NAME- OBIEFUNA JULIANA CHIDIMMA

MARRIC NUMBER- 16/MHS02/030

LEVEL- 400

ANSWERS TO THE ASSIGNMENT QUESTIONS

The partograph is a graphical presentation of the progress of labour, and of fetal and maternal condition during labour. It is the best tool to help you detect whether labour is progressing normally or abnormally, and to warn you as soon as possible if there are signs of fetal distress or if the mother’s vital signs deviate from the normal range.

MANAGEMENT OF FIRST STAGE OF LABOUR USING PARTOGRAPH

1. Transfer of a woman in labour from a peripheral unit (health centre) to a central unit
2. Augmentation of labour with oxytocin infusion.
3. Termination of labour by operative delivery (usually caesarean section).

Poor timing of, or failure to perform, these actions may lead to problems of

iatrogenesis or neglect. Without management guidelines, these decisions may be made

on the basis of intuition or experience which probably contributes to the widely

varying rate of, for example, caesarean section delivery.

Based on the experiences of Philpott and Bird the WHO Working Group

considered that the actions appropriate at different points on the partograph should be as

follows:

a. If cervical dilatation remains on or to the left of the alert line in the active phase - no

action is indicated.

b. If cervical dilatation moves between the alert and action lines (but not to the action

line)

* if in a peripheral unit, transfer to a central unit
* if in a central unit, no specific action indicated.

c. If cervical dilatation reaches or crosses the action line:

review by medical staff with a view to augmentation, termination of labour, or

supportive therapy.

d. Prolonged latent phase (8 hours of observed latent phase)

MANAGEMENT OF SECOND STAGE OF LABOUR

The second stage of labor is regarded as the climax of the birth by the delivering woman, her partner, and the care provider.

Second stage of labour is from full dilatation of the cervix up to the birth of the singleton baby or the last baby in a multiple pregnancy. At the start of the second stage, the fetal presenting part may or may not be fully engaged (meaning that the widest diameter has passed through the pelvic brim), and the woman may or may not have the urge to push.

During the second stage of labor, the midwife should:

* Continuously provide information, support, and encouragement to the woman and her companion.
* Encourage active pushing once the urge to bear down is present, with encouragement to adopt any position for pushing preferred by the woman, except lying supine which risks aortocaval compression and reduced uteroplacental perfusion.
* Listen frequently (every 5 minutes) to the fetal heart in between contractions to detect bradycardia.
* Check the maternal pulse and blood pressure, especially where there is a pre‐ existing problem of hypertension, severe anemia, or cardiac disease.
* Observe progressive descent and rotation of the presenting part. This includes observing progressive distension of the perineum and visibility of the presenting part, and vaginal examination especially where progress appears to be slow.
* Conduct the delivery with support for the perineum to avoid tears, and use of episiotomy only where a tear is very likely.
* Be ready to augment contractions with an intravenous oxytocin infusion during the second stage where contractions have become infrequent and where the fetal heart rate remains normal, to avoid the need for instrumental vaginal delivery or transfer.
* Be ready to undertake instrumental vaginal delivery (vacuum or forceps) where indicated for fetal bradycardia or nonadvance of the presenting part.

Close monitoring and the skills and capacity to offer timely intervention are required for all births to prevent adverse outcomes. High‐quality care in the second stage of labor is necessary to prevent stillbirth and newborn complications arising from undetected hypoxia and acidemia, as well as maternal mortality and morbidity from complications such as vesicovaginal fistula, genital tract lacerations, infection, hemorrhage.

MANAGEMENT OF THIRD STAGE OF LABOUR

The third stage of labor may be managed expectantly or actively. In expectant (physiological) management, uterotonic drugs are not given prophylactically, the cord may or may not be clamped early, and the placenta is delivered by maternal effort. In active management, uterotonic drugs are given before delivery of the placenta, the cord is usually cut 2–3 minutes after birth, and the placenta is delivered by controlled cord traction (CCT).

More recently, the following steps have been integrated into routine care for the woman AND her newborn and have been refined to include the following:

(1) Administration of a uterotonic drug within 1 minute after the baby’s birth and after ruling out the presence of another baby;

(2) Clamping and cutting the cord after cord pulsations have ceased or approximately 2–3 minutes after birth of the baby, whichever comes first;

(3) CCT during a contraction with counter traction to support the uterus, including gently turning the placenta as it is delivered to prevent tearing of the membranes;

(3) Massaging the uterus immediately after delivery of the placenta.