

Postpartum Care

Postpartum care is the attention given to the general social, mental, and physical welfare of the mother and infant during the postpartum period. The care should respond to the special and immediate needs of the mother and her baby during their hospital stay and follow up after discharge. The majority of the maternal deaths and morbidities occur during the postpartum period.

Biologically, the *postpartum period* is the time after birth, a time in which the mother's body, including hormonal levels and uterine size, return to pre-pregnancy conditions and extends up to the sixth week postpartum. It is also known as postnatal period or puerperium.

Components of postpartum care

1. Early detection and management of complications
2. Promoting health and preventing disease
3. Providing woman-centered education and counseling

1. Early detection and management of complications

The postpartum evaluation starts by reviewing the parturient clinical document including antepartum and intrapartum records. Complications such as cardiac disease, preeclampsia, obstructed labor, cesarean delivery that require close monitoring and treatment are identified in the patient's medical document. Besides reviewing the clinical records, the parturient should be evaluated thoroughly during the immediate postpartum period, 6th day and 6th week postpartum visits.

Generally, the postpartum evaluation of the *woman* during hospital discharge, or subsequent postpartum visits includes:

- how she feels; ask for pain, bleeding, difficulty in urination, breast feeding, any other concern she may have
- General physical
- Depression /psychosis. mood
- Malnutrition: general health, night blindness, goiter
- BP, pulse, temperature¹ - take BP and PR every:
 - 15 minutes for first 2 hours
 - 30 minutes for 1 hour
 - 3 hours then after
- Anemia: conjunctiva/tongue/palms, hemoglobin (if necessary)
- Condition of the breast and nipple; establishment of breastfeeding
- Checking for bladder distension and urine passed, incontinence/ fistula
- Fundal height and uterine consistency

¹ *The diagnosis of puerperal infection* in the first day of delivery should not be based on isolated findings of low grade fever and increased WBC, because normally, temperature may be elevated up to 38°C in the first day of delivery; and white Blood Cells (WBCs) increase during labor, marked leukocytosis (up to 20,000 to 30,000/ μ L) occurs in the first 24 hours postpartum; white blood cell (WBC) count returns to normal within one week.

- Inspecting the vaginal, perineum: episiotomy, lochia, bleeding, discharge, hematoma
- Thrombophlebitis: Homan's sign, inspection of legs
- The uterus involutes progressively:
 - After 5 to 7 days, it is firm and no longer tender, extending midway between the symphysis and umbilicus.
 - By the second week, it is no longer palpable abdominally.

Usually, no specific tests are required in the postpartum period if all the basic investigations are done in the ANC and intrapartum care. In case these tests were not undertaken, they have to be done before discharge. Besides, tests required in the management of any complication have to be undertaken as required. If the HIV status of the parturient is unknown, offer her testing.

After thorough evaluation and review of the parturient's antepartum and intrapartum records, parturients with complication are separated from those with normal postpartum conditions:

- Women with complications or risk factors such as hypertensive disorder of pregnancy, APH, PPH, cesarean delivery, ruptured uterus, or having newborns requiring neonatal admission are admitted to other wards where they get the basic postpartum care and treatment for their medical conditions.
- Women with normal conditions are managed in the labor ward or postpartum clinic and get the basic postpartum care.

2. Promoting health and preventing disease

- Iron/ folate: 1 tablet to be taken by mouth once a day for at least 40 days postpartum
- Vitamin A: one dose of 200,000 IU within 30 days after childbirth in vitamin A deficient regions
- Iodine supplementation: 400–600 mg by mouth or IM as soon as possible after childbirth if never given, or if given before the third trimester (only in areas where deficiencies exist)
- Six monthly presumptive treatments with broad-spectrum anti-helminthics in areas of significant prevalence
- Sleeping under a bed net in malarial areas
- Tetanus toxoid
- VDRL/ RPR
- HIV testing (opt-out)

3. Providing woman-centered education and counseling

The education and counseling should address postpartum needs such as nutrition, breastfeeding, family planning, sexual activity, early symptoms of complications and preparations for possible complications.

Postpartum counseling should take place at a private area to allow women to ask questions and express their concerns freely. If this is not feasible, counseling could be done by the women's bed provided that privacy is ensured. It is advisable to involve

husbands of postpartum women (after the permission of the woman) in this counseling and in receiving instructions before discharge.

Specific postpartum care and treatment

Nutrition:

- A regular diet should be offered as soon as the woman requests food and is conscious.
- Intake should be increased by 10% (not physically active) to 20% (moderately or very active) to cover energy cost of lactation.
- Women should be advised to eat a diet that is rich in proteins and fluids.
 - Eating more of staple food (cereal or tuber)
 - Greater consumption of non-saturated fats
 - Encourage foods rich in iron (e.g., liver, dark green leafy vegetables, etc.)
- Avoid all dietary restrictions

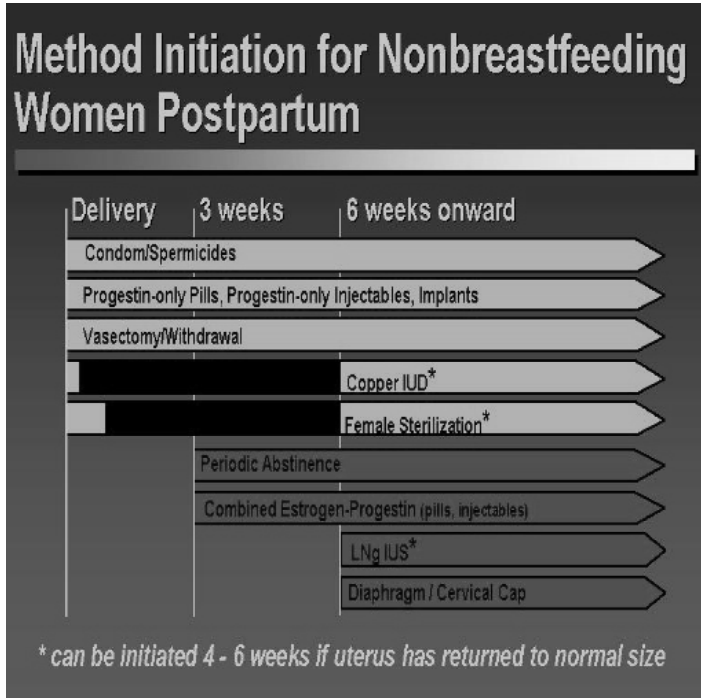
Breastfeeding

- Early skin to skin contact of mother and baby and immediate initiation of breast feeding
 - Initiate breastfeeding within 2-3 hours of CS; when the mother is conscious
 - In case breast feeding can't be started due to either maternal or newborn illness, feeding the baby has to be initiated if possible by milk sucked from the mother herself.
- Rooming in throughout the hospital stay of mother and baby
- Women should be encouraged to maintain exclusive breast feeding for six months and should be educated about effective breastfeeding practices, as well as common breastfeeding problems, how to continue breast feeding for two years and to start complementary feeding after six months. See PMTCT section on breast feeding advice regarding HIV infected women. Postpartum education and counseling includes:
 - Correct positioning of the baby at the breast
 - Exclusive breast feeding.: No other fluids e.g. herbs, glucose, or sugar water should be given
 - Encouraging breast feeding on demand
- If there is a medical contraindication to breastfeeding, firm support of the breasts can suppress lactation. For many women, tight binding of the breasts, cold packs, and analgesics followed by firm support effectively control temporary symptoms while lactation is being suppressed

Postpartum family planning

- All postpartum women should receive family planning education and counseling before discharge.
- Ideally, counseling for postpartum contraception should start during the antenatal period, and should be an integral part of antenatal care.
- Women who had no antenatal care and those who did not receive counseling during the ante natal period, should be counseled for family planning in the immediate post partum period, after their own and their baby's condition have stabilized.

- Women should be informed about the advantages of birth spacing for at least two years before getting pregnant again and about different family planning options. Women should also be given a choice of receiving a family planning method in the labor ward before discharge from hospital or at a family planning clinic within the first 40 days postpartum.
- Facilitate free informed choice for all women: The provider should make sure that the mother is not in pain and that her other concerns have been addressed. It is preferable to offer family planning counseling some time before discharge from hospital so as to give the woman time to make a free decision and to consider different contraceptive options.
- Women who will have elective C-section could be counseled pre-operatively.
- Family planning services should be provided by the attending doctor and nurse in the ward as well as FP workers.
- In settings where family planning methods are not available on the ward, the health provider should provide family planning counseling and refer the woman either to the hospital family planning clinic (if the woman is interested in immediate initiation) or to a family planning clinic near her residence.
- Reinforce that non-hormonal methods (lactational amenorrhea, barrier methods, IUD and sterilization) are best options for lactating mothers
- Initiate progestogen-only methods after 6 weeks postpartum to breastfeeding women, if woman chooses a hormonal method



- Advise against use of combined oral contraceptives in breastfeeding women in the first 6 months after childbirth or until weaning, whichever comes first
- Women who are interested in immediate initiation of contraception should be offered a family planning method before discharge.
- Women who were counseled during antenatal care and who had indicated a desire for postpartum IUD insertion or tubal ligation could have an IUD inserted at delivery (postplacental IUD insertion) or have minilap for tubal ligation. Other women could have an IUD inserted before discharge or receive any other method depending on their needs.

Exercise

- Normal activities may be resumed as soon as the woman feels ready.
- When to start an exercise routine depends on the woman; its safety depends on whether complications or disorders are present. Usually, exercises to strengthen abdominal muscles can be started once the discomfort of delivery (vaginal or cesarean) has subsided, typically within one day for women who deliver vaginally and later for those who deliver by cesarean section.
- Sit-ups or curl-ups, (rising from supine to semi-setting position), done in bed with the hips and knees flexed, tighten only abdominal muscles, usually without causing backache.
- Negel’s exercise are also recommended to strengthen the pelvic floor

Personal hygiene and perineal care

- If delivery was uncomplicated, showering and bathing are allowed.
- Vaginal douching is avoided in early puerperium, till after bleeding stops completely and all wounds are healed.
- The vulva should be cleaned from front to back.
- Women are encouraged to defecate before leaving the hospital, although with early discharge, this recommendation is often impractical.
- Maintaining good bowel function can prevent or help relieve existing hemorrhoids, which can be treated with warm sitz baths.

Emotional support

- Transient depression (baby blues) is common during the first week after delivery.
 - Symptoms are typically mild and usually subside by 7 to 10 days.
 - Treatment is supportive care and reassurance.
- Persistent depression, lack of interest in the infant, suicidal or homicidal thoughts, hallucinations, delusions, or psychotic behavior may require intensive counseling and antidepressants or antipsychotic.
- Women with a preexisting mental disorder are at high risk of recurrence or exacerbation during the puerperium and should be monitored closely.

Sexual activity

Intercourse may be resumed after cessation of bleeding and discharge, and as soon as desired and comfortable to the woman. However, a delay in sexual activity should be considered for women who need to heal from lacerations or episiotomy repairs.

Sexual activity after childbirth may be affected due to decreased sexual desire (due to fatigue and disturbed sleep patterns, genital lacerations/episiotomy), hypoestrogenization of the vagina, and power issues in marriage.

Bladder care:

- Avoid distention & encourage urination: voiding must be encouraged and monitored to prevent asymptomatic bladder overfilling.
- Do not routinely catheterize unless retention necessitates catheterization (e.g. retention of urine due to pain from peri urethral laceration at vaginal delivery)
- Rapid diuresis may occur, especially when oxytocin is stopped.

Pain management

Common causes: after-pain and episiotomy

- Episiotomy pain: immediately after delivery, ice packs may help reduce pain and edema at the site of an episiotomy or repaired laceration; later, warm sitz baths several times a day can be used. Analgesics are used if not relieved.
- Contractions of the involution uterus, if painful (after-pains), may require analgesics. Commonly used analgesics include:
 - Aspirin 600 mg,
 - Acetaminophen 650 mg
 - Ibuprofen 400 mg orally every 4 to 6 hours

Rh-negative blood group

Women with Rh-negative blood group, who have an infant with Rh-positive blood and are not sensitized, should be given Rh0(D) immune globulin 300 µg IM, as soon as possible (preferably within 72 hours of delivery) to prevent sensitization.

Hospital stay and follow up

Hospital stay:

Hospital stay after delivery varies depending on the parturients' condition. Women with complications stay longer period. Most women have normal pregnancy, labor, delivery and postpartum period; and usually they are discharged within a day of delivery. The minimum in-hospital stay is 6 hours after which the risk of life endangering conditions such as PPH due to atonic uterus or genital trauma, postpartum eclampsia etc. are less likely. The use of this hospital stay should be well organized so that all parturients and their babies get the basic postpartum care. At the time of discharge, the evaluation should be thorough; the parturient and her baby should get all the basic postpartum care; and appointment be given. Providing women with a summary of their condition, especially for those with complication, is essential.

Follow-up visit:

Women should be informed that they should make a follow up visit to the hospital or to a health unit on 6th day and at six weeks postpartum. The schedule should not be rigid. It should incorporate maternal (family) convenience and medical condition.

They should also be informed to come back to hospital if they feel any symptoms that worry them. The education regarding complication and preparedness includes:

Danger signals for woman

- Sudden and profuse blood loss, persistent or increased blood loss
- Fainting, dizziness, palpitations
- Fever, shivering, abdominal pain, and/or offensive vaginal discharge
- Painful or hot breast(s)
- Abdominal pain
- Calf pain, redness or swelling
- Shortness of breath or chest pain
- Excessive tiredness
- Severe headaches accompanied, visual disturbances
- Edema in hands and face

Danger signals for newborn

- Cord red or draining pus
- Suckling poorly
- Eyes swollen, sticky or draining pus
- Cold to touch in spite of re-warming
- Hot to touch in spite of undressing
- Difficulty breathing
- Lethargy
- Convulsions

Complication readiness

- Establish savings plan/ scheme
- Make plan for decision-making
- Arrange system of transport
- Establish plan for blood donation