REPRODUCTIVE HEALTH UNIT OBSTETRIC MANAGEMENT PROTOCOLS
HEALTH CENTRE

BLEEDING PROTOCOL

ANTEPARTUM HAEMORRHAGE (APH)

Definition
Vaginal bleeding from 28 weeks of pregnancy before delivery

Differential diagnosis of major obstetric causes of APH

Diagnosis	Typical Signs & Symptoms
Abruptio placenta	• Abdominal pain • Tense/tender uterus • Foetal distress or absent FHS • +/- vaginal bleeding
Placenta praevia	• Shock • Slight/severe vaginal bleeding • Uterus soft, non-tender and relaxed • Malpresentations are common • Foetal heart present or absent
Ruptured uterus	• Shock • Dehydration • Abdominal distension • Tender abdomen • Easily palpable foetal parts • Foetal distress or no FHS

Management
- Explain condition to the client
- Check vital signs
- Abdominal examination
- No vaginal examination
- Collect blood for Hb, grouping and cross-matching
- IV line with normal saline or Ringer's lactate
- Administer a plasma expanders i.e., Haemacel

PRIMARY POSTPARTUM HAEMORRHAGE

Definition
Increased vaginal bleeding (500 ml or greater and/ or causing worsening of pulse rate and blood pressure) within the first 24 hours after childbirth

Management
Placenta in:
- Call for help

Explain to woman:
- Rub up a contraction
- Give or repeat Oxytocin 10 Units IM
- Apply CCT
- Empty bladder/insert catheter
- Repeat Controlled Cord Traction (CCT)
- Take blood for Hb, grouping and cross-matching
- Put up IV line with saline or Ringer's lactate and run it fast; add 20 Units Oxytocin
- If CCT failed, remove placenta manually
- If manual removal fails, counsel and refer the client with blood donor

Placenta out:
- Call for help
- Explain to woman
- Rub up a contraction
- Give or repeat Oxytocin 10 IU IM
- Expel the clots
- Empty bladder and maintain indwelling catheter
- Put up IV line with Saline or Ringer's lactate with 20 to 40 Units Oxytocin
- Take blood for Hb, Grouping and cross-matching
- Repair tears of vulva, vagina, perineum, cervix or uterus
- Check pulse and blood pressure quarter hourly

If uterine atony persists in spite of the above:
- Put 20 units of Oxytocin in 1 L of normal saline or Ringer's lactate and run at 60 drops per minute initially, then 40 drops per minute with a maximum of 3 L
- If bleeding due to uterine atony persists, do bimanual compression
- If there is no improvement, refer to hospital with donors and inform the most senior person available

SECONDARY PPH

Definition
Increased vaginal bleeding after the first 24 hours to six weeks after childbirth

Signs and symptoms
- Bleeding is lighter of heavy
- Uterus is softer and larger than expected
- Fever
- Offensive lochia
- Anaemia

Management
- Admit the woman
- Rub up a contraction
- Empty bladder/insert catheter
- Inspect vagina
- Give Oxytocic 10 Units IM
- Take blood for Hb, grouping and cross-matching
- Set up IV line with saline or Ringer's Lactate
- Put 20 units of Oxytocin in 1 L of IV fluid, if necessary
- Give Metronidazole 500 mg IV, Benzyl penicillin 2 MU IV and Gentamycin 240 mg IM
- Refer to hospital with donors

POSTABORTION HAEMORRHAGE

Definition
Vaginal bleeding after an abortion

Management
- Explain to woman
- Rub up uterine contraction (in case of late abortion)
- Give Oxytocic drug
- Empty the bladder
- Put up an IV drip with saline and run it fast
- Do VE and remove products of conception from vaginal canal
- Conduct Manual Vacuum Aspiration
- Check vital signs
- If SEPTIC, give Metronidazole 500 mg IV stat, Gentamycin 240 mg IM stat, Benzyl penicillin 2 mega units IV/IM stat then refer
- If above treatment not available give Chloramphenicol 1 g IV stat
- Counsel and refer to hospital with donors

This poster was made possible by the generous support of the American people through the United States Agency for International Development (USAID), under the terms of the Cooperative Agreement #AID-612-A-11-00003 (Support for Service Delivery Integration - Services [SSDI-Services] program) and the Leader with Associates Cooperative Agreement GHS-A-00-08-00002-00 (Maternal and Child Health Integrated Program [MCHIP]). The contents are the responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government.

REPRODUCTIVE HEALTH UNIT OBSTETRIC MANAGEMENT PROTOCOLS
HEALTH CENTRE

BLOOD PRESSURE PROTOCOL

SEVERE PREECLAMPSIA

Diagnosis
- Diastolic BP 110 or over,
- Gestation 20 weeks or more, and
- Proteinuria 3+

Management
- Admit in labour ward
- Put up an IV line normal saline
- Give 4 g of 20% of Magnesium Sulphate solution IV over 5 minute period (20 mls)
- Administer 5 g of 50% Magnesium Sulphate (20 mls) with 1 ml of 2% Lignocaine IM deep in each buttock (total 10 g)
- Catheterize
- Monitor BP every 15 minutes until BP is lowered, then hourly
- In the event of a convulsion after 15 minutes administer 2 g of 50% Magnesium Sulphate solution IV over 5 minutes (4 mls)
- Monitor foetal heart half hourly
- Refer to hospital labour ward and the midwife to escort the woman

ECLAMPSIA

The following symptoms and signs are typically present:
- Convulsions
- Diastolic BP 90 mm Hg or more after 20 weeks gestation
- Proteinuria 2+ or more

A small proportion of women with eclampsia have normal BP or no proteinuria. Treat all women with convulsions as if they have eclampsia until another diagnosis is confirmed.

Differential diagnoses
Epilepsy, cerebral malaria, meningitis, encephalitis, hypoglycaemia

General management
- Place the woman on her side to reduce risk of aspiration
- Keep airway clear
- Protect the woman from injury
- Put up an IV line normal saline
- Give 4 g of 20% of Magnesium Sulphate IV over 5 minute period (20 mls)
- Administer 5 g of 50% Magnesium Sulphate (20 mls) with 1 ml of 2% Lignocaine IM deep in each buttock (total 10 g)
- Catheterize
- Monitor BP every 15 minutes until BP is lowered, then hourly
- In the event of a convulsion after 15 minutes administer 2 g of 50% Magnesium Sulphate IV over 5 minutes (4 mls)
- Monitor foetal heart half hourly
- Refer to hospital labour ward and the midwife to escort the woman

ADDITIONAL DETAILS ON MAGNESIUM SULPHATE ADMINISTRATION

Loading dose
- 4 g of 20% solution in 500 ml of normal saline over 5 minutes plus 5 g of 50% solution in each buttock deep IM

Observe closely for side effects if any
- Common side effect = flushing
- Less common side effects = nausea, vomiting, muscle weakness, thirst, headache, drowsiness and confusion
- Rare side effects = respiratory depression, respiratory and cardiac arrest

Keep antidote ready
In case of respiratory arrest:
- Assist ventilation (mask and bag)
- Give Calcium Gluconate 1 g (10 ml of 10% solution) IV slowly until respiration begins to stabilize

This poster was made possible by the generous support of the American people through the United States Agency for International Development (USAID), under the terms of the Cooperative Agreement #AID-612-A-11-00003 (Support for Service Delivery Integration - Services [SSDI-Services] program) and the Leader with Associates Cooperative Agreement GHS-A-00-08-00002-00 (Maternal and Child Health Integrated Program [MCHIP]). The contents are the responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government.

USAID FROM THE AMERICAN PEOPLE | SSDI SUPPORT FOR SERVICE DELIVERY INTEGRATION | MCHIP Maternal and Child Health Integrated Program

REPRODUCTIVE HEALTH UNIT OBSTETRIC MANAGEMENT PROTOCOLS HEALTH CENTRE

INFECTIONS PROTOCOL

PRELABOUR RUPTURE OF MEMBRANES

Definition

Rupture of the membranes before labour has begun (before, at or after 37 weeks gestation)

Diagnosis

Watery vaginal discharge

Management

Gestation less than 34 weeks:

- No digital vaginal examination should be done
- Provide pad and observe for amount, color and smell
- Monitor foetal condition
- Monitor vital signs every 4 hours:
  - BP
  - Respiration
  - Temperature
  - Pulse
- Observe for signs of labour
- Refer to the hospital for further management

Gestation 34 weeks or greater:

- Do vaginal examination to rule out cord prolapse (unnecessary if the head is engaged and the foetal heart normal). If in doubt, do sterile speculum exam and refer to the hospital immediately.
- Provide pad and observe for amount, color and smell
- If there are signs of infection, give triple antibiotic therapy
- Monitor foetal condition
- Observe for signs of labour
- Monitor vital signs every 4 hours:
  - BP
  - Respiration
  - Temperature
  - Pulse

PUERPERAL/ POSTABORTION SEPSIS

Definition

Infection of the genital tract following delivery/ abortion any time after deliver/abortion to 6 weeks

Diagnosis

Fever (38° C or more), foul-smelling discharge, tender uterus and subinvoluted, increased pulse rate and respiratory rate

Management

- Check vital signs
- Put up IV line
- Give Metronidazole IV 500 mg 8 hourly, Benzylpenicillin 2 MU IV every 6 hours and Gentamycin 240 mg IM single dose daily until 48 hours after the fever subsides, but not less than 5 days. (If above antibiotics not available give Chloramphenicol 1 g 6 hourly.)
- Give Paracetamol 1 g orally stat
- Counsel and refer to hospital with donors

CHORIOAMNIONITIS

Definition

Acute inflammation of the foetal membranes (Amnion and Chorion) due to bacterial infection

Diagnosis

Foul-smelling vaginal discharge after 28 weeks of pregnancy, fever/chills, uterine tenderness

Management

- If signs of intra-uterine infection are evident, give: Metronidazole IV 400 mg 8 hourly, Benzylpenicillin 2 MU IV every 6 hours and Gentamycin 240 mg IM single start. (If above antibiotics are not available give Chloramphenicol 1 g 6 hourly.)
- Counsel the woman and refer to hospital

HIV AND AIDS

Antenatal

- Ascertain HIV status, review health passport
- Offer HTC if not done
- If woman is already on ART, continue
- If not initiated, start ART as per PMTCT/ART protocol
- Give CPT to mother
- Give NVP syrup to mother for infant prophylaxis at birth (2 hours after delivery)
- Counsel on drug adherence health facility delivery
- Screen for chest infection/TB
- Refer to hospital for TB initiation if found with TB
- Provide LLIN if not received

If woman is in labour

- Ascertain HIV status
- Offer HIV test if status unknown or tested negative the past 3 months
- If woman already on ART, continue
- If not initiated, start ART
- Do not perform routine Episiotomy
- Avoid frequent vaginal examination and adhere to all infection prevention practices
- Deliver within 4 hours after rupture of membranes
- During third stage of labour do not milk the cord before cutting
- **Follow up on the following:**
  - Early Infant Diagnosis (DBS for PCR) at 6 weeks
  - Cotrimoxazole for mother
  - Cotrimoxazole for baby at 6 weeks
  - Counsel on infant and young child feeding

Postnatal

- Fill in exposed follow up card and register in HIV care clinic (HCC)
- Initiate breast feeding within an hour of birth
- Counsel for follow up after six weeks for DBS (PCR test) collection and CPT initiation of baby from 6 weeks to 18 months
- Cotrimoxazole initiation or continuation for the mother
- Counsel on safe sex, nutrition and family planning
- Counsel for postnatal care at one week and six weeks

This poster was made possible by the generous support of the American people through the United States Agency for International Development (USAID), under the terms of the Cooperative Agreement #AID-612-A-11-00003 (Support for Service Delivery Integration - Services [SSDI-Services] program) and the Leader with Associates Cooperative Agreement GHS-A-00-08-00002-00 (Maternal and Child Health Integrated Program [MCHIP]). The contents are the responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government.

USAID FROM THE AMERICAN PEOPLE

SSDI SUPPORT FOR SERVICE DELIVERY INTEGRATION

MCHIP Maternal and Child Health Integrated Program

REPRODUCTIVE HEALTH UNIT OBSTETRIC MANAGEMENT PROTOCOLS
HEALTH CENTRE

MALPRESENTATION PROTOCOL

OBSTRUCTED LABOUR

Definition

Obstructed labour refers to a situation where the descent of the presenting part is arrested during labour despite strong uterine contractions

Signs and symptoms

- Secondary arrest of: (i) cervical dilatation and (ii) descent of presenting part
- Caput (2+ or more)
- Moulding (2+ or more)
- Cervix poorly applied to presenting part
- Oedematous cervix
- Ballooning of lower uterine segment
- Formation of retraction band (Bandl's ring)
- Maternal and foetal distress

Management

- Explain condition to mother
- Take blood for Hb, grouping and cross-match
- Put up IV line (Ringer's Lactate if in shock, Dextrose 5% if exhausted and ketotic) with large (No. 14) cannula
- Insert urinary catheter
- Give Chloramphenicol 1 g IV stat
- Monitor vital signs
- Measure and record fluid intake and urinary output accurately
- Nil per os
- Check foetal heart sounds
- Counsel and refer with blood donors
- Document all interventions and observations

RUPTURED UTERUS

Definition

A tear of the uterus is usually caused by obstructed labour

Signs and symptoms

- Severe abdominal pain (may decrease after rupture)
- Cessation of the uterine contractions
- Foetal distress or no foetal heart
- Bleeding (intra-abdominal and/or vaginal)

NOTE: Rupture of the lower uterine segment into broad ligament will not release blood into the abdominal cavity.

Signs and symptoms sometimes present

- Shock
- Abdominal distension/free fluid
- Abnormal uterine contour
- Tender abdomen
- Easily palpable fatal parts
- Absent foetal movements and foetal heart sounds
- Rapid maternal pulse

Management

- Restore blood volume by infusing IV fluids (normal saline or Ringer's Lactate) with large (No. 14) cannula
- Give Chloramphenicol 1 g IV
- Monitor vital signs
- Measure and record fluid intake and urinary output accurately
- Nil per os
- Document all interventions and observations
- Counsel and refer to hospital with donors

MALPRESENTATION

Definition

Presentation of the foetus that is not cephalic e.g., Breech, transverse lie, oblique lie, and compound

Management

- Evaluate gestational age and size of baby
- If malpresentation persists after 36 weeks, counsel and refer to hospital

Breech

- Refer to hospital for delivery unless in advanced stage of labour
- DO NOT panic when conducting breech delivery
- When there is SRM do vaginal examination to exclude cord prolapse
- Explain to mother to avoid premature pushing
- Primigravida with breech presentation should be referred with blood donors for delivery by C/S if full term

VACUUM EXTRACTION

Indications

- Delayed second stage of labour—after 30 minutes in multipara and 60 minutes in primgravida
- Foetal distress in second stage of labour
- Maternal exhaustion
- Maternal condition requiring speedy delivery (anaemia, asthma, preeclampsia)
- Cord prolapse in second stage with cord pulsating

Contraindications

- CPD
- Malpresentation
- Prematurity (<37 weeks)
- Descent more that 1/5
- Incomplete cervical dilatation
- Suspected ruptured uterus
- Intrauterine death

Criteria for vacuum extraction

- Position of the occiput should be exactly known (do not place on the posterior fontanel)
- Contractions must be present
- The bladder must be empty
- The vertex must be presenting
- Descent 0/5; no moulding no caput

This poster was made possible by the generous support of the American people through the United States Agency for International Development (USAID), under the terms of the Cooperative Agreement #AID-612-A-11-00003 (Support for Service Delivery Integration - Services [SSDI-Services] program) and the Leader with Associates Cooperative Agreement GHS-A-00-08-00002-00 (Maternal and Child Health Integrated Program [MCHIP]). The contents are the responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government.