1. Define the following terms.

**Ruptured uterus**

Is the splitting of the membranes enclosing an infant during childbirth. It may be complete or incomplete. If the uterus is complete; the uterus is communicating directly with peritoneal cavity and bleeding will occur into the peritoneal cavity. If it is incomplete, bleeding will occur behind the visceral peritoneal.

**Cord prolapse**

It occurs when the cord lies in front of the presenting part of the baby after the membranes have ruptured.

**Cord presentation**

It occurs when the cord lies in front of the presenting part of the baby before the membranes have ruptured.

**Post-partum hemorrhage**

Is defined as excessive bleeding from the birth canal after birth of the baby Upto six weeks postpartum, amounting to 500ml or more or any amount that causes deterioration of the maternal condition.

**Acute inversion of the uterus**

Is a life threating condition of the third stage of labor caused by mismanagement in the third stage of labor, involving excessive cord traction to manage the delivery of the placenta actively; fetal macrosomia; short umbilical cord; combining fundal pressure and cord traction to deliver the placenta.

**Amniotic fluid embolism**

It occurs when amniotic fluid enters the maternal circulation via the uterus or placenta site; maternal collapse can be rapidly progressive.

**Maternal and fetal distress**

It occurs when the fetus suffers from oxygen deprivation and becomes hypoxic.

1. **Define puerperium**

Is a period about six weeks following childbirth when the reproductive organ are returning to their normal state.

**(b) As a midwife what care would you give to mama watoto during the first 8 hours.**

I would check the blood loss by estimating using the pad of the mother.

I would encourage bonding of the mother with the child.

I would encourage breastfeeding and teach the mother good positioning of breastfeeding.

I would do physical examination in order to rule out any abnormality that may arise.

I would take vital signs of the mother after every four hours.

I would teach the mother about nutrition by encouraging the mother to eat a balanced diet and to take drinks such as milk.

I would encourage the mother to avoid stress because stress will trigger milk not to come out especially when the baby is breastfeeding.

I would encourage the mother to maintain good hygiene.

**(c) Health talk**

***Mama watoto is taught about;***

Exclusive breastfeeding.

Good Positioning during breastfeeding.

Care of the baby’s cord.

Nutrition to replenish blood loss.

Care of the breast during breast examination.

Signs of infection and what to do.

Care of the baby to involve warm environment, and ensuring equipment used in the baby are cleaned.

Hygiene; by teaching the mother how to clean the umbilical cord of the baby.

1. **week 1**

The mother needs to look for lochia; for example, lochia rubra which is red in color, lochia serosa which is pink in color and lochia alba which is white cream in color.

Daily examination of the baby in order to rule out any deformities.

Encourage the mother to do sitz birth if she had a tear and the tear has been sutured.

**Week 2**

Mother needs to examine if she still bleeds. If there is still bleeding, she needs to seek medication at the health facility.

Mother needs to continue doing daily examination of the baby to rule out any abnormalities.

Mother needs to check for discharge including the amount and color of the discharge.

Mother needs to do breast examination.

Mother needs to ensure that the child is immunized against BCG.

**The rest of the period**

Mother needs to do physical examination of the baby in order to rule out any abnormality that may arise.

Mother needs to do breast examination in order to rule out formation of masses.

Mother needs to ensure that the child is fully immunized.

Mothers needs to ensure exclusive breastfeeding and right nutrition should be given to the child in order to rule out malnutrition.

Mother needs to ensure good hygiene to both herself and the child including the environment they are staying in.

1. **Danger signs mother should look out for.**

Excessive bleeding.

Fever.

Foul smelling discharge.

Abdominal cramps or pain.

Painful breast cracked nipples.

Extreme fatigue.

Facial swelling or hand swelling.

Severe headache.

Vomiting.

Depression.

Convulsions.

Puerperal blues.

Painful calf muscles.

1. **(a) Draw a crossection of a breast indicating the breast tissue, ducts, nipple and areola.**(Has been scanned )

**(b) Define latching and positioning.**

Refers to when the baby is able to breast feed well and also gain weight without getting hurt when placed in a good position of breastfeeding and also there is good effective transfer of milk.

**(c) Complications that may arise during breastfeeding e.g cracked nipples and engorged breasts.**

Plugged milk duct.

Breast infection.

Insufficient milk supply.

Mastitis.

Sore nipples.

leaking breasts.

Overabundant milk supply.

Breast pain.

Blocked ducts during breastfeeding.

Baby bites.

Breast tenderness.

**4.(a) Define puerperal depression**

Refers to a severe form of depression or elation occurring in the first few weeks after the baby is born.

**(b) Define puerperal psychosis**

Refers to severe mental illness after childbirth.

**(c) State the signs and symptoms of puerperal psychosis**

Purposeless activity.

Uncharacteristic behavior.

Disinhibition.

Fleeting anger.

Resistive behavior.

**(d) Discuss the management of puerperal psychosis**.

Most women with psychotic illness following childbirth will require admission to hospital, which should be a specialist mother and baby unit.

On set of needs of the mother can only be met on where specialist psychiatric nursing is available.

A specialist psychiatrist should be consulted when prescribing medication for puerperal psychosis. For example;

Mood stabilizers which includes lithium which work to stabilize mood and help reduce the

Antidepressant used to treat symptoms of depression that are part of the disorder.

Antipsychotic which assists with psychotic symptoms such as hallucinations.

**5.Define a “baby at risk”**

Also called preterm birth which refers to the birth of the baby before 37 complete weeks.

**6.Describe the management of babies with special needs (baby at risk)**

1. **Low birth weight**

Refers to any baby whose birth weight is below 2500gms at birth.

**Management of babies with low birth weight**

If a mother is in early labor comes where there is no neonatal facilities, transfer her immediately to a center with newborn unit.

All babies weighing 200gms and below at birth should be admitted in the newborn unit or referred.

1. **Baby of diabetic mother**

Refers to the baby with a birth weight of more than 4.0kgs.

**Management of baby of diabetic mother**

Initiate breastfeeding immediately and continue feeding on demand.

If the baby sleeps, wake him/her up and feed at least every three hours.

Closely monitor the baby to promptly recognize the associated problems.

Manage any complication detected.

Test the blood sugar level where possible.

Keep the baby warm.

If the mother is not already diagnosed as diabetic, investigate to rule out diabetes mellitus.

If confirmed positive, manage diabetic mother or refer.

1. **Congenital abnormalities**

Are abnormalities a baby is born with. Examples of congenital abnormalities includes;

**Imperforate anus**

Refers to when there is no anal opening.

**Management of imperforate anus**

Provide emotional support and reassurance to the mother.

Establish an IV line, and give only IV fluid at maintenance volume according to the baby’s age.

Ensure that the baby does not receive anything by mouth.

Insert a nasogastric tube and ensure free drainage.

Urgently refer the baby to a tertiary or specialized Centre for surgery.

**Spina bifida**

Occurs when there is a defect in vertebral column.

**Management of spina bifida**

Provide emotional support and reassurance to the parents.

If the defect is not covered with the skin; cover with a sterile gauze soaked in sterile normal saline.

Keep gauze moist all times and ensure that the baby is kept warm.

If ruptured give Benzyl penicillin 50,000 units/kg 12 hourly and gentamicin 5mg/kg daily for 5 days.

Organize transfer and refer the baby to a tertiary hospital or specialized center for further evaluation or surgical care if possible.

**Cleft lip palate**

Refers to a defect in the upper lip that may be accompanied by a defect in the palate.

**Management of cleft lip palate**

Provide emotional support and reassurance to the parents.

Mother needs to be told that feeding is important to ensure adequate growth until surgery can be formed.

Show the mother how to feed the baby with breast milk.

Take care to prevent aspiration.

Refer to surgeon for repair.

**Hydrocephaly**

Occurs when there is an unusually large head arising from blockage in the free flow of cerebrospinal fluid in the ventricular system.

**Management of hydrocephaly**

Monitor head circumference.

Refer early for surgical cerebrospinal fluid drainage.

1. **Asphyxia neonatorum**

These term refers to a condition that occurs when a baby does not get enough oxygen during birth process.

**Management of Asphyxia neonatorum**

Place the baby in warm place and in resuscitation position.

Extend the neck and turn to one side.

Clear the mouth and nose.

Assess breathing.

Dry skin thoroughly.

If the baby is not breathing/gasping, use use Ambu bag to inflate.

Assess heart rate; if the heart rate is under 80, ambu bag ventilation and chest compression.

If heart rate is increasing; continue ventilation and stop chest compression.

If there is response, watch for spontaneous breathing.

1. **Respiratory distress syndrome**

Refers to when a baby has difficulty in breathing.

**Management of respiratory distress syndrome**

Keep the baby warm.

Put baby on oxygen.

Where oxygen is not available refer.

Give antibiotics; crystalline penicillin 50,000 units per kg in 12 hourly and gentamicin 5mg/kg.

Feed the neonate.

Give vitamin k; if term 1mg stat; if preterm 0.5mg stat,

Admit or refer.

1. **Hypothermia neonatorum**

Refers to the body temperature below the normal range 36.5-37.5oc.

**Management of hypothermia neonatorum**

Keep the baby warm by;

Removing wet or cold clothes.

Skin to skin contact with the mother and cover with warm linen.

Adequately cover the baby (including hat and socks)

Keep clothed baby under radiant heat sources, nurse in a warm incubator if possible.

If the baby is blue or having difficulty in breathing, put the baby on oxygen.

1. **Opthalmia neonatorum**

It is a type of a bacteria conjunctivitis or infection of the eyelid tissues, occurring among newborns during delivery. The problem arises when the eyes of a newborn get infected while passing through the birth canal of a woman suffering from chlamydia trachomatis or Neisseria gonorrhea.

**Management of opthalmia neonatorum**

**Diagnosis**

Conjunctival cultures for bacteria.

Conjunctival scraping for gram stain (bacteria).

**Treatment of bacterial conjunctivitis**

Systemic penicillin G and a cephalosporin for Neisseria gonorrhea.

Topical erythromycin.

Other topical antibiotics including azithromycin.

Frequent irrigation until discharge ceases.

**Treatment of chlamydial conjunctivitis**

Systemic erythromycin.

Topical azithromycin.

1. **Birth injuries and trauma**

**Birth injuries**

Refers to an injury sustain by baby during the birth process and includes injuries to;

Skin and superficial tissue.

Muscle trauma.

Nerve trauma.

Fractures.

**Management of trauma**

Due to feeding difficulty, help mother to attach well; and if this fails give expressed breast milk.

**General management for fractures**

Confirm the diagnosis with x-ray.

Handle the baby gently when moving or turning and teach the mother how to do so.

Avoid movement of the affected limbs as much as possible.

Immobilize the limb to reduce pain when the baby is handled.

If the mother is able to care for the baby and there are no other problems requiring hospitalization, discharge the baby.

1. **Neonatal jaundice**

Refers to the yellow discoloration of the skin and mucous membranes as a result of raised bilirubin levels, occurring in the first 28 days of life.

**Management of neonatal jaundice**

Take history to determine cause of jaundice.

Examine to check on;

Yellowness of skin and mucous membrane.

Color of urine and stool.

Signs of infections.

Ability to suck properly.

Check for pallor.

Monitor bilirubin level.

Laboratory investigation on; full haemogram, blood for bilirubin and baby and mother blood group.

1. **Neonatal sepsis**

This refers to when a baby has generalized clinical features of sick infant.

**Management of neonatal sepsis**

**Immediate care**

Give pre-referral treatment (IV crystalline penicillin and gentamicin).

Keep baby warm.

Prevent hypoglycemia by feeding the baby (breastfeed or expressed breast milk).

If blood sugar is low, refer to section on hypoglycemia.

**Subsequent care (hospital**)

Keep baby warm depending on the baby size.

If there is skin infection use cloxacillin.

Ensure adequate feeds.

Frequently monitor vital signs.

Counsel the mother.

On discharge refer to MCH.

1. **Hypothermia**

is a condition when the baby’s temperature falls below 36.5oc (based on the axillary temperature).

**Management of hypothermia**

Keep the baby warm by;

Removing wet or cold clothes.

Skin to skin contact with the mother and cover with warm linen.

Adequately cover the baby (including hat and socks)

Keep clothed baby under radiant heat sources, nurse in a warm incubator if possible.

If the baby is blue or having difficulty in breathing, put the baby on oxygen

1. **Hypoglycaemia**

Occurs when blood glucose level is below 2.6mmol irrespective of the gestation and postnatal age.

**Management of hypoglycaemia**

**Blood glucose less than 1.1mmol**

Give a bolus of 2ml/kg body weight of 10% glucose IV slowly over 5 minutes.

If an IV cannot be established quickly give 2ml/kg body weight of 10% glucose by gastric tube.

Infuse 10% glucose at the daily maintenance volume according to the baby’s age.

Assess the blood glucose 30 minutes after the bolus of glucose.

If the blood glucose is less than 1.1 mmol, repeat the bolus of glucose above and continue the infusion then assess blood glucose again after 30 minutes.

If the blood glucose is between 1.1mmol and 2.6mmol, continue the infusion and repeat the blood glucose testing every three hours until blood glucose is 2.6mmol or more on two consecutive tests.

1. **Haemorrhagic diseases of a new born**

These are diseases caused by deficiency of vitamin k.

**Management of Haemorrhagic diseases of a new born**

**Diet**

The best source are green leafy vegetables, legumes, soybean and olive oil.

Breastfed infants should receive vitamin k supplementation.

**Transfer**

Infants with evidence of intracranial bleeding may require a transfer to level III nursery after stabilization with subcutaneous vitamin k and other aspects of supportive care.

**7.Discussion on what maternal and neonatal audit**

**Culture**

Refers to the behavioral patterns and beliefs of a particular group including their values. For examples in some religions, they don’t accept blood transfusion and this has led to neonatal and maternal death. So such people needs to be counselled and told the importance of blood transfusion in order to improve care of a patient.

**Postpartum haemorrhage**

Refers to excessive bleeding from the birth canal after the birth of baby upto 6 weeks postpartum amounting to 500mls and this has led to deterioration of maternal condition. So those women who has postpartum haemorrhage, needs close observation.

**Patograph**

Refers to graphic presentation which outlines the progress of a woman in labor including the fetal and maternal condition. Many women have passed alert line when laboring and this has led to maternal and neonatal death. So plotting progress of labor on patograph should be under good and close observations.

**Immunization**

Refers to the production of immunity by artificial means. Some women don’t attend antenatal care to receive maternal tetanus immunization, micronutrient supplement in pregnancy and fetal heart rate of the child to be heard and also the position the baby is lying. Mothers need to be taught the importance of going to the clinic in order to improve their care.

**Birth Asphyxia**

Is a condition where a newborn fail to initiate and maintain spontaneous adequate breathing at birth and this has led to neonatal death. So birth attendance are advised to encourage pregnant mothers not to lie on their back because the flow of blood to the uterus is decreased.

**Precipitate labor**

The period of onset of labor to delivery is less than an hour and this has led to neonatal death. So mothers who are pregnant are encouraged and advised to know their expected date delivery.

**Placenta Previa**

Occurs when placenta is partially or completely implanted in the lower uterine segment in either anterior or posterior wall and has led to neonatal death. Women suspected to have placenta Previa should be transfer to high observation obstetric unit in order to improve their care.

**Referral system**

Neonatal death has occurred many due to lack of money for transport to be taken to another hospital facility which have all the required resources; for example, if the baby is born underweight and needs to be put in an incubator.

**REFERRENCES**.

*MYLES TESTBOOK OF MIDWIVES.*

*NURSES IN MATERNITY.*

*MOTHERS AND CHILD HEALTH BOOKLET (MCH 216).*