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MOTHER AND CHILD HEALTH CARE SERVICES

MCH -1

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MOTHER AND CHILD- ONE UNIT

Mother and child must be considered as one unit because:

- During the antenatal period the foetus is part of mother
- Child health is closely related to mothers health
- Certain diseases of mother during pregnancy are likely to have their effects upon the foetus.

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MOTHER AND CHILD- ONE UNIT

- After birth the child is dependent upon the mother.
- In the care cycle of women, there are few occasions where service to the child is not called for.
- The mother is also the first teacher of the child.

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OBSTETRICS

Community Obstetrics:

- The old age concept that obstetrics is only antenatal, natal and post natal care, is thus converted mainly with technical skills, and is being replaced by the concept of **"Community obstetrics".**
- This combines obstetrical concern with concepts of primary health care.

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SOCIAL OBSTETRICS:

- The study of the interplay of social and environmental factors and human reproduction going back to the pre-conceptional or even to the premarital place.
- It is concerned with the delivery of comprehensive maternity and child health care services including family planning so that they can be bought within the reach of the total community.

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PREVENTIVE PAEDIATRICS:

Paediatrics which is the synonymous with child health, is that branch of medical science that deals with the care of children from conception to adolescence, in health and disease.

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SOCIAL PAEDIATRICS:

The applications of principals of social medicine to paediatrics is to obtain a more complete understandings of the problems of children in order to prevent and treat disease and promote their adequate growth and development, through an organized health structure.

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MATERNITY CYCLE

The stages are as follows:

- Fertilization
- Antenatal period or prenatal period
- Intranatal period
- Post natal period
- Inter-conceptional period

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THE PERIOD OF GROWTH

- **Prenatal period:**
  - Ovum 0 to14 days
  - Embryo 14 days to 9 week
  - Foetus 9th week to birth
- **Premature infant:** from 28-37 wee
- **Birth, full term:** average 280 d

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MOTHER AND CHILD HEALTH

- The term **"maternal and child health"** refers to the promotive, preventive, curative, and rehabilitative health care for mothers and children.
- It includes the subareas of maternal health, child health, adolescence, and health aspects of care of children in social settings such as a day care.

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MCH PROBLEMS

- Currently the main health problems affecting the health of mother and child in developing countries revolve round the **triad** of:
  - Malnutrition
  - Infection
  - Uncontrolled Reproduction

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OBJECTIVES OF MCH

1) Reduction of maternal, perinatal, infant and childhood mortality and morbidity
2) Promotion of reproductive health
3) Promotion of physical and psychological development of the child and adolescent within the family

The ultimate objective of MCH service is life long- health

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ANTENATAL CARE

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ANTENATAL CARE

- Antenatal care is the care of a woman during pregnancy.
- The primary aim of antenatal care is to achieve at the end of pregnancy a healthy mother and a healthy baby.
- Ideally this care should begin soon after conception and continue throughout pregnancy.

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OBJECTIVES

- To promote, protect, and maintain the health of mother during pregnancy.
- To detect **"high risk"** cases and give them special attention
- To foresee complications and prevent them
- To remove anxiety and dread associated with delivery
- To reduce maternal and infant mortality and morbidity

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OBJECTIVES (CONT)

- To teach the mothers elements of child care, nutrition, personal hygiene, and environmental sanitation
- To sensitize the mother to the need for family planning, including advice to cases seeking medical termination of pregnancy
- To attend to the under- fives accompanying the mothers

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PROGRAMES OF HEALTH CARE SERVICES

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1- Antenatal Visits:

A minimum of three visits covering the entire period of pregnancy should be the target:

- **First visit:** at 20 weeks or soon as th pregnancy is known
- **Second visit:** at 32 weeks
- **Third visit:** at 36 weeks

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- Further visits may be made if justified by the condition of the mother.
- At least one visit should be paid at the home of the mother.

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PREVENTIVE SERVICES FOR MOTHERS

ANTE NATAT CHECK-UPS

The first visit should include the following:

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1.HISTORY TAKING:

- Confirm the pregnancy
- Identify the complications in previous pregnancies
- Indentify current medical, surgical or obstetric condition which my complicate the current pregnancy.
- Record the LMP and calculate the EDD
- Record symptoms indicating complications
- History of any current systemic illness.
- History of drug allergies and habit forming drugs

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2. PHYSICAL EXAMINATION:

- Pallor
- Pulse
- Respiratory Rate
- Oedema
- Blood pressure
- Weight
- Breast Examination

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3. Abdominal Examination:

- Measurement of fundal height
- Foetal Heart Sounds
- Foetal Movements
- Foetal Parts
- Multiple Pregnancy
- Foetal Lie and presentation
- Inspection of abdominal scar or any other relevant abdominal findings

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4. Assessment of gestational age:

- The **"Gold Standard"** for assessmen is routine early ultrasound together with foetal measurements ideally in first trimester.
- Gestational age assessment based on the date of last menstrual period (LMP) is done.
- Many countries use the **"Best Obstetric Estimate",** combining ultrasound and LMP.

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5. Laboratory Investigations:

a. At the sub-centre:

- Pregnancy detection test
- Hemoglobin estimation tests
- Urine test for presence of albumin and sugar
- Rapid malaria test

b. At the PHC:

- Blood group, including Rh factor
- VDRL
- HIV testing
- Rapid Malaria test
- Blood sugar testing
- HBsAg for hepatitis B infection

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ESSENTIAL COMPONENTS OF ANTENATAL CHECK-UP:

- Take patients history
- Conduct a physical examination: Measure the weight, blood pressure, respiratory rate, check for pallor and odema
- Conduct abdominal palpation for foetal growth, foetal lie, and auscultation of foetal heart sounds
- Carry out laboratory investigations, such as hemoglobin, urine tests for sugar and proteins

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INTERVENTIONS AND COUNSELLING

- Iron and folic acid supplementation and medication as needed
- Immunization against tetanus
- Group or individual instruction on nutrition, family planning, self care, delivery and parent hood

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INTERVENTIONS AND COUNSELLING

- Home visiting by a female health worker/ trained dai
- Referral services, where necessary

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RISK APPROACH

- The central purpose is to identify **"high risk cases"** (as early as possible) from a large group of antenatal mothers
- arrange for them skilled care, while continuing to provide appropriate care fo all mothers.

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HIGH RISK CASES

- Elderly primi (30 years and over)
- Short statured primi (140 cm and below)
- Malpresentations, viz breech, transverse lie
- Antepartum haemorrhage
- Pre-eclampsia and eclampsia
- Anemia
- Twins, hydramnios

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HIGH RISK CASES

- Previous still birth, intrauterine death, manual removal of placenta
- Elderly grand multiparas
- Prolonged pregnancy (14-days-after expected date of delivery)
- History of previous caesarean or instrumental delivery
- Pregnancy associated with diseases, cardiovascular diseases, kidney disease, diabetes, tuberculosis, liver disease

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2-Prenatal Advice

Antenatal or prenatal advice. The mother is more receptive to advice concerning herself and her baby at this time than other times.

Important points are as follows:

- Diet
- Personal hygiene
- Drugs
- Radiation
- Warning Signs
- Child Care

3-Specific health Protection:

- Anemia
- Other nutritional deficiencies
- Toxemia of pregnancy
- Tetanus
- Syphilis
- German Measles
- Rh Status
- HIV Infection
- Prenatal genetic screening

4- Mental preparation

5- Family Planning

6- Paediatric component

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INTRANATAL CARE

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INTRANATAL CARE

- Child birth has associated complications.
- **Septicemia** may result from un skilled and septic manipulations, and **tetanus neonatorum** from the use o unsterilized instruments.
- The need for effective Intranatal care is indispensible, even if the delivery is going to be normal one. **The emphasis is on cleanliness**.

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AIMS OF GOOD INTRA NATAL CARE

- Thorough asepsis
- Delivery with minimum injury to the infant and mother
- Readiness to deal with complications: Prolonged labour, Antepartum haemorrhage, Convulsions, Malpresentations, Prolapse of the cord
- Care of the baby at delivery: Resusitation, care of the cord, care of the eyes

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1-DOMICILLARY CARE:

- Mothers with normal obstetric history may be advised to have their confinement in their own homes, provided the home conditions are satisfactory.
- In such cases, the delivery may be conducted by the health worker female or trained dai.
- This is known as **"domicillary midwifery service".**

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ADVANTAGES:

- The mother delivers in familiar surroundings of her home and this may remove the fear associated with delivery in the hospital
- The chance for cross infection are generally fewer at the home than in the nursery/hospital
- The mother is able to keep an eye upon her children and domestic affairs, this may tend to ease her mental tension.

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DISADVANTAGES:

- The mother may have less medical and nursing supervision than in the hospital
- The mother may have less rest
- She may resume her domestic duties too soon
- Her diet may be neglected

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DANGER SIGNALS

- The female health worker who is the pivot of domicillary care, should be adequately trained to recognize the **"danger signals"** during labour
- and seek immediate help in transferring the mother to the neares primary health centre or hospital.

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THE DANGER SIGNALS

- Sluggish pains or no pains after rupture of members
- Good pains for an hour after rupture of membranes, but no progress
- Prolapse of the cord or hand
- Meconium stained liquor or a slow irregular or excessive fast foetal hear

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THE DANGER SIGNALS

- Excessive **"show"** or bleeding during labour
- A placenta not separated with half an hour after delivery
- Post-partum haemorrhage or collapse
- A temperature of 38 deg C or over during labour.

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2-INSTITUTIONAL CARE

- Institutional care is recommended for all **"high risks"** cases, and where home conditions are unsuitable.
- The mother is allowed to rest in bed on the first day after delivery.
- The current practice is to discharge the women after 5 days lying – in period after a normal delivery.

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3-ROOMING-IN:

- keeping the baby's crib by the side of the mother's bed is called **"rooming-in".**
- This arrangement gives the mother to know her baby.
- This also allays the fear in the mothers mind that the baby is not misplaced in the central nursery. It also builds up her self- confidence

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POST NATAL CARE

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POST NATAL CARE

Care of mother (and the new born) after delivery is known as **"post natal or post- partal care".**

1) **Care of the mother:** which is primarily the responsibility of the obstetrician
2) **Care of the new born**: which is th combined responsibility of the obstetrician and the paediatrition. The combined area of responsibility is also known as **"Perinatology".**

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CARE OF THE MOTHER

Objectives:

1. To prevent the complications of post partal period
2. To provide care for the rapid restoration of the mother to optimum health
3. To check adequacy of breast feeding
4. To provide family planning services
5. To provide basic health education to mother /family

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1- COMPLICATIONS OF POST PARTAI PERIOD:

- Puerperal sepsis
- Thrombo- phlebitis
- Secondary haemorrhage
- Others

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2- RESTORATION OF MOTHER TO OPTIMUM HEALTH:

- The women can recuperate physically and emotionally from her experience of delivery.
- **The broad areas of this care fall into three divisions:**

➢ Physical:

- Post natal examinations, Anemia, Nutrition, Postnatal exercises.

➢ Psychological

➢ Social

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3- Breast feeding

4- Family Planning

5- Basic health education

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THANKS