وزارة الصحة
Ministry of Health

The Saudi Midwifery Clinic Standards

Midwifery Units Advisory Committee
Midwifery Department
General Department of Nursing Affairs
Deputyship for Therapeutic Services

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Preface

This document presents the **midwifery clinic standards** of care in Saudi Arabia recognising the need for evidence-based care, placing the family at the centre. Therefore, the Midwifery Department at the General Department of Nursing Affairs in the Ministry of Health, Saudi Arabia has initiated a Midwifery Units Advisory Committee (MUAC) on February, 2021 under Dr. Tareef Alaama, Deputy Minister for Curative Services and the support of Dr. Mohammed Alghamdi, General Director of Nursing Affairs, with a membership of consultants from Ministry of Health (MOH) and various sectors. The creation of the midwifery clinic standards is the first output of the advisory committee.

This is the first version of the midwifery clinic standards, which the committee has made great efforts to accomplish. It has adopted the international references and the publications of the International Confederation of the Midwives (ICM) and the MOH in Saudi Arabia. These standards should be reviewed every 5 years after audit from the time of implementation of these standards.

We would encourage stakeholders and leaders in Saudi Arabia to use this tool as part of local quality improvement and to take the initiative to move maternity care forward.

Chairperson of the Midwifery Units Advisory Committee

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Introduction

The Saudi Ministry of Health (MOH) initiated a new model of care for vision 2030 which shifts the focus from curative care to preventive care.

Systems of care will operate less in hospitals and more in people's homes and communities. In maternity care the future vision is to have low-risk birth at home or at a birth centre, in addition to hospitals depending on the preference of the woman and her family. Low-risk women will receive all antenatal and postnatal care by an appropriately trained and experienced primary care physician/midwife, as appropriate, with the option to refer to the comprehensive obstetrics service when needed (MOH, 2017).

Pregnancy and childbirth are considered normal life events and the midwife has been identified as the most suitable and cost-effective healthcare professional to provide care in normal pregnancy and childbirth, including risk assessment, recognition of complications, optimising normal biological, psychological, social, and cultural processes of reproduction and early life; timely prevention and management of complications; consultation with and referral to other services; respect for women's individual circumstances and views; and working in partnership with women to strengthen women's own capabilities to care for themselves and their families (Renfrew et al, 2014). Midwife-led continuity of care has been associated with positive outcomes including reduced maternal and neonatal morbidity, reduced stillbirths, reduced interventions in labour, improved psycho-social outcomes and increased birth spacing and contraceptive use (Sandall, et al., 2016).

The State of the World's Midwifery Report (SoWMY, 2021) showed that midwives, when educated, licensed and fully integrated in and supported by interdisciplinary teams, and in an enabling environment, can deliver about 90% of essential Sexual, Reproductive, Maternal, Newborn and Adolescent Health (SRMNAH) interventions across the life course and can provide a wide range of clinical interventions and contribute to broader health goals, such as advancing primary health care, addressing sexual and reproductive rights, promoting self-care interventions and empowering women.

Aim of Midwifery Clinic Standards

The aim of the midwifery clinic standards is to promote and support the development and implementation and growth of midwifery clinics which provide holistic care to women and their family throughout Saudi Arabia. In addition, to improve the quality of midwifery care, reduce variation in practices and facilitate a family-centred model of care.

Midwifery Scope of Practice

The scope of midwifery practice is the expected range of roles, functions, responsibilities and activities that a midwife registered with the Saudi Commission for Health Specialities (SCFHS) is educated for and is competent and authorised to perform. It defines the accountability and limits of practice in Saudi Arabia.

The midwife working in the clinic should provide necessary support, care and advice during pregnancy, and postnatal period. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the access of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare depending on the category of midwifery clinic.

Topic 1: Philosophy and Model of Care

The philosophy and model of midwifery care is to work in partnership with women, support the normal physiological process of pregnancy and childbirth, postpartum period and normal physiology of the newborn. In addition, prevention of disease/promotion of health for the woman and newborn, supported of individual responsibility, shared decision-making and self-sufficiency, and a holistic integrated approach to the delivery of health services. Midwives use professional knowledge, skills and attitudes to competently support the woman and her baby. Midwifery protects and enhances the health of women and babies as a family, which in turn protects and enhances the health and wellbeing of society as well as protection from harm.

Standard 1: Midwifery practice is underpinned by a philosophy that protects, promotes the safety and autonomy of the woman and respects her experiences, choices, priorities, beliefs and values

Having a written and public philosophy of safe care document which needs to be jointly agreed among stakeholders. This document includes statements on autonomy, diversity and equality and how this will be achieved, including women's reproductive rights and choices on care.

Topic 2: Scope of Midwifery Clinic

Standard 2: Midwives practise in line with legislation and professional guidance and are responsible and accountable within their scope of midwifery practice

The midwife clinic shall provide 3 categories of services according to the midwife's essential competencies (MOH, 2019; ICM, 2019). Care that the midwife clinic provides may include:

Category A: Antenatal and postnatal care

Category B: Sexual and reproductive health

Category C: Basic women's health

Depending on education and experience, midwives can be classified and be active in only one, two or all these three categories. Working in the different categories requires specific competencies of the midwife, below further developed/specified.

Category A: Antenatal and Postnatal Care

Antenatal Care

Antenatal care (ANC) should promote good pregnancy outcomes and reduce maternal and perinatal mortality and morbidity. ANC provides a platform for critical healthcare functions including holistic approaches, cultural sensitivity, health promotion, prevention, screening and detecting the risk factors. Implementing timely and appropriate evidence-based practices with informed consent during ANC can improve maternal and foetal health and consumer satisfaction. This is a great opportunity to communicate with and support women, families, and communities at this very pivotal time during their lives (WHO, 2017).

Standard 3: Booking appointment should ideally occur before 10 weeks of pregnancy with a minimum of eight contacts/visits are recommended

Booking appointment should ideally occur before 10 weeks of pregnancy with a minimum of eight contacts/visits are recommended to reduce perinatal mortality and improve women's experience of care

- Appointments should be adequate but flexible according to each woman's risk assessment, emotional and physical needs.
- All antenatal care should be recorded and documented according to the antenatal card (**see Appendix 1 and 2**).
- All women should have a named midwife throughout their pregnancy.
- Women with complex social, medical, obstetric or foetal conditions should have a named lead physician who works with the woman's named midwife.
- Women should be offered screening for factors which may impact on the outcome of the pregnancy

and where one or more of the risk factors are identified (**see Appendix 3**) or any deviation from the normal, they should be referred to an obstetrician/physician. The midwife should complete a referral form in full and sign and date it, then make sure it goes to the obstetrician/physician with the woman **(see Appendix 4).**

- The schedule of antenatal appointments should be determined and should ensure that women receive appropriate written information by the function, reasonable number, timing and content of the appointments and be flexible to each individual case, some visits can be done virtually when needed **(see Appendix 5**).
- Booking appointment should last for up to one hour. Longer appointments are needed in early pregnancy to allow comprehensive assessment and hold discussions around a working partnership and provide an individualised plan of care and risk assessment.
- Appointments should offer/perform routine tests and investigations that are in agreement with institution policy and to minimise any inconvenience to the women.
- All healthy pregnant women in the Primary Health Care (PHC) should be referred to an antenatal clinic in the health institution by 35 weeks for preparation for birth.

Standard 4: In the midwife clinic, according to women age and risk factors, midwife should provide consultation, early detection and preventative measure for antenatal care

During antenatal visits the midwife shall do the following but not limited to:

- Check vital signs, height and weight at each visit.
- Establish duration of pregnancy.
- Take woman's clinical history including allergies to food and drugs.
- Do obstetrics assessment and screening to low-risk pregnant women.
- Perform prenatal assessment (obtain history, abdominal palpation, auscultation of the foetal heart rate).
- Carry out perinatal mental health assessment.
- Assess for the risk of Venous Thromboembolism (VTE).
- Detect early maternal warning signs.
- Detect, stabilise, manage and refer women with complicated pregnancy.
- Check laboratory test results.
- Review woman's data in the system (e.g., history, blood tests and diagnostic results).
- Document findings in system.
- Provide follow up appointment.
- Request and follow up all routine investigations and ultrasounds as per midwife clinical pathway.
- Prescribe antenatal medications such as Vit D, Vit B12, Vit C, Folic acid, Ferrous sulphate (iron) (IV, or tablets), Anti D if mother Rh negative, Glycerine suppositories, antifungal cream/suppositories, paracetamol, heartburn medications
- Prescribe vaccination as needed
- Provide appropriate health and antenatal education to pregnant women during visits and document, one to one or group antenatal care (see Appendix 5).

Standard 5: The midwife who will make the risk assessment and determine the case low or high risk and therefore she will transfer the case to the obstetrician/physician

Pregnant women are considered low risk if:

- Age of the woman is more than 17 years old but less than 40 years old.
- Multipara woman with less than 6 births.
- Women with spontaneous pregnancy.
- Singleton pregnancy.
- Body Mass Index (BMI) should be more than 18 and less than 40.
- Previous caesarean section but not more than twice.
- No obstetric or medical, foetal and/or neonatal condition precluding a safe labour, birth and postpartum period such as: recurrent miscarriage, Gestational Diabetes Mellitus, Diabetes Mellitus, Hypertension, Pregnancy Induced Hypertension (PIH), Deep Vein Thrombosis (DVT), cardiac disease, renal or liver disease. etc**.**

Standard 6: The midwife clinic has a system of clear referral pathways during antenatal care

- The system of clear referral pathways is for women who require additional care because of pre-existing medical conditions or because of complications during their pregnancy are cared for and treated by the appropriate multidisciplinary or specialist teams, including anaesthetic assessment when problems are identified.
- It may be appropriate for a midwife to continue midwifery care and work alongside the obstetrician/physician (multidisciplinary team work).
- Services should provide personalized advice from an appropriately trained person on healthy eating and physical activity for pregnant women with a body mass index (BMI) of 30 or more at the booking appointment.
- Women who smoke should be referred to an evidence-based stop smoking service at the booking appointment.
- Women with history of drug or alcohol abuse should be referred to physician.

Standard 7: All women should be prepared for their birth during their antenatal appointments

- Women should be guided to select the companion to attend their birth. Check companion policy (MOH, 2019).
- Women and their companion should be encouraged to attend antenatal classes (in person or virtually).
- All women should be asked to fill in their individualised birth plan during their antenatal appointments (an individualised birth plan is a guide for midwife developed in discussion with the individual woman and her partner or main support people which reflects their preferences about the planned birth).

Postnatal Care

Postnatal period is a critical phase in the lives of mothers and newborn babies. Major changes occur during this period which determine the well-being of mothers and newborns. Yet, this is the most neglected time for the provision of quality services. Lack of appropriate care during this period could result in significant ill health and even death.

Standard 8: Shortly after birth an identified lead midwife, should be responsible for reassessing individual needs and coordinating the postnatal care of all babies and women

- Midwives should negotiate discharge planning and assesses woman's wellbeing prior to discharge.
- Postnatal follow up appointments should be arranged with the appropriate services before the women is discharged.
- Women should have access to their midwife as they require after having had their baby. Those requiring longer care should have appropriate provision and follow up in designated clinics.
- One to one or group postnatal care or sessions should be available to all postnatal women.
- Women should be provided with readily accessible information (including helpline numbers) including but is not limited to support in their chosen method of feeding, access to peer support groups, voluntary organisations, and physiotherapist, etc.
- At each postnatal contact, parents should be offered information and advice to enable them to:
  - Assess their baby's general condition.
  - Report early postnatal warning signs.
  - Identify signs and symptoms of common health problems seen in babies **(see Appendix 6).**
  - Contact a healthcare professional or emergency service if required.

Standard 9: The postnatal care should be arranged according to national postnatal care guidelines

- The schedule of postnatal appointments/visits should be determined and should ensure that women receive appropriate written information by the function, reasonable number, timing and content of the appointments and be flexible to each individual case and can be done virtually when needed (see Appendix 7).
- All postnatal care for the mother and newborn should be recorded and documented according to the postnatal card (see Appendix 8).

The minimum postnatal appointments are 2 visits:

- The recommended WHO (2013) postnatal visits should be as following:
- **If birth is in a health facility**, mothers and newborns should receive postnatal care in the facility for at least 24-36 hours after birth.
- If birth is at home, the first postnatal contact should be as early as possible within 24 hours of birth.
- At least three additional postnatal contacts are recommended for all mothers and newborns, on day 3 (48–72 hours), between days 7–14 after birth, and 6-8 weeks after birth.
- If there are issues or concerns about the mother or baby, additional **(virtual) phone contacts/ home visits** may be required.

Assessment of mother

First 24 hours after birth:

- Regular assessment of vaginal bleeding, uterine contraction, fundal height, temperature and heart rate (pulse) routinely.
- Assessment for the risk of Venous Thromboembolism (VTE).
- Assessment for early postnatal warning signs.
- Blood pressure should be measured shortly after birth. If normal, the second blood pressure measurement should be taken within six hours.
- Urine void should be documented within six hours.

Beyond 24 hours after birth

- At each subsequent postnatal contact, enquiries should continue to be made about general well-being and assessments made regarding the following: micturition and urinary incontinence, bowel function, healing of any perineal wound, headache, fatigue, back pain, perineal pain and perineal hygiene, breast pain, uterine tenderness and lochia.
- Breastfeeding progress should be assessed at each postnatal contact.
- At each postnatal contact, women should be asked about their emotional wellbeing, what family and social support they have and their usual coping strategies for dealing with day-to-day matters. All women and their families/partners should be encouraged to tell their health care professional about any changes in mood, emotional state and behaviour that are outside of the woman's normal pattern.
- At 10–14 days after birth, all women should be asked about resolution of mild, transitory postpartum depression ("maternal blues"). If symptoms have not resolved, the woman's psychological well-being should continue to be assessed for postnatal depression, and if symptoms persist, referral to specialist should be done.
- Women should be observed for any risks, signs and symptoms of domestic violence or abuse. Women should be told whom to contact for advice and management.
- All women should be asked about resumption of sexual intercourse and possible dyspareunia as part of an assessment of overall well-being four to six weeks after birth.
- If there are any issues of concern at any postnatal contact, the woman should be managed and/or referred according to national guidelines or local policies and procedure.

Postnatal care for the newborn

- The following signs should be assessed during each postnatal care contact and the newborn should be referred for further evaluation if any of the signs is present:
  - stopped feeding well,
  - history of convulsions,
  - fast breathing (breathing rate ≥60 per minute),
  - severe chest in-drawing,
  - no spontaneous movement,
  - fever (temperature ≥37.5 °C),
  - low body temperature (temperature >35.5 °C),
  - any jaundice in first 24 hours of life, or yellow palms and soles at any age.

- The family should be encouraged to seek health care early if they identify any of the above danger signs in-between postnatal care visits.

- Bathing should be delayed until 24 hours after birth.
- Appropriate clothing of the baby for ambient temperature is recommended.
- The mother and baby should not be separated and should stay in the same room 24 hours a day.
- Communication and play with the newborn should be encouraged. Immunization should be promoted as per existing national guidelines or local policies and procedure.
- Preterm and low-birth-weight babies should be identified immediately after birth and should be provided special care as per existing national guidelines or local policies and procedure.
- Clean, dry cord care is recommended for newborns born in health facilities and at home.

Exclusive breastfeeding

- All babies should be exclusively breastfed from birth until 6 months of age.
- Mothers should be counselled and provided support for exclusive breastfeeding at each postnatal contact.

Counselling

- All women should be given information about the physiological process of recovery after birth, and that some health problems are common, with advice to report any health concerns to a health care professional, in particular:
  - Signs and symptoms of Postpartum Haemorrhage (PPH): sudden and profuse blood loss or persistent increased blood loss, faintness, dizziness, palpitations/tachycardia.
  - Signs and symptoms of pre-eclampsia/eclampsia: headaches accompanied by one or more of the symptoms of visual disturbances, nausea, vomiting, epigastric or hypochondrial pain, feeling faint, convulsions (in the first few days after birth).
  - Signs and symptoms of infection: fever, shivering, abdominal pain and/or offensive vaginal loss.
  - Signs and symptoms of thromboembolism: unilateral calf pain, redness or swelling of calves, shortness of breath or chest pain.
- Women should be counselled on nutrition.
- Women should be counselled on hygiene, especially handwashing.
- Women should be counselled on birth spacing and family planning. Contraceptive options should be discussed, and contraceptive methods should be provided if requested.
- Women should be counselled on safer sex including use of condoms.
- All women should be encouraged to mobilize as soon as appropriate following the birth. They should be encouraged to take gentle exercise and make time to rest during the postnatal period.

Psychosocial support

- Screening for mental health and psychosocial support by a trained health professionals is recommended for the prevention of postpartum depression.
- Health professionals should provide an opportunity for women to discuss their birth experience during their hospital stay.
- A woman who has lost her baby should receive additional supportive care.

Standard 10: The midwife clinic has systems in place to provide women and their babies with an individualised postnatal care plan

- The postnatal care plan should be developed with the mother, ideally in the antenatal period or as soon as possible after birth which is reviewed and documented at each postnatal contact.
- At each postnatal contact, women should be asked about their emotional well-being, what family and social support they have and their usual coping strategies for dealing with day-to-day matters.
- Midwives should be able to distinguish normal emotional and psychological changes from significant mental health problems, and to refer women for support according to their needs.
- Local or national comprehensive clinical guideline and checklists should be used at each postnatal visit/check to ensure that all potential health and social needs are considered and addressed.
- Midwives should follow up with the parents that the national screening programs and vaccinations are completed.

Standard 11: The midwife clinic has a system of clear referral pathways during postnatal care

- A system of clear referral pathways during postnatal care is for women who require additional care because of pre-existing medical conditions or because of complications during their postnatal are cared for and treated by the appropriate multidisciplinary or specialist teams.
- Midwives should detect, treat and stabilise postnatal complications in woman and the newborn infant and refer when necessary.
- Women with a BMI of 30 or more at the 6–8 week postnatal check to be offered a referral for advice on healthy eating and physical activity.
- Midwives should ensure smooth transition between midwifery, obstetric and neonatal care.

Standard 12: Midwives should implement a structured programme that encourages breastfeeding, using the Baby Friendly Initiative as a minimum standard

- Breastfeeding support should be made available regardless of the location of care.

Standard 13: Midwives should advice and provide printed information to the family about newborn postnatal care

Printed information include but is not limited to:

- breastfeeding
- metabolic screening test
- cardiac screening test
- hearing screening test
- vaccination
- postnatal maternal warning sign and complictions

Category B: Sexual and Reproductive Health

Standard 14: In the midwife clinic, according to women age and risk factors, the midwife should provide consultation, early detection and preventative measure for sexual and reproductive health

The midwife should provide consultation, early detection and preventative measure for advanced women's health includes but is not limited to:

- General women's health history taking (medical, surgical, social, medications, allergies and family);
- Vital signs
- Weight and height
- Instant blood sugar test and urine analysis
- Routine laboratory tests (e.g., CBC).
- Sexual screening, counselling and **gynaecological exam** including but not limited to:
  - vaginal swabs,
  - cervical swab and screening (Pap test),
  - Sexual Transmitted Infections (STI) test.
- Comprehensive review of systems to find related risk factors that will guide screening, counselling recommendations and referral according to data interpretations.
- Family planning including IUCD insertion
- Abortion care and support
- Issues relating to sexuality and relationships
- Health education discussions with and for women and their families
- One to one or group session for women's health issues.

Category C: Basic Women's Health

Standard 15: According to women age and risk factors, midwife should provide consultation, early detection and preventative measure for basic women's health

The midwife should provide consultation, early detection and preventative measure for basic women's health includes but is not limited to:

- General women's health history taking (medical, surgical, social, medications, allergies and family);
- Vital signs
- Weight and height
- Instant blood sugar test and urine analysis
- Routine laboratory tests (e.g., CBC).
- Women cancer screening including breast, cervical, colorectal based on patients' values, and potential benefits and harms.
- Information, screening and counselling for:
  - lifestyle,
  - general body fitness, core body and pelvic floor exercise,

- menstrual health,
- preconception,
- osteoporosis,
- obesity,
- tobacco use,
- drug and alcohol misuse,
- domestic violence,
- peri and post-menopausal care,
- mental health.
- Health education discussions with and for women and their families
- One to one or group session for women's health issues
- Vaccination

Topic 3: Physical Location and Structure

Standard 16: The midwife clinic shall be located in the Primary Health Care (PHC), Outpatient Departments (OPD) within a hospital, or polyclinics

If the midwife clinic is located within polyclinics, the polyclinic should provide midwifery support services. And shall have the following:

- Screening and triage area
- Treatment room
- Point of Care (POC) system for investigations
- Support areas for staff
- Support areas for families, mothers and companions
- Room for MotherBaby-Family Unit education, training sessions, and consultation
- A space for group care and classes (e.g., breastfeeding courses, antenatal and postnatal care and education, women's health)
- OBGYN ultrasound unit
- Breastfeeding room.

Topic 4: Policy and Procedure and Training Requirements

Standard 17: The midwife clinic has a clear policy and procedures, training and skills required of midwives in place

The midwifery clinic has a document in place detailing the policy and procedure, training and skills required of midwives to work in the midwifery clinic include, but is not limited to:

- History and physical and risk assessment/reassessment of mothers and newborn recognising abnormalities
- Antenatal and postnatal care including clinical pathways including but not limited to perinatal mental health, Patient Health Questionnaire-9 (PHQ-9) in detecting perinatal depression, Venous Thromboembolism (VTE) prophylaxis in pregnancy and postpartum.
- Monitoring mother and newborn's vital signs and knowledge of acceptable deviations from the norm
- Eligibility criteria guidance
- Consultation, referral, transfer of care including specific referral pathways
- Communication skills
- Reflective and reflexive skills
- Ultrasound in pregnancy for level 1
- Vaginal examination during pregnancy and labour
- Use of Speculums
- Screening of vaginal and urine infection
- Care of women during normal childbirth and conducting normal birth
- Care of women during assisted vaginal birth (Instrumental birth)
- Assessment and monitoring of diabetes in pregnancy
- Labour position and comfort measure
- Perineal trauma and suturing
- Pain assessment
- Foetal Heart Rate (FHR) monitoring (Cardiotocography CTG, Doppler) assessment and interpretation of CTG the management of non-reassuring FHR
- Intravenous (IV) cannulation (insertion, maintenance, discontinuing)
- Iron intravenous administration
- Phlebotomy
- Investigations needed for women and newborn
- Anti-D immunoglobulin for Rhesus D prophylaxis
- Early maternal warning signs
- Urinary catheters
- Infection control measures
- Patient falls (assessment of risk and methods to prevent falls)
- Midwifery role in cardiac/respiratory arrest
- Midwifery role in disaster, fire, and other emergencies
- Operation of blood sugar testing equipment
- Emergency measures for obstetric emergency cases such as eclampsia and pre-eclampsia

- Breastfeeding and lactation support
- Postpartum haemorrhage recognition and care
- Immediate newborn care
- Maternal and newborn vaccination
- Health education for women and their families
- Detection and reporting of risks, signs and symptoms of mother and child abuse/violence
- Reporting sentinel event
- Sexual and reproductive health including family planning such as IUCD insertion
- Women's health annual screening such as pap smear test, breast examination, osteoporosis

Standard 18: Midwives should have demonstrated competency in the essential competencies for basic midwifery practice, keep up to date with midwifery practice by undertaking relevant Continuing Professional Development (CPD), and sufficient ongoing clinical midwifery training

1. Midwives assume responsibility for own decisions and actions as an autonomous practitioner
2. Midwives assume responsibility for selfcare and self-development as a midwife
3. Midwives recognise conditions outside midwifery scope of practice and refer appropriately
4. Midwives have the requisite knowledge and skills from obstetrics, neonatology, gynaecology, public health and ethics that form the basis of high quality, culturally relevant appropriate care for women, newborn, infant and childbearing families
5. Provide pre-pregnancy care
6. Midwives provide high quality, culturally sensitive health education and services to all in the community in order to promote **healthy family life, planned pregnancies**, and **positives parenting**
7. Midwives provide high quality of **antenatal health education** and care to maximize health during pregnancy and that includes **early detection and treatment or referral of selected complication**
8. Midwives provide high quality, culturally sensitive care d**uring labour, conduct an uncomplicated normal safe birth and handle emergency situations to maximize the health of mother and their infant**
9. Midwives provide comprehensive, high quality, culturally sensitive **postpartum care and health education and promotion for the mother**
10. Midwives provide high quality, comprehensive care for the **essentially healthy newborn from birth to two months of age**
11. Midwives assess, plan, provide and evaluate midwifery care in relation to **peri and post-menopausal care and advice**
12. Midwives provide a range of individualized, culturally sensitive **abortion-related care services** for women with applicable laws and regulations in accord with national policies.

Standard 19: There is a written agreed list of knowledge, skills and competencies required of midwives to work in a midwifery clinic

- The midwife clinic has a document (logbook) in place detailing the knowledge, skills and competencies required of midwives updated and reviewed annually.

Topic 5: Staffing and Workload

Standard 20: Qualified midwives shall be responsible for managing the midwife clinic

- Minimum of two qualified midwives should be responsible for managing the midwife clinic.
- In order for the midwife to run category B and C she should complete the necessary courses according to the midwives guidebook privileges such as family planning, ultrasound level 1, etc.

The following criteria are for the midwife who will run the midwifery clinic, her experience, training needed and competencies:

- **Technician Midwife (3 years' Associate Diploma):** should have **1 year** training in clinic supervised by physician/certified consultant practising midwife and completed the logbook for all competencies according to the category of midwifery clinic with a minimum of 2 years' experience as a midwife in labour and birth/antenatal and postnatal ward with logbook competencies or letter certifying completed competencies from health institution.
- **Specialist/ Senior Specialist/ Consultant Midwife**: should have **6 months** training in clinic supervised by physician/certified consultant practising midwife and completed the logbook for all competencies according to the category of midwifery clinic with a minimum of 1 year experience as a midwife in labour and birth/antenatal and postnatal ward with logbook competencies or letter certifying completed competencies from health institution.

Topic 6: Supplies and Equipment

Standard 21: The midwife clinic has equipment, medications, and tools that meet the needs of mother and newborn

The equipment and tools that meet the needs of mother and newborn include and is not limited to:

- Office table
- 3 chairs (space for companion/support chair)
- Computer connected to the internet
- Printer
- Telephone with line connection for internal and external communication
- Gynaecological examination bed, the direction of beds does not face the door and have curtain to ensure privacy
- Storage for supplies
- Area for written or electronic documentation
- Portable Ultrasound machine
- Foetal heart Doppler
- Cardiotocography (CTG) optional
- Automated blood pressure monitoring machines or the sphygmomanometers
- Pulse oximetry
- Disposable tape measure
- Towels
- Waste bins
- Handwashing station
- Adequate examination lights (ceiling and/or portable)
- Newborn weighing scale
- Adult weighing scale
- Stethoscope
- Thermometer
- Sterilized normal vaginal birth sets (including but not limited to sheets, neonates bulb suction, cord clamp, gauze, kidney dish, cord cutter, scissors) for emergency use
- Perineal and vaginal repairs trays (2 Artery forceps, scissors, tissue forceps, needle holder and sutures) for emergency use.
- Sterilized gloves, gowns, gauze, cotton balls and clean linens
- Blankets
- Pillows
- Disposable gloves
- Urine collection bottle
- Pap smear (liquid-based cytology)
- Vaginal swap (red and blue head cover)
- Needles and syringes and IV insertion set
- Blood test tubes

- Disposable examination bed cover sheet
- Speculums
- Vaginal k-y gel
- Ultrasound gel
- Xylocaine spray
- Disposable kidney dish
- Sharp container
- Antiseptic solution
- Under pad sheet
- Filled oxygen cylinder with cylinder carrier and a source of oxygen
- Urinary bladder catheters
- Urine dipstick strips for all parameter specifically sugar, ketone and protein
- Hammer
- Personal Protective Equipment (PPE)
- Dressing kit
- Glucocheck and strips
- Educational tools such as Doll Pelvis, Charts, Birth ball.

Topic 7: Clinical Governance

Standard 22: The midwife clinic has a robust information system

The midwife clinic has a robust information system which is in line with the Saudi Arabia regulations on data protection and storage at operational, managerial, and strategic levels that ensures:

- A system for documentation of discussion with the woman, evidence-informed clinical advice given and her decision in her notes.
- A system in place which can generate statistics and key performance indicators (KPIs) from the electronic data with clinical audits for their performance, productivity and outcome every 4 to 6 months.

Standard 23: The midwife collects and documents comprehensive assessments of the woman and/or baby's health and wellbeing

- Collects and constructs information from the first visit or with the first formal contact with the woman.
- Collects information from other health professionals with consent from the woman.
- Personal and family information's details, physical, psychological, emotional well-being, and cultural dimensions, physical social and cultural environment.
- Acknowledges the individual nature of each woman's pregnancy in assessments and documentation and employs the information as a basis for ongoing maternity care.

Standard 24: The midwife keeps purposeful, ongoing and updated records and makes them available to other relevant health professionals

- Remove link attached at every visit.
- Ensures information is dated, readable and signed.
- Records must be always available and within reach to the woman and others who may be involved in her care with the woman's knowledge and consent.
- Records of event, information given, and action planned with the woman's consent.
- Reports a safety and sentinel events.
- Confidentiality of information and the storage of records must be as per current legislation.
- The mother has copy of her own records.

Standard 25: An established consultation, collaboration or referral system to meet the needs of a woman or baby outside the scope of midwife clinic practice in both emergency and non-emergency circumstances

- Actions are prioritised and implemented appropriately without putting the woman or baby at risk.
- Actions are formed on the basis of current trustworthy knowledge and according to the acts, regulations, and relevant policies.
- Assessments must be ongoing and updated.
- Life threatening situations take priority.
- Demonstrates competency to act effectively in any maternity emergency situation.
- Identifies changes from the normal, informs the woman and with her consent consults and refers appropriately.
- Works as a team with other health professionals and community groups.

- Refer or consult appropriately when she has reached the limit of her expertise.
- Support women to ensure optimum health care.

Standard 26: The midwife should be accountable to herself, the woman, the profession, and the wider community

- Accountable for practice, clearly documenting all decisions and professional actions.
- Ensures clinical practice is based upon relevant available research.
- Knows that every exchange with the woman is a teaching/learning experience.
- Recognises own learning needs and undertakes education to meet them.
- Helps to maintain and improve policies and quality of service in the organisation/agencies where she works.
- Documents any misjudgements of practice and takes restorative measures.
- Client experience in the midwife clinic should be evaluated frequently.
- Midwives should reflect on their practice and behaviours frequently using any model of reflection practice such as Gibbs cycle (description, feelings, evaluation, analysis, and conclusion and action plan).

Standard 27: Midwives should provide respect, dignity and informed choices

- Treat every woman and newborn with respect and dignity, fully informing and communicating with the woman and her family in decision making about care for herself and her baby in a culturally safe and sensitive manner ensuring her the right to informed consent and refusal.
- Every woman has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, and social, groups and respects the dignity and independence of the individual.

Every woman has the right to:

- an environment that enables both woman and midwife to communicate openly, honestly, and effectively.
- effective communication in a form, language, and manner that enables the woman to understand the information provided.
- co-operation among providers to ensure quality and continuity of services.
- have her privacy respected.
- freedom from discrimination, coercion, harassment, and exploitation.
- express a preference as to who will provide services and have that preference met where practicable.
- honest and accurate answers to questions relating to services.
- have **one support persons** of her choice present, except where safety may be compromised, or another consumer's rights may be unreasonably infringed.
- refuse services and to withdraw consent to services.

Every woman has the right to the information including:

- the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option
- the results of tests and procedures
- the estimated time within which the services will be provided

- any proposed participation in teaching or research, including whether the research requires and has received ethical approval
- any other information required by legal, professional, ethical, and other relevant standards.

Standard 28: The midwife negotiates her role as a caregiver and identifies mutual responsibilities

The woman has a responsibility to take care of her health and learn and the midwife has a responsibility to educate and share knowledge

- Simplifies the decision-making process without personal opinion or force and respects the decision making, and the right to decline treatment or procedures.
- Clearly advises where professional judgement is in conflict with the decision or plans of the woman
- Discusses with the woman, her support person, and colleagues as necessary to find mutually satisfying solutions.
- Understands that the woman can exercise their right to make those decisions.
- Every consumer has the right to be treated with respect.
- Works in equal partnership with the woman and her family and establish a relationship of trust and confidentiality.
- Acknowledges that there are different ways of knowing. The woman also brings life experiences.
- Recognises that continuity of care strengthens the partnership.

Standard 29: The midwife clinic provides evidence-based practices and avoids potential harmful practices

- Systems should ensure that all women have access to care that is evidence based upon the best scientific evidence available and clinical judgment.
- Every woman has the right to have services provided in a manner that minimises the potential harm and optimises the quality of life.
- Determine and provide programmes of care and support for women which are:
  - o appropriate to the needs, contexts, culture and choices of women, babies and their families
  - o made in partnership with women.
  - o ethical,
  - o in collaboration with other healthcare professionals.

Appendix 1: Antenatal Card

Health institution Name: ..... **File Number:** .....

Personal Information			
Mother's Name			
Date of Booking		Age	
Nationality		Address	
Occupation		Husband's Name	
Contact Number		Emergency Contact	

Premarital test result	Normal	( ) Abnormal ( ) what is it…….……
Pregnancy test	Blood ( )	Urine ( )

Obstetric and Gynecological History:		
Gravida ( ) Para ( ) Full term ( ) Preterm ( ) Live Birth ( ) Still Birth ( ) Neonatal death ( ) Miscarriage ( ) Twins ( ) Previous ectopic pregnancy ( )	Regular Cycle: Yes ( ) No ( ) Frequency of Cycle:( ) days LMP …… EDD …… Based on: Date ( ) U/S ( )	Contraception use: Yes ( ) No ( ) What is the type? ....

Past Obstetric History:							
Date of birth	Gestation	Gender	Place of birth	Birth Weight	Mode of birth	Complications	Remarks

Medical History:	YES	NO	Medical History:	YES	NO
No significant medical history			Iron deficiency anaemia		
Essential Hypertension			Sickle cell anaemia		
Diabetes Mellitus			Tuberculosis		
Thyroid disease			Epilepsy		
Bronchial asthma			Recurrent urinary tract infection (UTI)		
Cardiac disease			Autoimmune disease		
Deep vein thrombosis or Pulmonary embolism			Malignancy		
Others					

Psychological History:	YES	NO	Psychological History:	YES	NO
Depression			Anxiety		
Others:					

Surgical History:	YES	NO	Surgical History:	YES	NO
Caesarean-section Indication and type of uterine incisi on.....			Laparotomy Indication		
Dilation and curettage			Cervical sutures		
Pelvic floor repair			Myomectomy		
Others:					

Blood Transfusion:	YES	NO
If yes, what is the reason?		

Drug History:	YES	NO
If yes, what is type of medication?		

Allergy History:	YES	NO
If yes, what type?		

Family History:	YES	NO	Family History:	YES	NO
No significant disease			Congenital anomalies		
Hypertension			Inherited diseases		
Diabetes Mellitus			Psychiatric illness		
Tuberculosis			Other (specify)		
Multiple pregnancy					

Social History :	
Marital status	
Education level	
Occupation	
Smoking	No ( ) Yes ( ) cigarette/day ……
Alcohol	No ( ) Yes ( ) amount/day……..
Substance abuse	No ( ) Yes ( )
Exercise	N0 ( ) Yes ( ) type …… how often ……

Physical Examination		
Height	Weight	BMI
Breast	Neck	Respiratory System
Cardiovascular System	Abdomen	Central Nervous System
Varicose vein	Teeth and Gum	

Laboratory Investigations	
Blood group & Rhesus factor (RH)	Hepatitis B surface antigen
Husband blood group & Rh (if needed)	Hepatitis C antibodies
Complete Blood Count (CBC)	Syphilis-VDRL (RPR)
Serum Ferritin Level	Rubella IgG
HbA1C/FBS	Human Immunodeficiency Virus Screening Test (HIV)
Indirect Coombs' Test	Rapid Urine Dipstick-test
Thyroid Stimulating Hormone Test (TSH)	Urine C/S
Vitamin B12	Vitamin D3
Toxoplasma IgG	Sickle cell

First visit before the 10th week	
Visit's date	Actual pregnancy age ( ) weeks
Mother Complaints	
Clinical Examination	
Blood Pressure	
Weight	
Pallor	
Edema	
Laboratory Investigations (at booking)	
Treatment & Immunization	
Iron (If needed)	
Folic acid	
Recommended vaccine	
Other treatment (specify)	
Assess for referral	
Assess for eligibility by using the risk assessment form, eligible for midwifery clinic follow up? Other indication for referral?	Yes ( ) No ( )
Health Education:	
Normal pregnancy	
Life style and mental health	
Nutrition and hydration	
U/S and medications	
Exercise	
Breastfeeding	
Open questions & answers	
Next appointment at (**16th**) weeks	
Physician/Midwife comments	
Midwife name & signature	

Ultrasound Examination (Dating Scan)	
Gestational sac	
Foetus	Alive ( ) Dead ( )
Number of foetus	
Crown Rump Length (CRL)	
Nuchal Translucency (NT), early anatomy and chrionicity if needed	
Gestational age	
EDD	
Other Observation	
Physician name & signature	

Second visit at the 16th week (virtual or physical)	
Type of visit: Virtual ( ) Physical ( )	
Visit's date	Actual pregnancy age ( ) weeks
Mother Complaints	
Clinical Examination	
Weight	Blood pressure
Pallor	Edema
Fundal height	
Foetal heart sound	
Laboratory Investigations	
Review and discuss blood and screening test results	
Rapid urine dipstick test	
Complete urine analysis, if needed	
Treatments & Immunization	
Iron	
Calcium & Vitamin D, Vitamin B12 (if needed)	
Recommended vaccine	
Other treatment (specify)	
Assess for referral	
Assess for eligibility by using the risk assessment form. Eligible for midwifery clinic follow up? Other indication for referral?	Yes ( ) No ( )
Health Education	
Routine anomaly scan	
Vitamin supplements	
Nutrition	
Risk factors in pregnancy and early maternal warning signs	
Open questions & answers	
Next appointment at (**18-22**th) weeks	
Midwife comments	
Midwife name & signature	

Ultrasound Examination (Anomaly Scan)	
Foetus	Alive ( ) Dead ( )
Number of foetus	
Foetal measurements	BPD ( ) HC ( ) AC ( ) FL ( )
Estimated foetus weight	
Gestational age	
EDD	
Amniotic fluid amount	
Placenta position	
Congenital anomalies	
Other observation	
Physician name & signature	

Third visit at the 24th week	
Type of visit: Virtual ( ) Physical ( )	
Visit's date	Actual pregnancy age ( ) weeks
Mother Complaints	
Foetal movement	Yes ( ) No ( )
Clinical Examination	
Weight	Blood pressure
Pallor	Edema
Fundal height	
Foetal heart sound	
Laboratory Investigations	
Rapid urine dipstick test	
Complete urine analysis, if needed	
Treatments & Immunization	
Iron	
Other treatment (specify)	
Assess for referral	
Assess for eligibility by using the risk assessment form. Eligible for midwifery clinic follow up? Other indication for referral?	Yes ( ) No ( )
Health Education	
Nutrition	
Foetal movement	
Risk factors in pregnancy	
Open questions & answers	
Next appointment at (**26-28**th) weeks	
Midwife comments	
Midwife name & signature	

Fourth visit at the 26-28th week	
Visit's date	Actual pregnancy age ( ) weeks
Mother Complaints	
Foetal movement	Yes ( ) No ( )
Clinical Examination	
Weight	
Blood pressure	
Pallor	
Edema	
Fundal height	
Foetal heart sound	
Laboratory investigations	
Complete Blood Count (CBC)	
Serum Ferritin Level	
Oral glucose tolerance test (OGTT-75gs or 100gs)	
Rapid urine dipstick test	
Complete urine analysis, if needed	
Treatment & Immunization	
Iron	
Calcium & Vitamin D if needed	
Recommended vaccine	
Other treatment (specify)	
Assess for referral	
Assess for eligibility by using the risk assessment form, eligible for midwifery clinic follow up? Other indication for referral?	Yes ( ) No ( )
Health Education	
Foetal movement	
Nutrition	
Exercise	
Smoking	
Breastfeeding	
Birth plan	
Open questions & answers	
Next appointment at (**32nd**) weeks	
Midwife comments	
Midwife name & signature	

Fifth visit at the 32nd week		
Type of visit: Virtual ( ) Physical ( )		
Visit's date	Actual pregnancy age ( ) weeks	
Mother Complaints		
Foetal Movement	yes ( ) No ( )	
Clinical Examination		
Weight	Blood pressure	Pallor
Edema	Fundal height	Fetal heart sound
Laboratory Investigations		
Indirect Coombs' test (if she is Rh negative)		
Rapid urine dipstick		Complete urine analysis, if needed
Treatment & Immunization		
Iron	Anti D (if needed)	Calcium & Vitamin D if needed
Recommended vaccine	Other treatment	
Assess for referral		
Assess for eligibility by using the risk assessment form, eligible for midwifery clinic follow up? Other indication for referral?	Yes ( ) No ( )	
Health education		
Nutrition		
Explain where & when to go in case of emergency		
Signs of preterm labor		
Open questions & answers		
Next appointment at (34th) weeks		
Midwife comments		
Midwife name & signature		

Ultrasound Examination				
Foetus	Alive ( ) Dead ( ) Number of foetus			
Foetal measurement	BPD ( ) HC ( ) AC ( ) FL ( )			
Estimated foetus weight		Gestational age		
EDD		Amniotic fluid amount		
Placenta position		Congenital anomalies		
Doppler measurement, if needed		Other Observation		
Physician name & signature				

Sixth visit at the 34th week		
Visit's date	Actual pregnancy age ( ) weeks	Foetal movement Yes ( ) No ( )
Mother Complaints		
Clinical Examination		
Weight	Blood pressure	Pallor
Edema	Fundal height (plot on chart page 3)	Foetal heart sound
Foetal lie and presentation		
Laboratory Investigations		
Complete Blood Count (CBC)	Serum ferritin	
Rapid urine dipstick	Complete urine analysis, if needed	

Treatment & Immunization	
Iron	Calcium & Vitamin D if needed
Recommended vaccine	Other treatment
Assess for referral	
*Reassess for the risk, eligible for midwifery clinic follow up? *Other indication for referral?	Yes ( ) No ( )
Health Education	
Preparation for labour and birth	
Breastfeeding	
Breast and perineal massage	
Importance of postpartum visits	
GBS test	
Open questions & answers	
Next appointment at (36th) weeks	
Midwife comments	
Midwife name & signature	

Sixth visit at the 36th week		
Visit's date	Actual pregnancy age ( ) weeks	Fetal movement Yes ( ) No ( )
Mother Complaints		
Clinical Examination		
Weight	Blood pressure	Pallor
Edema	Fundal height (plot on chart page 3)	Fetal heart sound
Foetal lie and presentation		Head engagement
Laboratory Investigations		
Rapid urine dipstick	Complete urine analysis, if needed	
Treatment & Immunization		
Iron	Calcium & Vitamin D if needed	
Recommended vaccine	Other treatment	
Health Education:		
Signs and symptom of labour		
Importance of postpartum visits.		
Family planning		
Newborn care and screening test		
Review of birth plan		
Open questions & answers		
Referral to hospital (to complete the other two ANC visits at (38/40) weeks		
Midwife comments		
Midwife name & signature		

Extra Visit (1):(if needed) Date:.....	Extra Visit (2):(if needed) Date:.....
Current Complaint	Current Complaint .....
Wt ..... Temperature ..... B.P	Wt ..... Temperature ..... B.P .....
Edema ( ) Signs of anaemia ( )	Edema ( ) Signs of anaemia ( )
Examination:	Examination: .....
Investigations:	Investigations:
Treatments & recommendations:	Treatments & recommendations: .....
Midwife name & signature	Midwife name & signature .....

Appendix 2: Antenatal Follow-up Chart

Name: ---------- Gravida: ---------- Para: ---------- Abortion: ----------

File No: ---------- Nationality: ---------- Blood group: ---------- Husband Blood Group: ----------

Age: ---------- Yrs. Obstetrician In- Charge: ---------- LMP: ---------- EDD: ----------

Date	Gestational Age (wks)	BP	pulse	Weight (kgs)	Urine			HB	Edema	FHR	Foetal movement	Fundal Height (cm)	Presentation	Remarks, comments, reports, actions and plans	Next Visit Weeks	Signature & stamp
					Protein	Glucose	Ketones									

Appendix 3: Antenatal Risk Assessment Form

Mother's Name: **MRN:** **Home Phone Number:** **Mobile Number:** **Work Phone Number:**	**Obstetrician Name:** **Midwife Name:** **Gravida:** **Para:** **Date of Birth:** **Age:** **LMP:** **Confirmed EDD:** **EDD by U/S:**
Any risk factors from risk assessment indicators see below	
Risk factors below indicate referral to Obstetrician/Physician for plan of care	
Maternal age < 17 & > 40 at term (nulliparous woman only) BMI < 18 or > 40 **Parity of 6 or more**	Learning disability Physical disability Multiple pregnancy
Past and Present Medical History	
Hypertension Diabetes Cardiac disease Renal or liver disease Epilepsy Anaemia Hb <10 g/dl or Ferritin < 40 mcg/l Asthma (severe) Spinal, pelvic or back trauma	Clotting disorder/Thromboembolism Crohn's disease/ Ulcerative colitis MS or other active neurological problem Carcinoma Thyroid dysfunction Blood disorder (Sickle Cell Anemia (SCA)/ Thalassemia/ Antiphospholipid Syndrome (APS)/ Lupus/ Autoimmune) Mental health problems
Past Gynaecology History	
Fibroids Uterine anomaly	Cervical cone biopsy and loop Sexually Transmitted Disease (STD) (last year)
Family History (first degree relative with)	
Diabetes (does not require a referral but OGTT should be arranged at 28 weeks Cardiac abnormality	Genetic abnormality Haemoglobinopathies Ataxia (the loss of full control of bodily movements)
Previous Obstetric History	
Previous spontaneous 2nd trimester abortion 3 consecutive miscarriages **Previous birth weight <10th centile** **Previous birth < 36 weeks** Stillbirth/neonatal death IUGR Shoulder dystocia 2 Caesarean sections Difficult instrumental delivery Pre-eclampsia or previous PIH	Congenital abnormality Placental abruption/praevia Retained placenta Rhesus antibodies/incompatibility Cholestasis Gestational Diabetes Mellitus (GDM) Previous abnormal GTT Previous 3rd or 4th degree tear Pre-existing continence problems Anaemia <9 gm/dl
Complications arising during current pregnancy	
Blood group antibodies Positive RPR/ Hep B or C/ HIV Abnormal TSH Hypertension Proteinuria without UTI Anaemia 10 g/ dl OGTT between 24-28 Small for dates	Reduced foetal movements Low lying placenta (after 34 weeks) Oligo/ Poly hydroniums Malpresentaion after 36 weeks Confirmed chicken pox/ rubella/ parvo infection Group B strep Any mental health concerns Other
Form completed by: **Print Name:** **Designation:** **Signature:** **Date:**	

Risk assessment is a continuous process and should be undertaken at every contact / Completed form to be filed at front of antenatal note

Appendix 4: Referral, Consultation and Feedback Form

Personal Information			
Mother's Name			
Clinic File number		Age	
Weight		Height	
Nationality		Address	
Occupation		Husband's Name	
Contact Number		Emergency Contact	

Referral and consultation form	Feedback form
Date: ……...Time:……	Date: ……Time:……
Referral type Elective ( ) Urgent ( ) Immediate ( )	Hospital name:
Transportation Type: Ambulance ( ) Private car ( ) Others ( )	Hospital file number
Temperature ……..…... B.P ……....	Temperature ……..…... B.P ……...:
Respiratory rate……pulse…….	Respiratory rate……pulse…….
Edema ( ) Signs of anaemia ( )	Edema ( ) Signs of anaemia ( )
Current Complaint and Duration …….……..……	Current Complaint and Duration …….……..……
Risk Factor	Risk Factor
Obstetric history	Obstetric history
Physical assessment and examination finding	Physical assessment and examination finding
Suspected diagnosis	Final diagnosis:
Examination: ……..……....	Examination: ……..……....
Investigations:	Investigations:
Summary of interventions:	Summary of interventions:
Treatments & recommendations: …….……..……	Treatments & recommendations: …….……..……
Midwife name and signature …….……..……	Physician name and signature …….……..……

Appendix 5: Antenatal Visits Schedule

Antenatal care				
Antenatal Visits		***Visit Location and Professional***	***Reason for Visit***	**Verbal and written information on topics** Verbal and written information supported by antenatal classes. **Give the following information, with an opportunity to discuss issues and ask questions.**
First trimester				
Nulliparous (no previous birth >23 weeks) **8 up to 12 weeks (ideally by 10 weeks)**	**Multiparous (at least one previous birth >23 weeks)** **8 up to 12 weeks (ideally by 10 weeks)**	**Midwife,** **Ultrasound Clinic,** **OPD Phlebotomist**	**Booking appointment (first visit)** • Measure height, weight and calculate Body Mass Index (BMI) • Urinalysis**,** Blood Pressure (BP)**,** Pulse (P), Respiratory Rate (RR) • Ask about LMP, examine the woman's full medical and obstetric, surgical, family, social history. • Ask about any past or present severe mental illness or psychiatric treatment, ask about mood to identify possible depression, home circumstances and domestic violence, the woman's occupation to identify potential risks • Identify women who have had genital mutilation and any risk factors for gestational diabetes and pre-eclampsia, antepartum haemorrhage, VTE • Routine blood tests**:** CBC, Ferritin, Rh Type and screen, RPR/VDRL, Rubella IgG, HBsAg. HIV, FBS, HbA1c, TSH, Toxoplasma IgG, Sickle cell**,** Vit B12, Vit D3, Husband blood Group & Rh **Ultrasound (11-14 weeks)** • To determine gestational age and +/- nuchal translucency	• Appointments and schedule of visits • Normal pregnancy and how the baby develops during pregnancy • Antenatal preparation classes • Nutrition including vitamin D and Folic acid supplementation-400 micrograms (mcg) • Food hygiene, including how to reduce the risk of a food-acquired infection and prevent complications. • Hydration • Emotional wellbeing, addressing self- coping mechanisms for any anxieties. • Lifestyle and mental health, including smoking cessation • All antenatal screening, including risks and benefits of the screening tests • Exercise, including pelvic floor exercises • Breastfeeding
16 weeks	**16 weeks**	**Midwife (Physically or virtually)**	• Measure Symphysis–Fundal Height (SFH), BP, P, RR, routine urinalysis, Foetal heart Rate (FHR) • Review and discuss blood and screening test results (if haemoglobin level below 11 g/dl or ferritin below 100 mcg/l consider iron supplementation, if Vit D level below 40 ng/ml consider Vit D supplementation, if Vit B12 level below 400 pg/ml consider Vit B12 supplementation).	· Vitamins supplementation · Routine anomaly scan · Risk factors in pregnancy and Early maternal warning signs · Nutrition
Second trimester				
18-22 weeks	**18-22weeks**	**Ultrasound Clinic**	**Anomaly scan** for the detection of structural anomalies and to check baby's organs and location of placenta	
24 weeks	**Not required**	**Midwife (Physically or virtually)**	Measure Symphysis–Fundal Height (SFH), BP, P, RR, routine urinalysis, FHR, discuss U/S results For a woman whose placenta is found to extend across the internal cervical os at this time, another scan at 34 weeks should be offered.	• Nutrition • Foetal movement • Risk factor in pregnancy
26-28 weeks	**26-28 weeks**	**Midwife** **OPD** **Phlebotomist**	• Measure SFH, BP, P, RR, routine urinalysis, FHR, weight • Assess foetal movement • Blood tests: CBC, Ferritin, Indirect coombs test (IDCT) (if blood group is –ve), if booking FBS was normal, Oral Glucose Tolerance Test (OGTT) with 75 or 100 g glucose • **Offer first anti-D if Rhesus negative (28 weeks)**	• Foetal movement • Nutrition • Exercise • Smoking • Prevention of Diabetes and associated complications. • Birth plan • Breastfeeding information, including technique and good management practices that would help a woman succeed, such as detailed in the UNICEF Baby Friendly Initiative (refer her to breastfeeding clinic if she has any problem).

Third trimester				
32 weeks	**Not required**	**Midwife (Physically or virtually)**	• Measure SFH, BP, routine urinalysis • Review 26-28 weeks blood test results (investigate a haemoglobin level below 10.5 g/100 ml and consider iron supplementation)	• Explain where and when to visit ER in case of a decrease in foetal movement (less than 10 movement a day) or have vaginal bleeding or water leaks. • Nutrition, information on how to prevent and identify anaemia and dietary advice to assist the absorption of iron. • Signs of preterm labour
34 weeks	**34 weeks**	**Midwife-** **Obstetricians for women who are rhesus negative** **Ultrasound clinic** **OPD Phlebotomist**	• Measure SFH, BP, P. RR, routine urinalysis, FHR, weight • Blood tests- CBC, Ferritin • **Vit D, Vit B12 level if supplements were taken** • Evaluate the readiness for breastfeeding by breast physical examination including nipple condition • **Offer second anti-D if Rhesus negative (34-36 weeks)** • Ultrasound scan for the growth, brain, heart, kidney, placenta and amniotic fluids • Plan for referral to a health institution chosen by the woman by 35 weeks	• Preparation for labour and birth, coping with pain in labour, the birth plan, recognition of active labour. • Breastfeeding. • Advice woman to **do breast massage** to prepare for breastfeeding and to reduce nipple cracks. • Advice woman to start **perineal massage** starting from 35 weeks using vitamin E oil or Almond oil or coconut oil (10 mins daily) • GBS Test • Importance of postpartum visits
36 weeks	**36 weeks**	**Midwife**	• Measure SFH, BP, P, RR, routine urinalysis, FHR, weight • Check position of baby- if breech, refer to consultant obstetricians' clinic, offer external cephalic version (ECV) if no contra-indications, • Review and discuss blood and urine test results • **Vaginal and rectal GBS test** • Check with the woman to confirm her appointment at the health institution	• Signs and symptom of labour • Importance of postpartum visits • If breech, show natural positioning, and dietary advice to turn the baby, Mode of birth • Breastfeeding information, including technique and good management practices that would help a woman succeed, such as detailed in the UNICEF Baby Friendly Initiative (refer her to breastfeeding clinic if she has any problem). • Newborn care and screening test including Vitamin K prophylaxis • Postnatal self-care, awareness of 'baby blues' and postnatal depression. • Review the birth plan and the complication readiness plan.
38 weeks	**38 weeks**	**Midwife (Physically or virtually)**	• Measure SFH, BP, P, RR, routine urinalysis, FHR, weight • Discuss GBS result	• Options for management of prolonged pregnancy; • Labour and Rupture of Membrane (ROM) • Plan of pregnancy care with the woman and explain what to expect between and at the next visit.
40 weeks	**40 weeks**	**Midwife**	• Measure SFH, BP, P, RR, routine urinalysis, Non stress Test (NST); FHR, weight	• Exercise and nutrition • Natural way to induce labour and advise that **Dates** should be taken only during labour
41 weeks	**41 weeks**	**Obstetrician**	• Measure SFH, BP, RR, routine urinalysis • Offer membrane sweep • Offer induction of labour before 42 weeks FHR by (CTG)	• Induction of labour leaflet • Options for prolonged pregnancy

Appendix 6: Neonatal Assessment Checklist for Critical Conditions: The 'Assess and Classify' Chart.

Ask and check	Classify	Action taken
• History of difficulty feeding or unable to feed now • History of convulsion or convulsing now • Newborn is lethargic or unconscious • Movement only when stimulated • Fast breathing • Severe lower chest in-drawing • Fever • Hypothermia	If there is any *one* of the general danger signs, classify as: **POSSIBLE SERIOUS INFECTION**	Refer URGENTLY to hospital or health centre. Keep the newborn baby warm and give him or her breast milk on the way.
• Baby developed yellowish discoloration before 24 hours of age • Jaundice observed on the palms and soles • There is swelling of the eyes or eye discharge • Umbilicus is draining pus • More than 10 pustules are found on the skin	If there is any *one* of these danger signs, classify as: **POSSIBLE INFECTION OR JAUNDICE**	Refer URGENTLY to hospital or health center Keep the newborn baby warm and give him or her breast milk on the way.
None of the above	**NORMAL BABY**	Breastfeeding and care to prevent infection and keep the baby warm.

Appendix 7: Postnatal Visits Schedule

Postnatal care				
Postnatal Visits		*Visit Location and Professional*	*Reason for Visit*	**Verbal and written information on topics**
24-36 hours after birth	**24-36 hours after birth**	**Midwife**	• Postnatal assessment and care of the mother and the newborn • Regular assessment of vaginal bleeding, uterine contraction, fundal height, temperature and heart rate (pulse) routinely. • Blood pressure should be measured shortly after birth. If normal, the second blood pressure measurement should be taken within six hours. • Urine void should be documented within six hours.	• Nutrition • Breastfeeding • Postnatal maternal warning sign and complications • Maternal CBC • Wound care • Newborn care including umbilical cord care, neonatal jaundice, sleeping position for newborn • Newborn screening tests and vaccination
Day 3 (48–72 hours)	**Day 3 (48–72 hours)**	**Midwife (Physically or virtually)**	• Enquiries should continue to be made about general well-being and assessments made regarding the following: micturition and urinary incontinence, bowel function, healing of any perineal wound, headache, fatigue, back pain, perineal pain and perineal hygiene, breast pain, uterine tenderness and lochia. • Breastfeeding progress	• Signs and symptoms of Postpartum Haemorrhage (PPH): sudden and profuse blood loss or persistent increased blood loss, faintness, dizziness, palpitations/ tachycardia. • Signs and symptom of infection, thromboembolism
Between 7–14 days after birth	**Between 7–14 days after birth**	**Midwife (Physically or virtually)**	• Resolution of mild, transitory postpartum depression (“maternal blues”). • Emotional wellbeing, what family and social support they have and their usual coping strategies for dealing with day-to-day matters. Breastfeeding progress	• Family planning and contraceptive options • Mobilisation and exercise
6-8 weeks after birth	**6-8 weeks after birth**	**Midwife**	• Breastfeeding progress	• Exercise, nutrition and water intake • Family planning • Baby vaccination and importance of well-baby clinic visits • Reassurance on infantile colic if there is no red flags

Appendix 8: Postnatal Card

Health institution Name: ..... **File Number:**

Personal Information:			
Mother's Name		Address	
Age		Child Name	
Contact Number		Emergency Contact	

First Postnatal visit at (1st) week				
Date of Visit Place of Visit Time of Visit after birth	...../...../..... At PHCC ( ) ( ) days	At Home ( )		

Visit's Cause: Routine ( ) Compliant ( )
What is the compliant? .....
.....

Birth and baby outcome			
	Home birth	( ) Hospital birth	( )
	Vaginal birth	( ) Instrumental delivery	( )
	Caesarean section	( )	
	Single	( ) Twins	( )
	Term	( ) Preterm ( ) Post-dated	( )
	Boy	( ) Girl	( )
	Discharged	( ) Admitted in hospital	( )
	if yes why?.....		

Mother's Assessment			
General assessment		Red flags assessment	
Episiotomy	( )	Persistent fever, breathing difficulty	( )
Perineal tear	( )	Prolonged or heavy bleeding	( )
Postpartum haemorrhage	( )	Unilateral leg pain and swelling	( )
Blood transfusion	( )	Severe headache and vomiting	( )
Urinary complications	( )	Postpartum depression	( )
Bowel complications	( )	Other res flags (Specify):	
Mood & psychological wellbeing	( )	.....	
Other complications (Specify):			

Any significant history .....
.....
.....

Clinical Examination

Pulse ( ) BP ( ) RR ( ) T ( ) Weight ( )

Pallor	
Breast examination	
Cardiovascular system	
Respiratory system	
Abdomen/Uterus	
Perineum	
Lower Limb	

Local examination for wound (if present) .....

.....

Special investigation if needed & its result. .....

.....

Immunization/Treatment .....

.....

Newborn Assessment

Newborn age ( ) days

Visit's Cause Routine ( ) Compliant ( ) What is the compliant? .....

.....

General assessment	**Red flags assessment**
Exclusive breastfeeding ( )	Poor feeding or sucking ( )
Only milk formula ( )	Fever or hypothermia ( )
Mixed feeding ( )	Discharge from umbilicus or redness of skin ( )
Frequency of feeding ( ) per day	Discharge or swelling of the eye ( )
Frequency of urination ( ) per day	Cannot move arms or legs ( )
Frequency of stooling ( ) per day	Other red flags (specify) .....
	.....

Vaccination at birth **Hep B ( )** **Other ( )**

Result of newborn screening

Hearing screening test	Normal ( )	Abnormal ( )
Congenital heart disease screening test	Normal ( )	Abnormal ( )
Metabolic screening test	Normal ( )	Abnormal ( )

If any abnormality, what is it?.....

.....

Any significant history .....
.....
.....

Clinical Examination

Temp ( ) HR ( ) RR ( )
Weight ( ) kg Length ( ) cm Head Circumference ( ) cm
Jaundice ..... Peripheral or central cyanosis .....
Cataracts ..... Dimorphism .....
Cleft lip/palate ..... Muscle tone .....
Neonatal reflexes ..... Murmur .....
Hepatomegaly ..... Splenomegaly .....
Abdominal masses ..... Umbilicus .....
External genital organs ..... Limbs .....
Hips ..... Anal orifice .....

Special investigation if needed & its result .....
.....

Immunization/Treatment .....
.....

Health Education

Reassurance on breastfeeding ( )
Healthy diet & exercise ( )
Breast care ( )
Wound care ( )
Umbilical cord care ( )
Neonatal Jaundice ( )
Sleeping position for newborn ( )
Postnatal maternal warning signs and complications such as (UTI, mastitis, breast abscess, anaemia, puerperal Sepsis, post-partum blue & depression, DVT..etc ( )

Next appointment between (3-14) days from birth

Midwife name & signature .....

Fourth Postnatal visit the (6th – 8th) weeks

Date of visit ...../...../.....	Time of visit after birth ( ) Weeks

Mother's Assessment

Visit's Cause: Routine ( ) Compliant ( ) What is the compliant? .....

Any significant history .....
.....
.....

Clinical Examination

Pulse ( ) BP ( ) RR ( ) T ( ) Weight ( )

Pallor	
Breast examination	
Cardiovascular system	
Respiratory system	
Abdomen/Uterus	
Perineum	
Lower limb	

Special investigation if needed & its result. .....
.....

Immunization/Treatment .....
.....

Infant Assessment

Health Education

Reassurance on breast feeding	( )
Healthy diet & exercise	( )
Family planning	( )
Vaccination of baby at age of 2 months & importance of well-baby clinic visits	( )
Reassurance on infantile colic if there is no red flags	( )

Midwife name & signature .....

Glossary

Midwife: A responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare. A midwife may practise in any setting including the home, community, hospitals, clinics or health units.

Midwife-led care: The midwife is the lead health-care professional, responsible for planning, organizing and delivering care.

Midwife-led continuity of care: Midwife-led continuity of care models, in which a known midwife, or a small group of known midwives, supports a woman throughout the antenatal, childbirth and postnatal continuum, are recommended for pregnant women in settings with well-functioning midwifery programmes.

Sexual, reproductive, maternal, newborn and adolescent health (SRMNAH) care: The continuum of sexual and reproductive health care and maternal and newborn health care, including for adolescents. Sexual health care involves the enhancement of life and personal relationships, not merely counselling and care related to procreation and sexually transmitted infections. Reproductive health enables people to have a responsible, satisfying and safe sex life, to have children, and to decide if, when and how often to do so.

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