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QUESTION:

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

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

**USE OF PARTOGRAPH IN THE MANAGEMENT OF FIRST STAGE OF LABOUR:**

Partography is a method of graphically recording the progress of labour. It may be used purely to record observations but management guidelines to indicate the appropriate timing of certain interventions can be incorporated.

The partograph with associated management guidelines is designed to improve the

timing of critical management decisions in labour. These are:

a. Transfer of a woman in labour from a peripheral unit (health centre) to a central unit

(hospital with facilities for caesarean section delivery).

b. Augmentation of labour with oxytocin infusion.

c. 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.

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): review by medical staff.

**MANAGEMENT OF 2ND STAGE OF LABOUR**

• If the client expresses a desire to push when there is reason to believe the cervix may

not be fully dilated, dilation should be checked by vaginal examination.

• If the client is less than 8 cm dilated and has an irresistible urge to bear down, assist

the client to avoid pushing and consider a change in position for comfort. If the urge to

push remains uncontrollable, consider regional analgesi.

• The fetal heart should be auscultated at least every 15 minutes during the latent phase.

• If the latent phase lasts longer than an hour and encouraging the client to push does

not produce a spontaneous urge and progress in descent, augmentation may be

considered

• The fetal heart should be auscultated after every contraction, or at least every five

minutes.

• Clients should be encouraged to push according to their comfort and preference.

• Encourage upright positioning and directed pushing when progress is not achieved

with natural bearing-down efforts. With upright positioning such as standing or use of a

birth chair, a change in position immediately after birth may reduce the risk of postpartum hemorrhage

**MANAGEMENT OF 3RD STAGE OF LABOUR**

Two distinct approaches to care exist, in that care can adhere to

1) a conservative or physiological pathway of expectant management, or

2) an active management of the third stage during which the clinician intervenes by use of the routine administration of a prophylactic uterotonic drug, cord clamping and cutting and the use of controlled cord traction. The expectant ‘hands off’ approach has clinicians observe for signs of placental separation and the placenta is then birthed with the aid of gravity and maternal pushing. To add to the discussion a mixed approach exists in some settings whereby clinicians offer some aspects of the components of active and expectant management, without remaining exclusive to all components of either.

For most women blood loss does occur during the third stage of labour with historical variation in what is considered to be a ‘normal’ volume to lose. The impact blood loss can have on the wellbeing of women is influenced by factors other than the amount, such as the general health status of the woman, her haemoglobin levels at the time. It has been estimated that at least 25% of maternal deaths in a number of countries are due to haemorrhage (most due to post partum haemorrhage PPH) and PPH remains as a leading cause of maternal death in sub-Saharan Africa. The gravity of the concerns in relation to blood loss are demonstrated by the Joint Policy Statements issued between the International Confederation of Midwives (ICM), the International Confederation of Gynaecology and Obstetrics (FIGO), the World Health Organisation and the National Institute for Health and Care Excellence (NICE) guidelines, they have all recommended active management of the third stage of labour.