> Exercise: Using Health Information

Module 9 – Reproductive Health

Case Study 1 (Safe Motherhood)

Rebecca, a 19 year old refugee, attended 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?

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 prophylaxis during this pregnancy? How will you record her TT status in 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?

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.

(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?

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.

(g) What is Rebecca's expected date of discharge from the postnatal program? What must you take into consideration when determining her exact date?

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

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?

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?

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

> Exercise: 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

RISK FACTORS													SERVICES (Enter Date Provided)									PREGNANCY OUTCOME						
1st Visit			2nd Visit			3rd Visit			4th Visit				Fansidar		RPR			TT		Mebend.	ITN	Abortion		Normal Delivery		Stillbirth		Vitamin A 200 000 IU
Date	Hb (g/dl)	ANC RF*	Date	Hb (g/dl)	ANC RF*	Date	Hb (g/dl)	ANC RF*	Date	Hb (g/dl)	ANC RF*		1	2	– ve	+ ve	Partner Treated	1	2			Compl.	Un-Compl.	Date of Delivery	Deliv. Compl. **	Fresh	Macer.	

* 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

> Exercise: 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

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		

* Delivery Complications:

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

> Exercise: Using Health Information

Module 9 - Reproductive Health

							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

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		

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

						DELIVERY DETAILS			
Serial No.	ANC No.	Name	Age	Status (Ref / Nat)	Address	Date of delivery	Mode of delivery	Delivery Compl.	Newborn Sex (M / F)

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

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 **

* Postnatal Complications:

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

** Reason for exit:

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