PRETERM BIRTH INITIATIVE - KENYA SAFE CHILDBIRTH CHECKLIST: FACILITY:_____

1	FIRST PRESENTATION OF THE MOTHER :		
Date:		**Time:**	**Collected by:**
Name:		**DOB/Age:**	**File #**
Gravidity:		**Parity:**	**Phone number:**
Sub-County		**Village:**	

1.	*Record all that apply.* Last normal menstrual period (LNMP): _____ Gestational age (GA) by LNMP: _____ GA by fundal height with tape measure, cm: _____ GA by ultrasound: _____	*If <37 weeks (preterm), admit or refer.*
2.	Does patient have a history of preterm delivery? □ Yes □ No	*If yes, risk of preterm delivery is elevated.*
3.	Does the mother need to be admitted for: □ High blood pressure □ High temperature/signs of active infection □ Vaginal bleeding □ High or low fetal heart rate □ Preterm labor □ Active Labor □ Premature Rupture of membranes □ Other, specify: _____ □ NONE	***Assess for indication that mother should be admitted or referred:*** • ***If systolic blood pressure >140 or diastolic blood pressure >90, admit or refer. Start management of pre-eclampsia.*** • ***If Temp ≥38°C or > 37.5°C axillary with signs of infection, admit or refer.*** • ***If FHR>160 or <110, admit or refer. Further monitor.*** • ***If preterm, initiate appropriate care or refer.*** • ***If dilation more than 4 cm, admit or refer.***
4.	Decision at this stage: □ Admitted □ Referred: Specify referral location: _____ □ Sent home: Indicate key plan/advise: _____ _____	***If unable to manage, refer.***

2	ON ADMISSION TO MATERNITY	
Date:	**Time:**	**Collected by:**
Mother's Name:	**Medical record/file #:**	

1.	Is baby likely to be born ≤34 weeks? □ Yes □ No	***<u>If YES, fill out <34 weeks section below.</u>*** ***<u>If NO, skip to ALL MOTHERS section below.</u>***
	IF MOTHER IS LIKELY TO DELIVER ≤ 34 WEEKS, CONSIDER CORTICOSTERIODS & TOCOLYTICS	
2.	Is she a candidate for Antenatal corticosteroids? □ Yes □ No	*Give antenatal corticosteroids per national protocol i.e. if no evidence of maternal infection and delivery is imminent within 24 hours to seven days* **Dexamethasone 6 mg IM BD x 2/7 OR** **Betamethasone 12 mg IM OD x 2/7**
3.	Is she a candidate for tocolytics? □ Yes □ No	*Consider tocolytics (e.g. nifedipene) if giving steroids* **Nifedipine 20 mg PO then 10-20 mg PO 4-8 hourly x 1-2/7**
4.	Is she a candidate for Magnesium Sulfate for fetal Neuroprotection? □ Yes □ No	*Give for fetal neuroprotection if baby expected to be delivered before 32 weeks and delivery is imminent, within the next 24 hours* **Magnesium sulfate 4 g IV with 5 g IM per buttock as initial dose (10 mg IM total), followed by 5 g IM q4 hours until delivery**

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5.	Preparation for preterm delivery? □ Yes □ No	*Prepare for preterm birth* • *Appropriate preterm bag and mask and/or PPV are available* • *Continuous warmth for unstable preterms (e.g blankets)* • *Ready to implement Kangaroo Care* • *Ready to do delayed cord clamping (DCC)* • *Staff assistance for delivery and resuscitation*
ALL MOTHERS		
6.	Confirm □ Supplies ready to clean hands □ Sterile gloves available for each vaginal exam? □ Birth companion encouraged to be present at birth □ Mother and companion informed to call for help if needed	*Call for help if any of the following:* • *Bleeding* • *Severe abdominal pain* • *Severe headache or visual disturbance* • *Unable to urinate* • *Urge to push* • *Convulsions* • *Any other abnormality*
7.	Does the mother require antibiotics? □ Yes □ No	*Give antibiotics if any of the following:* • *PPROM* • *Signs of infection (e.g Temperature ≥ 38°C, Foul-smelling vaginal discharge)* • *Planned c-section* • *Rupture of membranes > 18 hours*
8.	Does the mother require Anti-malarials? □ Yes □ No	*Give anti-malarials if mother has:* • *positive malaria smear* • *meets other diagnostic criteria for malaria*
9.	Does the mother require Antiretroviral medicines? □ Yes □ No	*If mother is HIV+, manage as per the guidelines*
10.	Does the mother require Anti- hypertensive treatment? □ Yes □ No	*If systolic blood pressure ≥160 or diastolic blood pressure ≥110, or if approaching these levels.* **For acute IV management:** **Hydralazine 5-10 mg IV, if still elevated after 20 min, repeat dose** **OR** **Labetalol 20 mg IV fist dose, if still elevated after 20 min, 40 mg** **Then initiate oral medication.**
11.	Does the mother require Magnesium sulfate for pre-eclampsia? □ Yes □ No	*Give Mg SO_4 if patient has the following:* • *systolic blood pressure ≥ 140 mmHg* • *diastolic blood pressure ≥ 90 mmHg* **AND** *any of the following:* • *convulsions or coma* • *severe headache* • *visual disturbance* • *epigastric pain* **OR** *SBP ≥ 160 mmHg OR diastolic blood pressure ≥ 110 mmHg* **Magnesium sulfate 4 g IV with 5 g IM per buttock as initial dose (10 mg IM total), followed by 5 g IM q4 hours until delivery**
12.	Is the mother bleeding? □ Yes □ No	*If yes, evaluate and treat per guidelines.* *Prepare for a Caesarean section delivery if indicated.* *Consider referral if unable to manage appropriately.*

13.	Does mother have other known disease? □ None □ Anemia □ Chronic hypertension □ Diabetes mellitus □ Other condition, specify: _____	*If yes, ensure appropriate treatment.*
14.	Has Partograph been started? □ Yes □ No, will start when ≥ 4cm	*Ensure adherence to partograph guidelines.*
15.	Does fetus have any concerning features/issues? □ No □ Fetal HR > 160 or < 100 □ Fetal heart rate irregular □ No fetal heart beat □ Malposition (breech, etc.) □ Suspicion for intrauterine growth restriction □ Suspected or confirmed fetal anomaly □ Multiple pregnancy □ Meconium stained liquor □ Other condition, specify: _____	*If yes, prepare for birth with additional staff assistance for delivery or call for appropriate help*
16.	Does mother need referral? □ Yes, Specify facility _____ □ No	*If referral is not possible, note reason here:*
17.	Does the mother have a plan for post-partum contraception? □ Yes □ No	*Discuss and offer family planning options to mother*

3	**JUST BEFORE AND DURING SECOND & THIRD STAGE**	
Date: _____	Time: _____	Collected by: _____
Mother's Name: _____	Medical record/file #:_____	

	CONFIRM ESSENTIAL SUPPLIES AND SKILLS FOR MANAGEMENT OF LABOUR AND NEWBORN INCLUDING PRETERM DELIVERY	
1.	Confirm availability of essential supplies for delivery. □ Sterile gloves □ Soap and clean water □ Delivery packs □ Oxytocin □ Syringes □ IV fluids and giving-sets □ Essential and Emergency medications	*Ensure all supplies for second and third stage are available.*
2.	Assistant identified and informed to be ready to help with birth INCLUDING skilled for management of a **preterm birth**? □ Yes □ No	*Prepare to care for baby immediately after birth:* 1. *Delayed cord clamping (DCC* 2. *Dry baby, keep warm* 3. *If not breathing, stimulate and clear airway if needed* 4. *If still not breathing:* • *clamp and cut cord* • *clean airway if necessary* • *ventilate with bag-and-mask* *shout for help*

3.	Confirm availability of essential supplies for the newborn baby including preterm babies. □ Clean towel □ Suction device □ Bag and mask, including appropriate size for preterm babies	
4.	Does mother have delayed second stage? □ Yes □ No	*If Yes, prepare for appropriate interventions e.g. assisted vaginal delivery, caesarean section and appropriate neonatal care.*
5.	Does the mother require Magnesium sulfate? □ Yes, for pre-eclampsia □ Yes, for fetal neuroprotection □ No	*See indications for when to give for fetal neuroprotection and/or maternal pre-eclampsia above.* **Magnesium sulfate 4 g IV with 5 g IM per buttock as initial dose (10 mg IM total), followed by 5 g IM q4 hours**
6.	Is mother likely to deliver a preterm? □ Yes □ No	*Prepare for preterm birth:* • *Appropriate preterm bag and mask and/or PPV are available* • *Continuous warmth for unstable preterms (e.g blankets)* • *Readiness to implement Kangaroo Care* • *Ready to do delayed cord clamping (DCC)* • *Staff assistance for delivery and resuscitation*

4.	**SOON AFTER BIRTH - WITHIN ONE HOUR**

Date:	Time:	Collected by:
Mother's name:	Medical record/file #:	Baby's name:

1.	Does mom have any concerning features? □ High blood pressure □ High temperature/signs of active infection □ Heavy vaginal bleeding □ Other _____ □ NONE	*IF yes treat appropriately*
2.	Does this baby have any concerning features? □ Yes □ No If yes, mark all that apply: □ Signs of respiratory distress □ Signs of birth asphyxia □ Fetal anomaly □ Weight <2500g □ Signs of Prematurity □ Signs of infection □ Signs of anemia □ Unable to suck well □ Other condition, specify: _____	*If yes,* • *Manage appropriately* • *Call for help* • *Ensure close monitoring after discharge*
3.	□ Ensure baby started immediate breastfeeding and skin-to-skin contact initiated (if mother & baby are well).	For preterm encourage breast milk BUT determine appropriate mode of feeding: □ Breastfeeding □ Cup feeding on Expressed Breast Milk □ Nasogastric Tube Feeding on Expressed Breast Milk

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4.	Routine newborn care: □ Delayed cord clamping □ Vitamin K injection □ Antibiotic eye ointment □ Cord care	**Vitamin K:** **Weight <1.5 kg: 0. 5 mg IM** **Weight >1.5 kg: 1 mg IM**
5.	Observations/anthropometric measurements taken? □ Weight: _____ gms □ Length _____ cm □ Head circumference _____cm □ Other, specify_____	
6.	Gestational age confirmed? □ Yes, _____ weeks □ No If yes, GA method used (weight, LMP, Ballard Score, Other): _____	*If below 37 weeks, initiate preterm care (i.e., thermal care, resuscitation as needed, weight based dosing of meds, referral, etc.) if needed.*
7.	Does the baby require Antibiotics? □ Yes □ No	*Give if:* • *antibiotics were given to mother* • *baby has signs of breathing too fast (>60 breaths min) or too slow (<30 breaths min)* • *chest in-drawing, grunting or convulsions* • *no movement on stimulation* • *baby's temperature is too cold (< 35°C and not rising after warming) or too hot (> 37.5°C)*
8.	Does the baby require Antiretrovirals? □ Yes □ No	*Adhere to MOH guidelines on management of ARVs use in infants.*
	CONFIRM NEED AND READINESS FOR CONTINUING THERMAL CARE	
9.	Confirm readiness for thermal care. □ Yes □ No □ NOT REQUIRED	*If YES Ensure the following:* • *Educate the mother on skin to skin and KMC (awareness)* • *Knowledge and skills of the health provider for KMC* • *Space and furniture for KMC* • *Continuous warmth for unstable preterm babies, eg. Blankets*
10.	Does baby require Kangaroo Mother Care? □ Yes, initiated immediately or within one hour after birth □ Yes, initiated more than one hour after birth □ Yes, but not initiated □ No	*Consider for stable preterm and low birth weight babies.*
11.	Is referral of baby needed? □ Yes, specify diagnosis:_____ □ No If yes, specify facility referred to: _____	*If yes, follow your facility's protocol for referral.*

5	**AT DISCHARGE**

Date: _____	Time: _____	Collected by: _____
Mother's name: _____	Medical record/file #: _____	Baby's name: _____
Telephone:_____	Village:_____	

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1.	Infant status? □ Alive □ Dead If Alive, indicate whether: □ Discharged home □ Referred	If referred, specify: Facility referred to: _____ Condition: _____	If discharged home, specify: Date of discharge: _____ Time of discharge: _____ Age at discharge (days)_____ Infant weight at discharge (grams)____
2.	Is the baby feeding well? □ Yes □ No	*If no, re-consider if needs to stay in nursery/facility for assistance in feeding* *If okay to be discharged, give appropriate advice and recommend close follow-up*	
3.	Has the baby been on antibiotics? □ Yes, dose completed □ Yes, dose not completed □ No	*Advise on completion of dose at home and recommend follow-up*	
4.	Does the baby need to continue with Kangaroo Mother care? □ Yes □ No	*If Yes:* • *Recommend and advise on KMC at home for preterm and low birth weight babies.* • *Recommend close follow-up including phone calls.*	
5.	Length of stay(days) in the facility: _____days If stay >28 days, specify reason(s):_____		
6.	Is the mother well? □ Yes □ No	*If No, states concerns and advise on appropriate management.*	
7.	Does the mother have a plan for post-partum contraception? □ Yes □ No	*Discuss and offer family planning options to mother*	
8.	□ Advise mother to report for review if the following danger signs are noted.	***Mother:*** • *Bleeding (soaking more than 2 pads per hour or otherwise concerned about the bleeding)* • *Severe abdominal pain* • *Severe headache or visual disturbance* • *Breathing difficulty* • *Fever or chills* • *Difficulty emptying bladder* • *Epigastric pain*	***Baby:*** • *Fast/difficult breathing* • *Fever, unusually cold* • *Stops feeding well* • *Less activity than normal* • *Whole body becomes yellow*
9.	Follow-up arranged for mother and baby? □ Yes □ No Date of next appointment: _____	***For preterm and/or low birth weight infants:*** • *Schedule telephone calls daily for the first 72 hours, thereafter twice weekly until baby is 28 days old.* • *Recommend weekly follow-up in health facilities* • *Actively follow-up will be done by phone and home visits if missed appointments*	
10.	**If the baby was preterm or low birth weight, request for consent for follow-up by phone calls and home visits.**		