Post Natal Care

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Introduction

- **Post natal care is** the care given to the mother and her newborn infant immediately after birth and for the first six weeks.
- It includes the systematic examination of the mother and baby and providing necessary advice.
- This is a critical transition phase for a woman—physiologically, emotionally, and socially.
- It is unique because it manages two lives simultaneously: the mother and the neonate.

Natal, Antenatal, Postnatal Periods

Antenatal (Prenatal): The period from conception to the onset of labor.

Natal (Intranatal): The period extending from the onset of true labor until the delivery of the placenta.

Postnatal (Postpartum): Begins immediately after the delivery of the placenta and continues for 6 weeks (42 days).

Puerperium: Often used interchangeably with the postnatal period; the time when reproductive organs return to their near pre-pregnant state.

Neonatal Period: Refers to the first 28 days of the infant's life (Early: 0–7 days; Late: 7–28 days).

Public Health Importance of Postnatal Period

Maternal Mortality: A large proportion of maternal deaths occur during the first 48 hours after delivery.

Neonatal Mortality: The first week of life is the most hazardous period for the infant (highest risk of death).

Neglected Phase: Historically, this period receives less attention compared to antenatal care, leading to "missed opportunities.“ Risks in this period include Puerperal Sepsis, Secondary PPH, and Postpartum Depression.

History Taking

Postnatal History – Demographic & Obstetric Summary

General Information: Age, parity (GPLAD Formula), and socioeconomic status.

Date/Time of Delivery: Vital to determine the exact "postnatal day" for specific screening.

Mode of Delivery: Spontaneous Vaginal Delivery (SVD), Instrumental, or Cesarean Section (LSCS).

Place of Delivery: Institutional (Public/Private) vs. Home delivery (important for risk of sepsis).

Birth Attendant: Skilled Birth Attendant (SBA) vs. Untrained Dais/Relatives.

Outcome: Gender of the baby, birth weight, and immediate cry/Apgar status

APGAR Score

Definition: A rapid, standardized numerical scoring system used to assess the clinical status of the newborn infant immediately after birth.

Timing: Assessment is strictly performed at **1 minute** (reflects the birth experience) and **5 minutes** (reflects the baby's adaptation to extra-uterine life).

The Five Parameters: Each is scored from 0 to 2:

- **A**ppearance (Skin Color)
- **P**ulse (Heart Rate)
- **G**rimace (Reflex Irritability/Response to stimulation)
- **A**ctivity (Muscle Tone)
- **R**espiration (Breathing effort)

APGAR Score

Clinical Sign	**Score 0**	**Score 1**	**Score 2**
Appearance (Color)	Blue or Pale all over	Body pink, extremities blue (Acrocyanosis)	Completely pink
Pulse (Heart Rate)	Absent	Slow (< 100 beats/min)	Fast (> 100 beats/min)
Grimace (Reflex)	No response to suction/slap	Grimace/feeble cry	Cry, sneeze, or cough
Activity (Muscle Tone)	Limp / Flaccid	Some flexion of limbs	Active motion / Well flexed
Respiration (Effort)	Absent	Slow, irregular, or gasping	Strong, lusty cry

APGAR Score

Scoring Interpretation:

7 to 10: Excellent condition (Normal).

4 to 6: Moderately depressed (Requires stimulation or oxygen).

0 to 3: Severely depressed (Requires immediate life-saving resuscitation).

Significance: While the 1-minute score identifies the need for immediate care, the 5-minute score is a better predictor of long-term neurological survival.

History of Current Labor & Immediate Postpartum

Duration of Labor: Prolonged labor increases the risk of infection and exhaustion.

Complications during Labor: History of obstructed labor, perineal tears, or manual removal of the placenta.

Blood Loss: Subjective assessment of "heavy bleeding" or need for blood transfusion.

Drug History: Administration of Vitamin K to the baby or Oxytocics/Magnesium Sulfate to the mother.

Post-delivery vitals: Any history of immediate postpartum seizures or fainting.

Bladder/Bowel: Time of first voiding after delivery (checks for bladder trauma or retention).

Maternal Symptom Review (The "Red Flags")

Fever/Chills: Suggestive of puerperal pyrexia or urinary tract infection.

Vaginal Discharge (Lochia): History of foul smell (sepsis) or excessive soaking of pads (PPH).

Pain: Site-specific pain (abdominal, perineal, or calf pain suggesting DVT).

Breast Symptoms: Painful engorgement, nipple cracks, or redness (mastitis).

Headache/Blurring of Vision: Warning signs of postpartum eclampsia.

Leg Swelling: Unilateral swelling or tenderness may indicate Thrombophlebitis.

History of Neonatal Progress

Feeding History: Time of initiation of breastfeeding (ideally within 1 hour).

Feeding Frequency: Is the baby feeding 8–12 times a day? Latching issues?

Elimination: Time of passing Meconium (within 24h) and Urine (within 48h).

Activity: History of lethargy, poor cry, or excessive irritability.

Skin Changes: History of yellowish discoloration (Jaundice) or bluish tint (Cyanosis).

Temperature: Does the baby feel too cold (hypothermia) or too hot to touch?

Past Obstetric & Medical History

Previous Pregnancies: History of PIH, GDM, or PPH in earlier deliveries.

Pre-existing Illness: Chronic hypertension, Diabetes, or Cardiac disease that may worsen postpartum.

Surgical History: Previous C-sections or pelvic surgeries.

Anemia History: Previous need for Iron Sucrose or Blood during the antenatal period.

Psychiatric History: Previous episodes of "baby blues" or postpartum psychosis.

Current Medications: Any ongoing treatment for chronic conditions.

Social and Nutritional History

Dietary Intake: Details of "special diets" often given in traditional Indian households.

Support System: Who is the primary caregiver at home for the mother and baby?

Housing Environment: Sanitation, ventilation, and space (crucial for preventing neonatal infections).

Financial Stress: Impact on purchasing nutritious food or accessing follow-up care.

Water & Hygiene: Availability of safe water for the mother's hygiene and baby's care.

Rest: Number of hours of sleep the mother is managing between feeds

Contraceptive & Immunization History

Contraceptive Awareness: Prior knowledge or use of spacing methods.

Lactational Amenorrhea (LAM): Check if the mother understands the criteria for LAM.

Immunization Status: Has the baby received "Zero Dose" BCG, OPV, and Hepatitis B?

Maternal Immunization: Check Tetanus Toxoid (Td) status during the antenatal period.

Future Plans: Desire for more children and preferred spacing.

Referral History: Was the mother referred from a lower center? If so, why?

Objectives of Postnatal Care

Objective 1: Prevention of complications and restoration of maternal health.

Objective 2: Rapid restoration of Mother's health to optimum health.

Objective 3: Check adequacy of breastfeeding and infant nutrition.

Objective 4: Provision of family planning services.

Objective 5: Basic health education and psychological support.

Objective 1 – Complications of Post Natal period

Most common Complications of postnatal period are

1. **Pureperal sepsis**
2. **Thrombophlebitis**
3. **Secondary Hemorrhage**
4. **Others like UTI, mastitis**

Objective 1 - Infection Control

Puerperal Sepsis: Defined as infection of the genital tract occurring within 42 days of delivery.

Asepsis: Teaching the mother hand hygiene before handling the baby or the perineum.

Perineal Care: Keeping the area clean and dry; use of sitz baths if recommended.

Symptom Awareness: Educating on warning signs: foul-smelling discharge, high fever, or abdominal pain.

Clean Environment: Ensuring the mother stays in a well-ventilated, clean room.

Avoidance of Harmful Practices: Discouraging the application of oils or herbs on the umbilical cord or perineum.

Objective 2 - Maternal Physical Restoration

Involution of Uterus: Monitoring the rate at which the uterus returns to its pelvic position.

Lochia Monitoring: Assessing Lochia Rubra, Serosa, and Alba for normal progression.

Healing: Checking the healing of the episiotomy site or C-section scar for signs of infection.

Vital Signs: Regular monitoring of BP and Pulse to prevent late-onset eclampsia or shock.

Rest and Sleep: Encouraging adequate rest to facilitate physical and mental recovery.

Early Ambulation: Encouraged to prevent Deep Vein Thrombosis (DVT). Moving on Bed.

Objective 2 - Management of Anemia & Vitals

Anemia Correction: Postnatal women often have depleted iron stores; continued supplementation is vital.

Iron & Folic Acid (IFA): Park recommends 100 days of IFA supplementation postpartum.

Screening: Checking for pallor in conjunctiva, tongue, and nails.

Cardiovascular Stability: Monitoring for signs of heart failure in mothers with pre-existing cardiac disease.

Renal Function: Monitoring urine output, especially if there was PIH during pregnancy.

Thyroid Function: Postpartum thyroiditis can occur; monitoring for mood/weight changes.

Objective 2 - Kegel Exercises

Purpose: To strengthen the pelvic floor muscles weakened during pregnancy and delivery.

Benefits: Prevents urinary incontinence and pelvic organ prolapse; improves sexual health.

Technique: Squeeze the muscles used to stop the flow of urine; hold for 3-5 seconds, then relax.

Frequency: Repeat 10–15 times, thrice daily.

Timing: Can be started as soon as the mother feels comfortable after delivery.

Instruction: Ensure the mother is not holding her breath or squeezing her thighs/abs.

Objective 2 - Psychological Health

Postpartum Blues: Common (50-80%); mild, transient, usually resolves by day 10.

Postpartum Depression: More severe; persistent sadness, inability to care for the baby.

Postpartum Psychosis: A medical emergency involving hallucinations or delusions.

Screening: Simple questions about mood, sleep, and interest in the baby.

Support: Encouraging family members to share household chores and childcare.

Destigmatization: Explaining that emotional struggles are common and treatable.

Objective 3 – Breastfeeding Initiation and Technique

Early Initiation: Within 1 hour of birth to utilize the "sucking reflex."

Colostrum: Highlighting its role as the "first vaccine"—rich in IgA and nutrients.

Latching Technique: The four signs of good attachment (Chin touching breast, Mouth wide open, Lower lip turned out, More areola seen above).

Positioning: Ensuring the mother is comfortable (sitting or side-lying) and the baby’s body is supported.

Demand Feeding: Encouraging feeding whenever the baby shows hunger cues, not on a strict schedule.

Elimination of Pre-lacteal feeds: Absolutely no honey, water, or ghutti

Objective 3 - Troubleshooting Breastfeeding

Breast Engorgement: Managed by frequent feeding and warm compresses.

Sore/Cracked Nipples: Usually due to poor attachment; corrected by improving latch.

Mastitis: Recognizing redness and fever; continued breastfeeding is usually encouraged to drain the breast.

Inadequate Milk Supply: Often a perception; check baby's weight gain and urine output (6+ times/day).

Working Mothers: Education on expressing breast milk and storage (safe at room temp for 4-6 hours).

Support: Role of "Mother Support Groups" and ASHAs in the community.

Objective 3 - Exclusive Breastfeeding (EBF)

Definition: Only breast milk, no other liquids or solids (not even water) for 6 months.

Benefits to Baby: Reduced risk of diarrhea, pneumonia, and obesity later in life.

Benefits to Mother: Aids uterine involution, reduces risk of breast/ovarian cancer, and natural birth control.

Growth Monitoring: Using the WHO Growth Charts to ensure the baby is thriving on EBF.

Vitamin D: Discussion on supplementation for the infant as per local guidelines.

Avoidance of Bottles: Discouraging pacifiers and bottles to prevent "nipple confusion" and infection.

Objective 4 - Importance of Spacing

Health Spacing: Park emphasizes a minimum of 2–3 years between births for optimal maternal recovery.

Concept of PPFP: Postpartum Family Planning (PPFP) should be discussed *before* the mother leaves the hospital.

Risks of Short Spacing: Increased risk of low birth weight, preterm birth, and maternal depletion syndrome.

Decision Making: Involving the husband/partner in the counseling process.

Method Selection: Choosing a method that does not interfere with breastfeeding.

Timing: Counseling should begin in the 3rd trimester and be reinforced in the postnatal period.

Objective 4 - Contraceptive Options (Non-Hormonal)

Lactational Amenorrhea Method (LAM): Effective if: EBF, <6 months postpartum, and menses have not returned.

PPIUCD: Postpartum Intrauterine Contraceptive Device—inserted within 48 hours of delivery.

Barrier Methods: Condoms are safe and protect against STIs; can be started anytime.

Permanent Methods: Tubal Ligation (Postpartum Sterilization) usually done within 7 days or after 6 weeks.

Vasectomy: Encouraging male participation in family planning.

Interval IUCD: Can be inserted after 6 weeks (at the first postnatal follow-up).

Objective 4 - Contraceptive Options (Hormonal)

Progesterone-Only Pills (POPs): "Minipills" are safe for breastfeeding mothers; can start at 6 weeks.

Injectable Contraceptives (Antara): Progesterone-only (DMPA) shots given every 3 months.

Centchroman (Chhaya): Non-hormonal, non-steroidal pill (weekly) available in India’s public health system.

Combined Oral Contraceptives (COCs): Avoided in the first 6 months of breastfeeding as estrogen may reduce milk supply.

Emergency Contraception: Education on its use in case of method failure.

Follow-up: Stressing the importance of returning for the next dose or check-up.

Objective 5 - Hygiene and Self-Care

General Cleanliness: Daily bathing and wearing clean, comfortable cotton clothes.

Perineal Hygiene: Washing from front to back to avoid fecal contamination of the vagina.

Handwashing: The most effective way to prevent "Cross-infection" between mother and baby.

Dental Care: Postnatal mothers should continue good oral hygiene to prevent infections.

Care of the Breasts: Keeping nipples dry; avoiding harsh soaps that cause cracking.

Environment: Keeping the living area smoke-free (preventing SIDS and respiratory issues).

Objective 5 - Warning Signs (Danger Signs)

For Mother: Excessive bleeding, foul discharge, high fever, severe headache, or calf pain.

For Baby: Convulsions, fast breathing (>60/min), chest indrawing, or high fever.

For Baby (cont.): Jaundice involving palms/soles, or the baby being "too cold" (hypothermia).

Action Plan: Clear instructions on *where* to go and *who* to call in an emergency.

Transport: Knowledge of "102" or "108" ambulance services in India.

Documentation: Keeping the "Mother and Child Protection (MCP) Card" safe and updated.

Neonatal Examination

Thermoregulation: Ensuring the baby is warm; Kangaroo Mother Care (KMC) for low birth weight babies.

Umbilical Cord Care: Keeping it clean and dry; watching for redness or discharge (Omphalitis).

Eye Care: Monitoring for discharge or redness (Ophthalmia neonatorum).

Skin: Checking for rashes, pustules, or significant jaundice.

Congenital Anomalies: Re-checking for any missed physical defects (Cleft lip, clubfoot, etc.).

Weight Gain: Expected weight gain is approx 25-30g/day after the initial weight loss period.

Screening for Complications

Hypoglycemia: Especially in babies of diabetic mothers or LBW infants.

Sepsis: Watching for "refusal to feed" as the earliest sign of neonatal sepsis.

Hyperbilirubinemia: Differentiating between physiological and pathological jaundice.

Respiratory Distress: Counting the respiratory rate for a full minute.

Gastrointestinal: Monitoring for vomiting or abdominal distension.

Neurological: Checking neonatal reflexes (Moro, Sucking, Rooting)

Referrals and Follow-up

Criteria for Referral: Any danger sign or birth weight <1800g (as per IMNCI guidelines).

SNCU: Role of Special Newborn Care Units in managing sick neonates.

First Follow-up: Usually scheduled at 6 weeks, coinciding with the first round of childhood immunizations.

Home Visits: Role of ASHA in conducting 6-7 home visits for postnatal care (HBNC).

Record Keeping: Ensuring every visit is documented on the MCP card.

Communication: Using clear, non-medical language with the parents.

Bonding and Attachment

Skin-to-Skin Contact: Promoting immediate contact to stabilize baby’s vitals and hormones.

Rooming-In: Keeping the mother and baby in the same bed/room 24/7.

Responsive Parenting: Encouraging the mother to respond to the baby’s cues (crying, rooting).

Paternal Involvement: Encouraging the father to hold and interact with the baby.

Hormonal Influence: Explaining how Oxytocin (the "love hormone") helps in both bonding and milk let-down.

Kangaroo Mother Care (KMC)

Components: Skin-to-skin contact, exclusive breastfeeding, and early discharge.

Indications: Premature or Low Birth Weight (LBW) infants (<2500g).

Duration: As long as possible, ideally 24 hours a day.

Benefits: Improves thermal regulation, reduces infection, and increases maternal confidence.

Who can do it: Mother, father, or any healthy family member.

Nutritional Advice for the Mother

Caloric Increase: An additional 600 kcal/day is needed during the first 6 months of lactation.

Protein: Extra 15–20g of protein to support milk production and tissue repair.

Calcium: Increased need (1200mg/day) to prevent maternal bone loss during breastfeeding.

Fluids: High fluid intake (water, milk, soups) is essential for adequate lactation.

Dietary Quality: Diverse diet including green leafy vegetables, fruits, eggs, and pulses.

Iodized Salt: Essential for the baby's brain development via breast milk.

Lifestyle Changes

Rest: "Sleep when the baby sleeps" to combat fatigue.

Avoidance of Harmful Substances: Zero alcohol, tobacco, or unnecessary medications.

Activity: Avoid heavy lifting for 6 weeks, especially after a C-section.

Sexual Activity: Can be resumed after 6 weeks once lochia has stopped and healing is complete.

Mental Well-being: Encouraging hobbies or light walks to reduce stress.

Hygiene: Emphasizing that tradition-based restrictions on bathing are often medically unnecessary.

Immunization Schedule for the Child

At Birth (Zero Dose): BCG (Intradermal), OPV (Oral), Hepatitis B (Intramuscular).

6 Weeks: Pentavalent-1, OPV-1, IPV-1, Rotavirus-1, PCV-1.

Side Effects: Advising the mother on mild fever or swelling after shots (paracetamol use).

Documentation: Stressing that the MCP card is a "passport to health."

Essential Newborn Care (ENC)

Cleanliness: Clean hands, clean surface, clean cord cut/tie.

Warmth: Drying the baby immediately; delayed bathing (after 24 hours).

Breathing: Monitoring for normal cry and respiratory effort.

Cord Care: No application of substances; it will fall off naturally in 5–15 days.

Eye Care: No "kajal" or traditional eye drops—risk of infection and lead poisoning.

Skin: No vigorous massaging in the first few days; use only mild oils if necessary.

Janani Shishu Suraksha Karyakram (JSSK)

Entitlements: Absolutely free and "no expense" delivery and C-section in public health institutions.

Maternal Benefits: Free drugs, consumables, diagnostics, diet, and blood.

Neonatal Benefits: Free treatment for sick newborns till 1 year of age.

Transport: Free transport from home to facility, inter-facility referral, and "drop back" home.

Eliminating OOP: Aims to eliminate Out-of-Pocket (OOP) expenditure which acts as a barrier to care.

Scope: Includes complications arising during the postnatal period.

Home-Based Newborn Care (HBNC)

Strategy: Trained ASHAs visit homes to provide care for the newborn and mother.

Schedule: 6 visits for institutional deliveries (Days 3, 7, 14, 21, 28, 42).

Schedule (Home birth): 7 visits (includes Day 1).

Tasks: Examining the baby for danger signs, weighing the baby, and counseling the mother on EBF.

Maternal Care: ASHA checks the mother’s lochia, fever, and nutrition.

Referral: ASHA facilitates referral to the nearest facility if any red flags are identified.

Postnatal Visit Schedule – Institutional vs. Home Birth

Institutional Deliveries: At least 6 home visits by the ASHA on days **3, 7, 14, 21, 28, and 42**.

Home Deliveries: A total of 7 home visits, adding an immediate visit on **Day 1** to the standard schedule.

Hospital Stay: For institutional births, the first 48 hours are spent in the facility under medical supervision.

Additional Visits: Extra visits are mandated for Low Birth Weight (LBW) or "Small for Date" babies.

Facility-Based Follow-up: The first formal hospital follow-up for the mother is usually at **6 weeks** (42 days).

Provider: Primarily the **ASHA** (Accredited Social Health Activist), supported by the **ANM** (Auxiliary Nurse Midwife).

The MCP Card – A Clinical Tool for Surveillance

Purpose: A joint document by MoHFW and MWCD for tracking health, nutrition, and development.

Postnatal Section: Contains dedicated checklists for both the mother and the newborn for every visit.

Visual Aids: Uses "Traffic Light" coding (Green/Yellow/Red) to help semi-literate families identify danger signs.

Weight Tracking: Includes the WHO Growth Chart to plot the baby's weight gain during postnatal visits.

Service Record: Tracks IFA supplementation, Vitamin A doses, and the full primary immunization cycle.

Verification: Every visit must be signed by the ASHA/ANM to ensure accountability and incentive processing.

Maternal Clinical Observations (ASHA/ANM Checklist)

Temperature: Checking for fever (Puerperal Pyrexia) which indicates infection.

Vaginal Discharge (Lochia): Assessing for foul smell, excessive clots, or return of bright red bleeding.

Uterine Involution: Feeling the abdomen to ensure the uterus is firm and decreasing in size.

Breast Health: Checking for cracked nipples, engorgement, or mastitis symptoms.

Leg Examination: Checking for unilateral swelling, redness, or pain (Sign of DVT).

Emotional State: Observing for signs of extreme sadness, withdrawal, or "Baby Blues."

Newborn Clinical Observations (The 7 Danger Signs)

Feeding: Is the baby "weakly sucking" or refusing to feed entirely?

Activity: Is the baby lethargic, unconscious, or having convulsions/fits?

Respiration: Counting the respiratory rate; checking for fast breathing (>60 bpm) or chest indrawing.

Temperature: Identifying "Cold Stress" (Hypothermia) or high fever (>37.5°C).

Jaundice: Observing if the yellow discoloration has reached the palms or soles (Danger sign).

Umbilical Cord: Checking for pus, redness, or a foul-smelling discharge.

Skin: Looking for multiple pustules or a large boil/abscess

Vital Actions during Home Visits

Weight Monitoring: Weighing the baby at every visit to ensure they are regaining birth weight.

Thermal Care: Counseling on "Kangaroo Mother Care" (KMC) if the baby is under 2.5kg.

Breastfeeding Support: Observing a full feed to correct latching and positioning issues.

Hygiene Education: Ensuring no harmful substances (oil, ash, cow dung) are applied to the cord.

Referral Linkage: If any "Red" sign is noted on the MCP card, the ASHA must facilitate immediate transport.

Documentation: Filling the "Postnatal Care" table in the MCP card to ensure the family knows the next visit date.

Summary of Postnatal Visits

Visit Number	Day of Visit	Key Focus Area
Visit 1	Day 1 (Home birth only)	Initiation of EBF and warmth
Visit 2	Day 3	Checking for Jaundice and cord status
Visit 3	Day 7	Weight check and maternal recovery
Visit 4	Day 14	EBF reinforcement and family planning

Summary of Postnatal Visits

Visit Number	Day of Visit	Key Focus Area
Visit 5	Day 21	Growth monitoring
Visit 6	Day 28	Closing the neonatal period; immunization prep
Visit 7	Day 42 (6 Weeks)	Final check; transition to 6-week vaccines

Summary

The "Fourth Trimester": Postnatal care is as vital as antenatal care for survival.

Integrated Approach: Successful outcomes depend on the triad of clinical care, nutrition, and social support.

Community Linkage: Understand that the ASHA and the MCP card are your strongest tools in the field.

Final Message: Every mother and newborn deserves a safe, dignified, and healthy start to their new journey.

Thank you…