clean delivery surface for the birth of the baby.
- Ask the attendant to wash her hands before touching you or the baby. The nails of the attendant should be short and clean.
- When the baby is born, **skilled and trained birth attendant** will place her/him on your abdomen/chest where it is warm and clean. Dry the baby thoroughly and wipe the face with a clean cloth. Then cover with a clean dry cloth. She also wil:
- Wait for the placenta to deliver on its own.
- Make sure you and your baby are warm. Have the baby near you, dressed or wrapped and with head covered with a cap.
- Advice you to Start breastfeeding when the baby shows signs of readiness, within the first hour of birth.
- Dispose of placenta (describe correct, safe culturally accepted way to dispose of placenta)

  DO NOT be alone for the 24 hours after delivery. DO NOT bath the baby on the first day.

-Advise to avoid harmful practices during labor

For example:

NOT to use local medications to hasten labour.

NOT to wait for water 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.

-Explain supplies needed for home delivery

- Warm spot for the birth with a clean surface or a clean cloth.
- Clean cloths of different sizes: for the bed, for drying and wrapping the baby, for cleaning the baby's eyes, for the birth attendant to wash and dry her hands, for use as sanitary pads.
- Blankets.
- Buckets of clean water and some way to heat this water.
- Soap.
- Bowls: 2 for washing and 1 for the placenta. Plastic for wrapping the placenta.

b- Discuss how to prepare for an emergency in pregnancy

- Discuss emergency issues with the woman and her husband/family:
- Where will she go?
- How will they get there?
- How much it will cost for services and transport?
- Can she start saving straight away?
- Who will go with her for support during labour and delivery?
- Who will care for her home and other children?
- Advise the woman to ask for help from the community, if needed
- Advise her to bring her card to the health center, even for an emergency visit.

c-discuss how to prepare for an emergency in postpartum:

-advice to have someone near for at least 24 hr after delivery to respond to any change in condition

-discus with woman and her husband and family about emergency issues

-where to go if danger signs

-how to reach the hospital

-cost involved

-family and community support

-advice the woman to ask for help from the community if needed

-advice the woman to bring her maternal record to the health facility even for an emergency

4-Advise on danger signs:

-during pregnancy

Advise to go to the hospital/health center immediately, day or night, WITHOUT waiting if any of the following signs:

- Vaginal bleeding.
- Fit.
- Severe headaches with blurred vision.
- Fever and too weak to get out of bed.
- Severe abdominal pain.
- Fast or difficult breathing.

She should go to the health center as soon as possible if any of the following signs:

- Fever.
- Abdominal pain.
- Feels ill.
- Swelling of fingers, face, legs.

-During labor:

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

- Waters break and not in labor after 6 hours.
- Labor pain/contractions continue for more than 12 hours.
- Bleeding .
- Placenta not expelled 1 hour after birth of the baby.

-after delivery:

Advise the mother to go to a health facility immediately, day or night, WITHOUT WAITING, if any of the following signs:

Mother:

< vaginal bleeding more than 2 or 3 pads soaked in 20-30 minutes after delivery OR bleeding increases rather than decreases after delivery.

< Fits.

< fast or difficult breathing.

< fever and too weak to get out of bed.

< severe abdominal pain.

Go to health center as soon as possible after delivery if any of the following signs:

< fever

< abdominal pain

< feels ill

< breasts swollen, red or tender breasts, or sore nipple

< urine dribbling or pain on micturition

< pain in the perineum or draining pus

< foul-smelling lochia

Baby

- Very small.
- Difficulty in breathing.
- Fits.
- Fever.
- Feels cold.
- Bleeding.
- Not able to feed.

5-Advise on labor signs

Advise to go to the facility or contact the skilled birth attendant if any of the following signs:

- A bloody sticky discharge.
- Painful contractions every 20 minutes or less.
- Waters have broken.

6-Counsel on importance of exclusive breastfeeding

INCLUDE husband OR OTHER FAMILY MEMBERS IF POSSIBLE Explain to the mother that:

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

Breastfeeding:

- Helps baby's development and mother/baby attachment
- Can help delay a new pregnancy

Breastfeeding advantages

FOR THE BABY

< During the first 6 months of life, the baby needs nothing more than breast milk — not water, not other milk, not cereals, not teas, not juices.< Breast milk contains exactly the water and nutrients that a baby's body needs. It is easily digested and efficiently used by the baby's body. It helps protect against infections and allergies and helps the baby's growth and development.

FOR THE MOTHER

< Postpartum bleeding can be reduced due to uterine contractions caused by the baby's sucking.< Breastfeeding can help delay a new pregnancy.

FOR THE FIRST 6 MONTHS OF LIFE, GIVE ONLY BREAST MILK TO YOUR BABY, DAY AND NIGHTAS OFTEN AND AS LONG AS SHE/HE WANTS.

Suggestions for successful breastfeeding

< Immediately after birth, keep your baby in the bed with you, or within easy reach.

< Start breastfeeding within 1 hour of birth

.< The baby's suck stimulates your milk production. The more the baby feeds, the more milk you will produce.

< At each feeding, let the baby feed and release your breast, and then offer your second breast. At the next feeding, alternate and begin with the second breast.

< Give your baby the first milk (colostrum). It is nutritious and has antibodies to help keep your baby healthy.

< At night, let your baby sleep with you, within easy reach.

< While breastfeeding, you should drink plenty of clean, safe water. You should eat more and healthier foods and rest when you can The health worker can support you in starting breastfeeding

< The health worker can help you to correctly position the baby and ensure she/he attaches to the breast. This will reduce breast problems for the mother.

< The health worker can show you how to express milk from your breast with your hands. If you should need to leave the baby with another care taker for short periods, you can leave your milk and it can be given to the baby in a cup.

< The health worker can put you in contact with a breastfeeding support group .If you have any difficulties with breastfeeding, see the health worker immediately .Breastfeeding and family planning

< During the first 6 months after birth, if you breastfeed exclusively, day and night, and your menstruation has not returned, you are protected against another pregnancy

.< If you do not meet these requirements, or if you wish to use another family planning method while breastfeeding, discuss the different options available with the health worker.

7- Counsel on the importance of family planning

- If appropriate, ask the woman if she would like her husband or another family member to be included in the counseling session.
- Explain that after birth, is not exclusively breastfeeding, she can become pregnant as soon as four weeks after delivery. Therefore it is important to start thinking early on about what family planning method they will use.
- Ask about plans for having more children. If she (and her husband) want more children, advise that waiting at least 2 years before trying to become pregnant again is good for the mother and for the baby's health.
- Information on when to start a method after delivery will vary depending whether a woman is breastfeeding or not.
- Counsel her directly (see the Decision-making tool for family planning providers and clients for information on methods and on the counseling process).
- Counsel on safer sex including use of condoms for dual protection from sexually transmitted infections (STI) or HIV and pregnancy. Promote especially if at risk for STI or HIV

Special considerations for family planning counseling during pregnancy Counseling should be given during the third trimester of pregnancy.

- If there is indication for woman sterilization:.Plan for delivery in hospital where they are trained to carry out the procedure.
- If the woman chooses an intrauterine device (IUD) if no sign of infection inform her about health facilities can provide this service if not available in your PHCC.

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Indications Of Referral of pregnant Women from PHC to Consultant clinic in hospital

Personal History of the pregnant woman:-

1-Age less than 16 years→ Refer at Labor

Obstetric History:

1- Primipara → Refer at Labor
2- Para 5 and more→ Refer at Labor
3- Previous fetus with congenital Anomalies, Previous child with weight Equal to2.5 Kg or less OR 4 Kg and more
Repeated abortion or Previous premature Labor. → Always Refer
4- Previous stillbirth or early neonatal death → Refer at Labor
(during the first week after delivery).
5- Previous obstructed labor
(Previous C/S OR Forceps delivery) → Refer at 37 weeks to decide method of delivery

6- Previous labor in less than 4 hours→ Refer one week prior to delivery date or during labor.
7- Previous labor with sever vaginal bleeding or convulsion→ Refer at Labor.
8- Rh –ve mother and Rh+ve husband→ Presence of sensitization of the pregnant mother blood(Refer immediately)and with no sensitization send monthly to assess antibodies level.

Past medical and surgical history

1- Fibroid or congenital malformation of the uterus→ Refer for consultation.
2- Previous cervical circulage → Refer for consultation during the first trimester of pregnancy.
3-Third degree perineal tear documented in previous delivery report → Refer at Labor.

4-History of chronic diseases (DM ,Epilepsy ,Heart disease, Renal disease ….etc → Always Refer

5- Patient on anti TB medication If the treatment given contain streptomycin injection Refer to change treatment.
6- Hepatitis B infection → Refer at Labor
Family History of disease
1-Congental anomalies → Refer when U/S is not available
3- Delivery of twin or more for the mother or her sister → Refer when U/S is not available.

Current mother condition:-

1- Woman height 150 cm or less → Refer to assure cephalopelvic proportion at 36 weeks of gestation.
2-Unknown EDD and U/S is not available → Refer for U/S and determine the date of delivery.

3-Sever hyper emesis gravid arum effected the pregnant woman general status → Refer immediately.

4- Possibility of fetal death (movement or fetal heart absent) → Refer immediately.
5-History of vaginal bleeding or any complications during the current pregnancy → Refer at Labor

6-Twin pregnancy→ Refer at Labor
7-Twin and first baby breech *presentation*→ Refer at36 weeks of gestation.
8-Premature uterine contractions , if the contractions are regular with less than 15 mint interval or painful contractions or rupture membrane → Refer immediately.

9-Cephalopelvic disproportion or unstable fetal position at 36 weeks of gestation in primipara. → Refer for consultation.

10-Uterine size and fundal height smaller or larger than fetal age → Refer when U/S is not available

11-Poly or oligohydraminous. → Always Refer

12-Abnormal fetal presentation(breech or transverse) or unclear cephalic presentation → Refer at36 weeks of gestation.
13-Prolong pregnancy(gestational age 41week or more) → Refer immediately.
14-Gental organ infection with herps→ Always Refer
15-Big fetal size→ Refer at37 weeks of gestation to determine whether delivery by NVD or C/S
16- German measles infection in first trimester of pregnancy. → Refer for consultation
17-Anemia:
-Sever (Hb% 7ml or less) → Refer immediately.
-Moderate(Hb% 7-11 ml) → Refer if not improved after one month from given ferrofolic tab(one tab twice daily)
18-Hypertension:
-Sever preeclampsia(diastolic BP higher or equal 110mmHg,with 3+protein urea or diastolic BP higher or equal 90mmHg in two readings, with 2 +protein urea ,with any of :sever headache- blurring vision-epigastric pain) → Refer immediately.
- preeclampsia(diastolic BP between90-11090mmHg in two readings, with 2 +protein urea) → Refer immediately.
- Hypertension(diastolic BP higher or equal90mmHg in two readings,and continue for more than one week or till the next visit) → Refer immediately.
19-Ruptuer membrane without labor

-Uterine and fetal infection(Temp 38c and offensive vaginal discharge) → Refer immediately.
-POSSIBLE Uterine and fetal infection(Rupture membrane before 8th of pregnancy) → Refer immediately.
-labor(Ruptuer membrane after 8th of pregnancy) → Refer immediately.
20-Fever or burning micturation
a-Sever febrile illness(fever more than 38c with any of the following signs:* rapid fast breathing * neck stiffness *sleepiness * sever weakness with inability to stand) → Refer immediately.
b-Upper UTI(fever more than 38c with any of the following signs:*Loin pain* burning micturation) → Refer immediately.
c-Lower UTI(burning micturation) → Refer if not improved within two days of treatment with Amoxcillin Cap 500 mg 1*3 or worsen condition.
21-Abdominal pain:a-In the first trimester of pregnancy with a mass in uterine appendix(ectopic pregnancy)
b-During the late stage of pregnancy→→ Refer immediately.
21-Bleeding during pregnancy:
a- Early stage(uterus not above the level of umbilicus) → Refer immediately
*Complications of abortion (vaginal bleeding accompanied with any of:*offensive vaginal discharge*abdominal pain*Temp more than 38c) → Refer immediately
*Signs of abortion(slight vaginal bleeding for 4-6hrs) → Refer immediately*Ectopic pregnancy(in case of presence of two or more of the following signs: abdominal pain,fainting,pallor,sever weakness) → Refer immediately
b- Late stage(uterus above the umbilicus level) →bleeding in this stage is dangerous PV exam is contraindicated Refer immediately

ANC &PNC data

Registration and analysis

1- **Daily Antenatal and post natal Care registers : AIM : A register had been designed to register name, age, family no., no .of visit of pregnant women ,gestational age, risk factors(if present) , some preventive measures, in addition to referral to hospital and feed back(if present) Instruction for use : every day at the end of the work the responsible person for registration of ANC&PNC data, collect maternal file , fill the columns in the register accordingly and calculate all indicators The instruction of filling the register are in the following page:**

of this service so that to present it to the responsible doctors .

الإحالة	التغذية الاسترجاعية		
	سبب الإحالة		
	إسم المستشفى		
فحص الأم ما بعد الولادة	عدد حبوب الفيروفول المصروفة		
	صرف كبسولة فيتامين A		
	الزيارة	بعد الاسبوع الاول الى الاسبوع السادس	
		خلال الاسبوع الاول من الولادة	
نسبة الهيموغلوبين 11غم/لتر فأكثر			
عامل خطورة جديد للحامل	أمراض أخرى تذكر		
	ارتفاع ضغط الدم	ارتفاع ظغط الدم المزمن	
		ارتفاع ظغط الدم الحملي	
	داءالسكري		
	حمل (توأم)		
	نزف أثناء الحمل الحالي		
	نقر الدم	من 7 - 10.9 غم/لتر	
		أقل من 7 غم/لتر	
	عدم تطابق الدم		
	ولادة ميتة سابقة		
	إجهاض	إجهاض متتالي 3 مرات فاكثر	
		حالتا إجهاض سابقة متتالية	
		حالتا إجهاض سابقة متتالية	
	الفترة من آخر ولادة أقل من سنتين		
	عملية قيصرية سابقة		
	عدد الولادات السابقة 5 أو اكثر		
فحص الأسنان			
عدد حبوب الفيرونول المصروفة			
الزيارات (ز)	مدة الحمل بالاشهر		
	ز5 فأكثر		
	ز4		
	ز3		
	ز2		
	ز1		
العمر	من 15 - 49 سنة		
	أقل من 15 عام		
إسم الحامل او الأم			
رقم الاســـرة			
[illegible]			

الية التوثيق في سجل الحوامل اليومي

1) يتم ترحيل كافة المعلومات من استمارة الحامل اثناء الزيارة الدورية لذلك اليوم حيث تنقل كافة البيانات المدونة في استمارة فحص الحامل (الفحص الدوري , عوامل الخطورة الفحوصات المختبرية , ...) الى السجل اليومي قبل نهاية الدوام الرسمي لذلك اليوم و اعادة الاستمارات الى وحدة الملفات يوميا .

2) يثبت التسلسل اليومي للحامل في حقل التسلسل(ت) .

3) يثبت رقم الاسرة في الحقل المخصص له.
4) يكتب في حقل اسم الحامل او الام , الاسم الثلاثي لها .
5) يؤشر في حقل العمر اذا كان اقل من 15 سنة او (15-49) سنة بعلامة (√) حسب العمر .
6) تؤشر الزيارة في حقل الزيارات و في الحقل المحدد لكل زيارة بعلامة (√) حسب التسلسل الزيارة
7) تثبت مدة الحمل بالاشهر لكل زيارة .
8) يثبت عدد حبوب الحديد و الفوليك اسد المصروفة خلال الزيارة مثلا (30) حبة .
9) يؤشر في الحقل الخاص بفحص الاسنان بعلامة (√) عن فحص الاسنان للحامل او الام وحسب السياقات المعمول بها.
10) يؤشر في حقل عوامل الخطورة (√) او (×) ولكل حقل في الجدول في حالة وجود عامل خطورة جديد .
11) يحوط بعلامة (O)تسلسل الحامل المعرضة للخطورة لاول مرة باللون الاحمروالمعرضة للخطورة سابقا باللون الاخضر
12) يثبت اي مرض اخر بالتحديد عند الاصابة به ا ثناء الحمل في حقل امراض اخرى تذكر .
13) يؤشر في حقل نسبة الهيموكلوبين (√) اذا كانت النسبة اكثر من (11)
14) في حقل عوامل خطورة اخرى وحسب فترة الزيارة بعد الولادة
15) تؤشر زيارة الام بعد الولادة بعلامة (√) وحسب وقت الزيارة لاول مرة.
16) يؤشر في حقل صرف كبسولة فيتامين A بعلامة (√) عند الصرف او(×) عند عدم توفرها
17) تثبيت عدد كبسولات الحديد و الفوليك اسد في الحقل المخصص (30) او (60)
18) يثبت اسم المستشفى مع سبب الاحالة عند احالة الحامل لاي سبب وبصورة واضحة . .
19) تؤشر التغذية الاسترجاعية بعد وصول كتاب من المستشفى التي احيلت اليه الحامل بعلامة (√).
20) يتم ترحيل المعلومات يوميا الى السجل الدائمي وحسب حقوله .

2- **permenant register of Antenatal Care data:**

AIM : A register had been designed to follow up defaulted pregnant women from routine and follow up visits .

Instruction of use :every day the responsible person for registration of ANC data will fill the columns in the register accordingly and each thursday counts the defaulters and give their names and addresses to the paramedics in PHCS who are responsible for doing home visits.

The instructions of filling this register are in the following page:

ت	رقم العائلة	اسم الحامل	تاريخ الزيارة الاولى / /				تاريخ الزيارة الثانية / /				تاريخ الزيارة الثالثة / /				تاريخ الزيارة الرابعة / /				تاريخ الزيارة الخامسة فأكثر					
			مدة الحمل بالاشهر		موعد الزيارة القادمة		مدة الحمل بالاشهر		موعد الزيارة القادمة		مدة الحمل بالاشهر		موعد الزيارة القادمة		مدة الحمل بالاشهر		موعد الزيارة القادمة		مدة الحمل بالاشهر		موعد الزيارة القادمة		مدة الحمل بالاشهر	موعد الزيارة القادمة
			معرضة للخطورة	كلا			معرضة للخطورة	كلا			معرضة للخطورة	كلا			معرضة للخطورة	كلا			معرضة للخطورة	كلا			معرضة للخطورة	كلا
				نعم	//			نعم	//			نعم	//			نعم	//			نعم	//			نعم	//

الية التوثيق في سجل رعاية الحوامل الدائمي :

1) يتم ترحيل البيانات اسبوعيا من سجل الحوامل اليومي .
2) يثبت تسلسل الحامل الدائمي
3) يثبت رقم الاسرة
4) يثبت تاريخ الزيارة : اليوم /الشهر / السنة و لكل زيارة
5) تثبيت مدة الحمل بالاشهر
6) يؤشر بعلامة (√) اذا كانت الحامل معرضة للخطورة تحت كلمة نعم و تحت كلمة كلا اذا كانت غير معرضة للخطورة .
7) يثبت موعد الزيارة القادمة فقط اذا كانت الحامل معرضة للخطورة باليوم و الشهر و السنة .
8) يتم اعتبار الحامل غير المعرضة للخطورة , متسربة اذا كانت مدة الحمل المسجلة اكبر من مدة الحمل المتوقعة لتاريخ الفرز بحيث لاتحقق الجدول التالي للزيارات :

عدد الزيارات	مدة الحمل بالأشهر
زيارة واحد ه	قبل الشهر الرابع من الحمل
زيارة واحد ه	خلال اي من الأشهر (الرابع , الخامس , السادس) من الحمل
زيارة واحد ه	خلال اي من الأشهر (السابع, الثامن) من الحمل
زيارة واحد ه	خلال الشهر (التاسع) من الحمل قبل الولادة

9) يتم اعتبار الحامل المعرضة للخطورة , متسربة عند مضي فترة أسبوع على موعد الزيارة المحددة لها من قبل الطبيبة ولم تقم الحامل بزيارة المركز الصحي
10) يحوط بعلامة بالاحمر (O) التسلسل الدائمي للحوامل المتسربات من الزيارات سواء أكانت زيارات متابعة او زيارات دورية.
11) تتم عملية الفرز لكافة الحوامل المسجلات في السجل الدائمي اسبوعيا عدا الحوامل اللواتي تم فرزهن كمتسربات سابقا.
12) يتم تزويد القائم بالزيارات المنزلية بالعنوان الكامل للمتسربات لغرض تقديم جزء من الخدمة و حسب سياقات العمل و عندما يتم ذلك يؤشر في السجل الدائمي وبعلامة (√) بالأحمر امام التسلسل الدائمي وبعلامة (O) باللون الاخضر اذا تلقت الحامل باقي الخدمة داخل المركز الصحي

3- Antenatal and postnatal care data analysis form at PHCCs

1- Percentage of the first visit for pregnant women is

$$\frac{\text{Total No. of first visit for pregnant women during a month}}{\text{Total no. of target pregnant women / month}} * 100$$

2- Percentage of the fourth visits for pregnant women is

$$\frac{\text{Total No. of fourth visit for pregnant women during a month}}{\text{Total no. of target pregnant women /month}} * 100$$

3- Percentage of pregnant women receiving ferrofolic tablets

$$= \frac{\text{No. of pregnant women after 3rd month of pregnancy receiving ferrofolic tablets during a month}}{\text{Total no. of pregnant women attended ANC care after the third month of pregnancy during the same month.}} * 100$$

4- Percentage of postnatal visit is

$$\frac{\text{(no. of women attended PHCCs during first postnatal week) + (no. of women attended PHCCs after the first postnatal week till 6w during a month)}}{\text{Total no. of target pregnant women /month}} 100$$

5- Percentage of women during postnatal care receiving Vit. A

$$= \frac{\text{No. of women receiving Vit. A during postnatal care during a month}}{\text{Total no. of postnatal women attended PHCS the same month}} * 100$$

Annexes

ANNEX 1

COMMUNITY SUPPORT FOR MATERNAL HEALTH

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 . < Work together with leaders and community groups to discuss the most common health problems and find solutions. Groups to contact and establish relations which include: < other health care providers < traditional birth attendants and healers < adolescent health services < schools < non governmental organizations < breast feeding support groups < district health committees < women's groups < agricultural associations < youth groups < Establish links with referral sites for women with special needs, including adolescents and women living with violence. Have available the names and contact information for these groups and referral sites, and encourage the woman to seek their support.	Establish links with traditional birth attendants and traditional healers < Contact traditional birth attendants and healers who are working in the health facility's catchment area. Discuss how you can support each other. < Respect their knowledge, experience and influence in the community. < Share with them the information you have and listen to their opinions on this. Provide copies of health education materials that you distribute to community members and discuss the content with them. Have them explain knowledge that they share with the community. Together you can create new knowledge which is more locally appropriate. < Review how together you can provide support to women, families and groups for maternal health. < Involve TBAs and healers in counseling sessions in which advice is given to families and other community members. Include TBAs in meetings with community leaders and groups. < Discuss the recommendation that all deliveries should be performed by a skilled birth attendant. When not possible or not preferred by the woman and her family, discuss the requirements for safer delivery at home, postpartum care, and when to seek emergency care. < Invite TBAs to act as labour companions for women they have followed during pregnancy, if this is the woman's wish. < Make sure TBAs are included in the referral system.< Clarify how and when to refer, and provide TBAs with feedback on women they have referred.

INVOLVE THE COMMUNITY IN QUALITY OF SERVICES

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

< Find out what people know about maternal and newborn mortality and morbidity in their locality .Share data you may have and reflect together on why these deaths and illnesses may occur. Discuss with them what families and communities can do to prevent these deaths and illnesses. Together prepare an action plan, defining responsibilities.

< Discuss the different health messages that you provide. Have the community members talk about their knowledge in relation to these messages. Together determine what families and communities can do to support maternal health.

< Discuss some practical ways in which families and others in the community can support women during pregnancy, post-abortion, delivery and postpartum periods:

< Recognition of and rapid response to emergency/danger signs during pregnancy, delivery and postpartum periods

< Accompanying the woman after delivery

< Motivation of husbands to help with the workload, accompany the woman to the clinic, allow her to rest and ensure she eats properly. Motivate communication between women and their husbands, including discussing postpartum family planning needs.

< Support the community in preparing an action plan to respond to emergencies. Discuss the following with them:

< Emergency/danger signs - knowing when to seek care

< Importance of rapid response to emergencies to reduce mother and newborn, disability and illness

< Transport options available, giving examples of how transport can be organized

< Reasons for delays in seeking care and possible difficulties.

< What services are available and where

< What options are available

< Costs and options for payment

< A plan of action for responding in emergencies, including roles and responsibilities.

Annex 2

Special Considerations in Managing The Pregnant Adolescent

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

When interacting with the adolescent

< Do not be judgmental.
< Encourage the girl to ask questions and tell her that all topics can be discussed.
< Use simple and clear language.
< Repeat guarantee of confidentiality .
< Understand adolescent difficulties in communicating about topics related to sexuality Support her when discussing her situation and ask if she has any particular concerns:
< Does she live with her parents, can she confide in them? Has she been subject to violence ?

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

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

Special Considerations for Supporting The Woman Living With Violence

Violence against women affects women's physical and mental health, including their reproductive health. While you may not have been trained to deal with this problem, women may disclose violence to you or you may see unexplained bruises and other injuries which make you suspect she may be suffering abuse. The following are some recommendations on how to respond and support her.

Support the woman living with violence

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

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

< Help raise awareness among health care staff about violence against women .
< Find out what if training is available to improve the support that health care staff can provide to those women who may need it.
< Display posters, leaflets and other information that condemn violence, and information on groups that can provide support.
< Make contact with organizations working to address violence in your area.. If specific services are not available, contact other groups such as, women's groups, or other local groups and discuss with them support they can provide or other what roles they can play, like resolving disputes. Ensure you have a list of these resources available

Annex3

Warm and clean room	Equipment	Drugs	Check urine for protein
■ Examination table or bed with clean linen ■ Light source ■ Heat source and cold source Hand washing ■ Clean water supply and sink ■ Liquid soap if not available soild soap ■ Clean tissues Waste ■ Bucket for soiled pads ■ Receptacle for soiled linens ■ Container for sharps disposal Sterilization ■ Instrument sterilizer ■ Jar for forceps Miscellaneous ■ Wall clock ■ Torch with extra batteries and bulb	-ultrasound ■ Blood pressure machine and stethoscope ■ Body thermometer ■ Fetal stethoscope ■ Baby scale ■ mother scale ■ soncaid&Gel ■ speculum Supplies ■ Gloves: →utility →sterile or highly disinfected ■ Urinary catheter ■ Syringes and needles -Suture material ■ Antiseptic solution (iodophors or chlorhexidine) ■ Spirit (70% alcohol) ■ Swabs ■ Bleach (chlorine base compound) ■ Impregnated bednet in endemic area ■ Condoms Tests ■ VDRL testing kit	■ Oxytocine ■ Ergometrine ■ Calcium gluconate ■ Diazepam ■ Adalat capsule ■ Ampicillin ■ Gentamicin ■ Metronidazole ■ Benzathine penicillin ■ Cloxacillin ■ Amoxycillin ■ Ceftriaxone ■ Trimethoprim + sulfamethoxazole ■ Clotrimazole vaginal pessary ■ Erythromycin ■ Ciprofloxacin ■ Tetracycline or doxycycline ■ Lignocaine ■ Adrenaline ■ Water for injection ■ Paracetamol	■ Label a clean container.■ Give woman the clean container and explain where she can urinate. ■ Teach woman how to collect a clean-catch urine sample. Ask her to: →Clean vulva with water →Spread labia with fingers →Urinate freely (urine should not dribble over vulva; this will ruin sample) →Catch the middle part of the stream of urine in the cup. Remove container before urine stops. ■ Analyse urine for protein using either dipstick or boiling method. DIP stick method. ■ Dip coated end of paper dipstick in urine sample. ■ Shake off excess by tapping against side of container. ■ Wait specified time (see dipstick instructions). ■ Compare with colour chart on label. Colours range from yellow (negative) through yellow-green and green-blue for positive. Boiling method ■ Put urine in test tube and boil top half. Boiled part may become cloudy. After boiling allow the testtube to stand. A thick precipitate at the bottom of the tube indicates protein.

■ work context ■ Records and cards -guideline ■ Refrigerator	■ Proteinuria sticks ■ general urine exam ■ Haemoglobin testing kit Blood Group test Blood sugar HBSAg PT -GSE	■ Gention violet powder ■ Iron/folic acid tablet ■ Mebendazole ■ Aldomet -Hydrocortison	■ Add 2-3 drops of 2-3% acetic acid after boiling the urine (even if urine is not→If the urine remains cloudy, protein is present in the urine. →If cloudy urine becomes clear, protein is not present. cloudy) →If boiled urine was not cloudy to begin with, but becomes cloudy when acetic acid is added,protein is present.

Annex 4

Mastitis	Cloxacillin 1 capsule (500mg) every 6 hours	10days	
lower urinary infection	One tablet amoxycilline 500mg every 8 hours	3 days	
Gonorrhea /woman	Cefetriaxone 250mg IM injecϴon	Once only	

Gonorrhea /husband	Ciprofloxacin 500mg	once only	not safe for pregnant or lactating women
Chlamydia/woman	Erythromycin 500mg every 6hours	for 7 days	
Chlamydia/husband	-Tetracycline 500mg every 6 hours for or -Doxycycline100 mg every 12 hours	7 days 7 days	not safe for pregnant or lactating women
Trichomonas or bacterial vaginal infection	Mitranidazole 2gm Or 500 mg	once only 7 days	Not use in the first trimester of pregnancy
Vaginal candida infection	Clotrimazole 1 pessary 200mg Or 500mg	3days once only	

Annex 5(Referral form)

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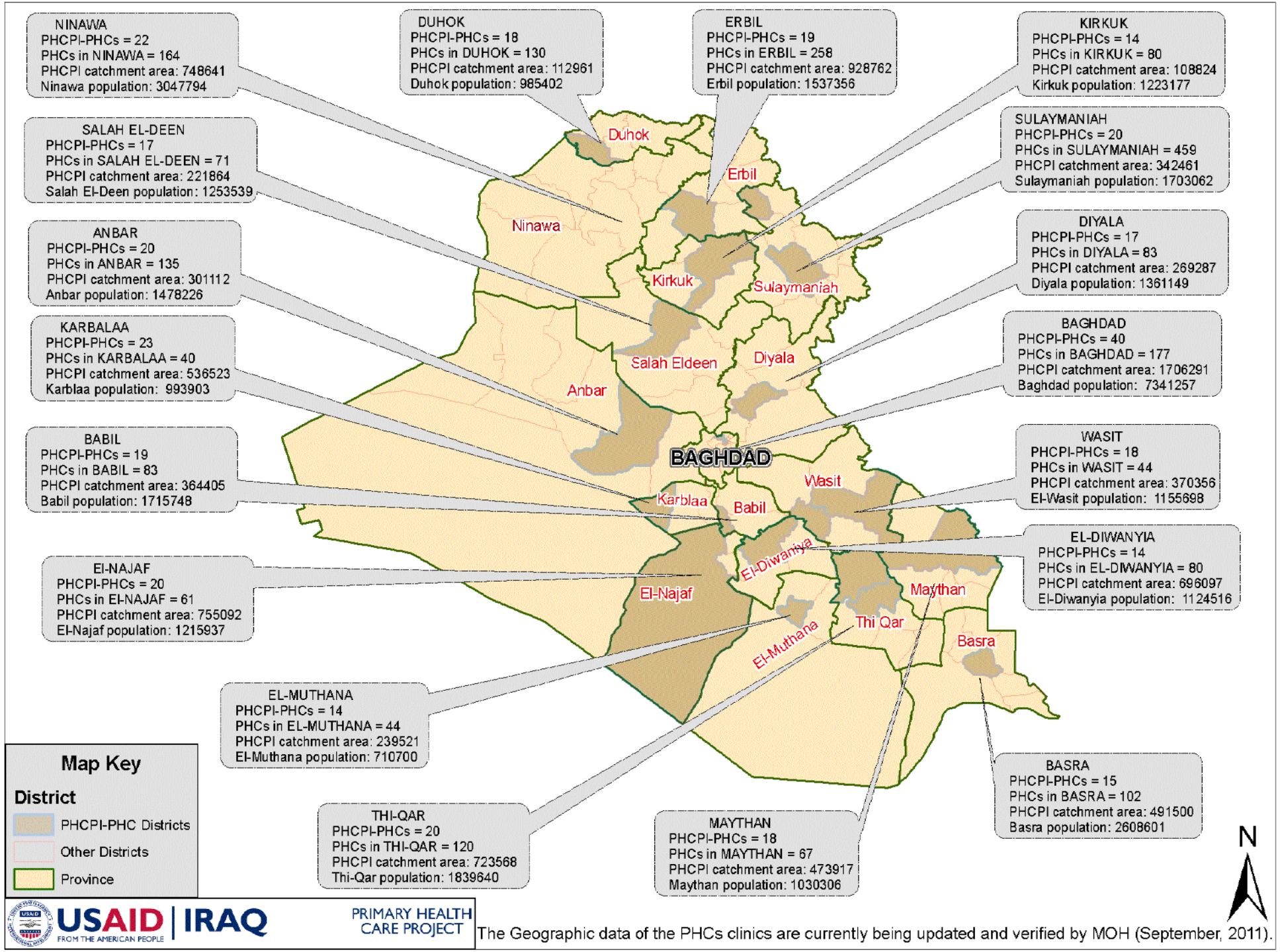
Committee involved in the antenatal care Guideline for Primary Health Care Clinics (Maternal and Child Health Care)

- **Dr. Ibtisam Faraj Hassan / Ministry of Health**
- **Dr. Inaam Hasoon Jawad / Ministry of Health**
- **Dr. Enas taha ALhamdani.**
- **Dr.Kabas Kazal ALmarsomy**
- **Dr. Fawzy Hashem Atshan**
- **Dr. Ramzea Rabee / Primary Health Care Project**

PHCPI-PHCs population mapped to IRAQ population



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The Geographic data of the PHCs clinics are currently being updated and verified by MOH (September, 2011).

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www.usaid.gov