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**Universalizing Availability**  
**of Emergency Obstetric Care Services**

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## **Introduction**

It is now universally recognised that universal availability of emergency obstetric care services is the most critical intervention to reduce the risk of death due to complications of pregnancy and delivery. Deaths associated with the pregnancy and delivery, commonly known as maternal deaths, are classified as direct obstetric deaths which are caused by complications that develop as the result of pregnancy, at the time of the delivery or during the post partum period. Indirect obstetric deaths, on the other hand, are due to pre-existing or an associated medical conditions that are made worse by pregnancy, delivery or during the post partum period.

Among the many direct causes of obstetric deaths, five are most common: haemorrhage, ante partum as well as post partum, complications associated with abortion including unsafe abortion, pregnancy-induced hypertension, infections and obstructed labour. In a country like India, direct obstetric deaths account for more than three fourths of all maternal deaths. Obviously, preventing deaths due to direct obstetric causes is the most effective approach towards reducing maternal mortality. The problem with most of the direct causes of maternal deaths is that they cannot be predicted in advance and the period between the onset of complications and the unwanted death is of a few hours only. The fact is that all pregnant women are at risk of developing obstetric complications during labour and after labour, during the post partum period. Most life-threatening complications occur during labour and delivery, and these cannot all be predicted. These complications can occur despite intensive pre natal care and screening (Rooks, Winikoff, Bruce 1990). Women *not* identified as "high-risk" can and do develop obstetric complications. Most obstetric complications occur among women with no risk factors. In a prenatal care programme in Zaire, pregnant women were screened for the risk of developing obstetric complications. Women with a 'bad history' (history of still birth, medical intervention during delivery, etc.) were identified as 'high risk' for developing obstructed labour. It was found that only 29 per cent of the women who actually developed obstructed labour were from the high risk group. More than two-third of the women who developed obstructed labour were not predicted by the screening (Kasongo Project Team 1986). A study in United States of America found that one in every thirteen women categorised as 'low risk' and receiving intensive prenatal care developed serious complications (Weatherby 1990). The only hope is that nearly all the direct causes of maternal mortality can be treated effectively and associated risk of death is significantly reduced when the causes are diagnosed early and appropriate care is provided. Making available appropriate obstetric care services during this very short period, therefore, is critical to preventing maternal death and reducing maternal mortality. If appropriate care and attention is not available during this period, there is little scope of survival. Because of the nature of these services, they are termed as emergency obstetric care services to differentiate them with the essential obstetric care services.

The widely prevailing perception about the emergency obstetric care services is that are highly specialised in nature and so can be provided only by a team lead by a person having specialisation in obstetric and gynaecology and that too in institutional settings having advanced level of infrastructure and facilities. The problem with this perception is that realisation of this perception seriously limits the availability of emergency obstetric services to only those health care delivery institutions where

specialists in obstetrics and gynaecology, necessary support staff and infrastructure and facilities are available.

The approach currently being followed in India for the provision of emergency obstetric care services is the case in point in this regard. The emphasis, in this approach, is on providing emergency obstetric care facilities at the community health centre level and name the community health centres as the first referral unit. Below the community health centre level, the official approach is totally silent about the need as well as the availability of emergency obstetric care services. The approach adopted by the Government of India indirectly assumes that nothing substantial can be done below the community health centre level in dealing with obstetric emergencies and the only option left with the people and the grass roots level health and family welfare services providers is to refer the woman with obstetric complication to the nearest first referral unit or a district hospital within the shortest possible time. This approach, incidentally, has a number of loopholes which are particularly related to Madhya Pradesh. Because of geographical vastness and low population density, a health and family welfare services delivery provider in Madhya Pradesh has to travel, on average, a longer distance and has to cover larger geographical area than the health services provider in West Bengal and Kerala and even in Uttar Pradesh. Similarly, a woman having obstetric complications and needing emergency obstetric care has to travel a longer distance to reach either a community health centre or a district hospital where emergency obstetric care services are available. Since no emergency obstetric care services are available below the first referral unit, this journey to either a community health centre or to a district hospital is virtually unattended with the result that in majority of the situations, the woman in emergency reaches the institution where emergency obstetric services are available in a virtually unmanageable condition or dies during the transit.

It is obvious that the above approach of making available emergency obstetric care services for reducing the risk death due to complications of pregnancy and delivery among women thereby preventing maternal deaths is associated with at least two types of delays in making available emergency obstetric care services in situations where most of the deliveries are home deliveries and are attended either by family members or untrained birth attendants or minimally trained birth attendants. The first delay is related to the identification of the obstetric emergency. Since no expertise is available in general at the level where the emergency normally occurs, the emergency is normally identified at a very late stage creating further complications and even hampering the referral of the woman in distress.

The second delay, on the other hand, is related to the time elapsed between the onset of the obstetric complication and the time of reaching a health care facility where emergency obstetric care services are available to address the complication. This time depends upon the distance and the type of transport facility available. In situations that prevails in Madhya Pradesh, it often takes hours to reach either a community health centre or a district hospital during which practically no attention and care is provided to the woman.

The above considerations suggest that the strategy of making available emergency obstetric care services at the community health centres and district hospitals only is not the best option for ensuring universal availability of emergency obstetric care services in a manner that has a telling impact on the risk of a maternal death and reduction in maternal mortality. It is important for preventing a maternal death that

appropriate obstetric care services should be available at the place where obstetric emergencies occur - the grass roots level in a State like Madhya Pradesh. It is agreed that all emergency obstetric care services cannot be made available at the grass roots level. However, it is stressed that, at least, those services can be made available which can help in identifying the obstetric emergency at the earliest possible and referring the patient to either a first referral unit or a district hospital in a manageable condition. For the survival of the woman in distress, it is important that she reaches a health care facility where range of emergency obstetric care services are available in a manageable condition. In other words, emergency obstetric care services should not be confined to a community health centre or a district hospital. Rather they should be distributed right up to the grass roots level in a logical manner.

In this chapter, we present a conceptual plan for making available the emergency obstetric care services right up to the grass roots level in a manner that the impact of the delay in diagnosing the obstetric complication and the delay in reaching a health care facility is minimised. The plan is based on the understanding that not all type of emergency obstetric care services are required to be made available at all tiers of the health care delivery system.

### **Classification of Emergency Obstetric Care Services**

Emergency obstetric care services refer to interventions necessary to save life of the women. They can be as simple as obstetric first aid to stabilize the patient before referral (Post, 1997). Such obstetric aid can be made available at the grass roots level through a comprehensive training programme for the community level service providers. At the same time, emergency obstetric care services may be as complicated as a Cesarean-section which requires availability of a specialists in obstetrics and gynaecology, an army of support staff and a comprehensive set of necessary infrastructure and facilities which can be made available only at secondary and tertiary level health care delivery institutions. What is important in reducing the risk of complications associated with pregnancy and delivery thereby preventing maternal deaths and reducing maternal mortality is that every pregnant woman needs access to health care facilities which have capabilities to provide emergency obstetric care to the women in distress. Neither effective prenatal care nor classification of women as high risk or low risk on the basis of complications during pregnancy will help women if emergency obstetric services are not available, not accessible, or not utilized. Emergency obstetric care services are also called signal functions. The key signal functions are:

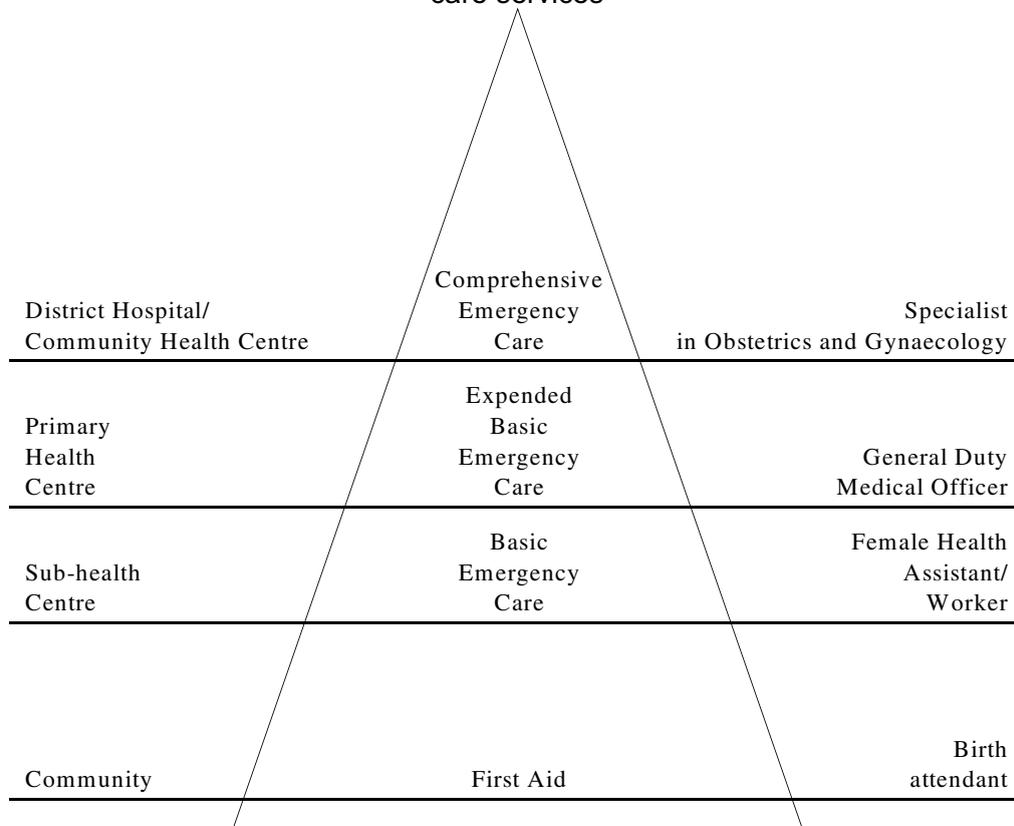
1. Administration of parenteral antibiotics.
2. Administration of parenteral oxytocic drugs.
3. Administration of parenteral anticonvulsants for preeclampsia and eclampsia.
4. Performing manual removal of placenta
5. Performing assisted vaginal delivery.
6. Performing surgery.
7. Performing blood transfusion.

Emergency obstetric care services have also been classified into four broad categories:

- a. *Obstetric First Aid*
  - Limited identification of the problem
  - Bimanual massage
  - Fluids by mouth
  - Oxytocin
  - Referral
- b. *Basic Emergency Obstetric Care*
  - Identification of the problems
  - Bimanual massage
  - IV
  - Oxytocin
  - Manual removal of retained placenta
  - Suturing perineum (up to 3<sup>rd</sup> degree)
  - Initial treatment of sepsis with injectable antibiotics and referral
  - Management of preeclampsia and eclampsia through initial dose(s) of diazepam or MGS and referral
- c. *Expanded Basic Emergency Obstetric Care*
  - Basic emergency obstetric care, and
  - Suturing cervix
  - Abortion (incomplete and elective)
  - Vacuum extraction
  - Essential newborn care, resuscitation
- d. *Comprehensive Emergency Obstetric Care*
  - Surgical obstetrics including caesarean-section, laparotomy for ectopic pregnancy, repair of vaginal and cervical tears, evacuation of retained products of incomplete abortion, amniotomy with or without oxytocin infusion to augment labour.
  - Safe blood
  - Anaesthesia
  - Medical treatment of shock, sepsis, eclampsia
  - Safe abortion
  - Essential newborn care, resuscitation.

The above classification of emergency obstetric care services is useful in evolving a hierarchical obstetric care delivery system that ensures availability of the emergency obstetric care services right up to the grass roots level, the level where most of the deliveries occur. This is essential to ensure for minimising the risk of death associated with obstetric complications thereby preventing maternal deaths and reducing maternal mortality. An advantage of the above classification is that emergency obstetric care services can be integrated with the existing primary health care delivery system, thus reducing the cost of making emergency obstetric care services universally available. Based on the aforesaid classification of emergency obstetric care services, it is possible to evolve a conceptual plan for making emergency obstetric care services available right up to the grass roots level. This conceptual plan is presented and discussed in the following section.

Figure 1  
The conceptual plan for universalising the availability of emergency obstetric care services



### **Integrated Approach to Universalising Emergency Obstetric Care Services**

The conceptual plan proposed for ensuring the universal availability of emergency obstetric care services is shown in figure 1 along with the linkages with the existing primary health care delivery system. This conceptual plan suggests that obstetric first aid should be made available at the community level whereas availability of the basic emergency obstetric care services should be ensured at the sub-health centre level. Similarly, the conceptual plan stresses that efforts should be made to make available expanded emergency obstetric care services at the primary health centre level whereas comprehensive emergency obstetric care services should be made available at the community health centres - the first referral units and the district and other specialised hospitals. This arrangement for making available the emergency obstetric care services ensures that obstetric complications are identified at the earliest possible at the community level; treated when possible; and referred to higher level of the health care delivery system in a manageable condition. This arrangement ensures that the chances of proper management and treatment of obstetric complications and the survival of the women in obstetric distress increase significantly even in a situation where most

of the deliveries are home deliveries and are conducted by non-professionals. Needless to emphasize, quick and correct diagnosis, proper case management and prompt referral and effective treatment are the key to minimise the risk of death due to complications of pregnancy and delivery and hence reducing maternal mortality and avoiding a significant proportion unwanted maternal deaths. The institution based approach has some serious limitations in this regard.

The conceptual plan presented in figure 1 also identifies the category of health service provider required at different tiers of the primary health care delivery system to ensure universal availability of emergency obstetric care services. The only issue that is worth stressing in this framework is the availability of professionally trained birth attendants at the community level to provide obstetric first aid to women in obstetric distress. It is important that the birth attendants must be trained and competent in life saving skills necessary to deal with life-threatening problems. In this context, the current approach of training of traditional birth attendants may contribute little to making emergency obstetric care services universally available. The reason is that these traditional birth attendants have been trained in conducting only the normal deliveries. Moreover, quite a substantial proportion of traditional birth attendants, despite all training and motivation, keep on believing that certain practices help women during delivery, although these, in fact cause harm.

Based on the conceptual plan given in figure 1, a comprehensive description of what should be done and what should not be done at different tiers of the primary health care delivery system has been developed for selected obstetric complications that are responsible for most of the maternal deaths. This specification is given in table 1 separately for the community level and for different tiers of the primary health care delivery system. The purpose of this specification is twofold. The first is to assess the human resources development needs at different tiers and the second is to assess the requirements of infrastructure and facilities necessary for making the emergency obstetric care services universally available. It is obvious that a comprehensive human resources development programme and availability of necessary infrastructure and facilities are essential for an efficient and effective emergency obstetric care services delivery system.

## **Conclusions**

Madhya Pradesh is one of those States of India where the risk of death due to complications of pregnancy and delivery continues to be amongst the highest in the country. According to the sample registration system, it is estimated that, around the year 1997, approximately 498 mothers died of the complications of pregnancy and delivery for 100,000 live births in the State (Government of India 1999), although this estimate of maternal mortality is rated as an underestimate of the actual situation. The Madhya Pradesh Population Policy which was announced in the year 2000 aims to reduce the risk of death due to complications of pregnancy and delivery to approximately 220 maternal deaths per 100,000 live births per year by the year 2011 (Government of Madhya Pradesh, 2000). In order to achieve this goal, the Policy stresses on promoting institutional deliveries and creating comprehensive emergency obstetric care facilities at the district hospitals and at the first referral units.

The present chapter argues that universal availability of emergency obstetric

care services is an essential requirement to achieve the goal of a maternal mortality of 220 maternal deaths per 100,000 live births as targeted in the Madhya Pradesh Population Policy. It stresses that just by providing comprehensive obstetric care services at the district hospital and community health centre levels, this goal may not be achieved. The chapter calls for a more pragmatic approach which can ensure universal availability of emergency obstetric care services which are critical to preventing majority of the maternal deaths. In this context, the chapter outlines a conceptual plan that may constitute the basis for planning for the universal availability of these services right up to the community level. One advantage of the conceptual plan presented here is that it can readily be integrated with the existing primary health care delivery system. This integration makes the universal availability of emergency obstetric care services, a cost-effective proposition. Another advantage of the integrated framework suggested here is that provision of emergency obstetric care services can be easily institutionalised within the existing system.

## References

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Table 1: Conceptual plan for the availability of services for specific obstetric complications at different levels of the primary health care delivery system				
History and Clinical Assessment	Sub-health Centre	Primary Health Centre	Community Health Centre	District Hospital
<i>Haemorrhage (Ante Partum)</i>				
G.C.- Pulse	I/V Fluid, Oxygen	Management of	Management of	Management of
B.P. R.R.	Life saving drugs	shock if present	shock, if	shock, if present
Gestational age	Catheterization	Injectable sedative	present	Blood transfusion
Abdominal Palpation	Provide sterile pad	Counselling	Blood transfusion	Caesarean section
Foetal Heart sound	Injectable sedative	Refer the patient	Caesarean section	Neonatal resuscitation
Amount, duration & colour of blood loss	No vaginal or rectal exam		Neonatal resuscitation	Counselling
Sign of labour (Pain)	Counselling		Counselling	Follow up
	Refer the Patient		Follow up	
	Immediately			
	Accompany the patient			
<i>Complications of Abortion</i>				
G.C.- Pulse	I/V Fluid	Management of	Management of	Management of
B.P., R.R.	Injection	shock if present	shock, if present	shock, if present
LMP	Methergin	I/V Fluid	Suction evacuation/	Suction evacuation/
Bleeding	Diazepam,	Injectable	Laparotomy	Laparotomy
Pervaginam amount & duration	Antibiotic	Oxytocics, sedative	Blood transfusion if required,	Blood transfusion if required,
Pain	Provide sterile pad	Antibiotic	Counselling	Counselling
	Counselling	Suction and evacuation	Follow up	Follow up
	Refer the Patient	Counselling	Family planning	Family planning
		Follow up		
<i>Ectopic Pregnancy</i>				
G.C.- Pulse	I/V Fluid	Management of	Management of	Management of
B.P., R.R.	Refer	shock, if present	shock, if present	shock, if present
Date of LMP			Laparotomy	Laparotomy
Bleeding pervaginam			Blood transfusion if required	Blood transfusion if required
Pain in abdomen			Counselling	Counselling
Urine for pregnancy test			Follow up	Follow up
			Family planning advise	Family planning advise

History and Clinical Assessment	Sub-health Centre	Primary Health Centre	Community Health Centre	District Hospital
<i>Haemorrhage (Post Partum)</i>				
G.C.- Pulse B.P., R.R. Abdominal & vaginal examination Amount of bleeding Time of delivery Cause of bleeding Atonic / Traumatic	Lower the Head end Start breast feeding I/V Fluid Injection Methergin IV Oxytocin Suturing of tear if possible No uterine exploration Pack the vagina Injectable antibiotics Counselling Refer the patient immediately Accompany the patient	Management of shock I/V Fluid, Catheterization Injection Methergin I/V Oxytocics Uterine massage Vaginal pack with abdominal binder Suturing of tear in traumatic PPH Injectable antibiotics Warmth of patient Blood grouping & Rh typing If bleeding is not controlled refer immediately	Management of shock Oxygen inhalation I/V Fluids, Investigations Blood transfusion Exploration atonic PPH Bimanual compression of uterus Injection of oxytocics, Suturing of vaginal/ cervical tear in traumatic PPH Hysterectomy if required Counselling Follow up	Management of shock Oxygen inhalation I/V Fluids, Investigations Blood transfusion Exploration Atonic PPH Bimanual compression of uterus Injection of oxytocics Suturing of vaginal/ cervical tear in traumatic PPH Hysterectomy if required Counselling Follow up
<i>PET</i>				
G.C.- Pulse B.P. Complained of swelling over limbs and face Rapid weight gain Headache/ blurring of vision Epigastric pain, vomiting Abdominal palpation Foetal heart sound Vaginal examination Urine for albumin	Sedative (diazepam) if high BP Urine for albumin Counselling Rest, sleep, diet rich in protein. Avoid extra salt Refer the patient for institutional delivery	Hospitalization Drugs Sedative, Anti-hypertensive if required Investigation Complete blood picture and urine R/M Counselling Refer the Patient for institutional delivery	Hospitalization Rest-left lateral position, sleep, diet Sedative Anti-hypertensive if required Complete blood picture and urine R/M Induction of labour Spontaneous labour Neonatal resuscitation Counselling Follow up	Hospitalization Rest-left lateral position, sleep, diet Sedative Anti-hypertensive if required Complete blood picture and urine R/M Induction of labour Spontaneous labour Neonatal resuscitation Counselling Follow up

History and Clinical Assessment	Sub-health Centre	Primary Health Centre	Community Health Centre	District Hospital
<i>Eclampsia</i>				
G.C.- Pulse	Keep the head	Keep the head	Hospitalization	Hospitalization
B.P., R.R.	turned to one	turned to one	Injectable sedatives	Injectable
Swelling over limbs and face	side.	side	and anti-convulsant	sedatives and anti-convulsant
Gestational age	Clear the air passage by	Clear the air passage by	Assisted vaginal	Assisted vaginal
Abdomen palpation	suction	suction	delivery/	delivery/
Foetal heart sound	Use padded spoon	Use padded spoon	Cesarean	Cesarean
Vaginal examination	if unconscious	if unconscious	Section	Section
Amount of urine	I/V Fluid	I/V Fluid	Neonatal resuscitation	Neonatal resuscitation
Urine albumin	Catheterization	Catheterization		
Number and Frequency of convulsions	Injectable sedative Counselling Refer immediately Accompany the patient	Sedation Anticonvulsant Counselling Refer immediately		
<i>Severe Anaemia</i>				
G.C.- Pulse	Advise regarding	Advise regarding	Hospitalization	Hospitalization
B.P., R.R.	diet, rest	diet, rest	rest, sleep, diet	rest, sleep, diet
Swelling over limbs and face	Hb%	Hb%	Treatment of the underlying cause	Treatment of the underlying cause
Pallor of conjunctiva/skin	Deworming Iron & Folic Acid Counselling Refer for blood transfusion	Blood group, Rh, urine, Stool Deworming Iron & Folic Acid Counselling Refer for blood transfusion	Complete investigation Blood transfusion if required Counselling Follow up	Complete investigation Blood transfusion if required Counselling Follow up
History of bleeding				
History of LMP				
<i>Prolonged / Obstructed Labour</i>				
G.C.- Pulse	Keep the woman nil orally	Management of shock if present	Management of shock if present	Management of shock if present
B.P.				
Temperature	I/V Fluid	Keep the woman nil orally	Assisted vaginal delivery	Assisted vaginal delivery
History of previous delivery	Injectable sedative Antibiotic	I/V Fluid	Cesarean Section	Cesarean Section
Gestational age	Catheterization	Injectable sedative	Blood transfusion if required	Blood transfusion if required
Abdomen palpation	Counselling	Catheterization	Neonatal resuscitation	Neonatal resuscitation
Pattern of uterine contraction	Refer Accompany the patient	Counselling Refer	Counselling Follow up Family planning advise	Counselling Follow up Family planning advise
Foetal heart sound				
Vaginal examination				
Progress of labour				

History and Clinical Assessment	Sub-health Centre	Primary Health Centre	Community Health Centre	District Hospital
<i>Retained Placenta</i>				
G.C.- Pulse B.P. ,R.R Temperature Time of delivery Amount of bleeding Abdominal palpation Vaginal examination	Start breast feeding I/V Fluid Catheterization IV oxytocine Antibiotic Controlled cord traction If placenta is still retained refer immediately Accompany the woman	Start breast feeding I/V Fluid Catheterization IV oxytocine Antibiotic Controlled cord traction Blood for blood group, Rh, Hb If placenta is still retained refer immediately	Manual removal of placenta Blood transfusion if required Counselling Follow up Family planning advise	Manual removal of placenta Blood transfusion if required Counselling Follow up Family planning advise
<i>Puerperal Sepsis</i>				
G.C.- Pulse B.P. Temperature Time of delivery Breast examination Abdominal/ vaginal examination Colour and smell of Lochia Examination of lower extremities Pain	Fluid intake(oral/I/V) Hb, Urine Antibiotics Metronidazol Methergin Analgesic Anti malarial in endemic region Continue breast feeding Psychological support Counselling Refer	Fluid intake (oral/ I/V ) Complete blood picture, urine Antibiotics IV Metronidazol Analgesic Anti malarial in endemic region Psychological support Counselling Refer	Hospitalization Complete blood picture, urine R/M Explore the cause Drugs Antibiotics Metronidazol (I/V) Vaginal douche Counselling Psychological support Follow up	Hospitalization Complete blood picture, urine R/M Explore the cause Drugs Antibiotic Metronidazol (I/V) Vaginal douche Counselling Psychological support Follow up
<i>Care of new born</i>				
Cry (immediate or delayed) Temperature Feed Weight Jaundice/ Sepsis Immunization	Suction Initiate breathing Oxygen Ventilation with ambubag Maintain circulation Keep the baby warm Breast feeding Antibiotic Identify neonate at high risk Counselling Refer Continue resuscitation if necessary	Suction Initiate breathing Oxygen Ventilation with ambubag Maintain circulation Keep the baby warm Breast feeding Antibiotic Identify neonate at high risk Counselling Refer Continue resuscitation if necessary	Birth asphyxia Neonatal resuscitation Care of pre term Incubator Phototherapy Injectable antibiotics if sepsis Counselling Follow up	Birth asphyxia Neonatal resuscitation Care of pre term Incubator Phototherapy Injectable antibiotics if sepsis Counselling Follow up

Table 2: Specifications of obstetric aid that should be made available at the Community level		
Obstetric Complication	General Assessment	Action
Haemorrhage (Ante Partum)	Assess general condition Gestational age Abdominal Palpation Amt. duration and colour of blood lost Sign of labour	Do not leave the woman unattended Position the woman Empty the bladder. Do not attempt vaginal examination Counselling Refer and accompany
Complications of abortion	Assess general condition LMP Abdominal Palpation Tenderness, distension Bleeding per vaginum Amount duration and colour of blood lost	Do not leave the woman unattended Position the woman Empty the bladder. Counselling Refer and accompany
PPH	Assess her general condition Abdominal and vaginal examination Amount of bleeding Time of delivery Placenta delivered out/not	Do not leave the woman unattended Lower the head end Start breast feeding Empty the bladder Abdominal massage Abdominal binder and vaginal packing Counselling Refer and accompany
PET	Assess general condition Gestational age Watch for swelling over limbs and face Rapid Weight Gain Headache/ Blurring of vision Epigastric pain, vomiting Abdominal and vaginal examination	General information regarding diet, rest and sleep Counselling Refer for institutional delivery
Eclampsia	Assess general condition Gestational age Watch for swelling over limbs and face Rapid Weight Gain Headache/ Blurring of vision Epigastric pain Vomiting Abdominal and vaginal examination	Keep the head turned to one side Nil orally Counselling Explain the condition to her family members Refer immediately Accompany the patient

Obstetric Complication	General Assessment	Action
	Number and frequency of convulsions	
Severe Anaemia	Assess general condition (pallor, puffines) Swelling over limbs and face History of LMP	Advise regarding diet, rest and regular antenatal checkup Iron and folic acid tablets Counselling Refer for investigations and blood transfusion
Puerperal Sepsis	General condition Temperature Time of delivery Breast examination Abdominal examination Colour and smell of Lochia	Fluid intake Continue breast feeding Psychological support Counselling Refer the patient
Care of new born	Cry (immediate or Delayed) Temperature Feed Weight Jaundice/ Sepsis Immunization	Suction by mucus extractor Initiate Breathing Tactile stimulation Keep the baby warm Early breast feeding Identify neonate at high risk Counselling Refer