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Gauteng Antenatal Care Policy Document

Introduction

There is a need to define a minimum standard package of antenatal care in Gauteng Province. This helps with:

- Facilitation of central and regional budgeting
- Guidance for service providers about the content of antenatal care
- Definition of standards
- Communication to consumers - pregnant women and their families

1. THE NEED FOR ANTEnatal CARE

There is general acceptance that antenatal care should be provided for all pregnant women. Some obvious benefits of modern antenatal care are:

- Meeting consumer demand for health care during pregnancy
- Screening, e.g. for congenital syphilis or fetal anomalies
- Early detection of pregnancy problems, e.g. hypertension
- Advice for pregnant women and preparation for delivery, including specific delivery plans

2. OBJECTIVES

The general objective of antenatal care is to ensure the best possible pregnancy outcomes for pregnant women and their unborn babies through optimal physical and psychological preparation before delivery. Two specific indices that reflect the status of antenatal care are the incidence of congenital syphilis in a population and the rate of unbooked deliveries presenting at maternity units. Both are easily measurable.

Specific objectives for the province should be, by the year 2002:

- The eradication of congenital syphilis
- The rate of unbooked emergencies dropping below 5 per cent

3. INSTITUTIONS PROVIDING ANTEnatal CARE

Any Gauteng health facility may provide antenatal care - mobile clinics, day clinics, midwife obstetric units (MOUs) and hospitals. In smaller facilities antenatal care may be integrated with other functions to provide comprehensive services.
3.1. Non-Gauteng government antenatal care

Non-government organisations, private caregivers and other provinces may offer antenatal care to Gauteng pregnant women. This is acceptable to the province as long as the minimum standards set out in this document are satisfied.

The relationship between the government antenatal service and private caregivers should be one, which agrees on a general uniformity of approach and encourages dialogue. Private doctors and midwives who provide antenatal care should be aware of the contents of this document and, in particular, should be asked to give attention to the following recommendations:

• Syphilis screening must be performed on all pregnant women at the first opportunity
• The antenatal record should be retained by the pregnant woman
• Ultrasound results, especially those giving information about gestational age, should be made known to the pregnant woman and a written report retained by her
• Women who present to private caregivers for confirmation of pregnancy should be offered, or referred for, a full package of antenatal care as soon as possible

This information will be disseminated by the publication of this document and by the presentation thereof at meetings and workshops.

3.2. Staff

Registered midwives and medical practitioners (doctors) are the only professionals that may provide antenatal care in Gauteng. While less qualified staff may perform some of the support functions, e.g. urine testing, clinical assessments must be performed and signed by at least a registered midwife or doctor. Senior medical or nursing students may be allowed to take on these responsibilities under direct supervision of a qualified person. Ideally an advanced midwife or a doctor should be assess each pregnancy on at least one occasion. This may not be possible at all institutions.

3.3. Levels of care

For efficient functioning of the antenatal service, pregnant women must be classified according to their categories of risk
Table 1: Level of Care

<table>
<thead>
<tr>
<th>Risk category</th>
<th>Problems expected</th>
<th>Antenatal care staff</th>
<th>Antenatal care Institution</th>
<th>Place of delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk</td>
<td>None</td>
<td>Midwives</td>
<td>Clinic, MOU</td>
<td>MOU</td>
</tr>
<tr>
<td>Intermediate risk, e.g. previous Caesarean section</td>
<td>Labour problems</td>
<td>Midwives§</td>
<td>Clinic, MOU</td>
<td>Hospital</td>
</tr>
<tr>
<td>High risk, e.g. hypertension</td>
<td>Pregnancy and labour problems</td>
<td>Doctors§</td>
<td>Hospital</td>
<td>Hospital</td>
</tr>
<tr>
<td>Special risk, e.g. diabetes</td>
<td>Serious disorders</td>
<td>Specialists§</td>
<td>Hospital</td>
<td>Central hospital where possible</td>
</tr>
</tbody>
</table>

*Certain intermediate risk women may need to be seen by doctors, depending on the specific problem

§Allied disciplines should be available to provide support to the antenatal clinic: social workers at the MOUs, and physiotherapists at the hospitals. A full range of disciplines and medical referral facilities should be on offer at central hospitals.

Each woman must receive care according to her risk category as shown in the table. Lists of conditions fulfilling these criteria appear in the Appendix (1). Each referral centre should define its own lists of risk categories, according to local conditions and within the broad guidelines provided in the policy. Pregnant women are not entitled to higher risk levels of care than their particular category indicates.

3.4. Antenatal care working hours

Working hours should be most convenient to pregnant women, caregivers and support services. The most suitable hours should be negotiated at each institution. Evening and weekend clinics would be acceptable to the province, as are traditional weekday hours.

3.5. Facilities for pregnant women and partners

The antenatal clinic needs to be housed in a building, which is clearly adequate for its purposes. There should be a comfortable waiting area (with seating), hygienic and private ablution, and examination cubicles that allows privacy and confidentiality. Where facilities are adequate and
privacy can be assured, the presence of partners attending with pregnant women should be encouraged, whether these are husbands, boyfriends or other family members.

4. RECORD KEEPING

The essential record keeping tool is the antenatal card. This gives essential information on personal details, history, examination, and special investigations and pregnancy progress. The card must be retained by the woman throughout her pregnancy and brought to clinic or hospital for any antenatal attendance and at delivery. Continuity of antenatal care is more easily assured by this practice.

Records that must be kept at the antenatal clinic are pregnant women's names, dates of attendance, results of blood tests and copies of any ultrasound reports. High and special risk groups may require hospital files to be opened.

The Gauteng antenatal card (TPH 261a) is recommended as the standard format. Any record, however, that provides a minimum amount of information, as described in 7. (below), is acceptable. Women who have started their antenatal care at other institutions frequently present with cards of a different format. As long as these cards give all essential information, notes should be added on them instead of issuing new Gauteng antenatal cards.

The Gauteng antenatal card must be available to any institution, midwife or doctor providing antenatal care in the province. This includes private practitioners. Cards should be issued at a nominal fee.

5. PREGNANCY CONFIRMATION

Women who suspect that they are pregnant may present themselves to doctors or nurses working in Gauteng hospitals or clinics, for confirmation of pregnancy. Those who are found to be pregnant must be referred as soon as possible to the nearest antenatal clinic. If antenatal facilities are available on the premises, an antenatal card should be issued, and the essential elements of the first visit completed (see below in 7.). Women who request termination of pregnancy should not be offered antenatal care and must be referred appropriately.

6. SCHEDULE FOR ROUTINE ANTENATAL VISITS

For low-risk pregnant women, two schedules apply, depending on parity. Each visit has a particular emphasis. This is shown in tables 1 and 2. Higher risk women may need to undertake more frequent visits as decided by local protocols. Detailed description of content will follow below in 7.
Table 2: Antenatal visits schedule for a multipara

<table>
<thead>
<tr>
<th>Visit number</th>
<th>Gestational age (weeks)</th>
<th>Specific objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6 - 20</td>
<td>Risk assessment, gestational age and blood tests</td>
</tr>
<tr>
<td>2</td>
<td>24 - 28</td>
<td>Multiple pregnancy, hypertension and risk for preterm labour</td>
</tr>
<tr>
<td>3</td>
<td>32 - 34</td>
<td>Fetal growth and hypertension</td>
</tr>
<tr>
<td>4</td>
<td>36 - 38</td>
<td>Fetal growth, lie, presentation, hypertension and anaemia</td>
</tr>
<tr>
<td>5</td>
<td>40 - 42</td>
<td>Fetal growth, lie, presentation, hypertension and post-dates</td>
</tr>
</tbody>
</table>

Table 3: Antenatal visits schedule for a nullipara

<table>
<thead>
<tr>
<th>Visit number</th>
<th>Gestational age (weeks)</th>
<th>Specific objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6 - 20</td>
<td>Risk assessment, gestational age and blood tests</td>
</tr>
<tr>
<td>2</td>
<td>24 - 28</td>
<td>Multiple pregnancy, hypertension, and risk for preterm labour</td>
</tr>
<tr>
<td>3</td>
<td>28 - 30</td>
<td>Hypertension*</td>
</tr>
<tr>
<td>4</td>
<td>32 - 34</td>
<td>Fetal growth and hypertension</td>
</tr>
<tr>
<td>5</td>
<td>34 - 36</td>
<td>Hypertension*</td>
</tr>
<tr>
<td>6</td>
<td>36 - 38</td>
<td>Fetal growth, lie, presentation, hypertension, and anaemia</td>
</tr>
<tr>
<td>7</td>
<td>38 - 40</td>
<td>Hypertension*</td>
</tr>
<tr>
<td>8</td>
<td>40 - 42</td>
<td>Fetal growth, lie, presentation, hypertension and post-dates</td>
</tr>
</tbody>
</table>

*Where convenient, antenatal clinics should perform only blood pressure and urine protein checks at these visits, omitting other physical examinations. Pregnant women undergoing this type of limited assessment need to receive an explanation of the rationale of this practice, preferably early in the pregnancy, to avoid misunderstanding.

7. CLINICAL CONTENT OF ANTENATAL VISITS

The content of each visit should be linked to the objectives shown in the tables in 5. (above). This will include:
7.1. The antenatal first visit

a. Personal details: age, address, and telephone number

b. Past obstetric history: complications and outcomes of all previous pregnancies

c. Medical and family history: conditions affecting or affected by pregnancy, psychological health, and family history of congenital abnormality, diabetes or twins.

d. Clear recording of gestational age and method used to determine it, with an estimated date of delivery

e. General physical examination including weight

f. A problem list: risk factors found or anticipated, with a brief delivery plan, e.g. for hospital or MOU delivery.

7.2. Pregnancy progress at each visit

Blood pressure, proteinuria, fetal movements, fetal lie and presentation, symphysis-fundal height in centimetres should be recorded and a note made of any problems. In nulliparas, there are three visits where only the blood pressure and urine protein need be checked. Refer to table 2 in 6.

8. ROUTINE SPECIAL INVESTIGATIONS

8.1. Urine tests

a. At all visits the urine is tested for protein and glucose.

b. Urine pregnancy test for suspected pregnancies when the uterus is not palpable abdominally.

8.2. Blood tests

The following tests are performed on all pregnant women:

a. RPR or equivalent (e.g. VDRL) for syphilis screening, at the first visit, using card tests

b. Rhesus blood grouping (Rh), at the first visit, using a rapid test kit

c. Haemoglobin level (Hb), at the first visit and at 36 weeks, using a portable haemoglobinometer or copper sulphate test
d. The health institutions that offer HIV testing at first visits, using ELISA test should ensure that pre-counselling and post-counselling is done. Written consent should be obtained from the client before testing.

RPR, Rh and Hb should be done on site, giving results and treatment before women leave the clinic. Midwifery staff can be trained to perform the tests. Quality control is the responsibility of the MOU or hospital concerned.

8.3. Ultrasound and genetic counselling with amniocentesis

Any pregnant woman who is 35 years old or more, and less than 20 weeks pregnant, or any pregnant woman who has previously given birth to an abnormal fetus and is less than 20 weeks pregnant, must be offered these tests and be referred to the nearest facility that can perform them.

8.4. Other tests not offered by the province

Despite wide usage elsewhere, many other tests are either inappropriate or too expensive to offer routinely to pregnant women at provincial facilities. These include:

a. Urine: dipstick for leucocytes, nitrites, ketones and blood; urine culture

b. Blood: FTA-Abs, TPHA, triple screen, Toxoplasma, Rubella, Hepatitis B, Glucose screening

c. Cytology: cervical (Papanicolaou) smear

d. Baseline ultrasound scan

These tests are to be done only for specific clinical indications, never as routines.

All pregnant women should be informed at the first visit that certain tests (mainly ultrasound, rubella and triple screen) are not done routinely in provincial facilities. Women who request these tests can pay private rates to have them done or be referred to private practitioners of their choice.

9. MEDICATIONS

9.1. Supplementation

The following supplements should be given to all pregnant women:

- In the first 12 weeks of pregnancy and, if possible, before conception: folic acid 0.8 mg daily or equivalent dosage depending on the size of available tablets
- From 13 weeks of pregnancy: elemental iron 60 mg daily
9.2. Tetanus vaccination

All pregnant women should receive tetanus toxoid to prevent neonatal tetanus, according to standard protocol, unless they can provide evidence of having had antitetanus immunisation. This would ideally be indicated on the new 'women's health card.'

9.3. Treatment of common ailments

Pregnancy-associated ailments, e.g. heartburn, must be treated by appropriately trained staff at the antenatal clinic. 'Appropriately trained staff' may be midwives, primary health care nurses or doctors, depending on local conditions or specific circumstances. Medicines to treat these disorders should be available on the Essential Drugs List (EDL).

9.4. Treatment of sexually transmitted diseases

Appropriately trained staff, as defined in 9.3. (above), should be available to diagnose and treat these conditions according to standard protocols.

10. INFORMATION FOR PREGNANT WOMEN

It is essential to maintain friendly and open communication between staff and antenatal clinic attenders. Certain information must be provided to all pregnant women:

- **A delivery plan:** the estimated date and place of delivery

- **Five danger symptoms:** pregnant women should immediately report to the planned place of delivery any of the following: severe headache, abdominal pain, reduced fetal movements, passage of liquor from the vagina, or ante-partum haemorrhage.

- **Preparation for childbirth and motherhood:** content will depend on local circumstances. Information will include aspects of self-care in pregnancy and advice on childcare. Antenatal classes and exercises may also be provided.

- **Routine tests that are not performed:** this informs pregnant women that certain expensive tests, e.g. rubella serology and triple screen, are not done routinely by the province, although they might on occasion detect serious fetal problems.

**Information leaflets** that summarise the above should be produced at hospitals and clinics, to suit local conditions and languages, and be handed out to pregnant women. This does not replace the need for effective spoken communication. There should be a leaflet that applies to all of Gauteng, and another, specific to and produced by the institution or district concerned.
11. AUDIT

Antenatal clinics' performance should be audited as follows:

a. Numbers of antenatal first attenders
b. Numbers of antenatal repeat visits
c. Numbers of antenatal clinic referrals to and from other levels of care
d. Numbers of deliveries with syphilis (RPR) results positive, negative and unknown
e. Numbers of unbooked deliveries in the clinic and hospital labour wards. 'Unbooked' is defined as a mother who delivers without having had any structured antenatal care.

Monthly totals should be examined and discussed by staff at the antenatal clinics, and returns sent monthly to the Directorate of Maternal, Child and Women's Health and Nutrition in the Gauteng Health Department or district/regional offices.

12. MANAGEMENT GUIDELINES

Clearly written clinical management guidelines ('protocols') should be used at all provincial institutions that offer antenatal care. This helps to ensure a high standard of pregnancy care for all women. These are ideally drawn up at referral hospitals in consultation with the clinics and in accordance with national guidelines and the EDL. Acceptable primary care obstetric guidelines are available from the Directorate of Maternal and Child Health and Nutrition in the Gauteng Health Department.
APPENDIX 1: Suggested list of high and intermediate risk pregnancy problems

High risk conditions at booking (antenatal care and delivery in hospital):

- Primigravida aged 35 or more
- Previous infertility treatment
- Previous myomectomy
- Previous cervical or vaginal surgery including cerclage
- Previous hysterotomy
- Previous perinatal death
- Previous baby with major congenital abnormalities
- Last pregnancy preterm delivery at 7 months or less
- Last pregnancy pre-eclampsia before 7 months
- Three or more previous miscarriages
- Diabetes mellitus
- Chronic hypertension or renal disease
- Symptomatic asthma
- Epilepsy
- Active tuberculosis
- Heart disease
- Autoimmune disease
- History of venous thrombosis
- Psychiatric illness, including previous puerperal psychosis
- Thyroid disease or thyroidectomy
- Serious disease or deformity of the spine, pelvis or hip
- Any other serious medical condition

Intermediate risk conditions (antenatal care at MOU and delivery at hospital):

- Maternal age 15 or less
- Previous postpartum haemorrhage requiring blood transfusion
- Last pregnancy forceps or vacuum delivery
- Parity 5 or more
- Previous Caesarean section

Problems arising in the pregnancy (requiring referral and further assessment)

- Anaemia
- Uterus large for dates (over 90th centile SFH); suspected twins or hydramnios
- Uterus small for dates (under 10th centile SFH); suspected IUGR
- Malpresentation after 34 weeks
- Rhesus negative blood group with antibodies
- No maternal weight gain in women who weighed less than 60kg at booking
- Pregnancy reaching 42 weeks
- Reduced fetal movements after 28 weeks
- Hypertension or pre-eclampsia
- Antepartum haemorrhage
APPENDIX 2: List of Participants:

Dr. E Buchmann (Chairperson of the Gauteng Antenatal Care Policy Group).

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Dr. N. Simelela
Ms. N. Thembekile
All the Health Institutions that participated in the development of the policy

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Dr M. L. Modise (Director : MCH & Nutrition)