EMOC Training Recommendations

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Overview

Two-year project in January 2016 aiming to support and improve new-born health care interventions in refugee operations which was funded by the Bill and Melinda Gates Foundation (BMGF) .

- The project emphasizes the expansion of key low-cost, high-impact new-born care interventions:
  - Proper cord care
  - Thermal care
  - Initiation of breathing and resuscitation (Helping Baby Breath, NRP)
  - Early initiation of exclusive breastfeeding
  - Kangaroo Mother Care (KMC)
  - Eye care
- Activities included: Baseline Assessment, Trainings, Procurements

Activities in Jordan

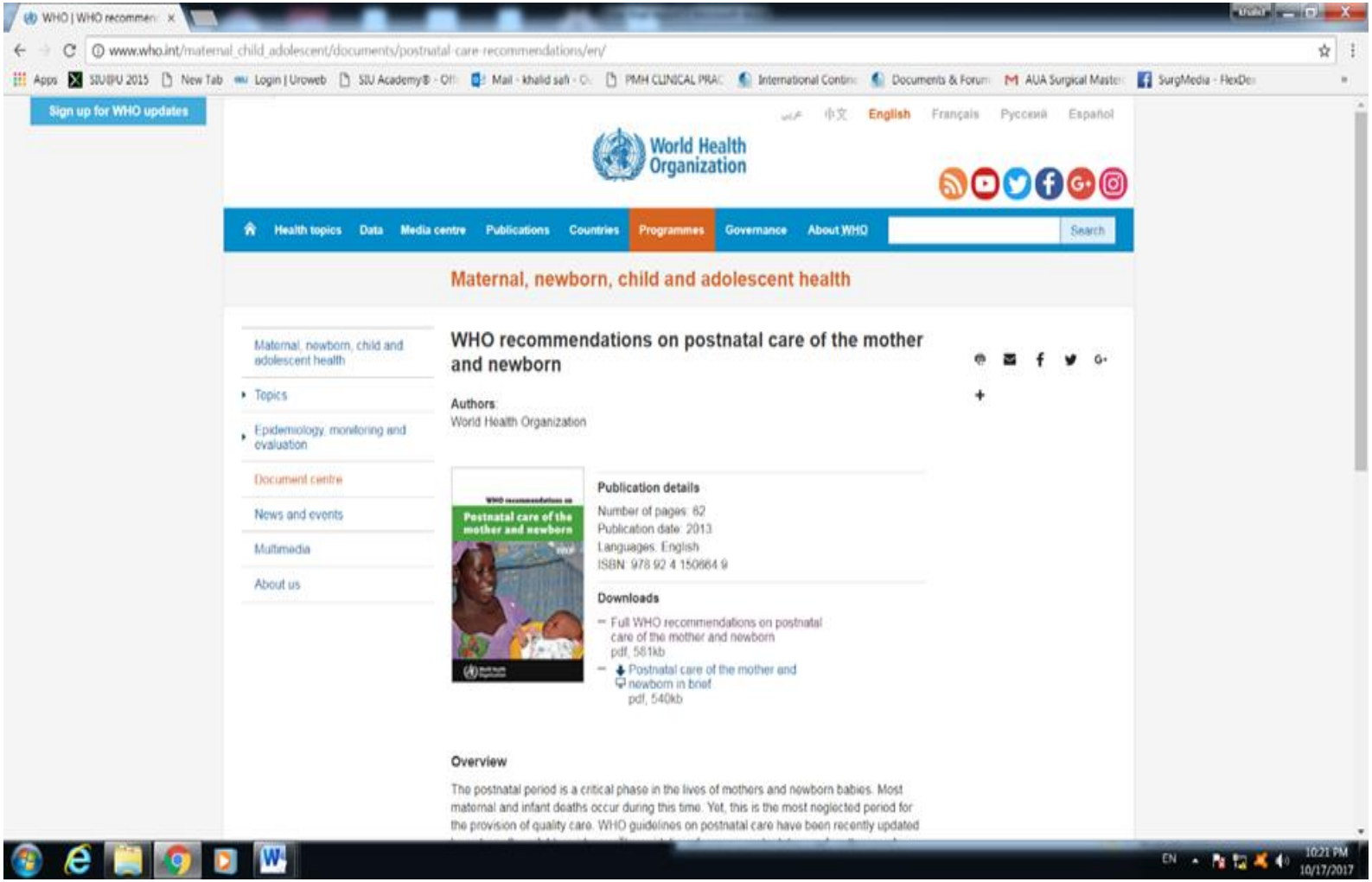
1. Baseline Assessment
   - *New-born Health Baseline Assessment JORDAN*
   - Neonatal Care Action Plan (Azraq and Za'atri Camp, June to December 2016)

Jordan Activities Cont'd

2. Trainings

- Gynaecologist Contracted by UNHCR
- Develop a training curriculum (Match the Gap with a focus on low technology, high impact interventions), based on priority and in consultation with UNFPA
- Conduct two trainings courses (four days each) for HCW on in Emergency obstetric Care
- Identify potential trainers from amongst the trainees
- Conduct follow up monitoring and supervision to both camp

References


www.who.int/maternal_child_adolescent/documents/postnatal-care-recommendations/en/
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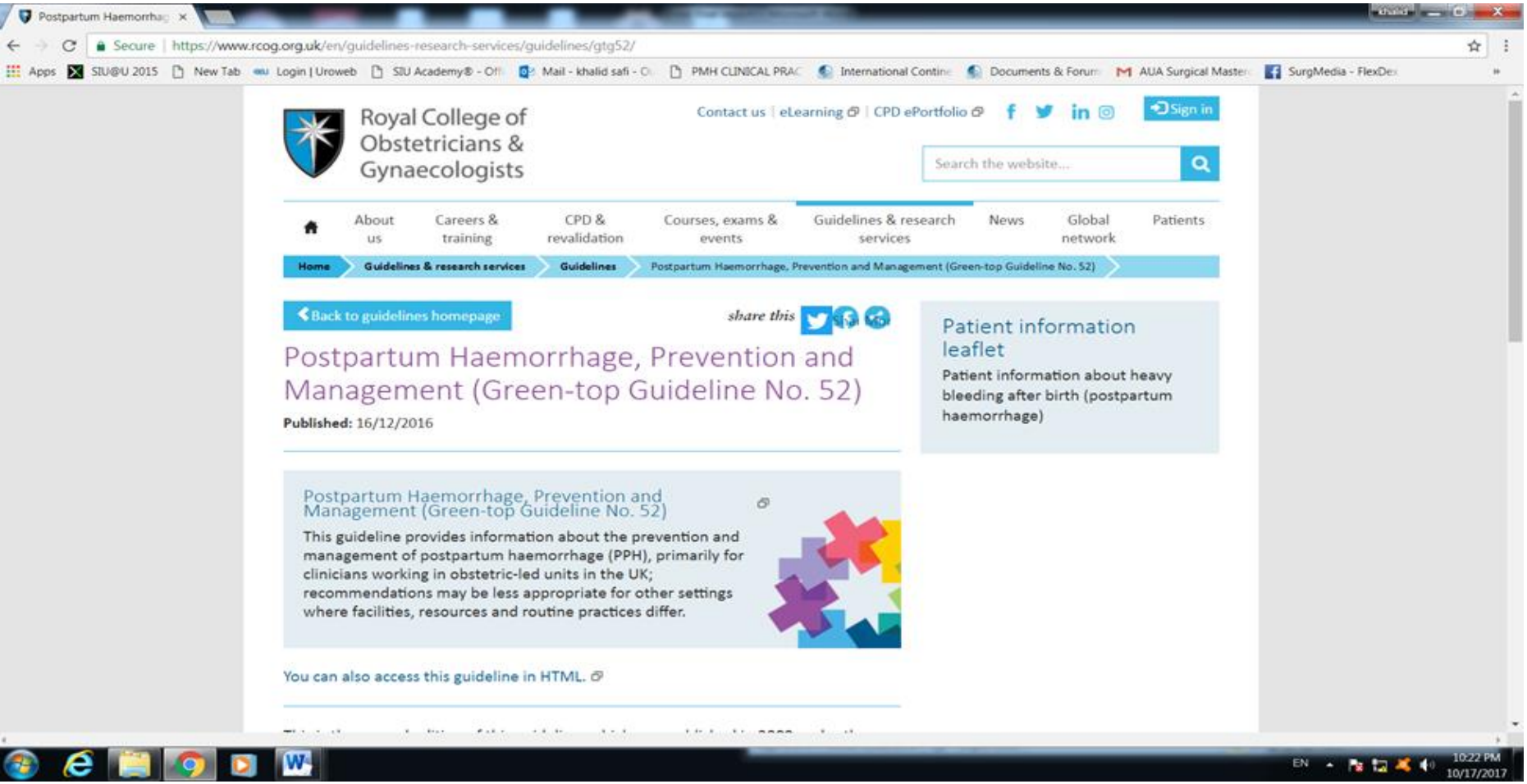
WHO recommendations on postnatal care of the mother and newborn
Authors
World Health Organization
Postnatal care of the mother and newborn
Publication details
Number of pages: 62
Publication date: 2013
Languages: English
ISBN: 978 92 4 150684 9
Downloads
Full WHO recommendations on postnatal care of the mother and newborn
pdf, 581kb
Postnatal care of the mother and newborn in brief
pdf, 540kb
Overview
The postnatal period is a critical phase in the lives of mothers and newborn babies. Most maternal and infant deaths occur during this time. Yet, this is the most neglected period for the provision of quality care. WHO guidelines on postnatal care have been recently updated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Postpartum Haemorrhage, Prevention and Management (Green-top Guideline No. 52)
Published: 16/12/2016
Patient information leaflet
Patient information about heavy bleeding after birth (postpartum haemorrhage)
Postpartum Haemorrhage, Prevention and Management (Green-top Guideline No. 52)
This guideline provides information about the prevention and management of postpartum haemorrhage (PPH), primarily for clinicians working in obstetric-led units in the UK; recommendations may be less appropriate for other settings where facilities, resources and routine practices differ.
You can also access this guideline in HTML.
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Interpretation of the Electronic Fetal Heart Rate During Labor
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AMIR SWEHA, M.D., and TREVOR W. HACKER, M.D., Mercy Healthcare Sacramento, Sacramento, California
JIM NUOVO, M.D., University of California Davis, School of Medicine, Davis, California
Am Fam Physician. 1999 May 1;59(9):2487-2500.
Related Editorial
Electronic fetal heart rate monitoring is commonly used to assess fetal well-being during labor. Although detection of fetal compromise is one benefit of fetal monitoring, there are also risks, including false-positive tests that may result in unnecessary surgical intervention. Since variable and inconsistent interpretation of fetal heart rate tracings may affect management, a systematic approach to interpreting the patterns is important. The fetal heart
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Jordan Activities Cont'd

3. Procurements of Essential Medications and Equipment

- Child Birth Simulators
- High over shoes
- Dose meter
- Calcium
- Iron Sulphate, Fumarate??

General Recommendations Both Camps

- *It is recommended to have a minimum of 8 ANC contacts throughout pregnancy*

First trimester	contact 1: up to 12 weeks
Second trimester	contact 2: 20 weeks
	contact 3: 26 weeks
Third trimester	contact 4: 30 weeks
	contact 5: 34 weeks
	contact 6: 36 weeks
	contact 7: 38 weeks
	contact 8: 40 weeks

- It is also advised for the last antenatal contact to be at 40 weeks and for the pregnant woman to return for delivery at 41 weeks if she doesn't give birth(for low-risk pregnancy).
- It is recommended that ultrasound scan is done only once before 24 weeks as opposed to at every visit. The main purpose of ultrasound before 24 weeks is to confirm dating of gestation and due date, which should be documented in the medical record, and to exclude twin pregnancy.

- Full blood count should be done at booking, instead of checking haemoglobin only by Hemocue.
- Mid-stream urine culture should be made available at the facility for diagnosis of asymptomatic bacteriuria, so that appropriate antibiotics can be given for treatment (Antibiotics should only be given according to urine C&S).
- all pregnant women should be on iron supplements during pregnancy (Availability of sulphate or fumarate is preferable over gluconate as they contain more elemental iron per tablet, this results in less tablets and more compliance).

- Calcium supplementation should be given during antenatal period to reduce the risk of pre-eclampsia.

- Grey cannula should be available on labour wards (in the emergency tray) to be used in cases of postpartum haemorrhage while green cannula should be used for women in labour.

- Low risk and High-risk pregnancy scoring system in place

- Every pregnant woman should have an assessment for risk factors for venous thromboembolism as early as her booking visit. This should be documented in her medical card.

- Postpartum Family Planning is to be discussed with the woman at booking, second and third trimesters and postpartum before discharge

- WHO modified Partogram should be the one used.

- To apply the rule of fifths to assess descent of fetal head by abdominal examination prior to vaginal examination

- High risk labours with the need of continuous electronic foetal heart rate monitoring should be identified .

- It is recommended that active management of third stage of labour should be implemented on all delivering women.

- Knee-length over shoes provision (to minimize spread of blood and reduce risk of consequent blood borne infection).

- It is mandatory to have clear protocol for the management of hypertension at facility level (Antenatal care, intrapartum management, medications to be used, and when to refer to an internist).

- Magnesium sulphate (MgSo4) is the drug of choice for prevention and treatment of eclamptic fits and should be used instead of diazepam.
- To adopt an agreed protocol for management of Gestational DM (whom and how to screen, medical management (metformin, insulin), blood sugar monitoring, and the criteria of referral to an endocrinologist).
- Protocol that outlines management of women presenting with preterm labour or PPROM (premature pre-labour rupture of membranes). ANC corticosteroids should be given ASAP before transferring the woman

- PPROM patients (have a vaginal swab taken at first examination, can be managed as outpatient after excluding chorioamnitis, provided she is reliable to check her temperature every 4 hours, and referral protocols) .

- All postpartum women should have regular assessment of vaginal bleeding, uterine contraction, fundal height and vital signs routinely during the first 24 hours starting from the first hour after birth, urine void should be documented within six hours, and ensure early initiation of breastfeeding.

- Proper discharge counselling to all postnatal women (Danger signs, maternal blues, DV, and Hygiene)
- All postnatal women should be counselled on PPFP
- All postnatal women should be provided with iron and folic acid supplementation for at least three months.
- provide refresher training, and retraining of staff is recommended every 2 years
- Defined trainers should have a regular schedule to repeat the course and teach other staff practical skills as well as delivering knowledge.

- Monitoring quality of care, regular on site supervision (morning reports, department drills, and monthly statistics)

- Clear policy regarding the referral of patients (the persons in charge of carrying out the referral arrangements in both transferring and receiving hospitals, the continuation of care, a follow-up update, and a discharge letter)

Posters

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Protocol for the management of iron deficiency Anemia in pregnancy

- All pregnant women should have FBC test at booking visit & at 28 weeks gestation.
- All pregnant women (not anaemic) should have iron supplement daily throughout pregnancy.

Daily Iron: 30–60 mg of elemental iron& Folic acid: 400 µg (0.4 mg).

Folic acid supplementation should begin as early as possible.

- If a woman is diagnosed with anaemia in a clinical setting, she should be treated with:

Daily iron (120 mg of elemental iron) and folic acid (400 µg or 0.4 mg).

Until her haemoglobin concentration rises to normal.

- Then switch to the standard antenatal dose to prevent recurrence of anaemia.
- Repeat Hb at 2 weeks to assess response to treatment
- The haemoglobin concentration should rise by approximately 20 g/l over 3–4 weeks
- Once Hb is in the normal range supplementation should continue for 3 months and at least until 6 weeks postpartum to replenish iron stores.
- Women with Hb <100 g/l in the postpartum period should be given 100–200 mg elemental iron for 3 months.
- Iron should be taken on an empty stomach, 1 h before meals with a source of vitamin C (ascorbic acid) such as orange juice to maximize absorption.
- Other medications, calcium supplements & antacids should not be taken at the same time
- For nausea and epigastric discomfort, preparations with lower iron content should be tried and slow release and enteric-coated forms should be avoided.
- Women with known haemoglobinopathy should have serum ferritin checked and offered oral supplements if their ferritin level is <30 µg/l.

- Parenteral iron should be considered from the second trimester onwards and during the postpartum period for women with confirmed iron deficiency who fail to respond to or are intolerant of oral iron.

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WHEN UTERINE ATONY IS PERCEIVED TO BE A CAUSE OF THE BLEEDING, THE FOLLOWING MECHANICAL AND PHARMACOLOGICAL MEASURES SHOULD BE INSTITUTED, IN TURN, UNTIL BLEEDING STOPS:

1. BIMANUAL UTERINE COMPRESSION (RUBBING UP THE FUNDUS) TO STIMULATE CONTRACTIONS.
2. ENSURE BLADDER IS EMPTY (FOLEY CATHETER, LEAVE IN PLACE).
3. SYNTOCINON 5 UNITS BY SLOW IV INJECTION (MAY HAVE REPEAT DOSE).
4. ERGOMETRINE 0.5 mg BY SLOW IV OR IM INJECTION (CONTRAINDICATED IN WOMEN WITH HYPERTENSION).
5. SYNTOCINON INFUSION (40 UNITS IN 500ml HARTMANN'S SOLUTION AT 125ml/hour) UNLESS FLUID RESTRICTION IS NECESSARY.
6. CARBOPROST 0.25 mg BY IM INJECTION REPEATED AT INTERVALS OF NOT LESS THAN 15 MINUTES TO A MAXIMUM OF 8 DOSES (CONTRAINDICATED IN WOMEN WITH ASTHMA).
7. DIRECT INTRAMYOMETRIAL INJECTION OF CARBOPROST 0.5 mg (CONTRAINDICATED IN WOMEN WITH ASTHMA), WITH RESPONSIBILITY OF THE ADMINISTERING CLINICIAN AS IT IS NOT RECOMMENDED FOR INTRAMYOMETRIAL USE.
8. MISOPROSTOL 1000 MICROGRAMS RECTALLY."