> Answers: Using Health Information

Module 9 – Reproductive Health

Case Study 1 (Safe Motherhood)

Rebecca, a 19 year old refugee, attends antenatal clinic on 3 June 2008. This is her second pregnancy. She is married and has one healthy 18 month child, born by spontaneous vaginal delivery in January 2007.

She tells you that her last menstrual period was on 4 March 2008. She has not yet attended the antenatal clinic during this pregnancy. She is tested for Haemoglobin, which is 10.2 g/dl, and tests negative for syphilis. She is also given an insecticide treated net.

(a) Update her information into the antenatal register. What is her expected delivery date?
See sample Antenatal Register

She has already received 2 doses of tetanus toxoid under the routine EPI program. Her last dose (TT2) was on 28 February 2008.

(b) Based on your knowledge of the routine TT vaccination schedule, does she need to receive any further TT prophlylaxis during this pregnancy? How will you record her TT status in the Antenatal register?
According to most MoH schedules, TT3 should be administered 6 months after TT2 Rebecca should therefore receive TT3 on 28 August 2008 (which is approx. 6 months after TT2 on 28 February 2008)

The date of the two most recent TT doses (TT2 and TT3) should be entered into the Antenatal Register

She comes back for second visit on 12 August. Her Haemoglobin is 12.6 g/dl, and no antenatal risk factors are detected. She receives a dose of mebendazole and fansidar.

On 7 October she attends for the third check-up. On examination you notice that she has a transverse lie, and her blood pressure is 170/100. She receives a second dose of fansidar at this visit.

(c) Record the information for the second and third visits in the register. What steps would you take following the findings from the third visit?
See sample Antenatal Register

She has an abnormal lie and high blood pressure (pre-eclampsia). She should be monitored closely at ANC in subsequent visits, to assess whether the transverse lie persists or reverts to a normal position.

She should be referred for further assessment and investigation of pre-eclampsia (e.g. urinalysis for proteinuria) and/or medical management.

Rebecca misses her final scheduled visit on 11 November, and on 27 November is admitted in second stage of labour to the maternity ward. Her BP is 140/80 and the fetal heart rate is 110 bpm.

Her progress in labour is unsatisfactory; she is diagnosed with a persistent transverse lie and the decision is made to refer her to theatre and conduct a caesarean section. The operation was carried out by the on-call Doctor at 3 am in the morning. During the course of the procedure she lost approximately 500 mls of blood.

The newborn girl was weighed immediately after the operation, and birth weight was recorded as 1900g. At five minutes, skin colour was normal but there was weak movements and response to stimulation. Respiratory rate was poor and heart rate was 90 bpm. Rebecca was given a postnatal dose of vitamin A on the maternity ward the day after the operation.

(d) Update this information into the delivery register.
See sample Delivery Register

(e) Now update this delivery information into the antenatal register. What mechanism do you have in place to ensure this happens in your camp? Where else should this information be recorded. Why?
See Sample Antenatal Register. Pregnancy outcome should be updated into the Antenatal register as soon as possible after delivery.

This information should also be recorded in the Antenatal Tally Sheet, to facilitate easy reporting of statistics at the end of each week.

Rebecca is kept under observation for one week and discharged from the maternity unit on 4 December 2008. She attends for her first postnatal visit a week later on 11 December. No risk factors are present.

(f) Enter this information into the postnatal register.
See sample Postnatal Register

(g) What is Rebecca's expected date of discharge from the postnatal program? What must you take into consideration when determining her exact date?
Expected date of discharge is 6 weeks (42 days) after the date of delivery.

The date of discharge should take into account the 7 days that Rebecca spent as an inpatient on the maternity ward. The 6 weeks should start on her date of discharge from the ward (i.e. 4 December 2008).

Expected date of discharge = 6 weeks after 4 December = 15 January 2007

The second and third visits are attended on time, with no complications detected in either.

(h) Enter this information into the register to complete the postnatal entry for Rebecca
See sample Postnatal Register

Case Study 2 (Family Planning)

Rebecca attends family planning clinic on 29 May 2008. She has not attended the clinic in the camp before. After counselling, you provide her with 25 pieces of condoms and 3 monthly cycles of high-dose COCP. You schedule a repeat visit on 28 August.

(a) Record this visit in the Family Planning Register. How will you know if she attends for the repeat visit on time or not?

See sample Family Planning Register

A family planning future appointments book should be maintained to record dates of scheduled visits, and to predict when visits are due and which clients are expected on each day.

She comes back to the clinic on 5 September 2008. She decides to stop using lo-femenal and to move to Depo-provera. You provide her with the 1st injection of Depo, provide another 25 pieces of condoms, and schedule another appointment for 3 months time.

(b) What type of user is she? What do you take into consideration in making your decision?

She has attended the Family Planning clinic 8 days after her scheduled appointment.

Based on the guidance provided in the manual, a client is defined as discontinued if more than 7 days have elapsed since the scheduled appointment. Therefore, for the purposes of this exercise, she has been classified as discontinued user.*

*(*__NOTE__: the exact number of days that elapse before a user is classified as discontinued depends on the Reproductive Health Policy of the country).*

(c) Record this second visit into the Family Planning register

See sample Family Planning Register

She was considered to have discontinued both COCP and condoms on 4 September after missing the appointment by 7 days.

On 5 September, both Depo-provera and Condoms were started again and she should be registered as a new user for both methods.

Note that each method of family planning should be entered into a new row of the Family Planning Register. This is to permit accurate reporting of the types of user of each method at the end of every week.

> Answers: Using Health Information

Module 9 - Reproductive Health

						REGISTRATION								OBSTETRIC HISTORY				
Serial No.	ANC No.	Name	Age	Status (Ref / Nat)	Address	Date of visit	Marital Status	Gravidity	Parity	No. of children	LMP	EDD	Gest. age	Stillbirth	Abortion	Caesarian Section	Last Born	
																	Birth date	Alive / Dead
001	001	Rebecca	19	Ref	Camp	3/6/08	Married	2	1	1	4/3	11/12	13/36	0	0	0	1/04	Alive

Antenatal Care Register

RISK FACTORS												SERVICES (Enter Date Provided)									PREGNANCY OUTCOME						Vitamin A 200 000 IU
1st Visit			2nd Visit			3rd Visit			4th Visit			Fansidar		RPR			TT		Mebend.	ITN	Abortion		Normal Delivery		Stillbirth		
Date	Gest Age	ANC RF*	Date	Gest Age	ANC RF*	Date	Gest Age	ANC RF*	Date	Gest Age	ANC RF*	1	2	– ve	+ ve	Partner Treated	1	2			Compl.	Un-Compl.	Date of Delivery	Deliv. Compl. **	Fresh	Macer.	
3/6	13/36	A	12/8	23/36	X	7/10	31/36	H	-	-	-	12/8	7/10	3/6			28/2	28/8	12/8	3/6			28/11/08	OL/CS			29/11

* Antenatal Risk Factors:

X = No risk factor
A = Anaemia
O = Oedma
P = Proteinuria
H = High BP (above 140/90)
U = Not gaining weight
APH = Antepartum Haemorr.
M = Abnormal Lie (after 32 weeks)
Ot = Other

** Delivery Complications:

X = No complication
PPH = Postpartum Haemorr.
E = Eclampsia
PS = Puerpueral Sepsis
OL = Obstructed Labour
B = Breech
T = Third Degree Tear
CS = Caesarian section
Ot = Other

> Answers: Using Health Information

Module 9 - Reproductive Health

						REGISTRATION												
Serial No.	ANC No.	Name	Age	Status (Ref / Nat)	Address	Date of admission	Time of admission	Gravidity	Parity	No. of children	LMP	EDD	Gest. age	Blood Pressure	Fetal HR	Present'n	RPR	
																	– ve	+ ve
001	001	Rebecca	19	Ref	Camp	27/11/08	1200	2	1	1	4/3	11/12	39/36	140/80	110	Tran	3/6	

Delivery Register

Sample Delivery Register

DELIVERY DETAILS					DELIVERY OUTCOME						NEWBORN						
Date of delivery	Time of delivery	Mode of delivery	Location of delivery	Att'd by skilled hlth worker	Normal Delivery	Delivery Compl.*	Stillbirth		Blood Loss (mls)	Perineum state	Sex (M / F)	Condition	Apgar Score	Birth Weight		Weighed < 72 hours	Name
							Macer.	Fresh						< 2500g	> 2500g		
28/11/08	0300	LSCS	Hospital	Doctor		OL/CS			500	Intact	F	Poor	6/10	1900		Y	Doctor Name

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							REGISTRATION			
Serial No.	FP Code No.	Name	Age	Sex (M / F)	Status (Ref / Nat)	Address	Date of visit	Re-visit (Y / N)	Marital Status	No. of children
001	001	Rebecca	36	F	Ref	Camp	29/5/08	N	Married	4
002	001	Rebecca	36	F	Ref	Camp	28/8/08	Y	Married	4
003	001	Rebecca	36	F	Ref	Camp	5/9/08	Y	Married	4

Family Planning Register

Sample Family Planning Register

FAMILY PLANNING METHOD												
COCP Low Dose ***Micro-gynon Nordette***	COCP High Dose ***Lo-Femenal***	POP ***Micro-val Micro-lut***	ECP ***Postinor-2***	Injectable ***Depo-Provera***	Implantable ***Norplant***	IUCD	Condom		Sterilisation		Type of User*	Next appt. date
							Male	Female	Date of acceptance	Date of procedure		
	3 cycles										New	28/8/08
						25					New	8/8/08
	X										Discont.	4/9/08
						X					Discont.	4/9/08
				1st inj.							New	5/12/08
						25					New	5/12/08

* Type of User: 1. New User 2. Repeat User 3. Discontinued
(see guidelines for definitions)

> Answers: Using Health Information

Module 9 - Reproductive Health

						DELIVERY DETAILS			
Serial No.	ANC No.	Name	Age	Status (Ref / Nat)	Address	Date of delivery	Mode of delivery	Delivery Compl.	Newborn Sex (M / F)
001	001	Rebecca	19	Ref	Camp	28/11/08	LSCS	OL	F

† Note: Discharge date should be 6 weeks post-delivery, if no complications are present

Postnatal Care Register

1st Postnatal Visit			2nd Postnatal Visit			3rd Postnatal Visit					
Date	PNC compl.*	Comment	Date	PNC compl.*	Comment	Date	PNC compl.*	Comment	Expected discharge date †	No. of visits made	Reason for exit **
11/12	X	On mat. ward for 7d post del.	1/1	X	On time	15/1	X	On time	15/1	3	Discharge

* Postnatal Complications:

X = No complication
PPH = Postpartum Haemorr.
PS = Puerperal Sepsis
A = Anaemia
L = Lactational Prob.
CS = Cord Sepsis
E = Eclampsia
Ot = Other

** Reason for exit:

1. Discharge
2. Death
3. Default
4. Referral