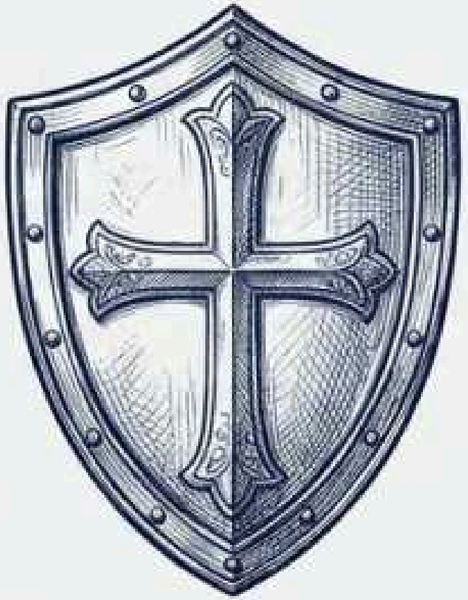
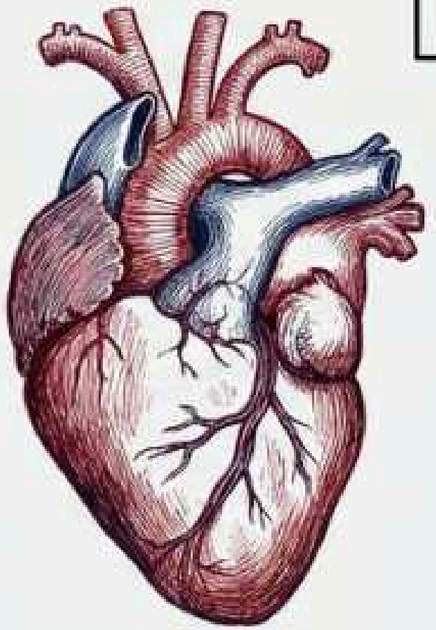
¶ 1.1



Detect & Manage Early
(Identify complications)

Mother & Baby Health
(Core biological goal)



Antenatal Care Aims



Informed Choices
(Supporting patient agency)

Preparation
(Birth and parenthood readiness)



WHO Standard:
$\geq$ 8 Contacts during pregnancy

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The Booking Visit

¶ 1.2

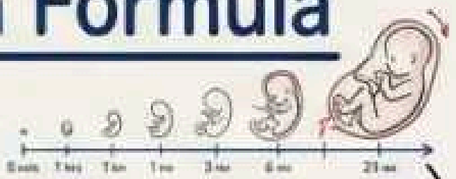


Timing: Ideally < 10 weeks

History Domains: Medical, Obstetric, Family, Social

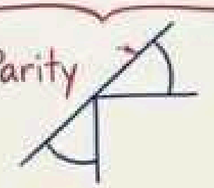
High-Alert Historical Risks: Previous Caesarean section, pre-eclampsia, preterm birth, stillbirth

Obstetric Notation Formula



$$G = Gravidity\left(\sum \text{total pregnancies}\right)$$

$$P = Parity\left(\sum \text{births} > 24 \text{ weeks}\right)$$



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Maternal Assessment

¶ 1.3

Risk Factors: Pre-existing conditions (Diabetes, High BP, Epilepsy, Heart disease, Mental illness), Age, BMI, Smoking, Domestic Abuse (often begins/worsens in pregnancy).

High Risk



Obstetrician-led care

Low Risk

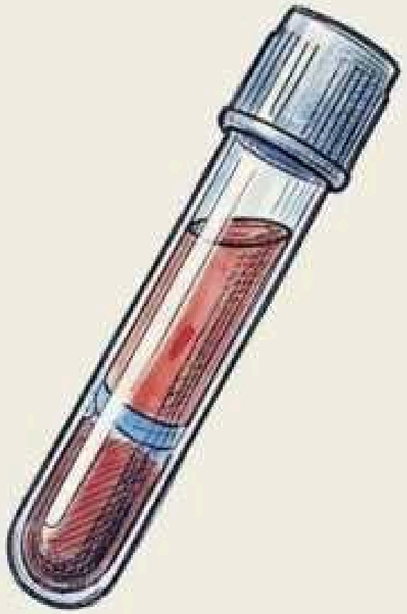


Midwife-led care

Evidence: Clinical trials confirm this pathway is safe and associated with fewer medical interventions.

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Routine Screening

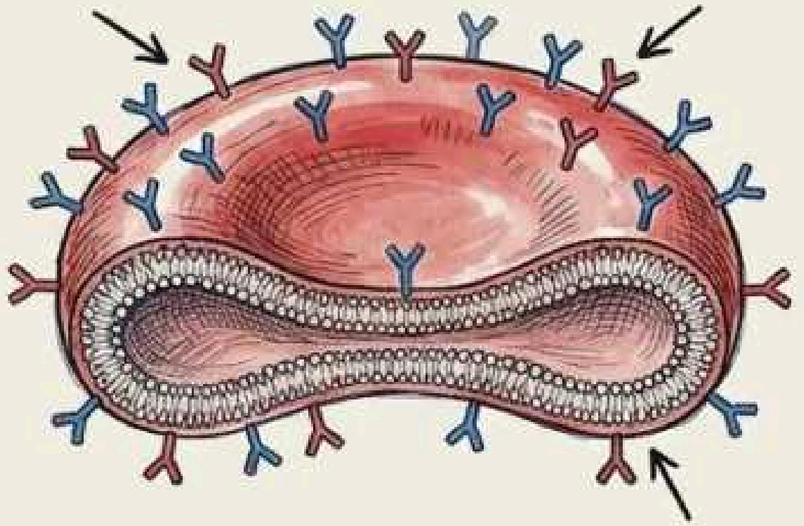


Checks for: Anaemia, Blood Group & Antibodies

Infectious Disease Panel: HIV, Hepatitis B, Syphilis (Ref: Med 532 B)

Rhesus Management

¶ 1.4



Mechanism: If Maternal blood is Rh(-), there is a risk of antibody formation against the fetus.

Intervention: Anti-D injections administered.

Outcome: Has made haemolytic disease of the newborn exceptionally rare.

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¶ 1.5





11–14 Weeks: Dating Scan

- Confirms the due date.
- Detects multiple pregnancies (twins).
- Often combined with screening for chromosome conditions.

18–21 Weeks: Anomaly Scan

- Conducts a detailed check of the baby's anatomy.

Patient Agency: All screening tests offer information, and it is the woman's choice which to have.

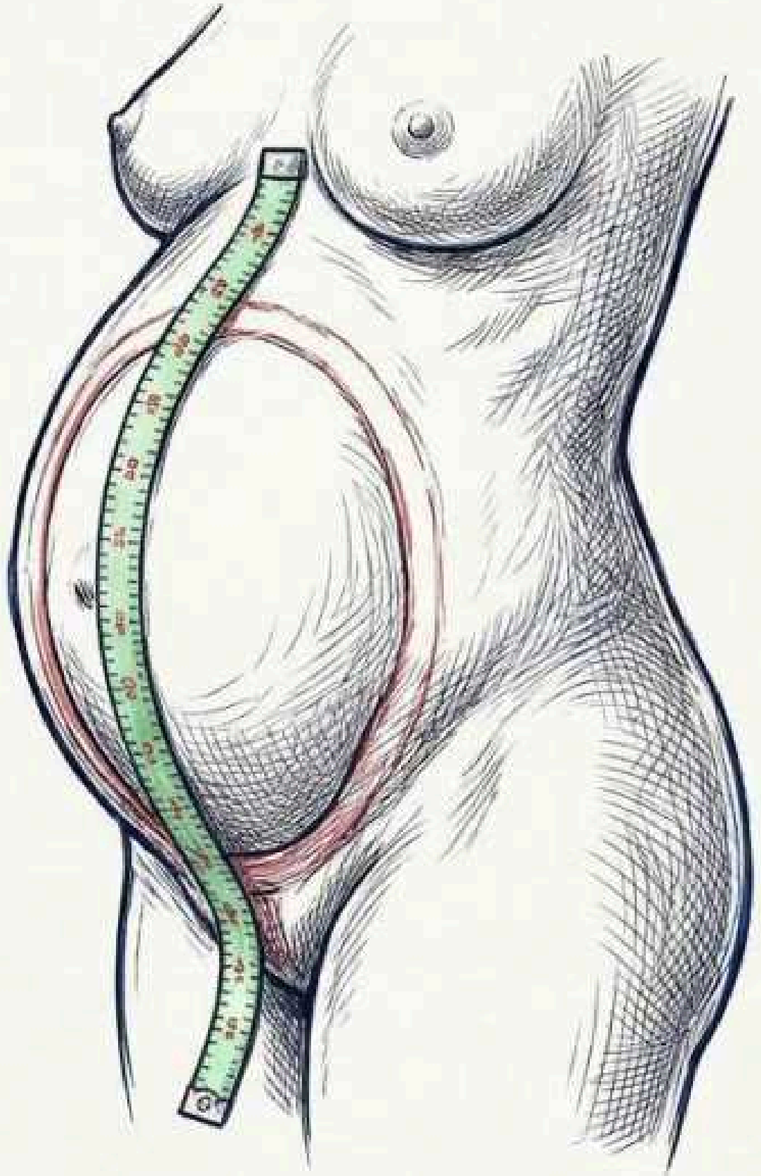
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¶ 1.6

Continuous Checks

Every Visit: BP + Urine Analysis → Detect Pre-eclampsia.

BP > 140/90 = Alert



Growth Tracking

From ≥ 24 Weeks: Uterus size (SFH) measured.

Growth Scans: Offered if baby measures small/large, or if maternal risk is high.

Red Flag Warning: Small babies (IUGR), especially those not growing as expected, carry an elevated stillbirth risk.

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¶ 1.7

Supplement

Folic Acid (ideally pre-conception), Vitamin D.

Avoid

Alcohol, Smoking (Raises risk of miscarriage, preterm birth, low birth weight, and stillbirth). Foods carrying infection risks like listeria.

Lifestyle

Stay physically active.

Vaccinate

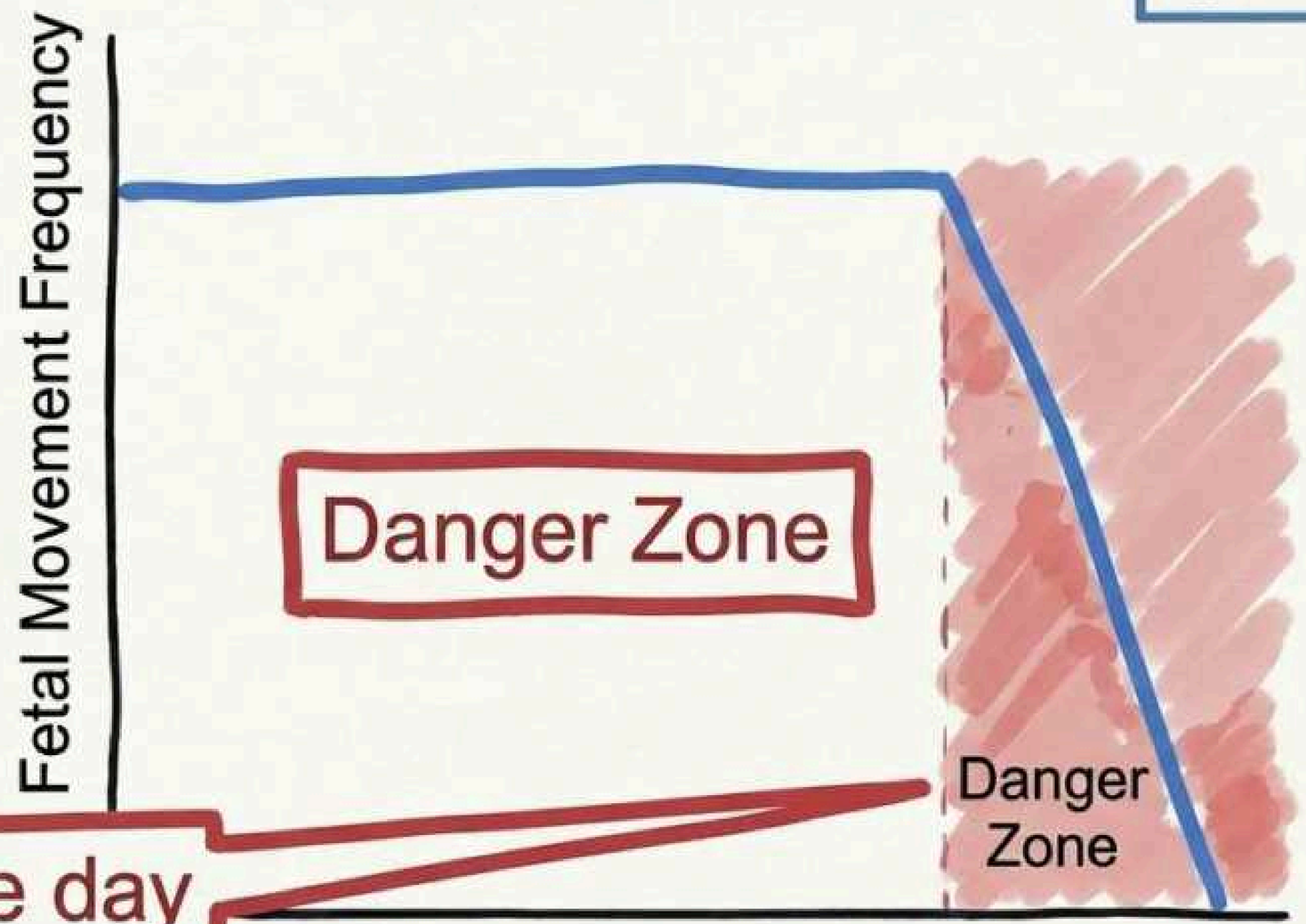
Influenza, Pertussis (Whooping cough), COVID-19, RSV (in many countries).

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¶ 1.8

Onset: Awareness begins in the second half of pregnancy.

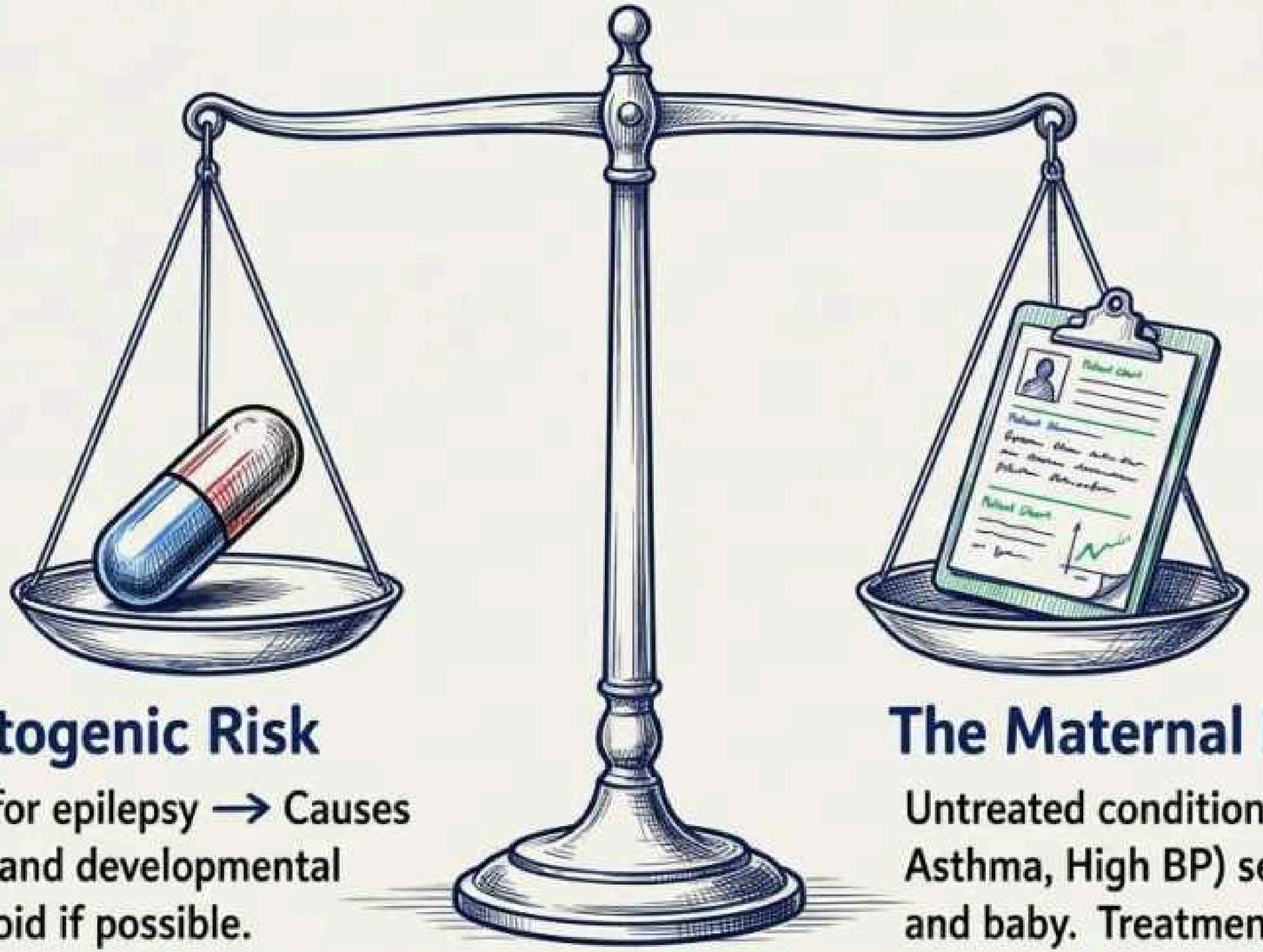
Pathology: Reduced movements are a known precursor to stillbirth.



Seek help the same day if movements reduce.

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¶ 1.9



The Teratogenic Risk

e.g., Valproate for epilepsy → Causes birth defects and developmental problems. Avoid if possible.

The Maternal Illness Risk

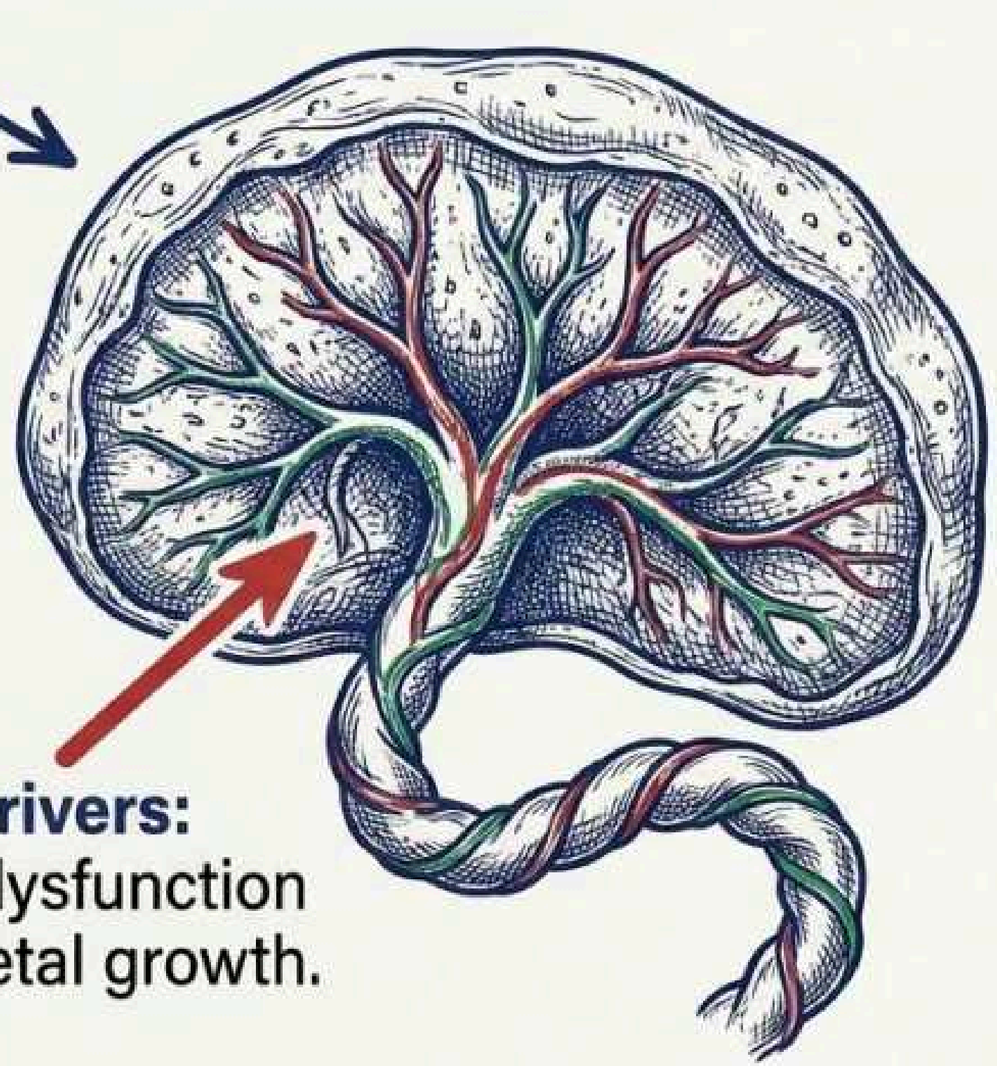
Untreated conditions (Epilepsy, Depression, Asthma, High BP) severely harm both mother and baby. Treatment must continue.

Medicines require careful, highly individualized advice. No universal rules.

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¶ 1.10

Definition: Death of a baby before birth, after > 24 weeks gestation.



Primary Drivers:
Placental dysfunction and poor fetal growth.

Effective Care Bundles to Reduce Rates

1. Smoking cessation.
2. Detecting poor growth trajectories.
3. Immediate response to reduced movements.
4. Timely delivery.

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¶ 1.11

Assess: Risk stratification at booking.



Screen: Blood tests & anatomy scans.



Monitor: Fetal growth & maternal blood pressure.





Support: Healthy lifestyle choices & supplements.





Respond: Quick intervention for warning signs.



→ **Next Lecture: Complications of Pregnancy**

Gemini Notebook