MATRIC NUMBER: 17/MHS02/114

COURSE: MATERNAL HEALTH AND NORMAL MIDWIFERY II

LEVEL: 400

Question

Reading assignment

1. USE OF PARTOGRAPH IN THE MANAGEMENT OF FIRST STAGE OF LABOUR

2. MANAGEMENT OF 2ND AND 3RD STAGES OF LABOUR

**ANSWERS (SUMMARY)**

1. **USE OF PARTOGRAPH IN THE MANAGEMENT OF FIRST STAGE OF LABOUR**

A partograph can be defined as a tool for assessing the progress of labour that offers normal progress or an early warning for complications such as fetal distress, prolonged or obstructed labor.

Its uses in the first stage of labor include;

* To monitor contractions
* To monitor the levels of dilatation
* To determine presentation
* Level of pain
* Determine type of delivery (i.e. either vaginal delivery or elective caesarian section

**2) MANAGEMENT OF 2ND AND 3RD STAGES OF LABOUR**

1. The timing and process of active pushing should be guided so that this is encouraged only when the cervix is fully dilated and when the presenting part has engaged in the pelvis and the woman feels the urge to push. The skilled attendant also has the role of encouraging the mother to adopt positions for active pushing that are culturally appropriate, comfortable, and mechanically beneficial; for example, squatting or sitting up as opposed to lying flat on a bed.

Unfortunately, in many hospitals in low‐resource countries, lying supine while in labor has become the norm. This may occur as a result of lack of available cushions or the use of non-flexible delivery beds where the upper part cannot be elevated.

1. Use of oxytocin during the second stage of labor

Intramuscular oxytocin administration before delivery is contraindicated. Intravenous oxytocin should be administered only according to a health facility protocol (describing indications, dose, and intravenous route) by a trained care provider. Where the contractions are poor and the fetal presentation, position, and heart rate have been confirmed as normal, the use of oxytocin infusion may reduce the need for instrumental vaginal delivery.

1. Pain relief during the second stage of labor

Pain relief options must be discussed with the woman prior to the onset of labor and offered according to her wishes and using health facility protocols and norms. The need for pain relief is highly variable between individuals and should be individually assessed. Usually the second stage is relatively short and self‐limiting. Local anesthesia should be used for perineal infiltration prior to cutting an episiotomy, and the practice of cutting an incision without anesthesia is to be deprecated.

1. Episiotomy

An episiotomy is an incision made into the perineum for the purpose of enlarging the soft tissue outlet for a breech infant or to decrease the length of the second stage if the baby is in distress. Multiple reviews have demonstrated that a policy of restricted episiotomy (episiotomy only when necessary) has better maternal outcomes than a policy of routine episiotomy, with no adverse effects for the newborn. There are 3 main types of episiotomy that can be carried out;

* Mediolateral
* Median and
* J‐shaped.

 In general, median episiotomy is associated with less blood loss and is easier to perform and repair than the mediolateral procedure. However, median episiotomy is also associated with a higher risk of injury to the maternal anal sphincter and rectum than mediolateral episiotomies or spontaneous obstetric lacerations. Mediolateral episiotomy is recommended for instrumental vaginal delivery. When performed on an “as necessary” basis, episiotomies should be performed under anesthesia, whether anesthesia is already in place for labor, such as epidural, or by administering a local infiltration. Episiotomy and laceration repair should always be performed under adequate perineal anesthesia.