ETHIOPIA BEMONC

BASIC EMERGENCY OBSTETRIC & NEWBORN CARE (BEmONC)

LRP

Participant's Guide

Federal Democratic Republic of Ethiopia
Ministry of Health
August, 2014

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Foreword

Ethiopia strives to attain a reduction in maternal deaths in line with the indicator set in the Millennium Development Goal #5 and has shown substantial reduction in child mortality. Ethiopia has formulated and issued strong policies, strategies and guidelines for implementation of programs related to maternal and child health, including the Health Sector Development Program (HSDP) and the Five Year National Growth and Transformation Plan (2010/11 – 2014/15).

The Federal Ministry of Health (FMOH) developed and launched the 20-year rolling Health Sector Development Program (HSDP), which has currently reached its fourth stage—HSDP IV—with some of the prime priorities being maternal health, neonatal and child health. With the implementation of the Civil Service Reform Program, considerable achievement has been made in transforming customer-based care throughout the health system. The FMOH has undertaken initiatives for measures to reduce maternal mortality through the provision of clean and safe delivery at the Health Extension Program (HEP) level, skilled delivery and emergency obstetric care at the facility level, and family planning at all levels of the health care system.

To assure uniform high quality maternal and newborn health service provision in the country, the Federal Ministry of Health recognized the need for a standardized Basic Emergency Obstetric and Newborn Care(BEmONC) training, based on a standard training curriculum and training materials, grounded in the objective realities in the country. This BEmONC Training package can be used uniformly by all Maternal and Child Health stakeholders involved in training of health workers; the training package is meant to serve as a standard guide and resource both for pre-service and in-service trainings of health professionals on BEmONC.

The Federal Ministry of Health would like to extend its compliments to those individuals and organizations that have expended their precious time and resources for the realization of this training package.

Acronyms

AMDD	Averting Maternal Death and Disability
AMTSL	Active Management of Third Stage of Labor
ANC	Ante Natal Care
APH	Ante Partum Hemorrhage
ART	Anti Retroviral Therapy
ARV	Anti Retro Viral
BEmONC	Basic Emergency Obstetric & Newborn Care
CBT	Competency-based training
CCT	Controlled Cord Traction
CEmONC	Comprehensive Emergency Obstetric & Newborn Care
CPD	Cephalo Pelvic Disproportion
C/S	Cesarean Section
EDD	Expected Date of Delivery
EDHS	Ethiopian Demographic Health Survey
EOC	Emergency Obstetric Care
EmONC	Emergency Obstetric & Newborn Care
FANC	Focused antenatal care
FGC	Female Genital Cutting
FHB	Fetal Heart Beat
FP	Family Planning
GA	Gestational Age
GBV	Gender Based Violence
HELLP	Haemolysis Elevated Liver enzymes and Low Platelets
HLD	High Level Disinfection
HTC	HIV Testing and Counseling
ICPD	International Conference on Population and Development
IM	Intra Muscular
IMPAC	Integrated Management of Pregnancy and Childbirth
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IP	Infection Prevention

ITN	Insecticide Treated (bed) Nets
IUCD	Intra Uterine Contraceptive Device
IUGR	Intra Uterine Growth Restriction
IV	Intra Venous
KMC	Kangaroo Mother Care
LAM	Lactational Amenorrhoea Method
LBW	Low Birth Weight
LNMP	Last Normal Monthly Period
LRP	Learning Resource Package
MDG	Millennium Development Goal
MVA	Manual Vacuum Aspiration
PID	Pelvic Inflammatory Disease
POC	Products Of Conception
PPH	Post Partum Hemorrhage
PS	Patient Safety
SBA	Skilled Birth Attendant
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TOT	Training Of Trainers
TT	Tetanus Toxoid
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAW	Violence Against Women
WHO	World Health Organization

Acknowledgement

The Federal Ministry of Health of Ethiopia would like to thank Jhpiego Ethiopia, Maternal and Child Health Integrated Program (MCHIP), Integrated Family Health program (IFHP), WHO, Intra Health, Ethiopian Society of Obstetricians and Gynecologists, UNICEF, Addis Ababa University Medical Faculty, UNFPA, Ethiopian Midwives Association, JSI/L-10 K and Clinton Health Access Initiative (CHAI) for major contribution to the development of this Basic Emergency Obstetric and Newborn Care Training Package.

Members of the technical working group that made major contributions to the development of this Basic Emergency Obstetric and Newborn Care Training Package

Name	Organization
Abiy Seifu	Maternal and Child Health Integrated Program
Alemnesh Tekelberhan	Maternal and Child Health Integrated Program
Aster Berhe	UNFPA
Aster Teshome	Ethiopian Midwives Association
Dr. Asheber Gaym	UNICEF
Dr. Eyasu Mesfin	Addis Ababa University Medical Faculty
Dr. Fikir Melesse	WHO
Dr. Khynn Win Win Soe	UNICEF
Dr. Luwam Teshome	WHO
Dr. Marta Minwyelet	FMOH
Dr. Mengistu Hailemariam	FMOH
Dr. Mulualem Gessesse	Yekatit 12 Hospital
Dr. Nebreed Fesseha	JSI-L10 K
Dr. Nega Tesfaw	Jhpiego Ethiopia
Oumer Aweku	Clinton Health Access Initiative (CHAI)
Dr. Tadesse Ketema	FMOH
Takele Yeshiwas	Intra Health
Dr. Tenagne Setargie	FMOH
Dr. Wassie Lingerih	Integrated Family Health Program (IFHP)
Dr. Yirgu Gebrehiwot	Ethiopian Society of Obstetricians and Gynecologists

APPROVAL STATEMENT OF THE MINISTRY

The Federal Ministry of health of Ethiopia has been working towards standardization and institutionalization of in-service (IST) trainings at national level. As part of this initiative the ministry developed a national in-service training directive and implementation guide for the health sector. The directive requires all in-service training materials fulfill the standards set in the implementation Guide to ensure the quality of in-service training materials. Accordingly, the ministry reviews and approves existing training materials based on the IST standardization checklist annexed on the IST implementation guide.

As part of the national IST quality control process, this Basic Emergency Obstetric and Neonatal Care (BEmONC) IST package has been reviewed based on the standardization checklist and approved by the ministry in August 2014.

Dr Wendemagegn Enbiale Yeshaneh
Human Resources Development & Administration Directorate
Federal Ministry of Health, Ethiopia

PREFACE

Most pregnancies and births are uneventful with good maternal and perinatal outcome, however, approximately 15% of all pregnant women develop a potentially life-threatening complication that calls for skilled care and some will require a major obstetrical intervention to survive. This participant's handout is a component of the **Basic Emergency Obstetric and Newborn Care (BEmONC)** learning resource package (LRP) prepared for use in Ethiopia in in-service training of doctors, midwives, health officers and/or nurses with midwifery skills who, as team members, will provide Basic Emergency Obstetric and Newborn Care (BEmONC) at health centers and district hospitals to avert maternal and newborn mortality & morbidity. Although the learning resource package is developed primarily for use in district hospital and health centers, it can also be used by the same mid level health care providers in higher level facilities to provide initial care and until consultation.

Components of the learning resource package are: ***Training manual, Facilitator's Guide, Participant's Guide, power point presentations, technical videos and other relevant resources.*** There are six modules in the package and each module describes the learning objectives, learning outlines, learning materials and assessment tools. Module one is introduction to maternal and newborn health, module two on rapid initial assessment and emergency management; module three on care during pregnancy; module four on care during labor and child birth; module five on post partum maternal care and module six on newborn care. Modules 4-6 start with basic care and then cover care for life-threatening obstetric emergencies and newborn problems following a symptom-based approach.

The training manual contains updated and summarized essential technical information from the relevant references and is intended to be used as the reference manual by both the facilitators and participants. The facilitator's hand book has two parts; guide for TOT and facilitator's guide. The guide for TOT part has a 6 days curriculum for training of facilitators and programmers. The facilitator's guide part contains the course out lines, learning guides and checklists, exercises, role plays and answer keys for each module and will guide how to facilitate the training. The participant handout is intended primarily to serve for the participant and contains, learning guides and checklists, exercises, role plays and answer keys of each module.

This training is intended to be completed over three weeks period with 8 days classroom theoretical sessions & practice on model and 10 days of clinical practice in selected health facilities. Anatomic models are to be used for training clinical skills in simulated situations and several technical videos are included for use with the learning resource package. The videos can be used in the classroom to supplement lectures or to support clinical skills learning. The videos include normal childbirth, assisted breech delivery, vacuum delivery, active management of the third stage of labor, newborn resuscitation, etc.

INTRODUCTION

TRAINING IN EMERGENCY OBSTETRIC CARE

Although most pregnancies and births are uneventful, approximately 15% of all pregnant women develop a potentially life-threatening complication that calls for skilled care and some will require a major obstetrical intervention to survive. The main causes of maternal death and disability are complications arising from hemorrhage, sepsis, unsafe abortion, eclampsia and obstructed labor. This training course is, therefore, designed to train doctors, health officers, midwives and/or nurses with basic emergency obstetric and neonatal care skills who, as team members, will provide basic EmONC services in hospitals and health centers to avert maternal death and disability.

The course follows a symptom-based approach to the management of life-threatening obstetric emergencies. The main topics in this training course and the reference manuals (MCPC/Managing Complications in Pregnancy and Childbirth, PCPNC/ Pregnancy, childbirth, postpartum and newborn Care & MNP/Management of Newborn Problems) are arranged by **symptom** (e.g., vaginal bleeding in early pregnancy is how someone with unsafe abortion will present, convulsions is how a patient with eclampsia presents, shock is how someone with severe postpartum hemorrhage presents). The emphasis in this course is on rapid assessment and decision-making and clinical action steps based on clinical assessment with limited reliance on laboratory or other tests, suitable for district hospital and health centers in low resource settings. In addition, throughout the training course emphasis is placed on recognition of and respect for the right of women to life, health, privacy and dignity.

COURSE DESIGN

The course builds on each participant's past knowledge and takes advantage of her/his high motivation to accomplish the learning tasks in the minimum time. Training emphasizes **doing**, not just knowing, and uses **competency-based evaluation** of performance.

Specific characteristics of this course are as follows:

- During the morning of the first day, participants demonstrate their knowledge of EmONC by completing a written **Precourse Questionnaire**.
- Classroom and clinical sessions focus on key aspects of EmONC.
- Progress in knowledge-based learning is measured during the course using a standardized written assessment (**Midcourse Questionnaire**).

- Clinical skills training builds on the participant's previous experience relevant to EmONC. For many of the skills, participants practice first with anatomic models, using learning guides that list the key steps in performing the skills/procedures for managing obstetric emergencies. In this way, they learn the standardized skills more quickly.
- Progress in learning new skills is documented using the clinical skills learning guides.
- A clinical trainer uses competency-based skills checklists to evaluate each participant's performance.
- Clinical decision-making is learned and evaluated through case studies and simulated exercises and during clinical practice with patients.
- Appropriate interpersonal skills are learned through behavior modeling, role play and evaluation during clinical practice with patients.

Successful completion of the course is based on mastery of the knowledge and competency in skills components, as well as satisfactory overall performance in providing care for women who experience obstetric emergencies. Competency in clinical skills for rare clinical conditions is evaluated in a simulated setting.

EVALUATION

This clinical training course is designed to produce healthcare providers (i.e., doctors, health officers, midwives and/or nurses) who are qualified to provide EmONC, as team members, in hospitals and health centers.

The evaluation methods used in the course are described briefly below:

- **Midcourse Questionnaire**. Knowledge will be assessed at the 7th day of the course. A score of 85% or more correct indicates knowledge-based mastery of the material presented during classroom sessions. For those participants scoring less than 85% on their first attempt, the clinical trainer should review the results with the participant individually and guide her/him on using the reference manual(s) to learn the required information. Participants scoring less than 85% can take the Midcourse Questionnaire again at any time during the remainder of the course.
- **Clinical Skills**. Evaluation of clinical skills will occur with models in a simulated setting and with patients at the clinical training site. In each setting, the clinical trainer will use skills checklists to evaluate each participant as they perform the skills and procedures needed to manage obstetric emergencies and interact with patients. Case studies and clinical simulations will be used to assess problem-solving and decision-making skills. Evaluation of the interpersonal communication skills of each participant may take place at any point during this period through observation of participants during role plays. Participants should be competent in performing the steps/tasks for a particular skill or procedure in a simulated setting before undertaking supervised practice at a clinical site.

- **Clinical Practice**. It is the clinical trainer's responsibility to observe each participant's overall performance in providing BEmONC during the group-based course and during the self-directed practicum. This includes observing the participant's attitude—a critical component of quality service provision—toward women who experience obstetric emergencies and toward other members of the BEmONC team. By doing this, the clinical trainer assesses how the participant uses what s/he has learned.

COURSE SYLLABUS

Course Description

This clinical training course is designed to prepare participants to manage obstetric emergencies and work effectively as members of a BEmONC team. The course begins with an 18 days block at a designated training site and focuses on the development, application and evaluation of knowledge and skills; the first 8 days take place in the classroom and then 10 days in designated clinical sites, which should be as close to the classroom as possible.

Course Goals

- To influence in a positive way the attitudes of the participant towards team work and her/his abilities to manage and provide basic emergency obstetric and neonatal care services.
- To provide the participant with the knowledge and clinical skills needed to respond appropriately to obstetric and neonatal emergencies.
- To provide the participant with the decision-making skills needed to respond appropriately to obstetric and neonatal emergencies
- To provide the participant with the interpersonal communication skills needed to respect the right of women to life, health, privacy and dignity

Participant Learning Objectives

By the end of the training course, the participant will be able to:

- Describe maternal and newborn morbidity and mortality in Ethiopia
- Explain the goals and activities of Basic Emergency Obstetric and Newborn Care
- Describe components of 'Woman and Family Friendly Care'
- Provide focused antenatal care including preparation of an individual birth plan
- Manage normal labor and assist birth including immediate newborn care and active management of the third stage of labor
- Demonstrate ability to recognize abnormal progress of labor, give initial management and refer if necessary
- Provide appropriate care to a woman and the newborn up to 6 hours postpartum
- Explain management of common maternal and newborn life threatening conditions during postpartum period
- Describe management of malaria in pregnancy
- Describe HIV/AIDS in pregnancy
- Provide effective and appropriate counseling in the provision of maternal/newborn care

Training/Learning Methods

- Illustrated lectures and group discussions
- Case studies
- Role plays
- Simulated practice with anatomic models
- Simulations for clinical decision-making
- Guided clinical activities (providing care and performing procedures)

Learning Materials

The learning materials for the course are as follows:

- Reference manuals:
  - ***Management Protocol on Selected obstetrics topics,*** *Federal Democratic Republic of Ethiopia, Ministry of Health,* January 2010.
  - ***Managing Complications in Pregnancy and Childbirth****: A Guide for Midwives and Doctors* (WHO 2000)
  - ***Pregnancy, Childbirth, Postpartum and Newborn Care:*** *A guide for essential practice* (WHO 2006)
  - ***Managing Newborn Problems*** *(Integrated management of pregnancy and childbirth): a guide for doctors, nurses, and midwives* (WHO 2004)
  - ***Infection Prevention and Patient Safety:*** *Reference manual for service providers and managers in healthcare facilities of Ethiopia, Federal Ministry of Ethiopia, 2011*
  - ***Guidelines for Prevention of Mother****-to-Child Transmission of HIV in Ethiopia, Federal HIV/AIDS Prevention and Control Office, Federal Ministry of Health, 2007.*

- Other resources:
  - ***Malaria Diagnosis And Treatment Guidelines For Health Workers In Ethiopia*** *– 2nd edition, July 2004* (The Federal Ministry of Health)
  - ***Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia:*** Federal Ministry of Health; May 2006
  - ***(Almost) Everything You Want to Know about Using the UN Process Indicators of Emergency Obstetric Services:*** Averting Maternal Death and Disability (AMDD) Workbook
  - ***Family Planning: A GLOBAL HANDBOOK FOR PROVIDERS*** (WHO), 2011

- Audiovisuals on managing complications in pregnancy and childbirth:
    - Videotapes
        - *New born resuscitation*
        - *Infection prevention*
    - Videoclips (CD)
        - *Labor companionship (RHL)*
        - *Breech delivery (RHL)*
        - *Vacuum extraction (RHL)*
        - *Active third stage management (RHL)*
- Use of Manual Vacuum Aspiration and Recommended Practices for Processing MVA Instruments (JHPIEGO Post-abortion Care Video Photoset), 1996
- Interactive training package Partograph (WHO)

A skilled health provider is: an accredited health professional – midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postpartum period and in the identification, management and referral of complications in women and newborns (Making pregnancy safer: The critical role of the skilled attendant: A joint statement by WHO, ICM & FIGO 2004)

Participant Selection Criteria

- Participants for this course must be practicing clinicians (doctors, health officers, midwives and/or nurses with midwifery skills) who work in a hospital or health center where basic EmONC is being provided or planned.
- Participants must be actively involved in the provision of labor and childbirth care at the beginning of the course and be committed to continuing their involvement on completion of the course, including the provision of EmONC.
- Participants preferably should be selected from health facilities capable of providing consistent institutional support for EmONC (i.e., supplies, equipment, supervision, linkages with referral facilities, etc.).
- Participants should have the support of their supervisors or managers to achieve improved job performance after completing the course. In particular, participants should be prepared to communicate with supervisors or managers about the course and seek endorsement for training, encouragement for attendance and participation, and involvement in the transfer of new knowledge and skills to their job.

Methods of Evaluation

- ***Participant***
  - Pre and Midcourse Knowledge Questionnaires.
  - Learning Guides and Checklists for emergency obstetric skills/procedures.
  - Simulations for clinical decision-making.
- ***Course***
  - Course evaluation (to be completed by each participant).

Course Duration

- The course is composed of 8 days classroom sessions, followed by 10 days of supervised clinical practice.

Suggested Course Composition

- Up to 20 health professionals with mixed qualifications (5 doctors and 15 health officers, midwives and/or nurses with midwifery skills)
- Four clinical trainers (two doctors and two midwives)

BASIC EMERGENCY OBSTETRIC AND NEWBORN CARE (BEmONC) - COURSE SCHEDULE (18 Days)

DAY 1	DAY 2	DAY 3	DAY 4
Opening Ceremony: • Welcome & Introductions **Course Overview:** • Expectations – participant/trainer • Group norms Goals, objectives, schedule • Review of course materials **Pre-course knowledge assessment questionnaire** **Presentation and Discussion:** • Competency based training and how to use learning guides and checklists • Reduction of Maternal and Newborn Mortality in Ethiopia	**Agenda and opening activity** **Presentation and Discussion:** • Rapid initial assessment and managing emergencies: • Recognizing and managing "shock". **Skill demonstration:** managing shock **Illustrated lecture-discussion:** •Focused antenatal care (FANC) **Group work** – Birth preparedness & complication readiness **Skill Demonstration and practice:** Focused ANC	**Agenda and opening activity** **Video:** MVA Ipas Video **Skill Demonstration and Practice:** MVA using model, post abortion family planning counseling **Illustrated lecture-discussion:** Fever during pregnancy and labor **Illustrated lecture-discussion:** • Vaginal bleeding in later pregnancy and labor	**Agenda and opening activity** **Illustrated lecture-discussion:** best practices – care in labor **Skill Demonstration and Practice:** Assessment of woman in labor **Exercises:** Using the partograph **Video- normal birth**
LUNCH	**LUNCH**	**LUNCH**	**LUNCH**
Presentation and Discussion: • Overview Gender based violence and Female Genital Cutting • Women friendly care. **Discussion:** Review pre-course knowledge assessment questionnaire and individual & group assessment matrix **Skills revision /demonstration:** Infection prevention o Hand washing o PPE o Decontamination o Instrument handling and preparation o Sharps handling	**Role Play and discussion:** • Communicating About Complications During Pregnancy **Presentation and Discussion:** Prevention of mother to child transmission HIV (PMTCT) **Illustrated lecture-discussion:** • Vaginal bleeding in early pregnancy • Post abortion care **Case Study:** Vaginal bleeding in early pregnancy **Clinical simulation**: management of shock.	**Presentation and Discussion:** Headaches, blurred vision, convulsions, loss of consciousness, elevated BP **Case Study:** Pregnancy-induced hypertension **Skill Demonstration and practice:** Management of severe pre-eclampsia/eclampsia	**Skill Demonstration and Practice:** • Normal delivery • AMTSL • Immediate care of the newborn CD ROM - AMTSL **Skill practice:** Normal vaginal birth; immediate care of the newborn; AMTSL
Review of the day's activity	**Review of the day's activity**	**Review of the day's activity**	**Review of the day's activity**
Reading Assignment: module-1&2	**Reading Assignment:** module-3	**Reading Assignment: module-4**	**Reading Assignment: module-4**

BASIC EMERGENCY OBSTETRIC AND NEWBORN CARE (BEmONC) COURSE SCHEDULE (18 Days)			
DAY 5	**DAY 6**	**DAY 7**	**DAY 8**
Agenda and opening activity **Presentation, Discussion, and Videotape:** Breech delivery **Skill Demonstrations:** Breech delivery using models **Skill Practice:** Participants practice breech delivery in pairs using model	**Agenda and opening activity** **Presentation and Discussion:** Vaginal bleeding after childbirth **Case Studies:** Vaginal bleeding after childbirth **Skill Demonstrations:** Bimanual compression of uterus, manual removal of placenta, aortic compression **Skill Practice:** Bimanual compression of uterus, manual removal of placenta using model	**Agenda and opening activity** **Case Studies**: Fever after childbirth **Skill Demonstrations:** Perineal repair **Skill Practice:** Perineal repair **Skills Evaluation Using Models**	**Agenda and opening activity** **Midcourse Knowledge Assessment Questionnaire** **Illustrated lecture-discussion:** Care of the sick newborn in post natal period **Case Study:** Common newborn problems **Skills Evaluation Using Models**
LUNCH	**LUNCH**	**LUNCH**	**LUNCH**
Presentation and Discussion: Prolonged labor **Presentation & Video:** Vacuum extraction **Skill Demonstrations:** Vacuum extraction using models **Skill Practice:** Participants practice vacuum extraction in pairs using model	**Presentation and Discussion:** Care of the woman in the postpartum period **Role Play:** Post partum Care **Presentation and Discussion**: Fever during and after childbirth	**Illustrated lecture-discussion:** a) Basic newborn care b) Basic immediate postnatal care for preterm and low birth weight newborn **Skill Demonstration and Practice:** Newborn resuscitation	**Skills Evaluation Using Models** **Continue Skills Evaluation Using Models** **Discussion:** Review results of midcourse knowledge assessment questionnaire
Review of the day's activity	**Review of the day's activity**	**Review of the day's activity**	**Review of the day's activity**
Reading Assignment: module-5	**Reading Assignment:** modules-5,6	**Reading Assignment: module-6**	**Reading Assignment:** Participants who scored less than 85% on the midcourse questionnaire should study relevant sections of manual

BASIC EMERGENCY OBSTETRIC AND NEWBORN CARE (BEmONC) (SCHEDULE 18 Days)				
DAY 9	**DAY 10**	**DAY 11**	**DAY 12**	**DAY 13**
Agenda and opening activity **Activity:** Tour of clinical facilities **Discussion:** Instructions for Clinical Practice AND ON CALL **Discussion:** Review Clinical Experience Log Book	**Agenda and opening activity** **Clinical Duty:** **Team 1: Emergency/High Dependency Area** • Early pregnancy bleeding • Shock • Severe PE/Eclampsia **Team 2: Admission/Labor Room** • Assessment of women in labor, use of partograph • Care of women in labor **Team 3: Delivery Room** • Normal delivery • Episiotomy and repair • Complicated delivery • Management of PPH • Newborn (NB) resuscitation **Team 4: Postpartum and NB Care** • Postpartum care • Newborn	**Agenda and opening activity** **Clinical Duty:** **Team 2: Emergency/High Dependency Area** • Early pregnancy bleeding • Shock • Severe PE/Eclampsia **Team 3: Admission/Labor Room** • Assessment of women in labor, use of partograph • Care of women in labor **Team 4: Delivery Room** • Normal delivery • Episiotomy and repair • Complicated delivery • Management of PPH • Newborn (NB) resuscitation **Team 1: Postpartum** and **NB Care** • Postpartum exam Newborn care	**Agenda and opening activity** **Clinical Duty:** **Team 3: Emergency/High Dependency Area** • Early pregnancy bleeding • Shock • Severe PE/Eclampsia **Team 4: Admission/Labor Room** • Assessment of women in labor, use of partograph • Care of women in labor **Team 1: Delivery Room** • Normal delivery • Episiotomy and repair • Complicated delivery • Management of PPH • Newborn (NB) resuscitation **Team 2: Postpartum** and **NB Care** • Postpartum exam Newborn care	**Clinical Duty:** **Team 4: Emergency/High Dependency Area** • Early pregnancy bleeding • Shock • Severe PE/Eclampsia **Team 1: Admission/Labor Room** • Assessment of women in labor, use of partograph • Care of women in labor **Team 2: Delivery Room** • Normal delivery • Episiotomy and repair • Complicated delivery • Management of PPH • Newborn (NB) resuscitation **Team 3: Postpartum** and **NB Care** • Postpartum exam Newborn care
LUNCH	**LUNCH**	**LUNCH**	**LUNCH**	**LUNCH**
Continue Skills Evaluation Using Models	**Clinical Duty Continues** **Discussion:** Lessons from clinical experience	**Clinical Duty Continues** **Clinical simulation - eclampsia**	**Clinical Duty Continues** **Discussion:** Lessons from clinical experience	**Clinical Duty Continues** **Discussion:** Lessons from clinical experience **Presentation & Discussion:** Data collection and utilization of maternal and neonatal health service data
Review of the day's activities	**Review of the day's activities**	**Review of the day's activities**	**Review of the day's activities**	**Review of the day's activities**
Reading Assignment: Learning Guides. Review all relevant sections training manual. Review and become familiar with Clinical Experience Log Book				

BASIC EMERGENCY OBSTETRIC AND NEWBORN CARE (BEmONC) (SCHEDULE 18 DAYS)				
DAY 14	**DAY 15**	**DAY 16**	**DAY 17**	**DAY 18**
Clinical Duty: **Team 1: Emergency/High Dependency Area** • Early pregnancy bleeding • Shock • Severe PE/Eclampsia **Team 2: Admission/Labor Room** • Assessment of women in labor, use of partograph • Care of women in labor **Team 3: Delivery Room** • Normal delivery • Episiotomy and repair • Complicated delivery • Management of PPH • Newborn (NB) resuscitation **Team 4: Postpartum and NB Care** • Postpartum care • Newborn	**Clinical Duty:** **Team 2: Emergency/High Dependency Area** • Early pregnancy bleeding • Shock • Severe PE/Eclampsia **Team 3: Admission/Labor Room** • Assessment of women in labor, use of partograph • Care of women in labor **Team 4: Delivery Room** • Normal delivery • Episiotomy and repair • Complicated delivery • Management of PPH • Newborn (NB) resuscitation **Team 1: Postpartum** and **NB Care** • Postpartum exam Newborn care	**Clinical Duty:** **Team 3: Emergency/High Dependency Area** • Early pregnancy bleeding • Shock • Severe PE/Eclampsia **Team 4: Admission/Labor Room** • Assessment of women in labor, use of partograph • Care of women in labor **Team 1: Delivery Room** • Normal delivery • Episiotomy and repair • Complicated delivery • Management of PPH • Newborn (NB) resuscitation **Team 2: Postpartum** and **NB Care** • Postpartum exam Newborn care	**Clinical Duty:** **Team 4: Emergency/High Dependency Area** • Early pregnancy bleeding • Shock • Severe PE/Eclampsia **Team 1: Admission/Labor Room** • Assessment of women in labor, use of partograph • Care of women in labor **Team 2: Delivery Room** • Normal delivery • Episiotomy and repair • Complicated delivery • Management of PPH • Newborn (NB) resuscitation **Team 3: Postpartum** and **NB Care** • Postpartum exam Newborn care	**Agenda and opening activity** **Clinical check-out with clients for any remaining participants** **Group Work:** Develop action plans **Presentations:** Action plans **Next Steps:** Log book, on-the-job learning **Course Evaluation** **Course Summary** **Closing Ceremony**
LUNCH	**LUNCH**	**LUNCH**	**LUNCH**	**LUNCH**
Clinical Duty Continues **Discussion:** Lessons from clinical experience **Discussion with Trainers:** Review individual progress with participants	**Clinical Duty Continues** **Discussion:** Lessons from clinical experience Clinical simulation –NB resuscitation	**Clinical Duty Continues** **Discussion:** Lessons from clinical experience	**Discussion:** Lessons from clinical experience **Discussion with Trainers:** Determine further individual learning needs of participants **Discussion:** Action plans	
Review of the day's activities	**Review of the day's activities**	**Review of the day's activities**	**Review of the day's activities**	
Reading Assignment: Review relevant sections of Manual.	**Reading Assignment:** Review relevant sections of Manual.	**Reading Assignment:** Review relevant sections of Manual	Prep of action plans	

1. Time for clinical may be changed if there are clients in labor or if a clinic has specific hours of operation
2. Skill checkout can happen for participants at any point they feel ready.
3. Facilitators and participants will be on call from Day 8 of the training to take full advantage of clinical experiences.

Working in Teams

In a clinical team two participants are asked to work together as a team during their clinical experiences day or night. Teams are selected the first day of training and are asked to work together during the entire training. Team members take turns being the person that either does a skill or evaluates a skill using the learning guide. This way you learn more from ALL clinical experiences, those that you do and those that you evaluate. The helper can also coach her partner to remember things or to guide her to do the steps of a skill correctly. The responsibilities of each team member include:

Responsibilities When You "DO" a Skill:
1. Read the learning guide before doing the skill
2. Do the skill
3. Evaluate yourself after the skill is done and fill in the learning guide
4. Talk with your team partner about how you did the steps in the learning guide

Responsibilities When You "HELP" with a Skill:
1. Read the learning guide before helping
2. Watch your team partner do the skill and help if any step is forgotten
3. Evaluate your team partner using the learning guide while the skill is done
4. Talk with your team partner about how the skill was done using the learning guide

RESPONSIBILITIES OF PARTICIPANTS

DURING CLINICAL TRAINING IN LABOR AND DELIVERY

1. Wear appropriate clothing
   a. In labor room-cover gown, head cover
   b. In delivery room-cover gown, head cover, shoe covers, mask, glasses, and gloves
2. Politely introduce yourself to the doctors and midwives on duty.
3. Inform the staff when you finish caring for a patient before you leave labor and delivery to go to take a rest
4. Introduce yourself to the patient you care for. Be kind, gentle, and respectful.
5. Always tell the patient what you will do before starting a procedure such as start an IV, do a vaginal examination, give an injection
6. Report to the facilitator any abnormal findings, for example, abnormalities of labor progress, distress of the fetus, or distress of the patient (bleeding, fever, etc.)
7. Work with your team member and facilitator.
8. If you receive the baby, put on all infection prevention clothing. Wash hands before putting on gloves. Put gloves in decontamination solution when you remove them and wash your hands again.
9. Respect all decisions made by the facilitator.
10. If you are unable to do a skill, the facilitator will demonstrate the skill and explain so the next time you will be able to do the skill yourself.
11. Fill out the partograph for every labor patient you give care.
12. Do rounds in the morning on the patients you delivered according to the 6 hour postpartum checklist.
13. Give report to the responsible doctor on duty prior to leaving labor and delivery in the morning.

ROUNDS REPORT FORM					
DATE + TIME					
		MOTHER - 1	**MOTHER – 2**	**MOTHER -3**	**MOTHER -4**
BIRTH INFORMATION					
1. **NAME**					
2. **G/P/AB**					
3. **DELIVERY: DATE/TIME, METHOD**					
4. **PERINEUM CONDITION,ANESTHESIA**					
5. **BLOOD LOSS**					
6. **BABY - SEX, APGAR, POSITION**					
7. **PROBLEMS?**					
POSTPARTUM ROUNDS					
MOTHER	**1. FEVER?**				
	2. **BREASTS**				
	3. **UTERUS**				
	4. **LOCHIA**				
	5. **PERINEUM**				
	6. **PROBLEMS?**				
BABY	**1. EYES**				
	2. OBSERVE SUCKING				
	3. CORD				
	4. URINATION/STOOL				
	5. PROBLEMS?				

SKILLS PRACTICE CHART

NAME: _____

Instructions; Write the date at the top of the column and make a tick mark each time you do a skill in the clinical area

SKILL	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
1. 1st FANC Visit										
2. FANC Revisit										
3. Labor Admission										
4. Monitoring labor using Partograph										
5. 2nd Stage										
6. Active Mgmt 3rd Stage										
7. Bimanual Compression										
8. Manual Removal of Placenta										
9. Digital Evacuation of Clots										
10. Episiotomy/ laceration repair										
11. Infection Prevention										
12. Newborn Resuscitation										
13. 6 hour PP Exam										
14. Initiation of breast feeding										

MODULE –1

INTRODUCTION TO MATERNAL AND NEWBORN HEALTH

Participant learning objective: After completing this module, participants will be able to describe the global situation of maternal and newborn mortality & morbidities, best practices in maternal and newborn care and emergency management principles.

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Enabling objectives:

:

1. Describe the magnitude of maternal and neonatal mortality & morbidity in the developing world generally and in our country specifically.
2. Describe the current approach to reduction of maternal and neonatal mortality.
3. Describe GBV and FGC
4. Describe the prevalence and obstetric effects of GBV and FGC.
5. Describe the principles of women friendly care.
6. Describe best practices in infection prevention.
7. Describe the basic elements of initial rapid initial assessment and managing emergencies.
8. Demonstrate steps in detection and management of “shock”.

MODULE-2:

RAPID INITIAL ASSESSMENT AND EMERGENCY MANAGEMENT

Participant learning objective: After completing this module, participants will be able to provide care to obstetric emergencies in an organized and effective approach

Enabling objectives:

- Describe how to organize the facility to respond to an obstetric emergency.
- Describe key steps in rapid initial assessment of a woman with emergency problems.
- Outline key emergency management steps for specific obstetric emergency problems.
- Describe pre-referral management to a recognized emergency situation
- Demonstrate steps in detection and management of “shock”.

SKILLS PRACTICE SESSIONS
SKILLS PRACTICE SESSION 2-1: ADULT RESUSCITATION AND MANAGEMENT OF SHOCK

PURPOSE

The purpose of this activity is to enable participants to practice adult resuscitation and management of shock and achieve competency in the skills required.

INSTRUCTIONS

This activity should be conducted in a simulated setting with a fellow participant role-playing as a patient.

Participants should review Learning Guide 2-**1** before beginning the activity. The facilitator should demonstrate the initial steps/tasks in adult resuscitation and management of shock, followed by the key resuscitation steps and identification of response to the treatment. Under the guidance of the facilitator, participants should then work in pairs to practice the steps/tasks and observe each other's performance, using Learning Guide 2-1.

Participants should be able to perform the steps/tasks in Learning Guide 2-1 before skill competency is assessed by the trainer/teacher in the simulated setting, using Checklist 2-1.

Finally, following supervised practice at a clinical site, the facilitator should assess the skill competency of each participant, using Checklist 2-1.

RESOURCES

- Equipment for starting an IV line
- Needles and syringes
- Examination gloves
- BP apparatus
- Test tubes

Learning Guide 2-1: Adult resuscitation and management of shock
Checklist 2-1: Adult resuscitation and management of shock

LEARNING GUIDE 2:1 ADULT RESUSCITATION AND MANAGEMENT OF SHOCK

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR ADULT RESUSCITATION AND MANAGEMENT OF SHOCK (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GENERAL MANAGEMENT					
1. Shout for help.					
2. If the woman is conscious and responsive:- • Greet the woman respectfully and with kindness. • Tell the woman (and her support person) what is going to be done, listen to her, and respond attentively to her questions and concerns.					
3. Provide continual emotional support and reassurance, as feasible.					
4. Assess the women according to the ABC(Airway, Breathing and Circulation) rule					
IMMEDIATE MANAGEMENT					
1. Check the woman's vital signs: • Temperature • Pulse • Blood pressure • Respiration					
2. Evaluate her level of consciousness and colour					
3. Turn the woman onto her side and ensure that her airway is open. - If the woman is not breathing, begin resuscitation measures.					
4. Give oxygen at 6–8 L/minute by face mask or nasal cannula.					
5. Cover the woman with a blanket to ensure warmth.					
6. Elevate the woman's legs—if possible, by raising the foot of the bed.					

LEARNING GUIDE FOR ADULT RESUSCITATION AND MANAGEMENT OF SHOCK (Many of the following steps/tasks should be performed simultaneously.)						
STEP/TASK	**CASES**					
BLOOD COLLECTION, FLUID REPLACEMENT AND BLADDER CATHETERIZATION						
1. Wash hands thoroughly and dry.						
2. Connect IV tubing to a 1 L container of normal saline or Ringer's lactate.						
3. Run fluid through tubing.						
4. Select a suitable site for infusion (e.g., back of hand or forearm).						
5. Place a tourniquet around the woman's upper arm.						
6. Put on gloves.						
7. Clean skin with spirit.						
8. Insert 16- or 18-gauge needle or cannula into the vein.						
9. Draw blood for hemoglobin, cross-matching and bedside clotting test.						
10. Detach syringe from needle or cannula and connect IV tubing.						
11. Secure the needle or cannula with tape.						
12. Adjust IV tubing to run fluid at a rapid rate to infuse 1 L in 15–20 minutes.						
13. Place the blood drawn into a labeled test tube for hemoglobin and cross-matching.						
14. Place 2 mL of blood into a small glass test tube (approximately 10 mm x 75 mm) to do a bedside clotting test: • Hold the test tube in your closed fist to keep it warm. • After 4 minutes, tip the tube slowly to see if a clot is forming. • Tip it again every minute until the blood clots and the tube can be turned upside down. • If a clot fails to form or a soft clot forms that breaks down easily, coagulopathy is possible.						
15. Before removing gloves, dispose of waste materials in a leakproof container or plastic bag.						
16. Decontaminate needles and syringes by flushing with 0.5% chlorine solution						
17. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out and place them in a leakproof container or plastic bag.						
18. Use antiseptic handrub or wash hands thoroughly.						

LEARNING GUIDE FOR ADULT RESUSCITATION AND MANAGEMENT OF SHOCK (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
BLADDER CATHETERIZATION					
1. Put new examination or high-level disinfected surgical gloves on both hands.					
2. Explains to the woman and clean the external genitalia.					
3. Insert catheter into the urethral orifice and allow urine to drain into a clean receptacle -measures and record amount.					
4. Secure catheter and attach it to urine drainage bag.					
5. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out and place them in a leakproof container or plastic bag.					
6. Use antiseptic handrub or wash hands thoroughly and dry.					
REASSESSMENT AND FURTHER MANAGEMENT					
1. Reassess the woman's response to IV fluids within 15 minutes for signs of improvement: • Stabilizing pulse (90 beats/minute or less) • Increasing systolic blood pressure (100 mm Hg or more) • Improving mental status (less confusion or anxiety) • Increasing urine output (30 mL/hour or more)					
2. If the woman's condition improves: • Adjust the rate of IV infusion to 1 L in 6 hours. • Continue management for underlying cause of shock. • Continue to monitor vital signs and intake and output every hour.					
3. If the woman's condition fails to improve: • Infuse normal saline rapidly until her condition improves. • Continue oxygen at 6–8 L/minute. • Continue to monitor vital signs every 15 minutes and intake and output every hour. • Arrange for additional laboratory tests.					
4. Check for bleeding. If heavy bleeding is seen, take steps to stop the bleeding and transfuse blood, if necessary.					
5. Perform the necessary history, physical examination and tests to determine cause of shock if not already known.					
6. Record all vital signs fluids and any drugs given.					
7. Make arrangements to refer the woman to higher level of care if required.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

CHECKLIST 2:1 ADULT RESUSCITATION AND MANAGEMENT OF SHOCK

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

Participant/Student: _____Date Observed: _____

CHECKLIST FOR ADULT RESUSCITATION AND MANAGEMENT OF SHOCK (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GENERAL MANAGEMENT					
1. Shouts for help.					
2. If the woman is conscious and responsive:- • Greets the woman respectfully and with kindness. • Tells the woman (& her support person) what is going to be done, listens and respond attentively to her questions & concerns.					
3. Provides continual emotional support and reassurance.					
4. Assesses the women according to the ABC rule					
IMMEDIATE MANAGEMENT					
1. Checks the woman's vital signs					
2. Turns the woman onto her side and ensures that her airway is open, beginning resuscitation measures if needed.					
3. Gives oxygen at 6–8 L/minute					
4. Covers the woman with a blanket and elevates the woman's legs					
BLOOD COLLECTION, FLUID REPLACEMENT AND BLADDER CATHETERIZATION					
1. Washes hands thoroughly and dry. Puts on gloves.					
2. Inserts 16- or 18-gauge needle or cannula into the vein.					
3. Draws blood for hemoglobin, cross-matching & bedside clotting test					
4. Detaches syringe and connects IV tubing securely and begins IV infusion of 1 L normal saline or Ringer's lactate.					

CHECKLIST FOR ADULT RESUSCITATION AND MANAGEMENT OF SHOCK (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
5. Infuses 1 L in 15–20 minutes.					
6. Places the blood drawn into a labeled test tube for hemoglobin and cross-matching.					
7. Places 2 mL of blood into a small glass test tube and does a bedside clotting test					
8. Disposes of waste materials in a leakproof container or plastic bag.					
9. Decontaminates needles and syringes					
10. Removes gloves properly and uses antiseptic handrub or washes hands thoroughly and dries them.					
BLADDER CATHETERIZATION					
1. Puts on new examination or high-level disinfected surgical gloves					
2. Explains to the woman and cleans the external genitalia.					
3. Catheterizes and measures and records the urine amount.					
4. Secures catheter and to urine drainage bag.					
5. Removes gloves properly and uses antiseptic handrub or washes hands thoroughly and dries them.					
REASSESSMENT AND FURTHER MANAGEMENT					
1. Reassesses the woman's response to IV fluids within 15 minutes					
2. If the woman's condition improves adjusts IV infusion to 1 L in 6 hours and continues management for underlying cause of shock.					
3. If the woman's condition fails to improve: • Infuses normal saline rapidly until her condition improves. • Continues oxygen at 6–8 L/minute. • Continues to monitor vital signs every 15 minutes and intake and output every hour. • Arranges for additional laboratory tests.					
4. Checks for bleeding. If heavy bleeding is seen, takes steps to stop the bleeding and transfuse blood, if necessary.					
5. Performs the necessary steps to determine cause of shock					
6. Records all vital signs fluids and any drugs given.					
7. Makes arrangements for referral to higher level of care if required.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

CLINICAL SIMULATION 2-1: MANAGEMENT OF SHOCK (HYPOVOLEMIC OR SEPTIC SHOCK)

Purpose: The purpose of this activity is to provide a simulated experience for participants to practice problem-solving and decision-making skills in the management of hypovolemic or septic shock, with emphasis on thinking quickly and reacting (intervening) rapidly.

Instructions: The activity should be carried out in the most realistic setting possible, such as the labor and delivery area of a health center, clinic or maternity center, where equipment and supplies are available for emergency interventions.

- One participant should play the role of patient and a second participant the role of skilled provider. Other participant may be called on to assist the provider.
- The facilitator will give the participant playing the role of provider information about the patient's condition and ask pertinent questions, as indicated in the left-hand column of the chart next page.
- The participant will be expected to think quickly and react (intervene) rapidly when the facilitator provides information and asks questions. Key reactions/responses expected from the participant are provided in the right-hand column of the chart on the next page.
- Procedures such as starting an IV and giving oxygen should be role played, using the appropriate equipment.
- Initially, the facilitator and participant will discuss what is happening during the simulation in order to develop problem-solving and decision-making skills. The italicized questions in the simulation are for this purpose. Further discussion may take place after the simulation is completed.
- As the participant's skills become stronger, the focus of the simulation should shift to providing appropriate care for the life-threatening emergency situation in a quick, efficient and effective manner. All discussion and questioning should take place after the simulation is over.

***Resources**: Sphygmomanometer, stethoscope, equipment for starting an IV infusion, syringes and vials, oxygen cylinder, mask and tubing, bladder catheterization equipment, new examination or high-level disinfected surgical gloves.*

SCENARIO 1 **(Information provided and questions asked by the facilitator)**	***KEY REACTIONS/RESPONSES*** **(Expected from participant)**
1. Alemitu is a 36-year-old multigravida who has five children. Her husband, who tells you that she gave birth at home with the help of a family member, has carried her into the health center. The family member told him that the placenta delivered easily and completely immediately after birth, but Alemitu has been bleeding "too much" since then. The family tried numerous things to help Alemitu before bringing her to the health center, but she continues to bleed "too much." • What do you do?	• **Shout** for help to urgently mobilize all available personnel • Evaluate Alemitu immediately for shock, including vital signs (temperature, pulse, blood pressure and respiration rate), level of consciousness, color and skin temperature • Tell Alemitu (and her husband) what is going to be done, listen to her and respond attentively to their questions and concerns. • Turns Alemitu on her side, if unconscious or semi-conscious, and keeps the airway open
2. On examination, you find that Alemitu's blood pressure is 84/50 mm Hg, pulse 120 beats/ minute, respiration rate 34 breaths/minute, temperature 37º C. Her skin is cold and clammy. • What do you think is wrong with Alemitu? • What will you do now?	• State that Alemitu is in shock • Ask one of the staff that responded to your shout for help to start an IV infusion, using a large-bore cannula and normal saline or Ringer's lactate at a rate of 1 L in 15–20 minutes • While starting the IV, collect blood for appropriate tests (hemoglobin, blood typing and cross matching, and bedside clotting test for coagulopathy) • Start oxygen at 6–8 L/minute • Catheterize bladder • Look for the cause of shock (hypovolemic or septic) by palpating the uterus for firmness and tenderness, assessing the amount of blood loss • Cover Alemitu to keep her warm • Elevate legs

SCENARIO 1 **(Information provided and questions asked by the facilitator)**	***KEY REACTIONS/RESPONSES*** **(Expected from participant)**
*Discussion Question 1**: How do you know when a woman is in shock?***	***Expected Responses**: Pulse greater than 110 beats/ minute; systolic blood pressure less than 90 mm Hg; cold, clammy skin; pallor; respiration rate greater than 30 breaths/minute; anxious and confused or unconscious*
*Discussion Question 2**: If a peripheral vein cannot be cannulated, what should be done?***	***Expected Response**: A venous cut-down should be performed.*
3. On further examination, you find that Alemitu's uterus is soft and not contracted, but not tender. Her clothing from the waist down is blood- soaked. • What are Alemitu's main problems? • What are the causes of her shock and bleeding? • What will you do next?	• State that Alemitu reportedly lost "too much" blood after childbirth and considerable blood loss is evident on her clothes • State that Alemitu's uterus is soft and not contracted, but not tender; she has no fever • Determine that Alemitu's shock is due to postpartum hemorrhage, atonic uterus • Massage Alemitu's uterus to stimulate a contraction • Start a second IV infusion and gives 20 units oxytocin in 1 L of fluid at 60 drops/minute
4. After 15 minutes, the uterus is firm, bleeding has stopped, but Alemitu's blood pressure is still 88/ 60 mm Hg, pulse116 beats/minute, respiration rate 32 breaths/minute. • **What will you do now?**	• Give another liter of fluid to ensure 2 L are infused within an hour of starting treatment • Continue to give oxygen at 6–8 L/minute • Continue to check that uterus remains contracted • Continue to monitor blood pressure and pulse
5. After another 15 minutes, the uterus is still firm, there is no further bleeding, Alemitu's blood pressure is 100/60 mm Hg, pulse 90 beats/ minute, respiration rate 24 breaths/minute. • What will you do now?	• Adjusts rate of IV infusion to 1 L in 6 hours • Continue to check to ensure that uterus remains contracted • Continue to monitor blood pressure and pulse • Check that urine output is 30 mL/hour or more
6. Alemitu's conditions has stabilized. Twenty-four hours later, her hemoglobin is 6.5 g/dL. • What will you do now?	• Begin ferrous fumenate 120 mg by mouth PLUS folic acid 400 µg by mouth daily, and advise Alemitu that she will need to take this for 3 months

SCENARIO 2 (Information provided and questions asked by the facilitator)	*KEY REACTIONS/RESPONSES* (Expected from participant)
1. Lemlem is 26 years old and gave birth at home to her second child, with the help of her neighbor. The family reports that Lemlem has had a fever since yesterday, was very restless during the night and is very drowsy this morning. She was carried into the health center by her husband and neighbor. • What do you do?	• **Shout** for help • Evaluate Lemlem immediately for shock, including vital signs (temperature, blood pressure, pulse and respiration rate), level of consciousness, color and skin temperature • Tell Lemlem (and her husband and neighbor) what is going to be done, listen to them and respond attentively to their questions and concerns • Turn Lemlem on her side, if unconscious or semi-conscious, and keep the airway open
2. On examination, you find that Lemlem's blood pressure is 80/50 mm Hg, pulse 136 beats/minute; respiration rate 34 breaths/minute; temperature 39.4º C. She is confused and drowsy. • What do you think is wrong with Lemlem? • What will you do now?	• State that Lemlem is in shock • Ask one of the staff that responded to your shout for help to start an IV infusion, using a large-bore cannula and normal saline or Ringer's lactate at a rate of 1 L in 15–20 minutes • Collect blood for appropriate tests (hemoglobin, blood typing and cross match, and tests for coagulopathy), while starting the IV • Start oxygen at 6–8 L/minute • Catheterizes bladder • Look for the cause of the shock (hypovolemic or septic) by palpating the uterus for firmness and tenderness • Cover Lemlem to keep her warm • Elevate legs
3. On further examination, you find that Lemlem's uterus is tender and that she has foul-smelling lochia. Upon questioning, the neighbor admits that herbs were inserted into Lemlem's vagina during labor. • What are Lemlem's main problems? • What are the causes of her shock and why? • What will you do next?	• State that Lemlem has a fever, a tender uterus and foul-smelling lochia • Determine that Lemlem's shock is due to infection resulting from unclean labor and childbirth practices • Gives penicillin G 2 million units OR ampicillin 2 g IV (and repeats every 6 hours) PLUS gentamicin 5 mg/kg body weight IV (and repeats every 24 hours) PLUS metronidazole 500 mg IV (and repeats every 8 hours)

4. After 6 hours, Lemlem's blood pressure is 100/60 mm Hg, pulse 100 beats/minute, respiration rate 24 breaths/minute, temperature 38º C. She is easily roused and is oriented. • **What will you do now?**	• Adjust rate of IV infusion to 1 L in 6 hours • Continue to monitor blood pressure, pulse and temperature • Check that urine output is 30 mL/hour or more • Continue to administer antibiotics

MODULE-3:

PREGNANCY CARE

Participant learning objective: After completing this module, participants will be able to describe the evidence based approaches in the care of women during pregnancy to help decrease the existing high maternal and perinatal mortality & morbidity in our country.

Enabling objectives

1. Describe focused antenatal care.
2. Provide focused antenatal care to the pregnant woman.
3. Identify and provide care to pregnant women with diseases and complications.
4. Recognize an emergency situation during pregnancy which requires immediate treatment and urgent referral to a higher level health facility.
5. Describe pre-referral management to a recognized emergency situation.

SKILLS PRACTICE SESSIONS

SKILLS PRACTICE SESSION 3-1: Antenatal Care

PURPOSE

The purpose of this activity is to enable participants to practice those skills necessary to provide antenatal care, and to achieve competency in these skills.

INSTRUCTIONS

This activity should be conducted in a simulated setting. Participants should review Learning Guide for Antenatal Care before beginning the activity.1 The facilitator should demonstrate the steps/tasks in each learning guide one at a time. Under the guidance of the facilitator, participants should then work in groups of three and practice the steps/tasks in the Learning Guide for Antenatal Care and observe each other's performance; while one participant simulates her role as a pregnant client, another participant performs the skill, and the third participant should use the Learning Guide to observe performance. Participants should then rotate roles. Participants should be able to perform the steps/tasks before skills competency is assessed using the Checklist for Antenatal Care.

RESOURCES

- Childbirth model
- Stethoscope
- Sphygmomanometer
- Simulated tablets
- Table for client or model
- Sheets for draping
- 0.5% chlorine solution and receptacle for decontamination
- Leakproof container or plastic bag
- Learning Guide 3.1: Antenatal assessment (history and physical examination) and care
- Checklist 3.1: Antenatal assessment (history and physical examination) and care

[1] Content of Malaria and Other Causes of Fever in Pregnancy, as well as PMTCT content should be incorporated into this skills practice session.

LEARNING GUIDE 3-1: ANTENATAL ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR ANTENATAL ASSESSMENT AND CAR (Some of the following steps/tasks should be performed simultaneously				
STEP/TASK	**CASES**			
GETTING READY				
1. Prepare the necessary equipment				
2. Greet the woman respectfully & with kindness, introduce yourself and offer her a seat.				
3. Do a quick check followed by rapid initial assessment for danger signs.				
4. Respond immediately in the event of any of the danger signs or any other urgent problem(s).				
5. Tell the woman what is going to be done and encourage her to ask questions				
6. Provide continual emotional support and reassurance, as possible				
HISTORY (ASK/CHECK RECORD)				
FIRST VISIT				
Personal Information				
1. Ask her name, age, marital status, address and phone number. If the woman is less than 20 years of age, determine the circumstances surrounding the pregnancy (e.g. unprotected sex, multiple partners, incest, sexual abuse, rape, forced marriage)				
Present Pregnancy (First Visit)				
2. Ask about her menstrual history including Last Normal Monthly Period (LNMP), calculate the EDD and gestational age correctly. If she does not remember her LNMP probe more				
3. How many previous pregnancies (gravida), child births (Para) including abortions she has had.				
4. Ask the woman about social support (financial, moral, and physical),				

LEARNING GUIDE FOR ANTENATAL ASSESSMENT AND CAR (Some of the following steps/tasks should be performed simultaneously				
STEP/TASK	**CASES**			
also other problems or concerns related to her pregnancy.				
5. Have you felt the fetus move? If Yes, ask the woman when the fetus first moved and whether she has felt it move in the last day.				
6. Is the current pregnancy planned? Wanted? Supported?				
Contraceptive History (Fist Visit)				
7. Have you used a family planning method before? If Yes, ask: • Which method(s) have you used? • Did you like the method(s) and why? • Which method did you like the most and why? (if >1 method used				
8. How many more children do you plan to have?				
Daily Habits and Lifestyle (First Visit)				
9. Ask for workload and if she get enough sleep/rest?				
10. What do you usually eat in a day?				
11. If the woman sleeps under ITN every day				
12. Do you smoke, drink alcohol or use any other addictive substances?				
13. Who do you live with?				
14. Ask if she has experienced threats, violence or injury.				
Past Obstetric History (First Visit)				
15. Did you have any problem during a previous pregnancy or during/following childbirth? • convulsions (pre-eclampsia/eclampsia) • caesarean section or uterine rupture • Genital tears (or third- or fourth-degree tears) • postpartum hemorrhage • stillbirths, preterm, low birth weight or death before 1 month of age • three or more spontaneous abortions				
16. Have you had any problems breastfeeding (if multipara)? And; ask if the woman is currently breastfeeding.				
Medical History (First Visit)				
17. Do you have any allergies?				
18. Have you been tested for HIV? If Yes, ask if she know her status.				
19. Have you been tested for syphilis? If Yes, ask what the result was and if results were positive was treatment provided.				
20. Do you have any chronic illnesses or conditions such as tuberculosis, hepatitis, heart disease, diabetes, or any other serious disease?				

LEARNING GUIDE FOR ANTENATAL ASSESSMENT AND CAR (Some of the following steps/tasks should be performed simultaneously				
STEP/TASK	**CASES**			
21. Have you ever been in hospital or had surgery?				
22. Are you taking any drugs/medications (including traditions/local preparations, over-the-counter drugs, vitamins, or dietary supplements)?				
23. Have you had tetanus toxoid (TT) immunizations? If Yes, find out how many doses and when the last dose was.				
24. Discuss with the woman and her companion about birth preparedness and emergency readiness plan.				
Interim History (Return Visits)				
25. Revise the chart				
26. Have you had any problems since your last visit or at present? If Yes, ask or discuss about the problem.				
27. Has your address or lifestyle changed since your last visit? If Yes, review the birth preparedness and emergency readiness plan				
28. Did you take drugs/medications prescribed and followed the advice/recommendations (plan of care) provided at your last visit?				
29. Have you had any reactions to or side effects from immunizations or drugs/medications given at your last visit or any other time?				
30. Record all the information in the woman's card/chart				
PHYSICAL EXAMINATION (LOOK/LISTEN/FEEL)				
Assessment of General Well-Being (Every Visit)				
1. Observe gait and movements (i.e. walks steadily and without a limp).				
2. Observe facial expression (i.e. is alert and responsive).				
3. Observe general cleanliness (i.e. no visible dirt, no odor. etc.).				
4. Observe skin (i.e. free from lesions and bruises)				
5. Explain to the woman before conducting the examination what you are going to do to her and respond to her concerns, and at each step of the physical examination.				
6. Measure vital signs, blood pressure from right arm while the woman is seated and relaxed or lying in left lateral position: • If diastolic BP is >90 mm Hg., ask her if she has severe headache, blurred vision or epigastric pain, and check urine for protein.				
7. Ask the woman to empty her bladder before physical examination begins, save and test the urine for protein and sugar even if blood pressure is normal				
8.Woman body weight should be taken at every visit, but height should be taken once on the first visit				
9. Before asking the woman to undress, observe privacy and confidentiality in				

LEARNING GUIDE FOR ANTENATAL ASSESSMENT AND CAR (Some of the following steps/tasks should be performed simultaneously				
STEP/TASK	**CASES**			
the examination room.				
10. Ask the woman to lie on the examination bed, while helping her on the bed and place a pillow under her head and neck. Assure privacy and cover her abdomen.				
11. Wash hands thoroughly with soap and water and dry them.				
12.Conduct head to toe assessment, check the woman's conjunctiva and palms for pallor for anaemia, face and hands for oedema				
13. Inspect the breasts (i.e. contours, skin, nipples, abnormalities): • If nipples appear inverted test for protracted by placing the thumb and fingers on either side of areola and gently squeezing • If the nipple goes in it is inverted • Respond accordingly in the event of any breast problem				
Abdominal Examination (Every Visit)				
14. Ask the woman to uncover her abdomen and lie on her back with her knees slightly bent.				
15. Inspect abdomen for surgical scars, while checking for size and shape of the abdomen at the same time asking for fetal movement if more than 20 weeks of gestation				
Fetal Lie and Presentation (After 36 weeks)				
Fundal Palpation				
16. Measure fundal height: gently palpate the abdomen above the symphysis • Fundal height at level of symphysis pubis corresponds to 12 weeks. • Fundal height at level of umbilicus corresponds to 22 weeks. • If 12-22 weeks or more than 22 weeks, estimate weeks of gestation by determining distance between top of fundus and symphysis pubis using the finger method or measuring tape.				
17. Carry out lateral palpation: • Move hands smoothly down sides of uterus to feel for fetal back: − It will feel firm and smooth in contrast to the small parts, which will feel knobby and easily moveable; • Keep dominant hand steady against side of uterus, while using palm of other hand to apply gentle pressure to explore opposite side of uterus; • Repeat procedure on other side of uterus.				
18. Carry out pelvic palpation: • Turn and face the woman's feet (the woman's knees should already be bent slightly to relax abdominal muscles): • Place hands on either side of uterus with palms below the level of the umbilicus and fingers pointing to symphysis pubis • Grasp fetal part snugly between hands				

LEARNING GUIDE FOR ANTENATAL ASSESSMENT AND CAR (Some of the following steps/tasks should be performed simultaneously				
STEP/TASK	**CASES**			
− If fetal part is above symphysis pubis, feel shape, size, consistency and mobility − If head is presenting, a hard and round mass will be felt • Observe the woman's face for signs of pain during palpation				
Fetal Heart Beat				
19. Listen to the fetal heart rate: • Place fetal stethoscope on abdomen at right angles to it (on the same side that you palpated the fetal back) • Place your ear in close, firm contact with fetal stethoscope • Move fetal stethoscope around to where fetal heart is heard most • Remove hands from fetal stethoscope and listen to fetal heart • Listen and count beats for a full minute, • Feel the woman's pulse at wrist, simultaneously, to ensure that fetal heart tones, and not maternal pulse, are being measured				
Vaginal Examination (First Visit/As Needed)				
20. Ask the woman to uncover her genital area and cover or drape her to preserve privacy and modesty.				
21. Ask the woman to separate her legs while keeping knees slightly bent.				
22. Turn on light and direct toward genital area.				
23. Wash hands thoroughly with soap and water and dry them				
24. Put new examination gloves on both hands.				
25. Touch the inside of the woman's thigh before touching genital area.				
26. Look at perineum, noting scars, lesions, inflammation, or cracks in skin.				
27. Separate labia majora with two fingers, check labia minora, clitoris, urethral opening and vaginal opening, noting signs of female genital cutting, sores, ulcers, warts, nits, lice, blood or foul-smelling discharge, urine, or stool coming from vaginal opening.				
28. Palpate the labia minora: • Look for swelling, discharge, tenderness, ulcers and fistulas; • Feel for irregularities and nodules.				
29. Check Skene's gland for discharge and tenderness: • With palm facing up, insert index finger into vagina and gently push upward against urethra and milk gland on each side and then directly on urethra.				
30. Check Bartholin's glands for discharge and tenderness: • Insert index finger into vagina at lower edge of opening and feel at base of each labia majora; • Using finger and thumb, palpate each side for swelling or tenderness.				

LEARNING GUIDE FOR ANTENATAL ASSESSMENT AND CAR (Some of the following steps/tasks should be performed simultaneously				
STEP/TASK	**CASES**			
31. Hold the labia open and ask the woman to bear down: • Check for abnormal discharge and bulging of anterior or posterior vaginal walls.				
32. Immerse both gloved hands in 0.5% chlorine solution and remove gloves by turning them inside out.				
33. Wash hands thoroughly with soap and water and dry them.				
34. Help the woman off the examination table.				
35. Record all relevant findings from the physical examination on the woman's record/antenatal card				
Laboratory Testing				
1. Do a hemoglobin test (1st visit, at about 28 weeks, and as needed): • If hemoglobin is less than 7 g/dL, refer woman to hospital • If hemoglobin is 7-11 g/dL, give iron/folate 1 tablet twice daily				
2. Determine BG & Rh, VDRL, and urinalysis (glucose, protein, infection				
3. Provide HIV testing and counseling using the national guideline, or refer woman to VCT services for HIV test, if she volunteers:				
CARE PROVISION **Note:** Individualize care considering all information gathered during assessment.				
1. Explain and discuss with the woman about danger signs during pregnancy and that she should report to a health facility in the event of any of the following: • Severe headache with blurred vision and or epigastric pain • Vaginal bleeding • Severe abdominal pain • Fever • Convulsions and or loss of consciousness				
2. Provide advice and counseling about diet and nutrition: • Eat a balanced diet and a variety of foods rich in iron and vitamin A, calcium, magnesium, vitamin C • Eat an extra serving of staple food per day • Eat smaller more frequent meals, if necessary • Use Iodated salt in her family food				
3. Develop a birth preparedness and emergency readiness plan with the woman and her companion if present: • Skilled provider and place of birth • Transportation/emergency transportation and funds/emergency funds • Decision making and support person • Items needed for clean and safe birth and for newborn				

LEARNING GUIDE FOR ANTENATAL ASSESSMENT AND CAR (Some of the following steps/tasks should be performed simultaneously				
STEP/TASK	**CASES**			
• Review the Danger signs and signs of labor				
4. Provide advice and counseling about: • Use of potentially harmful substances • Prevention of infection/hygiene • Rest and activity • Sexual relations and safer sex • Sleeping under ITN • Early and exclusive breast feeding				
1. Offer HIV testing and counseling service If her test result turned out positive start her on HAART • Discuss on infant feeding options • Discuss on test result disclosure to her partner • Discuss on partner testing				
Immunizations and Other Prophylaxis				
2. . Give tetanus toxoid (TT) based on woman's need.				
7. Dispense sufficient supply of 1 iron/folate tablet daily until next visit and counsel the woman about the following: • Avoid tea, coffee and colas; explain reason for not taking with iron • Possible side effects and management.				
8. Dispense medications based on region/population-specific need as follows: • Antimalarial tablets • Mebendazole • Iron tablets				
Return Visits				
9. Schedule the next antenatal visit: • Make sure the woman knows when and where to come; • Answer any additional questions or concerns; • Advise her to bring her records with her to each visit; • Make sure she understood that she can return any time before the next scheduled visit if she has a problem; • Review danger signs and key points of the complication readiness plan;				
10. Complete all information in the woman's record/antenatal card				
11.Thank the woman and her family member for coming				

CHECKLIST 3-1: ANTENATAL ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

PARTICIPANT/STUDENT _____Date Observed _____

CHECKLIST FOR ANTENATAL ASSESSMENT AND CARE (Some of the following steps/tasks should be performed simultaneously				
STEP/TASK	**CASES**			
GETTING READY				
1. Prepares the necessary equipment				
2. Greets the woman respectfully & with kindness, introduce yourself and offer her a seat.				
3. Does a quick check followed by rapid initial assessment for danger signs.				
4. Responds immediately in the event of any of the danger signs or any other urgent problem(s).				
5. Tells the woman what is going to be done and encourage her to ask questions				
6. Provides continual emotional support and reassurance, as possible				
HISTORY (ASK/CHECK RECORD)				
FIRST VISIT				
Personal Information				
1. Asks her name, age, marital status, address and phone number.				
Present Pregnancy (First Visit)				
2. Asks about her menstrual history including Last Normal Monthly Period (LNMP), calculate the EDD and gestational age correctly.				
3. Asks how many previous pregnancies (gravida), child births (Para) including abortions she has had.				
4. Asks the woman about social support (financial, moral, and physical), also other problems or concerns related to her pregnancy.				
5. Asks if the woman has felt the fetus move. If Yes, asks the woman when the fetus first moved and whether she has felt it move in the last day.				
6. Asks if the current pregnancy was planned? Wanted? Supported?				

CHECKLIST FOR ANTENATAL ASSESSMENT AND CARE (Some of the following steps/tasks should be performed simultaneously				
STEP/TASK	**CASES**			
Contraceptive History (Fist Visit)				
7. Inquires about history of family planning method use and satisfaction (if used)				
8. Asks her the number of children she plans to have in the future.				
Daily Habits and Lifestyle (First Visit)				
9. Asks the woman:- • for workload and if she get enough sleep/rest? • What she usually eat in a day? • If she sleeps under ITN every day • Do you smoke, drink alcohol or use any other addictive substances? • Who do you live with? • if she has experienced threats, violence or injury.				
Past Obstetric History (First Visit)				
10. Asks if the woman had any problem during a previous pregnancy or during/following childbirth?				
11. Asks if the woman had any problems breastfeeding (if multipara)? And; asks if the woman is currently breastfeeding.				
Medical History (First Visit)				
12. Asks if the woman had any allergies.				
13. Asks if the woman had been tested for HIV and syphilis? • If yes, asks if she know the result. • If results were positive for syphilis was treatment provided.				
14. Inquires about history of:- • any chronic illnesses or conditions. • hospital admission or any surgery • taking any drugs/medications				
15. Asks if the woman had tetanus toxoid (TT) immunizations? If Yes, finds out how many doses and when the last dose was.				
16. Discusses with the woman and her companion about birth preparedness and emergency readiness plan.				
Interim History (Return Visits)				
17. Revises the chart				
18. Asks if the woman • had any problems since her last visit or at present? • had changed her address or lifestyle since last visit and reviews the birth preparedness and emergency readiness plan, if needed				

CHECKLIST FOR ANTENATAL ASSESSMENT AND CARE (Some of the following steps/tasks should be performed simultaneously				
STEP/TASK	**CASES**			
• is taking drugs/medications (if prescribed) properly • any reactions to or side effects from immunizations or drugs/medications				
19. Record all the information in the woman's card/chart				
PHYSICAL EXAMINATION (LOOK/LISTEN/FEEL)				
Assessment of General Well-Being (Every Visit)				
1. Observes gait and movements, facial expression, general cleanliness and skin for lesions & bruises.				
2. Explains to the woman before conducting the examination what is going to done and each step of the examination responding to her concerns.				
3. Measures body weight (height taken once on the first visit) and vital signs, • If diastolic BP is >90 mm Hg., asks her if she has severe headache, blurred vision or epigastric pain, and check urine for protein.				
4. Ensures that the bladder is empty her before physical examination begins,				
5. Ensures her privacy and confidentiality throughout the examination.				
6. Asks the woman to lie on the examination bed, while helping her on the bed and place a pillow under her head and neck.				
7. Washes hands thoroughly with soap and water and dry them.				
8.Conducts head to toe assessment, checks the woman's conjunctiva and palms for pallor for anemia, face and hands for oedema				
9. Inspects the breasts (i.e. contours, skin, nipples, abnormalities) and responds accordingly in the event of any breast problem				
Abdominal Examination (Every Visit)				
10. Asks the woman to uncover her abdomen and lie on her back with her knees slightly bent.				
11. Inspects abdomen for surgical scars and for size & shape of the abdomen at the same time asking for fetal movement if more than 20 weeks of gestation				
Fetal Lie and Presentation (After 36 weeks)				
Fundal Palpation				
12. Measures fundal height gently palpating the abdomen and using the finger method or measuring tape.				
13. Carries out lateral palpation to determine the side of the fetal back				
14. Turning and facing the woman's feet carries out pelvic palpation determine the presentation observing the woman's face for signs of pain.				
Fetal Heart Beat				
15. Listens to the fetal heart rate with fetal stethoscope and counts beats for a full minute, while feeling the woman's pulse at wrist simultaneously.				

CHECKLIST FOR ANTENATAL ASSESSMENT AND CARE (Some of the following steps/tasks should be performed simultaneously				
STEP/TASK	**CASES**			
Vaginal Examination (First Visit/As Needed)				
16. Asks the woman to uncover her genital area and covers or drapes her to preserve privacy and prepares her for examination.				
17. Washes hands thoroughly with soap and water and dry them				
18. Puts new examination gloves on both hands.				
19. Touches the inside of the woman's thigh before touching genital area.				
20. Looks at perineum, noting scars, lesions, inflammation, or cracks in skin.				
22. Separates labia majora with two fingers, check labia minora, clitoris, urethral opening and vaginal opening, noting signs of female genital cutting, sores, ulcers, warts, nits, lice, blood or foul-smelling discharge, urine, or stool coming from vaginal opening.				
23. Palpates the labia minora: • Looks for swelling, discharge, tenderness, ulcers and fistulas; • Feels for irregularities and nodules.				
24. Checks Skene's gland for discharge and tenderness:				
25. Checks Bartholin's glands for discharge and tenderness:				
26. Holding the labia open and asking the woman to bear down checks for abnormal discharge and bulging of anterior or posterior vaginal walls.				
27. Immerses both gloved hands in 0.5% chlorine solution and removes gloves by turning them inside out.				
28. Washes hands thoroughly with soap and water and drirs them.				
29. Helps the woman off the examination table.				
30. Records all relevant findings on the woman's record/antenatal card				
Laboratory Testing				
1. Determines the hemoglobin (1st visit, at about 28 weeks, and as needed): • If hemoglobin is less than 7 g/dL, refers woman to hospital • If hemoglobin is 7-11 g/dL, gives iron/folate 1 tablet twice daily				
2. Determines BG & Rh, VDRL, and urinalysis (glucose, protein, infection)				
3. Provides HIV testing and counseling using the national guideline, or refers woman to VCT services for HIV test, if she volunteers:				
CARE PROVISION **Note:** Individualize care considering all information gathered during assessment.				
1. Explains and discusses with the woman about danger signs during pregnancy and that she should report to a health facility in the event of any of the signs.				
2. Provides advice and counseling about diet and nutrition:				

CHECKLIST FOR ANTENATAL ASSESSMENT AND CARE (Some of the following steps/tasks should be performed simultaneously				
STEP/TASK	**CASES**			
3. Develops a birth preparedness and emergency readiness plan with the woman and her companion if present.				
4. Provides advice and counseling about: • Use of potentially harmful substances • Prevention of infection/hygiene • Rest and activity • Sexual relations and safer sex • Sleeping under ITN • Early and exclusive breast feeding				
5. Offers HIV testing & counseling service. If her test result turned out positive • Starts her on HAART • Discuss on infant feeding options • Discuss on test result disclosure to her partner and partner testing				
Immunizations and Other Prophylaxis				
6. Gives tetanus toxoid (TT) based on woman's need.				
7. Dispenses sufficient supply of 1 iron/folate tablet daily until next visit and counsel the woman about precautions, possible side effects and management.				
8. Dispenses preventive medications based on region/population-specific need.				
Return Visits				
9. Schedules the next antenatal visit making sure the woman knows when and where to come.				
10. Completes all information in the woman's record/antenatal card				
11.Thank the woman and her family member for coming				

SKILLS PRACTICE SESSION 3-2:

POSTABORTION CARE (MANUAL VACUUM ASPIRATION [MVA]) AND POSTABORTION FAMILY PLANNING COUNSELING

PURPOSE

The purpose of this activity is to enable participants to practice manual vacuum aspiration, achieve competency in the skills required and develop skills in post abortion family planning counseling.

INSTRUCTIONS

This activity should be conducted in a simulated setting, using the appropriate models. Participants should review Learning Guide 3.2.1 and Learning Guide 3.2.2 before beginning the activity. The facilitator should demonstrate the preliminary steps (medical evaluation, explaining the procedure, pelvic examination), followed by the steps in the MVA procedure. Under the guidance of the facilitator, participants should then work in pairs to practice the steps/tasks and observe each other's performance, using Learning Guide 3.2.1.

The facilitator should then demonstrate the steps/tasks in providing post abortion family planning counseling. Under the guidance of the facilitator, participants should then work in groups of three to practice the steps/tasks and observe each other's performance; one participant/student should take the role of the post abortion woman, the second should practice counseling skills, and the third should observe performance using Learning Guide 3.2.2. Participants should then reverse roles until each has had an opportunity to practice counseling skills. Participants should be able to perform the steps/tasks in Learning Guide 3.2.1 and Learning Guide 3.2.2 before skill competency is assessed by the facilitator in the simulated setting, using Checklist 3.2.1 and Checklist 3.2.2. Finally, following supervised practice at a clinical site, the facilitator should assess the skill competency of each participant, using Checklist 3.2.1 and Checklist 3.2.2

[2] If patients are not available at clinical sites for participant/students to practice postabortion care in relation to obstetric emergencies, the skills should be taught, practiced and assessed in a simulated setting.

RESOURCES

The following equipment or representations thereof:

- Pelvic model
- High-level disinfected or sterile surgical gloves
- Personal protective barriers
- MVA syringes and cannula
- Vaginal speculum
- Single-toothed tenaculum or vulsellum forceps
- Learning Guide 3.2.1: Postabortion Care (Manual Vacuum Aspiration [MVA])
- Learning Guide 3.2.2: Postabortion Family Planning Counseling
- Checklist 3.2.1: Postabortion Care (Manual Vacuum Aspiration [MVA])
- Checklist 3.2.2: Postabortion Family Planning Counseling

SKILLS PRACTICE SESSION 3-2.1:

LEARNING GUIDE 3.2.1: POSTABORTION CARE (MANUAL VACUUM ASPIRATION [MVA])

(To be completed by **Participant/students**)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently

3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR POSTABORTION CARE (MVA) (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
INITIAL ASSESSMENT					
1. Greet the woman respectfully and with kindness.					
2. Assess patient for shock and other life-threatening conditions.					
3. If any complications are identified, stabilize patient and transfer, if necessary.					
MEDICAL EVALUATION					
1. Take a reproductive health history.					
2. Perform limited physical (heart, lungs and abdomen) and pelvic examinations.					
3. Perform indicated laboratory tests.					
4. Give the woman information about her condition and what to expect.					
5. Discuss her reproductive goals, as appropriate.					
6. Counsel her on FP and if she is considering an IUCD: • She should be fully counseled regarding IUCD use. • The decision to insert the IUCD following the MVA procedure will be dependent on the clinical situation.					

LEARNING GUIDE FOR POSTABORTION CARE (MVA) (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Tell the woman (and her support person) what is going to be done, regarding the procedure listen to her and respond attentively to her questions and concerns.					
2. Provide continual emotional support and reassurance, as feasible.					
3. Tell her she may feel discomfort during some of the steps of the procedure and you will tell her in advance.					
4. Ask about allergies to antiseptics and analgesics					
5. Give pethidine 100mg and/or Diazepam 10mg or Diclophenac 75 mg IM as appropriate to the woman before the procedure.					
6. Determine that required sterile or high-level disinfected instruments are present.					
7. Make sure that the appropriate size cannula and adapters are available.					
8. Check that patient has recently emptied her bladder.					
9. Put on personal protective barriers.					
10. Wash hands thoroughly with soap and water and dry with a clean, dry towel or air dry.					
11. Put high-level disinfected or sterile surgical gloves on both hands.					
12. Arrange sterile or high-level disinfected instruments on sterile tray or in high-level disinfected container.					
13. Check the MVA syringe by charging it (establish vacuum)					
PREPROCEDURE TASKS					
1. Give Oxytocin and/or antibiotics IV if there is an indication					
2. Clean the genitalia using cotton and appropriate antiseptic solution					
3. Place sterile drapes – one under buttocks and one on abdomen.					
4. Perform bimanual pelvic examination, checking the size and position of uterus and degree of cervical dilatation					
5. Insert the speculum and remove blood or tissue from vagina using sponge forceps and gauze.					

LEARNING GUIDE FOR POSTABORTION CARE (MVA) (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
6. Apply antiseptic solution to cervix and vagina two times using gauze or cotton sponge.					
7. Remove any products of conception (POC) from the cervical os and check cervix for tears.					
Administering Paracervical Block (when necessary)					
8. Prepare 20 mL 0.5% lignocaine solution without adrenaline.					
9. Draw 10 mL of 0.5% lignocaine solution into a syringe.					
10. Gently grasp anterior lip of the cervix with a single-toothed tenaculum or vulsellum forceps (preferably, use ring or sponge forceps if incomplete abortion).					
11. With tenaculum or vulsellum forceps on the cervix, use slight traction and movement to help identify the area between the smooth cervical epithelium and the vaginal tissue.					
12. Insert the needle just under the epithelium and aspirate by drawing the plunger back slightly to make sure the needle is **not** penetrating a blood vessel.					
13. Inject about 2 ml of a 0.5% lignocaine solution just under the epithelium, **not** deeper than 3 mm, at 3, 5, 7 and 9 o'clock.					
14. Wait 2 minutes and then pinch the cervix with the forceps. (If the woman feels the pinch, wait 2 more minutes and then retest.)					
MVA PROCEDURE					
1. Inform woman of each step in the procedure prior to performing it.					
2. Gently apply traction on the cervix to straighten the cervical canal and uterine cavity.					
3. If necessary, dilate cervix using progressively larger cannula.					
4. While holding the cervix steady, push the selected cannula gently and slowly into the uterine cavity until it just touches the fundus (not more than 10 cm). Then withdraw the cannula slightly away from the fundus.					
5. Attach the prepared syringe to the cannula by holding the cannula in one hand and the tenaculum and syringe in the other. Make sure cannula does not move forward as the syringe is attached.					
6. Release the pinch valve(s) on the syringe to transfer the vacuum through the cannula to the uterine cavity.					

LEARNING GUIDE FOR POSTABORTION CARE (MVA) (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
7a. Evacuate any remaining contents of the uterine cavity by rotating the cannula and syringe from 10 to 2 o'clock and moving the cannula gently and slowly back and forth within the uterus.					
7b. If the syringe becomes half full before the procedure is complete, detach the cannula from the syringe. Remove **only** the syringe, leaving the cannula in place.					
7c. Push the plunger to empty product of conception (POC) into the strainer					
7d. Recharge syringe, attach to cannula, release pinch valve(s) and evacuate any remaining content					
8. Check for signs of completion (red or pink foam, no more tissue in cannula, a "gritty" sensation and uterus contracts around the cannula). Withdraw the cannula and MVA syringe gently.					
9. Remove cannula from the MVA syringe and push the plunger to empty POC into the strainer.					
10. Remove tenaculum or forceps from the cervix before removing the speculum.					
11. Perform bimanual examination to check size and firmness of uterus.					
12. If the uterus is still soft or bleeding persists, repeat steps from 3-10.					
13. Quickly inspect the tissue removed from the uterus to be sure the uterus is completely evacuated. (If necessary rinse the tissue with water or saline)					
14. If no POC are seen, reassess situation to be sure it is not an ectopic pregnancy.					
POST-PROCEDURE TASKS					
1. Before removing gloves, dispose of waste materials in a leakproof container or plastic bag.					
2. Place all instruments in 0.5% chlorine solution for 10 minutes for decontamination.					
3. Dispose needle and syringe in a puncture-proof container or safety box .					
a. Attach used cannula to MVA syringe and flush both with 0.5% chlorine solution.					
b. Detach cannula from syringe and soak them in 0.5% chlorine solution for 10 minutes for decontamination.					

LEARNING GUIDE FOR POSTABORTION CARE (MVA) (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
c. Empty POC into utility sink, flushable toilet, latrine or container with tight-fitting lid.					
d. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out. • If disposing of gloves, place them in a leakproof container or plastic bag. • If reusing surgical gloves, submerge them in 0.5% chlorine solution for decontamination.					
8. Wash hands thoroughly with soap and water and dry with a clean, dry towel or air dry.					
9. Allow the patient to rest comfortably for at least 30 minutes where her recovery can be monitored.					
10. Check for bleeding and ensure that cramping has decreased before discharge.					
11. Instruct patient regarding post abortion care and warning signs.					
12. Tell her when to return if follow-up is needed and that she can return anytime she has concerns.					
13. Discuss reproductive goals and, as appropriate, provide family planning.					

CHECKLIST 3.2.1: POSTABORTION CARE (MANUAL VACUUM ASPIRATION [MVA])

(To be used by the **Trainer/teacher** at the end of the module)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

PARTICIPANT/STUDENT _____ Date Observed _____

CHECKLIST FOR POSTABORTION CARE (MVA) (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
INITIAL ASSESSMENT					
1. Greets woman respectfully and with kindness.					
2. Assesses patient for shock or complications.					
MEDICAL EVALUATION					
1. Takes a reproductive history and perform physical examination and laboratory tests.					
2. Gives her information about her condition.					
3. Discusses her reproductive goals.					
GETTING READY					
1. Tells the woman (and her support person) what is going to be done, listen to her and respond attentively to her questions and concerns.					
2. Provides continual emotional support and reassurance, as feasible.					
3. Asks about allergies to antiseptics and anesthetics..					
4. Gives pethidine 100mg and/or Diazepam 10mg or Diclophenac 50 mg as appropriate to the woman before the procedure.					

CHECKLIST FOR POSTABORTION CARE (MVA) (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
5. Determines that required sterile or high-level disinfected instruments and cannula are present.					
6. Checks that patient has recently emptied her bladder and washed her perineal area.					
7. Puts on personal protective barriers.					
8. Washes hands thoroughly and puts on high-level disinfected or sterile surgical gloves.					
9. Arranges sterile or high-level disinfected instruments on sterile tray or in high-level disinfected container.					
10. Checks MVA syringe and charges it (establish vacuum). Ensure that appropriate size cannula and adapters are available.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
PREPROCEDURE TASKS					
1. Gives Oxytocin and/or antibiotics IV if there is an indication.					
2. Cleans the genitalia and drapes the woman					
3. Performs bimanual examination.					
4. Inserts speculum.					
5. Applies antiseptic to cervix and vagina two times.					
6. Removes any products of conception (POC) and checks for any cervical tears.					
MVA PROCEDURE					
1. Explains each step of the procedure prior to performing it.					
2. Puts single-toothed tenaculum or vulsellum forceps on anterior lip of cervix.					
3. Administers paracervical block (if necessary).					
4. Applies traction on cervix.					
5. Dilates the cervix (if needed).					
6. Inserts the cannula gently through the cervix into the uterine cavity.					
7. Attaches the prepared syringe to the cannula.					

CHECKLIST FOR POSTABORTION CARE (MVA) (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
8. Evacuates contents of the uterus.					
9. When signs of completion are present, withdraws cannula and MVA syringe. Empties contents of MVA syringe into a strainer.					
10. Removes forceps or tenaculum and speculum.					
11. Performs bimanual examination.					
12. . If uterus is still soft or bleeding persists, repeats steps 5–10					
13. Inspects tissue removed from uterus to ensure complete evacuation					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
POST-PROCEDURE TASKS					
1. Before removing gloves, disposes of waste materials in a leakproof container or plastic bag.					
2. Flushes MVA syringe and cannula with 0.5% chlorine solution. And disposes needle and syringe in a puncture proof container or safety box					
3. Decontaminates gloves in 0.5% chlorine solution and disposes in leakproof container					
4. Washes hands thoroughly.					
5. Checks for bleeding and ensure cramping has decreased before discharge.					
6. Instructs patient regarding post abortion care.					
7. Discusses reproductive goals and, as appropriate, provides family planning.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

SKILLS PRACTICE SESSION 3-2.2:

LEARNING GUIDE 3.2.2: POSTABORTION FAMILY PLANNING COUNSELING

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently

3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR POSTABORTION FAMILY PLANNING COUNSELING (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
INITIAL INTERVIEW					
1. Treat the woman respectfully and with kindness.					
2. Assess whether counseling is appropriate at this time (if not, arrange for her to be counseled at another time and be sure she understands that she can become pregnant before her next menses).					
3. Assure necessary privacy.					
4. Obtain biographic information (name, address, etc.).					
5. Ask if she was using contraception before she became pregnant. If she was, find out if she: • Used the method correctly • Discontinued use • Had any trouble using the method • Has any concerns about the method					
6. Provide general information about family planning.					
7. Explore any attitudes or religious beliefs that either favor or rule out one or more methods.					
8. Give the woman information about the contraceptive choices available and the benefits and limitations of each: • Show where and how each is used • Explain how the method works and its effectiveness • Explain possible side effects and other health problems • Explain the common side effects					

LEARNING GUIDE FOR POSTABORTION FAMILY PLANNING COUNSELING (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
9. Discuss the woman's needs, concerns and fears in a thorough and sympathetic manner.					
10. Help the woman begin to choose an appropriate method.					
SCREENING					
1. Screen the woman carefully to make sure there is no medical condition that would be a problem (complete Screening Checklist).					
2. Explain potential side effects and make sure that each is fully understood.					
3. Perform further evaluation (physical examination), if indicated. (Nonmedical counselors must refer woman for further evaluation.)					
4. Discuss what to do if the woman experiences any side effects or problems.					
5. Provide follow-up visit instructions.					
6. Assure woman she can return to the same clinic at any time to receive advice or medical attention.					
7. Ask the woman to repeat instructions.					
8. Answer the woman's questions.					

CHECKLIST 3-2.2: POSTABORTION FAMILY PLANNING COUNSELING

(To be used by the **Facilitator** at the end of the module)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

PARTICIPANT/STUDENT _____ Date Observed _____

CHECKLIST FOR POSTABORTION FAMILY PLANNING COUNSELING					
STEP/TASK	**CASES**				
INITIAL INTERVIEW					
1. Treats woman respectfully and with kindness.					
2. Assesses whether counseling is appropriate at this time (if not, arrange for counseling at another time).					
3. Assures necessary privacy.					
4. Obtains biographic information (name, address, etc.).					
5. Asks about her previous experience with contraception. Provides general information about family planning.					
6. Gives the woman information about the contraceptive choices available and the benefits and limitations of each.					
7. Discusses woman's needs, concerns and fears. Helps her begin to choose an appropriate method.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
SCREENING					
1. Screens woman carefully to make sure there is no medical condition that would be a problem (complete Screening Checklist).					
2. Performs physical examination, if indicated. (Nonmedical counselors must refer woman for further evaluation.)					
3. Discusses what to do if the woman experiences any side effect/problem					
4. Provides follow up visit instructions and ensures woman that she can return to the same clinic at any time.					
5. Asks the woman to repeat instructions and answers any questions.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

SKILLS PRACTICE SESSION 3-3: MANAGEMENT OF SEVERE PRE-ECLAMPSIA/ECLAMPSIA

PURPOSE

The purpose of this activity is to enable participants to practice management of severe pre-eclampsia and eclampsia and achieve competency in the skills required. The main emphasis in the activity is on the preparation and use of anticonvulsant drugs.

INSTRUCTIONS

This activity should be conducted in a simulated setting with a fellow participant role-playing as a patient.

Participants should review Learning Guide 3-**3** before beginning the activity. The facilitator should demonstrate the initial steps/tasks in the management of severe pre-eclampsia/eclampsia, followed by the preparation and administration of magnesium sulfate. Under the guidance of the facilitator, participants should then work in pairs to practice the steps/tasks and observe each other's performance, using Learning Guide 3-3.

The facilitator should then demonstrate the use of diazepam, with particular emphasis on rectal infusion. Under the guidance of the facilitator, participants should then work in pairs, using Learning Guide 3-4 to observe each other's performance.

Participants should be able to perform the steps/tasks in Learning Guide 3-3 before skill competency is assessed by the trainer/teacher in the simulated setting, using Checklist 3-3.

Finally, following supervised practice at a clinical site, the facilitator should assess the skill competency of each participant, using Checklist 3-3.

RESOURCES

- Equipment for starting an IV line
- Needles and syringes
- Magnesium sulfate
- Diazepam
- Examination gloves

Learning Guide 3-3: Management of Severe Pre-Eclampsia/Eclampsia
Checklist 3-3: Management of Severe Pre-Eclampsia/Eclampsia

LEARNING GUIDE 3.3: Management of Severe Pre- Eclampsia /Eclampsia

(To be completed by Participants)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently

3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

Learning Guide: Management Of Severe Pre-Eclampsia /Eclampsia *(Some of the following steps/tasks should be performed simultaneously)*					
STEP/TASK	**CASES**				
GETTING READY					
1. If the woman is conscious and responsive, greet her respectfully and with kindness.					
2. Tell the woman (and her support person) what is going to be done and encourage her to ask.					
3. Listen to her and respond attentively to her questions & concerns.					
4. Provide continual emotional support and reassurance, as feasible.					
IMMEDIATE MANAGEMENT **Note:** different steps could be carried out simultaneously					
1. SHOUT FOR HELP to urgently mobilize available personnel.					
2. Turn the woman onto her left side to reduce the risk of aspiration of secretions, vomitus and blood.					
3. Ensure the woman's airway is open: • If the woman is not breathing, begin resuscitation measures.					
4. Give oxygen at 4–6 L per minute by mask or cannulae.					
5. If the woman is having a convulsion: - Protect her from injury but do not actively restrain. - Aspirate the mouth and throat, as necessary, after the convulsion.					
6. Establish an IV line and give normal saline or Ringer's lactate slowly — 1 liter in 6-8 hours (3 ml/minute)					
7. Check vital signs					

Learning Guide: Management Of Severe Pre-Eclampsia /Eclampsia ***(Some of the following steps/tasks should be performed simultaneously)***					
STEP/TASK	**CASES**				
INITIATE ANTICONVULSIVE THERAPY (MAGNESIUM SULPHATE) ***NOTE:*** *Give only the loading doses as below and refer urgently to a higher facility. Provide supportive care until referral is arranged.*					
Administering Loading Dose of Magnesium Sulphate					
1. Wash hands thoroughly with soap and water and dry.					
2. Tell the woman that she may experience a feeling of warmth when magnesium sulphate is given.					
3. Draw up 4 grams of magnesium sulphate (20 ml of 20% solution).					
4. Give by IV injection **SLOWLY** over 5 minutes.					
5. Draw up 10 grams of magnesium sulphate (20ml of 50% solution).					
6. Draw up 1 ml of 2% lignocaine **IN THE SAME SYRINGE**. ***(NB: if you only have 10 ml syringe draw 5gm Mgso4+1ml of 2% lignocaine in each syringe)***					
7. Give 5 grams (10 ml) by DEEP IM injection in upper outer quadrant of one buttock.					
8. Replace the needle on the syringe with another sterile one.					
9. Inject the remaining 5 grams by DEEP IM injection into the other buttock.					
10. If disposing of needle and syringe, decontaminate by flushing with 0.5% chlorine and place in puncture proof container.					
11. Wash hands thoroughly with soap and water and dry.					
12. If convulsions recur AFTER 15 minutes: • Draw up 2 grams of magnesium sulphate (10 ml of 20% solution or 4ml of 50% solution). • Give by IV injection **SLOWLY** over 5 minutes.					
13. Record drug administration and findings on the woman's record					
Monitoring for toxicity					
14. Insert an indwelling catheter and monitor input and output hourly					
15. Count respiratory rate for one minute every hour					
16. Check patellar reflexes every hour					
Administering Maintenance Dose of Magnesium Sulphate					
17. Give 5 grams of magnesium sulphate (10 mL of 50% solution), together with 1 mL of 2% lignocaine in the same syringe, by DEEP IM injection into alternate buttocks every 4 hours until 24 hrs after birth or after last convulsion (whichever is later)					

Learning Guide: Management Of Severe Pre-Eclampsia /Eclampsia *(Some of the following steps/tasks should be performed simultaneously)*					
STEP/TASK	**CASES**				
18. Before repeat administration check that: • Respiratory rate is at least 12 per minute. • Patellar reflexes are present. • Urinary output is at least 30 mL per hour over 4 hours.					
19. **WITHHOLD or DELAY** drug if: • Respiratory rate falls below 16 per minute. • Patellar reflexes are absent. • Urinary output falls below 30 ml per hour over the preceding 4 hours.					
20. If respiratory arrest occurs: • Assist ventilation. • Give calcium gluconate 1 g (10 mL of 10% solution) IV slowly until respiration begins to antagonize the effects of magnesium sulfate.					
ANTICONVULSIVE THERAPY (DIAZEPAM) Note: **Diazepam should be used ONLY if magnesium sulphate is not available.**					
Administering Loading Dose of Diazepam					
1. Wash hands thoroughly with soap and water and dry.					
2. Draw up 10 mg of diazepam.					
3. Give by IV injection SLOWLY over 2 minutes.					
4. Dispose of needle and syringe in puncture-proof container.					
5. Wash hands thoroughly with soap and water and dry.					
6. If convulsions recur, repeat loading dose.					
Administering Maintenance Dose of Diazepam					
7. Give 40 mg of diazepam in 500 mL of IV fluid (normal saline or Ringer's lactate), at a rate that keeps the woman sedated but rousable.					
8. If respiratory depression occurs (may occur if dose exceeds 30 mg in 1 hours): • Assist ventilation, if necessary					
Administering Diazepam Rectally (when IV access is not possible)					
9. Wash hands thoroughly with soap and water and dry.					
10. Draw up 20 mg of diazepam in a 10 mL syringe.					

Learning Guide: Management Of Severe Pre-Eclampsia /Eclampsia ***(Some of the following steps/tasks should be performed simultaneously)***						
STEP/TASK	**CASES**					
11. Remove the needle from the syringe.						
12. Lubricate the barrel of the syringe.						
13. Insert the syringe into the rectum to half its length.						
14. Discharge the contents of the syringe into the rectum.						
15. Leave the syringe in place and hold the buttocks together for 10 minutes.						
16. If convulsions are not controlled within 10 minutes, administer an additional 10 mg of diazepam per hour.						
17. Record drug administration and findings on the woman's records.						
CONTROL BLOOD PRESSURE (ANTI-HYPERTENSIVE THERAPY) **Note:** The goal is to keep the diastolic pressure between 90 and 100 mm Hg						
18. If the diastolic pressure is 110 mm Hg or more: – Give hydralazine 5 mg IV slowly (3-4 minutes). – If IV not possible give IM. – Repeat hydralazine 30 minutes interval until diastolic BP is around 90mmHg - Do not give more than 20 mg in total						
19. If hydralazine is not available, give:- - Labetalol 10 mg IV – If response is inadequate (diastolic blood pressure remains above 110 mm Hg) after 10 minutes, give labetalol 20 mg IV; - Increase the dose to 40 mg and then 80 mg if satisfactory response is not obtained after 10 minutes of each dose; o **OR** Nifedipine 5mg under the tongue. – If diastolic blood pressure remains > 90 mmHg, repeat the dose at 30 minute intervals until diastolic BP is around 90mmHg						
20. Record drug administration and findings on the woman's records.						

CHECKLIST 3.3: MANAGEMENT OF SEVERE PRE-ECLAMPSIA/ECLAMPSIA

(To be used by the facilitator at the end of the module)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

Participant/Student: _____Date Observed: _____

CHECKLIST FOR MANAGEMENT OF SEVERE PRE-ECLAMPSIA/ECLAMPSIA (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Greets the woman respectfully and with kindness.					
2. Tells the woman (and her support person) what is going to be done and encourage her to ask.					
3. Listens to her and respond attentively					
4. Provide continual emotional support and reassurance					
IMMEDIATE MANAGEMENT Note: different steps could be carried out simultaneously					
1. **SHOUTS FOR HELP**					
2. Turn the woman onto her left side					
3. Ensures airway is open: • Begins resuscitation measures if necessary					
4. Gives oxygen at 4–6 L per minute by mask or cannulae.					
5. Establishes an IV line and give normal saline or Ringer's lactate					
7. Checks vital signs					

CHECKLIST FOR MANAGEMENT OF SEVERE PRE-ECLAMPSIA/ECLAMPSIA (Some of the following steps/tasks should be performed simultaneously.)						
STEP/TASK	**CASES**					
INITIATE ANTICONVULSIVE THERAPY (MAGNESIUM SULPHATE) ***NOTE: Give only the loading doses as below and refer urgently to a higher facility. Provide supportive care until referral is arranged.***						
Administering Loading Dose of Magnesium Sulphate						
8. Wash hands thoroughly with soap and water and dry.						
9. Tells the woman that she may experience a feeling of warmth when magnesium sulphate is given.						
10. Draws up 4 grams of magnesium sulphate (20 ml of 20% solution).						
11. Gives by IV injection SLOWLY over 5 minutes.						
12. Draw up 10 grams of magnesium sulphate (20ml of 50% solution) with 1 ml of 2% lignocaine in the same syringe.						
13. Give 5 grams (10 ml) by DEEP IM injection in upper outer quadrant of one buttock, replace the needle and inject the remaining 5 grams by DEEP IM injection into the other buttock.						
14. If disposing of needle and syringe, place in puncture proof container.						
15.Wash hands thoroughly with soap and water and dry.						
16. If convulsions recur AFTER 15 minutes give 2 grams of magnesium sulphate (10 ml of 20% solution or 4ml of 50% solution) IV injection SLOWLY over 5 minutes.						
17.Record drug administration and findings on the woman's record						
Administering Maintenance Dose of Magnesium Sulphate						
18. Give 5 grams of magnesium sulphate (10 mL of 50% solution), together with 1 mL of 2% lignocaine in the same syringe, by DEEP IM injection into alternate buttocks						
19. Before repeat administration check respiratory rate, patellar reflexes and urinary output. WITHHOLD or DELAY drug if necessary.						
20. If respiratory arrest occurs assist ventilation and gives calcium gluconate 1 g (10 ml of 10% solution) by IV injection SLOWLY until respiration begins.						
ANTICONVULSIVE THERAPY (DIAZEPAM) Note: **Diazepam should be used ONLY if magnesium sulphate is not available.**						
Administering Loading Dose of Diazepam						
1.Wash hands thoroughly with soap and water and dry.						

CHECKLIST FOR MANAGEMENT OF SEVERE PRE-ECLAMPSIA/ECLAMPSIA (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
2. Draw up 10 mg of diazepam and give by IV injection SLOWLY over 2 minutes.					
3. Dispose of needle and syringe in puncture-proof container.					
4. Wash hands thoroughly with soap and water and dry.					
5. If convulsions recur, repeat loading dose.					
Administering Maintenance Dose of Diazepam					
6. Give 40 mg of diazepam in 500 mL of IV fluid at a rate that keeps the woman sedated but rousable.					
7. If respiratory depression occurs assist ventilation, if necessary					
Administering Diazepam Rectally (when IV access is not possible)					
8. Wash hands thoroughly with soap and water and dry.					
9. Draw up 20 mg of diazepam in a 10 mL syringe and remove the needle from the syringe.					
10. Lubricate the barrel of the syringe and insert the syringe into the rectum to half its length.					
11. Discharge the contents of the syringe into the rectum and leave the syringe in place and hold the buttocks together for 10 minutes.					
12. If convulsions are not controlled within 10 minutes, administers an additional 10 mg of diazepam per hour.					
13. Record drug administration and findings on the woman's records.					
CONTROL BLOOD PRESSURE (ANTI-HYPERTENSIVE THERAPY) **Note:** The goal is to keep the diastolic pressure between 90 and 100 mm Hg					
14. If the diastolic pressure is 110 mm Hg or more: • Give hydralazine 5 mg IV slowly (3-4 minutes). • If hydralazine is not available, give labetalol 10 mg IV o OR Nifedipine 5mg under the tongue					
15. If diastolic blood pressure remains > 90 mmHg, repeat the dose at 30 minute intervals until diastolic BP is around 90mmHg					
16. Record drug administration and findings on the woman's records.					

ROLE PLAYS, CASE-STUDIES AND CLINICAL SIMULATIONS

ROLE PLAY 3-1: VAGINAL BLEEDING IN EARLY PREGNANCY: COMMUNICATING ABOUT COMPLICATIONS DURING PREGNANCY

DIRECTIONS

The facilitator will select three participants to perform the following roles: skilled provider, antenatal patient and patient's husband. The three participants participating in the role play should take a few minutes to prepare for the activity by reading the background information provided below. The remaining learners, who will observe the role play, should at the same time read the background information.

The purpose of the role play is to provide an opportunity for participants to appreciate the importance of good interpersonal communication skills when providing care for a woman who experiences an obstetric complication.

PARTICIPANT ROLES

Provider: The provider is an experienced doctor who has good interpersonal communication skills.

Patient: Mamitu, who is 12 weeks pregnant, is a 25-year-old housewife, gravida two. She has a healthy 3-year-old daughter.

Patient's husband: Fantu is also 25 years old and works as a driver in a government office.

SITUATION

Mamitu's husband has brought her to the emergency department of the district hospital because she has vaginal bleeding. She has been assessed by the doctor, who has started an IV infusion to replace blood loss. Mamitu's diagnosis is incomplete abortion. She has no symptoms or signs of shock; however, both she and her husband are very upset and anxious about her condition. Mamitu's pregnancy was planned, and she and her husband were looking forward to completing their family with the birth of a second child. The doctor must tell Mamitu that it will be necessary to evacuate the remaining products of conception from her uterus, explaining the nature of the procedure and the risks involved.

FOCUS OF THE ROLE PLAY

The focus of the role play is the interpersonal interaction between the doctor and the patient and the appropriateness of the doctor's verbal and nonverbal communication skills.

DISCUSSION QUESTIONS

The facilitator should use the following questions to facilitate discussion after the role play:

1. **How did the doctor explain the procedure and the associated risks to Mamitu and her husband?**

2. **What nonverbal behaviors did the doctor use to encourage interaction among her/himself, Mamitu and her husband?**

3. **How did the doctor ensure that Mamitu and her husband understood what s/he had told them?**

CASE STUDY 3-1: VAGINAL BLEEDING DURING EARLY PREGNANCY

DIRECTIONS

Read and analyze this case study individually. When the others in your group have finished reading it, answer the case study questions. Consider the steps in clinical decision-making as you answer the questions. The other groups in the room are working on the same or a similar case study. When all groups have finished, we will discuss the case studies and the answers each group has developed.

CASE STUDY

Derartu is 28 years old. She is 12 weeks pregnant when she presents at the health center complaining of light vaginal bleeding. This is Derartu's first pregnancy. It is a planned pregnancy, and she has been well until now.

ASSESSMENT (History, Physical Examination, Screening Procedures/Laboratory Tests)

1. What will you include in your initial assessment of Derartu, and why?
2. What particular aspects of Derartu's physical examination will help you make a diagnosis or identify her problems/needs, and why?
3. What causes of bleeding do you need to rule out?

DIAGNOSIS (Identification of Problems/Needs)

You have completed your assessment of Derartu, and your main findings include the following:

- Derartu's temperature is 36.8º C, her pulse rate is 82 beats/minute and her blood pressure is 110/70 mm Hg.
- She has no skin pallor or sweating.
- She has slight lower abdominal cramping/pain and light vaginal bleeding.
- Her uterine size is equal to dates, she has no uterine tenderness and no cervical motion tenderness, and the cervix is closed.

4. Based on these findings, what is Derartu's diagnosis, and why?

CARE PROVISION (Planning and Intervention)

5. Based on your diagnosis, what is your plan of care for Derartu, and why?

EVALUATION

- Derartu returns to the health center in 3 days.
- She reports that the bleeding became heavier last night, and that since then she has been having cramping and lower abdominal pain.
- She has not passed any products of conception, her uterus corresponds to dates and her cervix is now dilated.
- She has no signs or symptoms of shock.
- Derartu is very upset about the possibility of miscarrying.

6. Based on these findings, what is your continuing plan of care for Derartu, & why?

CASE STUDY 3-2: ELEVATED BLOOD PRESSURE DURING PREGNANCY

DIRECTIONS

Read and analyze this case study individually. When the others in your group have finished reading it, answer the case study questions. Consider the steps in clinical decision-making as you answer the questions. The other groups in the room are working on the same or a similar case study. When all groups have finished, we will discuss the case studies and the answers each group has developed.

CASE STUDY

Shewit is 34 years old. She is 18 weeks pregnant. She attended the antenatal clinic 1 week ago, when it was found that her diastolic blood pressure was 100 mm Hg on two readings taken 4 hours apart. Shewit reports that she has had high blood pressure for years, which has not been treated with antihypertensive drugs. She does not know what her blood pressure was before she became pregnant. She moved to the district 6 months ago and her medical record is not available. She has come back to the antenatal clinic, as requested, 1 week later for follow-up.

ASSESSMENT (History, Physical Examination, Screening Procedures/Laboratory Tests)

1. What will you include in your initial assessment of Shewit, and why?
2. What particular aspects of Shewit's physical examination will help you make a diagnosis or identify her problems/needs, and why?
3. What screening procedures/laboratory tests will you include (if available) in your assessment of Shewit, and why?

DIAGNOSIS (Identification of Problems/Needs)

You have completed your assessment of Shewit and your main findings include the following:

- Shewit's diastolic blood pressure is 100 mm Hg.
- Her urine is negative for protein.
- She is feeling well and has no adverse symptoms (headache, visual disturbance or upper abdominal pain).
- Uterine size is consistent with dates.
- It has not been possible to obtain Shewit's medical record.

4. Based on these findings, what is Shewit's diagnosis, and why?

CARE PROVISION (Planning and Intervention)

5. Based on your diagnosis, what is your plan of care for Shewit, and why?

EVALUATION

- Shewit returns to the antenatal clinic in 1 week.
- She feels well and has no adverse symptoms.
- Her diastolic blood pressure is 100 mm Hg.
- Her medical record has been obtained and her pre-pregnancy blood pressure is noted as 140/100 mm Hg.

6. Based on these findings, what is your continuing plan of care for Shewit, and why?

CASE STUDY 3-3: PREGNANCY-INDUCED HYPERTENSION

DIRECTIONS

Read and analyze this case study individually. When the others in your group have finished reading it, answer the case study questions. Consider the steps in clinical decision-making as you answer the questions. The other groups in the room are working on the same or a similar case study. When all groups have finished, we will discuss the case studies and the answers each group has developed.

CASE STUDY

Fatuma is 16 years old. She is 30 weeks pregnant and has attended the antenatal clinic three times. All findings were within normal limits until her last antenatal visit 1 week ago. At that visit, it was found that her blood pressure was 130/90 mm Hg. Her urine was negative for protein. The fetal heart sounds were normal, the fetus was active and uterine size was consistent with dates. She has come to the clinic today, as requested, for follow-up.

ASSESSMENT (History, Physical Examination, Screening Procedures/Laboratory Tests)

1. What will you include in your initial assessment of Fatuma, and why?
2. What particular aspects of Fatuma's physical examination will help you make a diagnosis, and why?
3. What screening procedures/laboratory tests will you include in your assessment of Fatuma, and why?

DIAGNOSIS (Identification of Problems/Needs)

You have completed your assessment of Fatuma and your main findings include the following:

- Fatuma's blood pressure is 130/90 mm Hg, and she has proteinuria 1+.
- She has no symptoms suggesting severe pre-eclampsia (headache, visual disturbance, upper abdominal pain, convulsions or loss of consciousness).
- The fetus is active and fetal heart sounds are normal. Uterine size is consistent with dates.

4. Based on these findings, what is Fatuma's diagnosis, and why?

CARE PROVISION (Planning and Intervention)

5. Based on your diagnosis, what is your plan of care for Fatuma, and why?

EVALUATION

- Fatuma attends antenatal clinic on a twice-weekly basis, as requested.

- Her blood pressure remains the same, she continues to have proteinuria 1+, and the fetal growth is normal.
- Four weeks later, however, her blood pressure is 130/90 mm Hg and she has proteinuria 2+.
- Fatuma has not suffered headache, blurred vision, upper abdominal pain, convulsions or loss of consciousness and says that she feels well.
- However, she finds it very tiring to have to travel to the clinic by bus twice weekly for follow-up and wants to come only once a week.

6. Based on these findings, what is your continuing plan of care for Fatuma, and why?

CASE STUDY 3-4: PREGNANCY-INDUCED HYPERTENSION

DIRECTIONS

Read and analyze this case study individually. When the others in your group have finished reading it, answer the case study questions. Consider the steps in clinical decision-making as you answer the questions. The other groups in the room are working on the same or a similar case study. When all groups have finished, we will discuss the case studies and the answers each group has developed.

CASE STUDY

Zermechit is 23 years old. She is 37 weeks pregnant and has attended the antenatal clinic four times. No abnormal findings were detected during antenatal visits, the last of which was 1 week ago. Zermechit has been counseled about danger signs in pregnancy and what to do about them. Her mother has brought her to the health center because she developed a severe headache and blurred vision this morning.

ASSESSMENT (History, Physical Examination, Screening Procedures/Laboratory Tests)

1. What will you include in your initial assessment of Zermechit, and why?
2. What particular aspects of Zermechit's physical examination will help you make a diagnosis or identify her problems/needs, and why?
3. What screening procedures/laboratory tests will you include (if available) in your assessment of Zermechit, and why?

DIAGNOSIS (Identification of Problems/Needs)

You have completed your assessment of Zermechit and your main findings include the following:

- Zermechit's blood pressure is 160/110 mm Hg, and she has proteinuria 3+.
- She has a severe headache that started 3 hours ago.
- Her vision became blurred 2 hours after the onset of headache.
- She has no upper abdominal pain and has not suffered convulsions or loss of consciousness.
- Her reflexes are normal.
- The fetus is active and fetal heart sounds are normal.
- Uterine size is consistent with dates.

4. Based on these findings, what is Zermechit's diagnosis, and why?

CARE PROVISION (Planning and Intervention)

5. Based on your diagnosis, what is your plan of care for Zermechit, and why?

EVALUATION

- Two hours following the initiation of treatment, Zermechit's diastolic blood pressure is 100 mm Hg.
- She has not had a convulsion, but still has a headache.
- She does not have coagulopathy.
- During the past 2 hours, however, Zermechit's urinary output has dropped to 20 mL/hour.
- The fetal heart rate has ranged between 120 and 140 beats/minute.

6. Based on these findings, what is your continuing plan of care for Zermechit, and why?

CLINICAL SIMULATION 3-1: MANAGEMENT OF HEADACHE, BLURRED VISION, CONVULSIONS OR LOSS OF CONSCIOUSNESS, ELEVATED BLOOD PRESSURE

Purpose: The purpose of this activity is to provide a simulated experience for participant to practice problem-solving and decision-making skills in the management of headache, blurred vision, convulsions or loss of consciousness, elevated blood pressure, with emphasis on thinking quickly and reacting (intervening) rapidly.

Instructions: The activity should be carried out in the most realistic setting possible, such as the labor and delivery area of a health center, clinic or maternity center, where equipment and supplies are available for emergency interventions.

- One participant should play the role of patient and a second participant the role of skilled provider. Other participant may be called on to assist the provider.
- The facilitator will give the participant playing the role of provider information about the patient's condition and ask pertinent questions, as indicated in the left-hand column of the chart on the next page.
- The participant/student will be expected to think quickly and react (intervene) rapidly when the facilitator provides information and asks questions. Key reactions/responses expected from the participant are provided in the right-hand column of the chart on the next page.
- Procedures such as starting an IV and giving oxygen should be role-played, using the appropriate equipment.
- Initially, the facilitator and participant will discuss what is happening during the simulation in order to develop problem-solving and decision-making skills. The italicized questions in the simulation are for this purpose. Further discussion may take place after the simulation is completed.
- As the participant's skills become stronger, the focus of the simulation should shift to providing appropriate care for the life-threatening emergency situation in a quick, efficient and effective manner. All discussion and questioning should take place after the simulation is over.

***Resources**: Learning Guide sphygmomanometer, stethoscope, equipment for starting an IV infusion, syringes and vials, oxygen cylinder, mask and tubing, equipment for bladder catheterization, reflex hammer (or similar device), high-level disinfected or sterile surgical gloves.*

SCENARIO - 1 **(Information provided and questions asked by the facilitator)**	***KEY REACTIONS/RESPONSES*** **(Expected from participant)**
1. Ayantu is 16 years old and is 37 weeks pregnant. This is her first pregnancy. She has presented to the labor unit with contractions and says that she has had a bad headache all day. She also says that she cannot see properly. While she is getting up from the examination table she falls back onto the pillow and begins to have a convulsion. • What will you do?	• **Shout** for help to urgently mobilize all available personnel • Check airway to ensure that it is open, and turn Ayantu onto her left side • Protect her from injuries (fall) but does not attempt to restrain her • Have one of the staff members who responded to you shout for help take Ayantu's vital signs (temperature, pulse, blood pressure and respiration rate) and check her level of consciousness, color and temperature of skin • Have another staff member start oxygen at 4–6 L/minute • Prepare and give magnesium sulfate 20% solution, 4 g IV over 5 minutes • Follow promptly with 10 g of 50% magnesium sulfate solution, 5 g in each buttock deep IM injection with 1 mL of 2% lignocaine in the same syringe • At the same time, explain to the family what is happening and talk to the woman as appropriate
Discussion Question 1*: What would you do if there was no magnesium sulfate in the health center?*	***Expected Response****: Use diazepam 10 mg slowly over 2 minutes.*
2. After 5 minutes, Ayantu is no longer convulsing. Her diastolic blood pressure is 110 mm Hg and her respiration rate is 20 breaths/minute. • What is Ayantu's problem? • What will you do next? • What should the aim be with respect to controlling Ayantu's blood pressure? • What other care does Ayantu require now?	• State that Ayantu's symptoms and signs are consistent with eclampsia • Give hydralazine 5 mg IV slowly every 5 minutes until diastolic blood pressure is lowered to between 90–100 mm Hg • State that the aim should be to keep Ayantu's diastolic blood pressure between 90 mm Hg and 100 mm Hg to prevent cerebral hemorhage • Have one of the staff assisting with the emergency insert an indwelling catheter to monitor urinary output and proteinuria • Have a second staff member start an IV infusion of normal saline or Ringer's lactate and draw blood to assess clotting status using a bedside clotting test • Maintain a strict fluid balance chart

SCENARIO 1 (continuation)	***KEY REACTIONS/RESPONSES (continuation)***
***Discussion Question 2**: Would you give additional hydralazine after the first dose?*	***Expected Response**: Repeat hourly as needed, or give 12.5 mg IM every 2 hours as needed.*
3. After another 15 minutes, Ayantu's blood pressure is 94 mm Hg and her respiration rate is 16 breaths/minute. • What will you do now?	• Stay with Ayantu continuously and monitor blood pressure, pulse, respiration rate, patella reflexes and fetal heart • Check whether Ayantu has had any further contractions
4. It is now 1 hour since treatment was started for Ayantu. She is sleeping but is easily roused. Her blood pressure is now 90 mm Hg and her respiration rate is still 16 breaths/minute. She has had several more contractions, each lasting less than 20 seconds. • What will you do now?	• Continue to monitor blood pressure, pulse, respiration rate, reflexes and fetal heart • Monitor urine output and IV fluid intake • Monitor for the development of pulmonary edema by auscultating lung bases for rales • Assess Ayantu's cervix to determine whether it is favorable or unfavorable
5. It is now 2 hours since treatment was started for Ayantu. Her blood pressure is still 90 mm Hg and her respiration rate is still16 breaths/minute. All other observations are within expected range. She continues to sleep and rouses when she has a contraction. Contractions are occurring more frequently but still last less than 20 seconds. Ayantu's cervix is 100% effaced and 3 cm dilated. There are no fetal heart abnormalities. • What will you do now? • When should childbirth occur?	• Continue to monitor Ayantu as indicated above • State that membranes should be ruptured using an amniotic hook or a Kocher clamp and labor induced using oxytocin or prostaglandins • State that childbirth should occur within 12 hours of the onset of Ayantu's convulsions
Scenario 2 (Information provided and questions asked by the facilitator)	***KEY REACTIONS/RESPONSES* (Expected from participant)**
1. Hana is 20 years old. She is 38 weeks pregnant. This is her second pregnancy. Her mother-in-law has brought Hana to the health center this morning because she has had a severe headache and blurred vision for the past 6 hours. Hana. says she feels very ill. • What will you do?	• **Shout** for help to urgently mobilize all available personnel • Place Hana on the examination table on her left side • Make a rapid evaluation of Hana's condition, including vital signs (temperature, pulse, blood pressure, and respiration rate), level of consciousness, color and temperature of skin • Simultaneously ask about the history of Hana 's present illness

Scenario 2 (continuation)	***KEY REACTIONS/RESPONSES* (continuation)**
2. Hana's diastolic blood pressure is 96 mm Hg, her pulse 100 beats/minute and respiration rate 20 breaths/minute. She has hyper-reflexia. Her mother-in-law tells you that Hana has had no symptoms or signs of the onset of labor. • What is Hana's problem? • What will you do now? • What is your main concern at the moment?	• State that Hana's symptoms and signs are consistent with severe pre-eclampsia • Have one of the staff who responded to your shout for help start oxygen at 4–6 L/minute • Prepare and give magnesium sulfate 20% solution, 4 g IV over 5 minutes • Follow promptly with 10 g of 50% magnesium sulfate solution, 5 g in each buttock deep IM injection with 1 mL of 2% lignocaine in the same syringe • At the same time, tell Hana (and her mother-in-law) what is going to be done, listen to them and respond attentively to their questions and concerns • State that the main concern at the moment is to prevent Hana from convulsing
3. After 15 minutes, Hana is resting quietly. She still has a headache and hyper-reflexia. • What will you do now? • What will you do during the next hour?	• Have one of the staff assisting with the emergency insert an indwelling catheter to monitor urinary output and proteinuria • Start an IV infusion of normal saline or Ringer's lactate • Listen to the fetal heart • State that during the next hour will continue to monitor vital signs, reflexes and fetal heart, and maintain a strict fluid balance chart
4. It is now 1 hour since treatment for Hana was started. Her diastolic blood pressure is still 96 mm Hg, pulse 100 beats/minute and respiration rate 20 breaths/minute. She still has hyper-reflexia. You detect that the fetal heart rate is 80. • What is your main concern now? • What will you do now?	• State that main concern now is fetal heart abnormality • State that Hana should be prepared to go the operating room for cesarean section • Tell Hana (and her mother-in-law) what is happening, listen to their concerns and provide reassurance

MODULE – 4:

CHILD BIRTH CARE

(LABOR, DELIVERY AND IMMEDIATE POST PARTUM)

Participant learning objective: after completing this module, participants will be able to describe the continuum of care, the care during child birth (labor, delivery and immediate postpartum) to save the lives of mothers and babies and promote overall health. It introduces the basic components in the provision of care to the mother and the newborn and the additional cares required for selected common problems to decrease maternal and perinatal morbidity and mortality

Enabling Objectives

1. Provide basic care to the woman and the fetus during labor.
2. Provide basic care to the woman and the fetus during delivery.
3. Provide basic care to the woman and the newborn in the immediate postpartum period.
4. Detect and provide care for complications during labor.
5. Detect and provide care for complications during delivery.
6. Detect and provide care for complications to the woman in the immediate postpartum period.
7. Recognize an emergency situation during labor, delivery and immediate postpartum period which requires immediate treatment and, in most cases, urgent referral to a higher level health facility.
8. Describe steps in rapid initial assessment and emergency management of a sick neonate delivered in the health facility.
9. Provide pre-referral management to a recognized emergency situation.

SKILLS PRACTICE S ESSION 4-1: ASSESSMENT OF THE WOMAN IN LABOR

PURPOSE

The purpose of this activity is to enable participants to practice assessment of the woman in labor, including history and physical examination, and achieve competency in the skills required.

INSTRUCTIONS

This activity should be conducted in a simulated setting using the appropriate pelvic and fetal models. Participants should review Learning Guide 4.1 before beginning the activity.

The facilitator should demonstrate the steps/tasks in taking a **history** from the woman in labor for participants. Under the guidance of the facilitator, participants should then work in groups of three to practice the steps/tasks and observe each other's performance; while one participant takes a history from another, the third participant should use the relevant section of Learning Guide 4.1 to observe performance. Participants should then reverse roles until each has had an opportunity to take a history and be observed. Participants should be able to perform the steps/tasks relevant to taking a history from the woman in labor before progressing to physical examination of the woman in labor.

The facilitator should demonstrate the steps/tasks in **physical examination** of the woman in labor for participants. Under the guidance of the facilitator, participants should then work in pairs and, using the childbirth simulator, practice the steps/tasks and observe each other's performance; while one participant does the physical examination, the second participant should use the relevant section of Learning Guide 4.1 to observe performance. Participants should then reverse roles. Participants should be able to perform all of the steps/tasks in Learning Guide 4.1 before skills competency is assessed in the simulated setting by the facilitator, using Checklist 4.1.

Finally, following supervised practice at a clinical site, the facilitator should assess the skills competency of each participant using Checklist 4.1.

RESOURCES

- Childbirth simulator
- Sphygmomanometer and stethoscope
- Fetal stethoscope
- Examination gloves
- 0.5% chlorine solution and receptacle for decontamination
- Leakproof container or plastic bag

The BEmONC
Learning Guide 4.1: Assessment of the Woman in Labor
Checklist 4.1: Assessment of the Woman in Labor

LEARNING GUIDE 4.1: ASSESSMENT OF THE WOMAN IN LABOR

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently

3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR ASSESSMENT OF THE WOMAN IN LABOR (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepare the necessary equipment.					
2. Greet the woman respectfully and with kindness.					
3. Tell the woman (and her support person) what is going to be done, listen to her attentively, and respond to her questions and concerns.					
4. Provide continual emotional support and reassurance, as possible.					
HISTORY **(Ask the following questions if the information is not available on the woman's ANC record)**					
Personal Identification					
1. What is your name, age, address, and phone number? • If the woman is less than 20 years of age, determine the circumstances surrounding the pregnancy and rule out an abusive or unsafe relationship and barriers to care.					
Present Pregnancy					
2. How many previous pregnancies and births have you had?					

LEARNING GUIDE FOR ASSESSMENT OF THE WOMAN IN LABOR (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
3. Do you have a complication readiness plan if there are any problems during labor or childbirth? • If Yes, confirm that arrangements have been made for all essential components of complication readiness. • If No, make arrangements for all essential components of complication readiness.					
4. Are you having a particular problem at present? If Yes, find out what the problem is and ask the following additional questions: • When did the problem first start? • Did it occur suddenly or develop gradually? • When and how often does the problem occur? • What may have caused the problem? • Did anything unusual occur before it started? • How does the problem affect you? • Are you eating, sleeping, and doing other things normally? • Has the problem become more severe? • Are there other signs and conditions related to the problem? If Yes, ask what they are. • Have you received treatment for the problem? If Yes, ask who provided the treatment, what it involved, and whether it helped.					
5. When is your baby due? • If she does not know, estimate gestational age using onset of signs and symptoms of pregnancy or first day of last menstrual period. • If she does know, but is less than 37 weeks gestation and labor has started, conduct a rapid initial assessment and manage according to findings.					
6. Did you receive antenatal care during this pregnancy? • If Yes, ask who provided antenatal care, how many visits, and what was included.					
7. Have you had any (other) problems during this pregnancy? If yes, follow-up questions (see item 4 above).					
Present Labor/Childbirth					
8. Have your membranes ruptured/waters broken? • If Yes, ask when, what color the fluid was, and whether it smelled foul/bad.					
9. Have regular contractions started? • If No, assess the woman for false labor. • If Yes, ask when they began.					

LEARNING GUIDE FOR ASSESSMENT OF THE WOMAN IN LABOR (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
10. How often are you having contractions and how long does each one last?					
11. Have you felt the baby move in the past 24 hours?					
12. Have you taken any alcohol, drugs, herbs, or other preparations in the last 24 hours?					
13. When did you last eat or drink?					
Obstetric History					
14. Have you had a cesarean section, ruptured uterus, or any surgery to the uterus during a previous childbirth?					
15. Have you had any other complications during a previous pregnancy, childbirth, or postpartum/newborn period (e.g., convulsions [pre-eclampsia/eclampsia] during previous pregnancy, extensive tears [third- or fourth-degree] during previous births, previous stillbirths, preterm or low birth weight babies, babies who died before one month of age)? • If Yes, obtain additional information about the particular complication(s).					
16. Have you had any previous problems breastfeeding?					
Medical History					
17. Do you have any allergies?					
18. Have you been tested for HIV? If yes, ask whether the result was positive.					
19. Have you had anemia recently (within last three months)? If Yes, obtain additional information about signs and symptoms and possible cause.					
20. Have you been tested for syphilis? If Yes, ask whether the result was positive and if and when and with what she was treated.					
21. Have you had any chronic illness/condition, such as tuberculosis, hepatitis, heart disease, diabetes, or other serious chronic diseases?					
22. Have you ever been in hospital or had surgery/an operation?					
23. Are you taking any drugs/medications (including traditions/local preparations, herbal remedies, over-the-counter drugs, vitamins, or dietary supplements)?					

LEARNING GUIDE FOR ASSESSMENT OF THE WOMAN IN LABOR (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
24. Have you had a complete series of five tetanus toxoid (TT) immunizations? If Yes, find out if it has been less than 10 years since the woman's last booster.					
PHYSICAL EXAMINATION					
Assessment of General Well-Being					
1. Wash hands thoroughly or use anti septic hand rub					
2. Observe gait and movements, and behavior and vocalizations. • If not normal for the woman's culture, ask if she : - has been without food or fluids for a prolonged period; - has been taking drugs, herbs, etc.; - has had an injury; - is in the middle of a contraction.					
3. Check skin, noting lesions or bruises.					
4. Check conjunctiva for pallor.					
Vital Signs Measurements					
5. Have the woman remain seated or lying down with knees slightly bent, ensuring that she is comfortable and relaxed.					
6. Observe breathing, noting gasping, wheezing, or rales.					
7. Measure blood pressure, temperature, and pulse.					
Visual Inspection of Breasts (This part of the examination should only be performed if the woman is in the latent [or early active] phase of the first stage of labor and is not in acute distress.)					
8. Explain to the woman the next steps in the physical examination and obtain her consent to proceed.					
9. Ask the woman to empty her bladder and to lie on the examination bed					
10. Ask the woman to uncover her body from the waist up					
11. Check the contours and skin of the breasts, noting dimpling or visible lumps, scaliness, thickening, redness, lesions, sores, and scars.					
12. Check the nipples, noting any abnormal discharge, and inversion of nipples: • If nipples appear inverted, test for protactility by placing the thumb and fingers on either side of areola and gently squeezing; • If the nipple goes in when it is gently squeezed, it is inverted.					

LEARNING GUIDE FOR ASSESSMENT OF THE WOMAN IN LABOR (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
Abdominal Examination					
13. Ask the woman to uncover her stomach.					
14. Check the surface of the abdomen: • If there is a scar ask if it is from a cesarean section or other uterine surgery.					
15. Check the shape of the uterus, noting if it is longer horizontally than vertically.					
Fundal Height					
16. Measure fundal height: • Place zero line of tape measure on the upper edge of symphysis pubis; • Stretch tape measure across the contour of abdomen to top of fundus; • Use the abdominal midline as line of measurement.					
Lie and Presentation					
18. Carry out fundal palpation: • Make sure hands are clean and warm; • Stand at the woman's side, facing her head; • Place both hands on the sides of the fundus; • Make sure woman is not having a contraction; • Apply gentle but firm pressure to assess consistency and mobility of the fetal part: ➢ the buttocks feel softer and more irregular than the head and cannot be moved independently of body; ➢ the head feels harder than the buttocks and can be moved back and forth with both hands.					
19. Carry out lateral palpation: • Move hands smoothly down sides of uterus to feel for fetal back: ➢ the back feels firm and smooth in contrast to the small parts, which will feel knobby and easily moveable; • Keep dominant hand steady against the side of uterus while using palm of other hand to apply gentle but deep pressure to explore opposite side of uterus; • Repeat procedure on other side of uterus.					

LEARNING GUIDE FOR ASSESSMENT OF THE WOMAN IN LABOR (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
20. Carry out pelvic palpation: • Turn and face the woman's feet (the woman's knees should already be bent slightly to relax abdominal muscles); • Place hands on either side of uterus with palms below the level of the umbilicus and fingers pointing to symphysis pubis; • Grasp fetal part snugly between hands: ➢ If fetal part is above symphysis pubis, feel shape, size, consistency and mobility; ➢ If head is presenting, a hard mass with a distinctive round surface will be felt; ➢ Observe the woman's face for signs of pain/tenderness during palpation.					
Descent					
21. Feel the head above symphysis pubis with right hand.					
22. Using abdominal palpation, assess descent in terms of fifths of head palpable above symphysis pubis: • Locate anterior shoulder of fetus with one hand; • Place fingers of other hand horizontally on the woman's abdomen above the symphysis pubis; • Calculate the number of finger-breadths of head above the symphysis pubis: ➢ A head that is entirely above the symphysis pubis is five-fifths (5/5) palpable; ➢ A head that is entirely below the symphysis pubis is zero-fifths (0/5) palpable.					
Fetal Heart Rate					
23. Between contractions, place fetal stethoscope (fetoscope) on the woman's abdomen at right angles to it (on same side that you palpated fetal back).					
24. Listen to the fetal heart rate: • Place your ear in close, firm contact with fetal stethoscope; • Move fetal stethoscope around to where fetal heart is heard most clearly; • Remove hands from fetal stethoscope and listen to fetal heart; • Listen for a full minute, counting beats against second hand of clock/watch; • Feel the woman's pulse at wrist, simultaneously, to ensure that fetal heart tones, and not maternal pulse, are being measured.					

LEARNING GUIDE FOR ASSESSMENT OF THE WOMAN IN LABOR (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
Contractions					
25. Place a hand on the woman's abdomen and palpate contractions from beginning of a contraction to end of contraction and on to beginning of next contraction.					
26. Use a clock or watch to calculate frequency and duration of contractions: • Frequency is the number of contractions in 10 minutes; • Duration of contractions is the number of seconds from the beginning to the end of a contraction.					
Genital Examination					
27. Ask the woman to uncover her genital area, and cover or drape her to preserve privacy and respect modesty.					
28. Ask the woman to separate her legs while continuing to bend her knees slightly.					
29. Turn on light and direct it toward genital area.					
30. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.					
31. Put new examination or high-level disinfected gloves on both hands.					
32. Touch the inside of the woman's thigh before touching any part of her genital area.					
33. Separate labia majora with two fingers, check labia minora, clitoris, urethral opening and vaginal opening, noting anything protruding from the vagina, signs of female genital cutting, sores, ulcers, warts, nits, lice, blood or foul-smelling discharge, urine, or stool coming from vaginal opening.					
34. Palpate the labia minora: • Look for swelling, discharge, tenderness, ulcers, and fistulas; • Feel for irregularities and nodules.					
35. Look at perineum, noting scars, lesions, inflammation, or cracks in skin.					
36. Separate labia with gloved hand and observe introitus for visible bulging of membranes or fetal head/parts.					
Vaginal Examination					

LEARNING GUIDE FOR ASSESSMENT OF THE WOMAN IN LABOR (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
37. Gently insert index and middle fingers of exam hand into vagina, maintaining light downward pressure, moving fingers toward cervix: • Palpate mucosa and structural integrity along vaginal walls; • Insert middle and index fingers into open cervix and gently open them to cervical rim. (The distance between the outer aspect of both fingers is the dilatation in centimeters.)					
38. Assess condition of amniotic fluid and membranes: • With middle and index fingers still inserted into cervix, evaluate if bag of water is intact or ruptured: ➢ presence of a smooth membrane palpated over presenting part indicates presence of intact bag of waters; ➢ if bag of waters is ruptured, presenting part will be felt directly.					
39. Assess presentation and position of fetus and molding: • With index fingers still inserted into cervix: ➢ Feel fetal skull to confirm cephalic presentation and assess molding, noting whether bones touch or overlap; ➢ Withdraw examination hand and inspect glove for blood and/or meconium.					
40. Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out and place in a plastic bag or leakproof, covered waste container					
41. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.					

CHECKLIST 4.1: ASSESSMENT OF THE WOMAN IN LABOR

(To be used by the **Trainer** at the end of the module)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

PARTICIPANT _____Date Observed _____

CHECKLIST FOR ASSESSMENT OF THE WOMAN IN LABOR (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepares the necessary equipment.					
2. Greets the woman respectfully and with kindness.					
3. Tells the woman (and her support person) what is going to be done, listens to her attentively, and responds to her questions and concerns.					
4. Provides continual emotional support and reassurance, as possible.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
HISTORY **(Asks the following questions if the information is not available on the woman's ANC record)**					
Personal Identification					
1. What is your name, age, address, and phone number?					
Present Pregnancy					
2. How many previous pregnancies and births have you had?					
3. Do you have a complication readiness plan if there are any problems during labor or childbirth?					
4. Are you having a particular problem at present?					

CHECKLIST FOR ASSESSMENT OF THE WOMAN IN LABOR (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
5. Have you received care from another caregiver?					
6. When is your baby due?					
7. Did you receive antenatal care during this pregnancy?					
8. Have you had any (other) problems during this pregnancy?					
Present Labor/Childbirth					
9. Have your membranes ruptured/waters broken?					
10. Have regular contractions started?					
11. How often are you having contractions and how long does each one last?					
12. Have you felt the baby move in the past 24 hours?					
13. Have you taken any alcohol, drugs, herbs, or other preparations in the last 24 hours?					
14. When did you last eat or drink?					
Obstetric History					
15. Have you had a cesarean section, ruptured uterus, or any surgery to the uterus during a previous childbirth?					
16. Have you had any other complications during a previous pregnancy, childbirth, or postpartum/newborn period?					
17. Have you had any previous problems breastfeeding?					
Medical History					
18. Do you have any allergies?					
19. Have you been tested for HIV?					
20. Have you had anemia recently?					
21. Have you been tested for syphilis?					
22. Have you had any chronic illness/condition, such as tuberculosis, hepatitis, heart disease, diabetes, or other serious chronic disease?					
23. Have you ever been in hospital or had surgery/an operation?					
24. Are you taking any drugs/medications?					
25. Have you had a complete series of five tetanus toxoid (TT) immunizations?					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

CHECKLIST FOR ASSESSMENT OF THE WOMAN IN LABOR (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
PHYSICAL EXAMINATION					
Assessment of General Well-Being					
1. Observes gait and movements, and behavior and vocalizations.					
2. Checks skin, noting lesions or bruises.					
3. Checks conjunctiva for pallor.					
Vital Signs Measurements					
4. Have the woman remain seated or lying down, ensuring that she is comfortable and relaxed, and observe breathing and measure blood pressure, temperature, and pulse.					
Visual Inspection of Breasts (This part of the examination should only be performed if the woman is in the latent [or early active] phase of the first stage of labor and is not in acute distress.)					
5. Explains to the woman the next steps in the physical examination and obtains her consent to proceed.					
6. Asks the woman to empty her bladder.					
7. Asks the woman to uncover her body from the waist up, have her remain seated with her arms at her sides, and checks her breasts, noting any abnormalities.					
Abdominal Examination					
8. Asks the woman to uncover her stomach and lie on her back with her knees slightly bent.					
9. Checks the surface of the abdomen and the shape of the uterus, and measure fundal height.					
10. Makes sure hands are clean and warm.					
11. Stands at the woman's side, facing her head, make sure she is not having a contraction, and determines fetal lie and presentation.					
12. Determines descent through abdominal palpation.					
13. Between contractions, listens to fetal heart for a full minute.					
14. Palpates contractions from beginning of a contraction to end of contraction and on to beginning of next contraction.					

CHECKLIST FOR ASSESSMENT OF THE WOMAN IN LABOR (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
Genital and Vaginal Examination					
15. Asks the woman to uncover her genital area, covers or drapes her to preserve privacy and respect modesty, and asks her to separate her legs while keeping her knees slightly bent.					
16. Turns on light and directs it toward genital area.					
17. Washes hands thoroughly and puts new examination or high-level disinfected gloves on both hands.					
18. Inspects the labia, clitoris, and perineum and palpates the labia minora, noting any abnormalities.					
19. Assesses dilatation of cervix, membranes, and presenting part.					
21. Immerses both gloved hands briefly in a container filled with 0.5% chlorine solution; then removes gloves by turning them inside out and places in a plastic bag or leakproof, covered waste container					
22. Washes hands thoroughly.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

SKILLS PRACTICE SESSION 4-2: ASSISTING IN NORMAL BIRTH

PURPOSE

The purpose of this activity is to enable participants to practice conducting assisting in normal birth and achieve competency in the skills required.

INSTRUCTIONS

This activity should be conducted in a simulated setting, using the childbirth simulator.

Participants should review Learning Guide 4.2 before beginning the activity. The facilitator should demonstrate the steps/tasks in **assisting the birth** (up to but not including active management of third stage). Under the guidance of the facilitator, participants should then work in pairs and, using the childbirth simulator, practice the steps/tasks and observe each other's performance; while one participant assists the birth, the second participant should use the relevant section of Learning Guide 4.2 to observe performance. Participants should then reverse roles. Participants should be able to perform the steps/tasks relevant to assisting the birth before progressing to active management of third stage, examination of placenta, and inspection of vagina and perineum.

The facilitator should demonstrate the steps/tasks in **active management of third stage**, as well as the following steps of **examination of the placenta and inspection of the vagina and perineum for tears**. Under the guidance of the facilitator, participants should then work in pairs and, using the childbirth simulator, practice the steps/tasks and observe each other's performance; while one participant performs active management of third stage, examination of the placenta, and inspection of the vagina and perineum for tears, the second participant should use the relevant section of Learning Guide 4.2 to observe performance. Participants should then reverse roles. Participants should be able to perform all of the steps/tasks in Learning Guide 4.2 before skills competency is assessed in the simulated setting by the facilitator, using Checklist 4.2.

Finally, following supervised practice at a clinical site, the facilitator should assess the skills competency of each participant, using Checklist 4.2.

RESOURCES

- Childbirth simulator
- High-level disinfected or surgical gloves
- Personal protective barriers
- Delivery kit/pack
- 0.5% chlorine solution and receptacle for decontamination
- Leakproof container or plastic bag
- The BEmONC
- Learning Guide 4.2: Assisting in Normal Birth
- Checklist 4.2: Assisting in Normal Birth

LEARNING GUIDE 4.2: ASSISTING NORMAL CHILDBIRTH (INCLUDING IMMEDIATE NEWBORN CARE AND ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOR)

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently

3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR ASSISTING NORMAL BIRTH (Some of the following steps/tasks should be performed simultaneously.)						
STEP/TASK	***CASES***					
GETTING READY						
1. Washes hands with soap and running water and dries						
2. Prepares sterile delivery kit and other essential materials						
3. Encourages the woman to adopt the position of choice and continue spontaneous bearing down efforts.						
4. Tells the woman what is going to be done, listens to her, and responds attentively to her questions and concerns.						
5. Provides continual emotional support and reassurance, as feasible.						
6. Puts on personal protective barriers.						
ASSISTING THE BIRTH						
1. Washes hands thoroughly, put on 2 pairs sterile surgical gloves.						
2. Wait until head is visible and perineum distending. Ask woman to pant or give only small pushes with contractions.						
3. Clean the woman's perineum with antiseptic solution or soap and water, using gauze compress or cloth, wiping from front to back						
4. Place one sterile drape from delivery pack under the woman's buttocks and one over her abdomen						

LEARNING GUIDE FOR ASSISTING NORMAL BIRTH (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	***CASES***				
5. Control the birth of the head with the fingers of one hand to maintain flexion, allow natural stretching of the perineal tissue, and prevent tears, and use the other hand to support the perineum.					
6. Check that the eyes and mouth are clear of mucus and membranes. -Wipe with gauze if needed - especially if meconium stained liquor					
7. Feel around the baby's neck for the cord and respond appropriately if the cord is present: - If cord is loose slip over the head or under the baby body. - If tight, clamp the cord and cut					
8. Allow the baby's head to turn spontaneously and with the hands on either side of the baby's head, deliver the anterior shoulder.					
9. When the arm fold is seen, guide the head upward as the posterior shoulder is born over the perineum and lift the baby's head interiorly to deliver the posterior shoulder.					
10. Support the rest of the baby's body with both hands as it slides out and place the baby on the mother's abdomen.					
11. Note the time and sex of the baby and tell the mother.					
12. Thoroughly dry the baby and assess breathing. If baby does not breathe immediately, begin resuscitative measures (**see Learning Guide: Newborn Resuscitation)**.					
13. Remove wet towel and ensure that the baby is kept warm, using skin-to-skin contact on the mother's chest. Cover the baby with a cloth or blanket, including the head (with hat if possible).					
14. Palpate the mother's abdomen to rule out the presence of additional baby (ies) and proceed with active management of the third stage.					
ACTIVE MANAGEMENT OF THIRD STAGE OF LABOR					
15. If no additional baby, give oxytocin 10 units IM within one minute of birth					
16. Changes gloves or remove top pair.					
17. Clamp and cut the cord approximately 2-3 minutes after birth: - Clamp the cord at about 3 cm from the umbilicus and apply second clamp 2 cm apart, tie securely between clamps and cut with sterile scissors or blade.					

LEARNING GUIDE FOR ASSISTING NORMAL BIRTH (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	***CASES***				
18. Clamp the cord close to the perineum using sponge forceps. Hold the clamped cord and the end of forceps with one hand.					
19. Wait for a uterine contraction.					
20. With onset of the uterine contraction put the other hand above pubic bone, apply counter traction in an upward direction (towards the woman's head) to stabilize the uterus					
21. At the same time with the hand holding the clamped cord, pull with a firm, steady tension on the cord in a downward direction (follow direction of the birth canal.)					
22. If the placenta does not descend during 30 to 40 seconds of controlled cord traction, relax the tension and repeat with the next contraction.					
23. As the placenta emerges, deliver placenta slowly with hands, gently turning the entire placenta and lifting it up and down until membranes deliver.					
24. Immediately after placenta delivers, massage uterus until firm.					
Examination of Placenta and Membranes					
25. Hold the placenta with both palms of the hands, with maternal side facing upwards and check whether all lobules are present by fitting them together					
26. Turn the placenta and hold cord with one hand and allow membranes to hang down: insert hand and spread fingers out to inspect membranes for completeness.					
27. If one or more of the lobules missing perform manual removal using Learning Guide: Manual removal of placenta					
28. Dispose of the placenta and membranes into bucket lined with plastic bag or as culturally appropriate.					
Examination of Vagina and Perineum Tears					
29. Gently examine the vulva, perineum and vagina for lacerations/tears and carry out appropriate repair as needed.					
30. If 1st or 2nd degree tear/laceration: Repair using Learning Guide: perineum laceration/tear. If 3rd or 4th degree tear: Facilitate urgent transfer or referral to higher level facility					
31. Gently clean perineum with a warm non alcohol solution or soapy water and clean area beneath the woman and apply a pad or cloth to vulva.					

LEARNING GUIDE FOR ASSISTING NORMAL BIRTH (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	***CASES***				
32. Assist the mother to a comfortable position for continued breastfeeding and bonding with her newborn					
POST-PROCEDURE TASKS					
1. Dispose of contaminated items in a plastic bag or leakproof, covered waste container.					
2. Decontaminate instruments by placing in a container filled with 0.5% chlorine solution for 10 minutes.					
3. If disposing of needle and syringe, hold the needle under the surface of a 0.5% chlorine solution, fill the syringe, and push out (flush) three times; then place in a puncture-resistant sharps container.					
4. Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out. If disposing of gloves (examination gloves and surgical gloves that will not be reused), place in a plastic bag or leakproof, covered waste container.					
5. Wash hands thoroughly with soap and water					
6. Record all information on record including estimated blood loss.					
Immediate post partum and newborn care					
Observation of the baby:					
1. Check baby's temperature every 15 minutes for 1 hour by touching his/her chest.					
2. Encourage and support the mother in initiating breastfeeding within the first hour after birth.					
Immediate care of newborn:					

LEARNING GUIDE FOR ASSISTING NORMAL BIRTH (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	***CASES***				
3. After the baby has breastfed: • Identify the baby • Weigh the baby and record • Perform eye care with Tetracycline ointment • Give Vitamin K 1mg IM • Check the cord; if there is bleeding from the cord, retie it if necessary. • Ensure the baby is dressed warmly and with the mother • Explain to mother importance of delayed bathing and not to apply anything to the skin or cord					
Care of the mother:					
4. Monitors the woman every 15 minutes in the first hour, 30 minutes in the next two hours and 1hourly in the next four hours after complete delivery of the placenta checking: • Uterine tone • Vaginal bleeding • Blood pressure • Pulse • Hydration					
5. Encourage the woman to pass urine					
6. Encourage the woman to eat and drink.					
7. Encourage the woman to stay in the facility for at least 6 hours					
8. Record the information on the woman's clinical record.					

CHECKLIST 4.2: ASSISTING NORMAL BIRTH (INCLUDING IMMEDIATE NEWBORN CARE AND ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOR)

(To be used by the facilitator at the end of the module)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

Participant/Student: _____Date Observed: _____

CHECKLIST FOR ASSISTING NORMAL BIRTH (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Washes hands and prepares the necessary equipment.					
2. Encourages the woman to adopt the position of choice and continue spontaneous bearing down efforts.					
3. Tells the woman what is going to be done, listens to her, and responds					
4. Provides continual emotional support and reassurance					
5. Puts on personal protective barriers.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
ASSISTING THE BIRTH					
6. Washes hands thoroughly, and puts on 2 pairs of sterile surgical gloves.					
7. Cleans the woman's perineum and places one drape under the woman's buttocks and one over her abdomen - ask woman to pant or give only small pushes with contractions.					
8. Controls the birth of the head with the fingers of one hand to maintain flexion, allow natural stretching of the perineal tissue, and prevents tears, and use the other hand to support the perineum.					

CHECKLIST FOR ASSISTING NORMAL BIRTH (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
9. Wipes mucous or membranes with gauze if needed from baby's eyes and mouth					
10. Feels around the baby's neck for the cord and respond appropriately if the cord is present.					
11. Allows the baby's head to turn spontaneously and, with the hands on either side of the baby's head, delivers the anterior shoulder.					
12. When the arm fold is seen, guides the head upward as the posterior shoulder is born over the perineum and lifts the baby's head anteriorly to deliver the posterior shoulder.					
13. Supports the rest of the baby's body with both hand as it slides out, and places the baby on the mother's abdomen.					
14. Notes the time and sex of the baby and tells the mother.					
15. Thoroughly dries the baby and assess breathing. If baby does not breathe immediately, begins resuscitative measures (see **Checklist-Newborn Resuscitation**).					
16. Removes wet towel and ensures that the baby is kept warm, using skin-to-skin contact on the mother's chest. Covers the baby with a cloth or blanket, including the head (with hat if possible).					
17. Palpates the mother's abdomen to rule out the presence of additional baby (ies) and proceeds with active management of the third stage.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
ACTIVE MANAGEMENT OF THIRD STAGE OF LABOR					
33. If no additional baby, gives oxytocin 10 units IM within one minute of birth					
34. Changes gloves or removes top pair.					
35. Clamps and cuts the cord approximately 2-3 minutes after birth.					
36. Waits for a uterine contraction and clamp the cord close to the perineum					
37. Applies counter traction in an upward direction to stabilize the uterus.					
38. At the same time with the other hand, pulls with a firm, steady tension on the cord in a downward direction					
39. Delivers placenta with both hands, gently turning the entire placenta and lifting it up and down					

CHECKLIST FOR ASSISTING NORMAL BIRTH (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
40. Immediately after placenta delivers, massages uterus until firm.					
41. Examines the placenta, membranes, and cord and disposes into bucket lined with plastic bag or as culturally appropriate.					
42. Examines the vulva, perineum and vagina for lacerations/tears and carries out appropriate repair as needed.					
43. Cleanses perineum and area beneath the woman and applies a pad or cloth to vulva.					
44. Assists the mother to a comfortable position for continued breastfeeding and bonding with her newborn					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
POST-PROCEDURE TASKS					
1. Disposes of contaminated items in a plastic bag or leakproof, covered waste container.					
2. Decontaminates instruments by placing in a container filled with 0.5% chlorine solution for 10 minutes.					
3. Decontaminates needle and syringe, hold the needle under the surface of a 0.5% chlorine solution, fills the syringe, and pushes out (flush) three times; then places in a puncture-resistant sharps container.					
4. Immerses both gloves in 0.5% chlorine solution and removes gloves by turning them inside out.					
5. Washes hands					
6. Records all information on record including estimated blood loss.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
IMMEDIATE POST PARTUM AND NEWBORN CARE					
Immediate care of newborn:					

CHECKLIST FOR ASSISTING NORMAL BIRTH (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
7. After the baby has breastfed: • Checks baby's temperature every 15 minutes for 1 hour by touching his/her chest. • Identifies the baby • Weighs the baby and record • Performs eye care • Gives Vit K IM • Checks the cord • Ensures the baby is dressed warmly and with the mother • Explains to mother importance of delayed bathing and not to apply anything to the skin or cord					
Care of the mother:					
8.Monitors the woman every 15 minutes in the first hour after complete delivery of the placenta checking: • Uterine tone • Vaginal bleeding • Blood pressure • Pulse • Hydration					
9. Encourages the woman to pass urine					
10. Encourages the woman to eat and drink.					
11. Encourages the woman to stay in the facility for at least 6 hours					
12. Records the information on the woman's clinical record.					

SKILLS PRACTICE SESSION 4-3: NEWBORN RESUSCITATION (HBB)

PURPOSE

The purpose of this activity is to enable participants to practice newborn resuscitation using a bag and mask and achieve competency in the skills required.

INSTRUCTIONS

This activity should be conducted in a simulated setting, using the appropriate model.

Participants should review Learning Guide 4.3, before beginning the activity.

The facilitator should demonstrate the steps/tasks in the procedure of newborn resuscitation using a bag and mask. Under the guidance of the facilitator, participants should then work in pairs to practice the steps/tasks and observe each other's performance, using Learning Guide 4.3.

Participants should be able to perform the steps/tasks in Learning Guide 4.3, before skill competency is assessed by the facilitator in the simulated setting, using Checklist 3.3.

Finally, following supervised practice at a clinical site, the facilitator should assess the skill competency of each participant, using Checklist 4.3.

Note: **Practice at a clinical site will depend on the availability of cases; if practice at a clinical site is not possible, the skill should be taught, practiced and assessed in a simulated setting, as described above.**

RESOURCES

- Table
- Newborn resuscitation model
- Cloth or baby blanket to wrap model
- Suction apparatus
- Self-inflating bag (newborn)
- Infant face masks, size 0 and size 1
- Clock
- The BEmONC
- Learning Guide 4.3: Newborn Resuscitation
- Checklist 4.3: Newborn Resuscitation

LEARNING GUIDE 4.3: HELPING BABY BREATH/NEWBORN RESUSCITATION

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently

3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR NEWBORN RESUSCITATION *(Some of the following steps/tasks should be performed simultaneously)*					
STEP/TASK	**CASES**				
GETTING READY					
Note: Newborn resuscitation equipment should be available and ready for use at all births. Hands should be washed and gloves worn before touching the newborn.					
1. Dry the baby, remove the wet cloth, and wrap the baby in a dry, warm cloth, if possible with head cap.					
2. Place the baby on his/her back on a clean, warm surface and keep covered except for the face and chest.					
3. Tell the woman (and her support person) what is going to be done, listen to her and respond attentively to her questions and concerns.					
4. Provide continual emotional support and reassurance, as feasible.					
RESUSCITATION USING BAG AND MASK					
1. Position the head in a slightly extended position to open the airway.					
2. Clear the airway by suctioning **the mouth** first and **then the nose**: • Introduce catheter into the baby's mouth for approximately 3cm and suction while withdrawing catheter • Introduce catheter into each nostril approximately 2cm and suction while withdrawing catheter					

LEARNING GUIDE FOR NEWBORN RESUSCITATION *(Some of the following steps/tasks should be performed simultaneously)*					
STEP/TASK	**CASES**				
3. Place the mask on the baby's face so that it covers the chin, mouth and nose.					
4. Squeeze the bag with two fingers only or with the whole hand, depending on the size of the bag.					
5. Check the seal by ventilating two or three times and observing the rise of the chest.					
6. If the baby's chest is rising, ventilate at a rate of 40 breaths per minute, and observe the chest for an easy rise and fall.					
7. If the newborn's chest is not rising: • Check the position of the head again to make sure the neck is slightly extended. • Repeat suction of mouth and nose to remove mucus, blood or meconium from the airway. • Reposition the mask on the newborn's face to improve the seal between mask and face. • Squeeze the bag harder to increase ventilation pressure					
8. Ventilate for 1 minute then quickly assess the baby for spontaneous breathing and color; if breathing is normal, stop ventilating and give to mother and continue to monitor.					
9. If the baby is not breathing after 1 minute or is not breathing well, calls for help and improves ventilation (reposition the head, suction and open the mouth, reapply the mask).					
10. If the baby's heart rate is normal but breathing is less than 30 breaths per minute or irregular, continue to ventilate for 3-5 minutes until the baby is breathing well; stop ventilating and monitor baby with mother.					
11. If the baby is not breathing and the heart rate is normal or slow, continue ventilation with oxygen if available, organize transfer and refer baby to a tertiary care centre, if possible					
12. If there is no gasping or breathing at all after 20 minutes of ventilation, stop ventilating, provide emotional support to mother and family.					
CARE AFTER SUCCESSFUL RESUSCITATION					
1. Keep the baby skin-to-skin with the mother until the baby's condition is stable.					

LEARNING GUIDE FOR NEWBORN RESUSCITATION *(Some of the following steps/tasks should be performed simultaneously)*					
STEP/TASK	**CASES**				
2. Monitor the baby's respiratory rate every 15 minutes and observe for other signs of illness.					
3. Provide reassurance to the mother.					
4. Wash hands thoroughly					
POST-RESUSCITATION TASKS					
1. Soak suction catheters and mask in 0.5% chlorine solution for 10 minutes for decontamination.					
2. Wipe exposed surfaces of the bag and mask with a gauze pad soaked in 0.5% chlorine solution or 60-90% alcohol and rinse immediately.					
3. Wash hands thoroughly with soap and water and dry with a clean, dry cloth (or air dry).					
• 4. Record the following details: • Condition of the newborn at birth • Procedures necessary to initiate breathing • Time from birth to initiation of spontaneous breathing • Clinical observations during and after resuscitation measures • Outcome of resuscitation measures • Names of providers involved					

CHECKLIST 4.3: HELPING A BABY BREATHE/ NEWBORN RESUSCITATION

(To be used by the **Trainer** at the end of the course)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

Participant/Student: _____ Date Observed:_____

CHECKLIST FOR NEWBORN RESUSCITATION *(Some of the following steps/tasks should be performed simultaneously)*					
STEP/TASK	**CASES**				
GETTING READY					
1. Dries the baby, remove the wet cloth, and wraps the baby in a dry, warm cloth.					
2. Places the baby on his/her back on a clean, warms surface and keeps covered except for the face and chest.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
RESUSCITATION USING BAG AND MASK					
3. Positions the head in a slightly extended position to open the airway.					
4. Clears the airway by suctioning **the mouth** first and **then the nose**: • Introduces catheter into the baby's mouth for approximately 3cm and suctions while withdrawing catheter; • Introduces catheter into each nostril and suctions while withdrawing catheter					
5. Places the mask on the baby's face so that it covers the chin, mouth and nose.					
6. Squeezes the bag with two fingers only or with the whole hand, depending on the size of the bag.					
7. Checks the seal by ventilating two or three times and observing the rise of the chest.					

CHECKLIST FOR NEWBORN RESUSCITATION *(Some of the following steps/tasks should be performed simultaneously)*					
STEP/TASK	**CASES**				
8. If the baby's chest is rising, ventilates at a rate of 40 breaths per minute, and observes the chest for an easy rise and fall.					
9. If the baby's chest is not rising, determines why, rectify problem and continue to ventilate.					
10. Ventilates for 1 minute and then stops and quickly assesses the baby for spontaneous breathing and color; if breathing is normal, stop ventilating, and provide routine newborn care					
11. If the baby's heart rate is normal but breathing is less than 30 breaths per minute or irregular, continues to ventilate for 3-5 minutes until the baby is breathing well; stops ventilating and monitors baby with mother.					
12 .If breathing is not normal, and the heart rate is normal or slow manages accordingly (calls for help and improves ventilation; continues ventilation with oxygen if available)					
13. If the baby is not breathing regularly after 20 minutes of ventilation, continues ventilation with oxygen, organizes transfer and refers baby to a tertiary care centre, if possible.					
14. If there is no gasping or breathing at all after 20 minutes of ventilation stops ventilating, provides emotional support to mother and family.					
CARE AFTER SUCCESSFUL RESUSCITATION					
15. Keeps the baby skin-to-skin with the mother until the baby's condition is stable.					
16. Monitors the baby's respiratory rate and observes for other signs of illness.					
17. Provides reassurance to the mother.					
POST-RESUSCITATION TASKS					
18. Soaks suction catheters and mask in 0.5% chlorine solution for 10 minutes for decontamination.					
19. Wipes exposed surfaces of the bag with a gauze pad soaked in 0.5% chlorine solution or 60-90% alcohol and rinses immediately.					
20. Washes hands thoroughly with soap and water and dries with a clean, dry cloth (or air dry).					
21. Completes records with details of resuscitation and condition of newborn					

SKILLS PRACTICE SESSION 4-4 & 4.5: BIMANUAL COMPRESSION OF THE UTERUS, AORTIC COMPRESSION

PURPOSE

The purpose of this activity is to enable participants to practice those psychomotor skills necessary to manage bleeding after childbirth and to achieve competency in these skills.

INSTRUCTIONS

This activity should be conducted in a simulated setting. Participants should review Learning Guides for: Bimanual Compression (4-4) and Aortic Compression (4-5) before beginning the activity.

The facilitator should demonstrate the steps/tasks in each learning guide one at a time. Under the guidance of the facilitator, participants should then work in pairs and practice the steps/tasks in each individual Learning Guide and observe each other's performance; while one participant performs the skill, the second participants should use the relevant section of each Learning Guide to observe performance. Participants should then reverse roles. Participants should be able to perform the steps/tasks relevant each skill before skills competency is assessed in a simulated setting

RESOURCES

- Childbirth simulator
- Delivery instrument kit
- Needles and syringes
- High-level disinfected or surgical gloves
- Gauntlet gloves
- Personal protective barriers
- 0.5% chlorine solution and receptacle for decontamination
- Leakproof container or plastic bag
- Learning Guides 4-4: Bimanual Compression,
- Learning Guides 4-5: Aortic Compression,
- Checklist 4-4: Bimanual Compression,
- Checklist 4-5: Aortic Compression

The BEmONC training manual module-4

LEARNING GUIDE 4:4 BIMANUAL COMPRESSION OF THE UTERUS

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR BIMANUAL COMPRESSION OF THE UTERUS (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.					
2. Provide continual emotional support and reassurance, as feasible.					
3. Put on personal protective barriers.					
Note: Steps 1 and 2 should be implemented at the same time as the following steps.					
BIMANUAL COMPRESSION					
1. Wash hands and forearms thoroughly with soap and water and dry with a clean, dry cloth or air dry.					
2. Clean the vulva and perineum with antiseptic solution.					
3. Put high-level disinfected or sterile surgical gloves on both hands.					
4. Insert one hand into the vagina and form a fist.					
5. Place the fist into the anterior vaginal fornix and apply pressure against the anterior wall of the uterus.					
6. Place the other hand on the abdomen behind the uterus.					
7. Press the abdominal hand deeply into the abdomen and apply pressure against the posterior wall of the uterus.					
8. Maintain compression until bleeding is controlled and the uterus contracts.					

LEARNING GUIDE FOR BIMANUAL COMPRESSION OF THE UTERUS (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
POST-PROCEDURE TASKS					
1. Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out and place in a plastic bag or leak proof					
2. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.					
3. Monitor vaginal bleeding and take the woman's vital signs: • Every 15 minutes for one hour; • Then every 30 minutes for two hours.					
4. Palpate the uterine fundus to ensure that the uterus remains firmly contracted.					
5. Complete documentation					

CHECKLIST 4:4: BIMANUAL COMPRESSION OF THE UTERUS

(To be used by the **Trainer** at the end of the module)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently

3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

PARTICIPANT _____Date Observed _____

CHECKLIST FOR BIMANUAL COMPRESSION OF THE UTERUS (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Tells the woman what is going to be done, listens to her, and responds attentively to her questions and concerns.					
2. Provides continual emotional support and reassurance, as feasible.					
3. Puts on personal protective barriers.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
BIMANUAL COMPRESSION					
1. Washes hands and puts on high-level disinfected or sterile gloves.					
2. Cleans the vulva and perineum with antiseptic solution.					
3. Inserts fist into anterior vaginal fornix and applies pressure against anterior wall of uterus.					
4. Places the other hand on the abdomen behind the uterus, presses the hand deeply into the abdomen, and applies pressure against the posterior wall of the uterus.					
5. Maintains compression until bleeding is controlled and the uterus contracts.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

CHECKLIST FOR BIMANUAL COMPRESSION OF THE UTERUS (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
POST-PROCEDURE TASKS					
2. Immerses both gloved hands briefly in a container filled with 0.5% chlorine solution; then removes gloves by turning them inside out and places in a plastic bag or leak proof, covered waste container					
2. Washes hands thoroughly.					
3. Monitors vaginal bleeding, takes the woman's vital signs and makes sure that the uterus is firmly contracted.					
4. Completes documentation					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

LEARNING GUIDE 4-5: COMPRESSION OF THE ABDOMINAL AORTA

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR COMPRESSION OF THE ABDOMINAL AORTA (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.					
2. Provide continual emotional support and reassurance, as feasible.					
Note: Steps 1 and 2 should be implemented at the same time as the following steps.					
COMPRESSION OF THE ABDOMINAL AORTA					
1. Place a closed fist just above the umbilicus and slightly to the left.					
2. Apply downward pressure over the abdominal aorta directly through the abdominal wall.					
3. With the other hand, palpate the femoral pulse to check the adequacy of compression: • If the pulse is palpable during compression, the pressure is inadequate; • If the pulse is not palpable during compression, the pressure is adequate.					
4. Maintain compression until bleeding is controlled.					
POST-PROCEDURE TASKS					
1. Monitor vaginal bleeding and take the woman's vital signs: • Every 15 minutes for one hour; • Then every 30 minutes for two hours.					
2. Palpate the uterine fundus to ensure that the uterus remains firmly contracted.					

CHECKLIST 4.5: COMPRESSION OF THE ABDOMINAL AORTA

(To be used by the **Facilitator** at the end of the module)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

PARTICIPANT _____Date Observed _____

CHECKLIST FOR COMPRESSION OF THE ABDOMINAL AORTA (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Tells the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.					
2. Provides continual emotional support and reassurance, as feasible.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
COMPRESSION OF THE ABDOMINAL AORTA					
1. Places a closed fist just above the umbilicus and slightly to the left.					
2. Applies downward pressure over the abdominal aorta directly through the abdominal wall.					
3. With the other hand, palpates the femoral pulse to check the adequacy of compression.					
4. Maintains compression until bleeding is controlled.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
POST-PROCEDURE TASKS					
1. Monitors vaginal bleeding, take the woman's vital signs, and ensures the uterus is firmly contracted.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

SKILLS PRACTICE SESSION 4-6: MANUAL REMOVAL OF PLACENTA

PURPOSE

The purpose of this activity is to enable participants to practice manual removal of the placenta and achieve competency in the skills required.

INSTRUCTIONS

This activity should be conducted in a simulated setting, using the appropriate models.

Participants should review Learning Guide 4.6 before beginning the activity.

The facilitator should demonstrate the steps/tasks in the procedure of manual removal of the placenta for participants. Under the guidance of the trainer, participants should then work in pairs to practice the steps/tasks and observe each other's performance, using Learning Guide 4.6

Participants should be able to perform the steps/tasks in Learning Guide 4.6 before skill competency is assessed by the facilitator in the simulated setting, using Checklist 4.6.

Finally, following supervised practice at a clinical site, the facilitator should assess the skill competency of each participant, using Checklist 4.6.

Note: If patients are not available at clinical sites for participants to practice the procedure of manual removal of the placenta, the skills should be taught, practiced, and assessed in a simulated setting.

RESOURCES

- Childbirth simulator
- High-level disinfected or sterile surgical gloves
- Personal protective barriers
- Receptacle for placenta

The BMNC

Learning Guide 4.6: Manual Removal of Placenta

Checklist 4.6: Manual Removal of Placenta

LEARNING GUIDE 4:6 MANUAL REMOVAL OF PLACENTA

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR MANUAL REMOVAL OF PLACENTA (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepare the necessary equipment.					
2. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.					
3. Provide continual emotional support and reassurance, as feasible.					
4. Ask the woman to empty her bladder or insert a catheter, if necessary.					
5. Give anaesthesia or analgesia such as pethidine and diazepam IV slowly or ketamine					
6. **Give a single dose of prophylactic antibiotics:** • Ampicillin 2 g IV PLUS metronidazole 500 mg IV • OR Cefazoline 1 g IV PLUS metronidazole 500 mg IV					
7. Put on personal protective barriers.					
MANUAL REMOVAL OF PLACENTA					
1. Wash hands and forearms thoroughly with soap and water and dry with a clean, dry cloth or air dry.					
2. Put high-level disinfected or sterile surgical gloves on both hands. (Note: elbow-length gloves should be used, if available.)					
3. Clean the vulva and perineum with antiseptic solution					
4. Place a drape under the woman's buttocks and over her abdomen					

LEARNING GUIDE FOR MANUAL REMOVAL OF PLACENTA (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
5. Hold the umbilical cord with a clamp.					
6. Pull the cord gently until it is parallel to the floor.					
7. Insert the other hand into the vagina and up into the uterus.					
8. When the placenta has been located, let go of the cord and move that hand onto the abdomen to support the fundus abdominally and to provide counter-traction to prevent uterine inversion.					
9. Move the fingers of the hand in the uterus laterally until the edge of the placenta is located.					
10. Detach the placenta from the implantation site by keeping the fingers tightly together and using the edge of the hand to gradually make a space between the placenta and the uterine wall.					
11. Proceed slowly all around the placental bed until the whole placenta is detached from the uterine wall: • If the placenta does not separate from the uterine surface by gentle lateral movement of the fingertips, suspect placenta accreta and arrange for surgical intervention.					
10. When the placenta is completely separated: • Hold the placenta and slowly withdraw the hand from the uterus, bringing the placenta with it; • With the other hand, continue to provide counter-traction to the fundus by pushing it in the opposite direction of the hand that is being withdrawn.					
11. Palpate the inside of the uterine cavity to ensure that all placental tissue has been removed.					
12. Give oxytocin 20 units in 1 L IV fluid (normal saline or Ringer's lactate) at 60 drops/minute.					
13. Have an assistant massage the fundus to encourage a tonic uterine contraction.					
14. If there is continued heavy bleeding, give ergometrine 0.2 mg IM, or give prostaglandins.					
15. Examine the uterine surface of the placenta to ensure that it is complete: • If any placental lobe or tissue is missing, explore the uterine cavity to remove it.					
16. Examine the woman carefully and repair any tears to the cervix or vagina, or repair episiotomy.					

LEARNING GUIDE FOR MANUAL REMOVAL OF PLACENTA (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
POST-PROCEDURE TASKS					
2. Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out and place in a plastic bag or leakproof, covered waste container					
2. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.					
3. Monitor vaginal bleeding and take the woman's vital signs: • Every 15 minutes for one hour • Then every 30 minutes for two hours.					
4. Palpate the uterine fundus to ensure the uterus remains contracted.					
5. Completes documentation					

CHECKLIST 4:6: MANUAL REMOVAL OF PLACENTA

(To be used by the **Trainer** at the end of the module)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

PARTICIPANT _____Date Observed _____

CHECKLIST FOR MANUAL REMOVAL OF PLACENTA (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepares the necessary equipment.					
2. Tells the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.					
3. Provides continual emotional support and reassurance, as feasible.					
4. Asks the woman to empty her bladder or inserts a catheter.					
5. Gives anesthesia or analgesia.					
6. Gives prophylactic antibiotics.					
7. Puts on personal protective barriers.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
MANUAL REMOVAL OF PLACENTA					
1. Washes hands and forearms thoroughly and puts on high-level disinfected or sterile surgical gloves (use elbow-length gloves, if available).					
2. Cleans the vulvas and perineum and drapes the woman					
3. Holds the umbilical cord with a clamp and pulls the cord gently.					
4. Inserts the other hand into the uterine cavity and locates the placenta.					

CHECKLIST FOR MANUAL REMOVAL OF PLACENTA (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
5. Provides counter-traction abdominally.					
6. Detaches the placenta by slowly working around the placental bed until the whole placenta is separated from the uterine wall.					
7. Withdraws the hand from the uterus, bringing the placenta with it while continuing to provide counter-traction abdominally.					
8. Ensures that all placental tissue has been removed.					
9. Gives oxytocin in IV fluid.					
10. Have an assistant massage the fundus to encourage a tonic uterine contraction.					
11. If there is continued heavy bleeding, gives ergometrine by IM injection, or give prostaglandins.					
12. Examines the uterine surface of the placenta to ensure that it is complete.					
13. Examines the woman carefully and repairs any tears to the cervix or vagina, or repairs episiotomy.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
POST-PROCEDURE TASKS					
2. Immerses both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out and places in a plastic bag or leakproof, covered waste container					
3. Washes hands thoroughly.					
4. Monitors vaginal bleeding, take the woman's vital signs, and ensure that the uterus is firmly contracted.					
5. Completes documentation					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

SKILLS PRACTICE SESSION 4.7: EPISIOTOMY AND REPAIR OF GENITAL TRACT LACERATIONS

PURPOSE

The purpose of this activity is to enable participants to practice episiotomy and repair and achieve competency in the skills required.

INSTRUCTIONS

This activity should be conducted in a simulated setting, using the appropriate models.

Participants should review the Learning Guide 4.7 before beginning the activity.

The facilitator should demonstrate the steps/tasks in the procedure of episiotomy and repair, repair of cervical tears and repair of 1st & 2nd degree vaginal and perineal tears for participants. Under the guidance of the facilitator, participants should then work in pairs to practice the steps/tasks and observe each other's performance, using Learning Guide 4.7.

Participants should be able to perform the steps/tasks in Learning Guide 4.7 before skill competency is assessed in the simulated setting by the trainer, using Checklist 4.7.

Finally, following supervised practice at a clinical site, the facilitator should assess the skill competency of each participant, using Checklist 4.7.

Note: If patients are not available at clinical sites for participants to practice episiotomy and repair, repair of cervical tears and repair of 1st & 2nd degree vaginal and perineal tears, the skills should be taught, practiced, and assessed in the simulated setting.

RESOURCES

- Pelvic model or "foam block" to simulate a vagina and cervix
- High-level disinfected or sterile surgical gloves
- Personal protective barriers
- Examination light
- Vaginal speculum
- Ring or sponge forceps
- Local anesthetic
- Suture materials
- Needle and syringe

The BMNC
Learning Guide & Checklist 4.7.1: Episiotomy and Repair
Learning Guide & Checklist 4.7.2: Repair of cervical tears
Learning Guide & Checklist 4.7.3: Repair of 1st & 2nd degree vaginal and perineal tears

LEARNING GUIDE 4.7.1: EPISIOTOMY AND REPAIR

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently

3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR EPISIOTOMY AND REPAIR (Some of the following steps/tasks should be performed simultaneously				
STEP/TASK	**CASES**			
GETTING READY				
1. Prepare the necessary equipment				
2. Tell the woman what is going to be done and encourage her to ask questions				
3. Listen to what the woman has to say				
4. Make sure that the woman has no allergies to lidocaine or related drugs.				
5. Provide emotional support and reassurance, as feasible.				
ADMINISTERING LOCAL ANESTHETIC				
1. Cleanse perineum with non alcohol antiseptic solution.				
2. Draw 10 ml of 0.5% or 1% lignocaine / lidocaine into a syringe: • (To prepare 0.5% from 2% lignocaine –draw 2.5ml Lignocaine and draw 7.5ml of water for injection. • To prepare 1% from 2% lignocaine: 5ml lignocaine and 5ml sterile Water)				
3. Place two fingers into vagina along proposed incision line (medio lateral direction).				
4. Insert needle beneath skin for 4–5 cm following same line.				
5. Draw back the plunger of syringe to make sure that needle is not in a blood vessel: • If blood is returned in syringe, remove needle, recheck position carefully, and try again; • If no blood is withdrawn, continue as follows.				
6. Inject lidocaine into vaginal mucosa, beneath skin of perineum and				

LEARNING GUIDE FOR EPISIOTOMY AND REPAIR (Some of the following steps/tasks should be performed simultaneously				
STEP/TASK	**CASES**			
deeply into perineal muscle; instill slowly while withdrawing the needle, do the same in all three directions				
7. Wait two minutes and then pinch incision site with forceps, checking for sensitivity				
8. If the woman feels the pinch, wait two more minutes and then retest.				
MAKING THE EPISIOTOMY				
1.Wait to perform episiotomy until: • perineum is thinned out; • 3–4 cm of the baby's head is visible during a contraction.				
2. Wearing sterile gloves, insert two fingers into the vagina between the baby's head and the perineum.				
3. Insert open blade of scissors between perineum and two fingers: • Cut the perineum about 3–4 cm in a mediolateral direction (45º angle to the midline towards a point midway between ischial tuberosity and anus); • Cut 2–3 cm up middle of posterior vagina.				
4. If birth of head does not follow immediately, apply pressure to episiotomy site between contractions, using a piece of gauze, to minimize bleeding.				
5. When it is time for the expulsion of the head, control birth of head and shoulders to avoid extension of the episiotomy.				
REPAIRING THE EPISIOTOMY				
1. Ask the woman to position her buttocks toward lower end of bed or table (use stirrups if available).				
2. Check if the sensitivity has returned to the incision area, If Yes, repeat giving lignocaine 5ml of 0.5%				
2. Prepare stand light or ask an assistant to direct a strong light onto the woman's perineum.				
3. Check if the episiotomy has extended through anal sphincter or rectal mucosa and if so manage as 3rd or 4th degree tears respectively.				
4. Gently clean area around episiotomy with antiseptic solution.				
5. Ensure a sterile field by putting a sterile drape under the woman's buttocks				
6. Using 2/0 suture, insert suture needle just above (1 cm) the apex of the vaginal cut.				

LEARNING GUIDE FOR EPISIOTOMY AND REPAIR (Some of the following steps/tasks should be performed simultaneously				
STEP/TASK	**CASES**			
7. Use a continuous suture from apex downward to level of vaginal opening.				
8. At opening of vagina, bring together cut edges.				
9. Bring needle under vaginal opening and out through incision and tie.				
10. Use interrupted or continuous sutures to repair perineal muscle, working from top of perineal incision downward.				
11. Use interrupted or continuous subcuticular sutures to bring skin edges together.				
12. Wash perineal area with antiseptic, pat dry, and place a sterile sanitary pad over the vulva and perineum.				
POST-PROCEDURE TASKS				
1. Dispose of waste materials (e.g., blood-contaminated swabs) in a leak proof container or plastic bag.				
2. Decontaminate instruments by placing in a plastic container filled with 0.5% chlorine solution for 10 minutes.				
3. Dispose of needle and syringe in a puncture proof container				
4. Remove gloves and immense in 0.5% chlorine solution then turn them inside out and place in leak proof container or plastic bag.				
5. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.				
6. Explain to the woman how to keep the area clean and dry and to return for postpartum care.				
7. Offer the woman analgesic/anti inflammatory for 48hrs: • Diclofenac 50 mg TDS if no contraindications				
8. Record the procedure on woman's record.				

CHECKLIST 4:7.1 EPISIOTOMY AND REPAIR

(To be used by the **Facilitator** at the end of the module)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently

3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

Participant/Student: _____Date Observed: _____

CHECKLIST FOR EPISIOTOMY AND REPAIR *(Some of the following steps/tasks should be performed simultaneously)*					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepares the necessary equipment.					
2. Tells the woman what is going to be done and encourages her to ask questions.					
3. Listens to what the woman has to say.					
4. Makes sure that the woman has no allergies to lignocaine or related drugs.					
5. Provide emotional support and reassurance, as feasible.					
ADMINISTERING LOCAL ANESTHETIC					
6. Washes hands and puts on sterile gloves					
7. Cleanses perineum with antiseptic solution and places drape under the woman's buttocks and over her abdomen.					
8. Draws 10 ml of 0.5% or 1% lignocaine into a syringe.					
9. Places two fingers into vagina along proposed incision line.					
10. Inserts needle beneath skin for 4–5 cm following same line.					
11. Draws back the plunger of syringe to make sure that needle is not in a blood vessel: • If blood is returned in syringe, remove needle, rechecks position					

CHECKLIST FOR EPISIOTOMY AND REPAIR *(Some of the following steps/tasks should be performed simultaneously)*					
STEP/TASK	**CASES**				
carefully, and try again; • if no blood is withdrawn, continues as follows.					
12. Injects lignocaine into vaginal mucosa, beneath skin of perineum and deeply into perineal muscle.					
13. Waits two minutes and then pinches incision site with forceps.					
14. If the woman feels the pinch, waits two more minutes and then retests.					
MAKING THE EPISIOTOMY					
1.Waits to perform episiotomy until: • Perineum is thinned out • 3–4 cm of the baby's head is visible during a contraction					
2. Places two fingers between the baby's head and the perineum.					
3.Inserts open blade of scissors between perineum and two fingers: • Cuts the perineum about 3 cm in a mediolateral direction (45º angle to the midline toward a point midway between ischial tuberosity and anus).					
4. If birth of head does not follow immediately, applies pressure to episiotomy site between contractions, using a piece of gauze, to minimize bleeding.					
5. Controls birth of head and shoulders to avoid extension of the episiotomy.					
REPAIRING THE EPISIOTOMY					
6. Asks the woman to position her buttocks toward lower end of bed or table (use stirrups if available).					
7. Asks an assistant to direct a strong light onto the woman's perineum.					
8. Gently cleans area around episiotomy with antiseptic solution.					
9. Using 2/0 suture, inserts suture needle just above (1 cm) the apex of the vaginal cut.					
10. Uses a continuous suture from apex downward to level of vaginal opening.					
11. At opening of vagina, brings together cut edges.					
12. Brings needle under vaginal opening and out through incision and tie.					
13. Uses interrupted or continuous sutures to repair perineal muscle, working from top of perineal incision downward.					
14. Uses interrupted or continuous subcuticular sutures to bring skin edges together.					

CHECKLIST FOR EPISIOTOMY AND REPAIR *(Some of the following steps/tasks should be performed simultaneously)*					
STEP/TASK	**CASES**				
15. Washes perineal area with antiseptic, pat dry, and places a sterile sanitary pad over the vulva and perineum.					
16. Explains to the woman how to keep the area clean and dries and to return for postpartum care.					
17.Gives analgesic where necessary					
POST-PROCEDURE TASKS					
18. Disposes of waste materials (e.g., blood-contaminated swabs) in a leakproof container or plastic bag.					
19. Decontaminates instruments by placing in a plastic container filled with 0.5% chlorine solution for 10 minutes.					
20.Disposes of needle and syringe in a puncture proof container					
21.Immerses both gloved hands in 0.5% chlorine solution and remove gloves by turning them inside out, dispose in leak proof container					
22. Washes hands thoroughly with soap and water and dries with clean, dry cloth or air dry.					
23. Records procedure on woman's record.					

LEARNING GUIDE 4.7.2: REPAIR OF CERVICAL TEARS

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR REPAIR OF CERVICAL TEARS (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepare the necessary equipment.					
2. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.					
3. Provide continual emotional support and reassurance, as feasible.					
4. Have the woman empty her bladder or insert a catheter, if necessary.					
5. Give anesthesia (IV pethidine and diazepam, or ketamine), if necessary.					
6. Put on personal protective barriers.					
REPAIR OF CERVICAL TEARS					
1. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.					
2. Put high-level disinfected or sterile surgical gloves on both hands.					
3. Have an assistant shine a light into the vagina.					
4. Clean the vagina and cervix with antiseptic solution.					
5. Have the assistant massage the uterus and provide fundal pressure.					
6. Insert a ring or sponge forceps into the vagina and gently grasp the cervix on one side of the tear.					
7. Insert a second ring or sponge forceps and grasp the cervix on other side of the tear.					
8. Place the handles of both forceps in one hand: • Hold the cervix steady by gently pulling the forceps toward you.					
9. Place the first suture at the top (the apex) of the tear.					

LEARNING GUIDE FOR REPAIR OF CERVICAL TEARS (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
10. Close the tear with a continuous suture (0 chromic catgut): • Be sure to include the whole thickness of the cervix each time the suture needle is inserted.					
11. If a long section of the rim of the cervix is tattered, under-run it with a continuous suture.					
12. If the apex is difficult to reach and ligate: • Grasp the apex with artery or ring forceps; • Leave the forceps in place for four hours; • After four hours, open the forceps partially but do not remove; • After another four hours, remove the forceps completely.					
POST-PROCEDURE TASKS					
1. Before removing gloves, dispose of waste materials in a leak proof container or plastic bag.					
2. Place all instruments in 0.5% chlorine solution for 10 minutes for decontamination.					
3. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out: • If disposing of gloves, place them in a leak proof container or plastic bag; • If reusing surgical gloves, submerge them in 0.5% chlorine solution for 10 minutes for decontamination.					
4. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.					

CHECKLIST 4.7.2: REPAIR OF CERVICAL TEARS

(To be used by the **Facilitator** at the end of the module)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently

3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

PARTICIPANT _____ Date Observed _____

CHECKLIST FOR REPAIR OF CERVICAL TEARS (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepares the necessary equipment.					
2. Tells the woman what is going to be done, listens to her, and responds attentively to her questions and concerns.					
3. Provides continual emotional support and reassurance, as feasible.					
4. Have the woman empty her bladder or insert a catheter.					
5. Gives anesthesia, if necessary.					
6. Puts on personal protective barriers.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
REPAIR OF CERVICAL TEARS					
1. Washes hands thoroughly and puts on high-level disinfected or sterile surgical gloves.					
2. Cleans the vagina and cervix with an antiseptic solution.					
3. Grasps both sides of the cervix using ring or sponge forceps (one forceps for each side of tear).					
4. Places the first suture at the top of the tear and closes it with a continuous suture, including the whole thickness of the cervix each time the suture needle is inserted.					
5. If a long section of the rim of the cervix is tattered, under-runs it with a continuous suture.					
6. If the apex is difficult to reach and ligate, grasps it with forceps and leaves them in place for eight hours.					

CHECKLIST FOR REPAIR OF CERVICAL TEARS (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
POST-PROCEDURE TASKS					
1. Before removing gloves, disposes of waste materials in a leakproof container or plastic bag.					
2. Places all instruments in 0.5% chlorine solution for 10 minutes for decontamination.					
3. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out: • If disposing of gloves, places them in a leakproof container or plastic bag; • If reusing surgical gloves, submerges them in 0.5% chlorine solution for 10 minutes for decontamination.					
4. Washes hands thoroughly.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

LEARNING GUIDE 4.7.3: REPAIR OF 1ST AND 2ND DEGREE VAGINAL AND PERINEAL TEARS

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

1. Needs Improvement: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. Competently Performed: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently

3. Not Observed: Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR REPAIR OF 1ST AND 2ND DEGREE TEARS (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepare the necessary equipment.					
2. Tell the woman what is going to be done and encourage her to ask questions.					
3. Listen to what the woman has to say.					
4. Make sure that the woman has no allergies to lidocaine or related drugs.					
5. Provide emotional support and reassurance, as feasible.					
ADMINISTERING LOCAL ANESTHETIC					
1. Complete inspection of vagina, perineum, and cervix to rule out additional tears.					
2. Cleanse perineum with antiseptic solution.					
3. Draw 10 ml of 0.5% lidocaine or lignocaine into a syringe.					
4. Insert the needle beneath the vaginal mucosa, beneath the skin of the perineum, and deeply into the perineal muscle along the borders of the tear(s).					
5. Draw back the plunger of syringe to make sure that needle is not in a blood vessel: • If blood is returned in syringe, remove needle, recheck position carefully, and try again; • If no blood is withdrawn, continue as follows.					
6. Inject lidocaine into vaginal mucosa, beneath skin of perineum and deeply into perineal muscle.					

LEARNING GUIDE FOR REPAIR OF 1ST AND 2ND DEGREE TEARS (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
7. Wait two minutes and then pinch the area with forceps.					
8. If the woman feels the pinch, wait two more minutes and then retest.					
REPAIRING THE TEARS					
1. Ask an assistant to direct a strong light onto the woman's perineum.					
2. Using 2-0 suture, insert suture needle just above (1 cm) the apex of the vaginal tear.					
3. Use a continuous suture from apex downward to level of vaginal opening.					
4. At opening of vagina, bring together the torn edges.					
5. Bring needle under vaginal opening and out through the tear and tie.					
6. Use 2-0 interrupted sutures to repair perineal muscle, working from top of perineal tear downward.					
7. Use interrupted or subcuticular sutures to bring together skin edges.					
8. Wash perineal area with antiseptic, pat dry, and place a sterile sanitary pad over the vulva and perineum.					
9. Gently lay the woman's legs down together at the same time, and make her comfortable.					
POST-PROCEDURE TASKS					
1. Dispose of waste materials (e.g., blood-contaminated swabs) in a leakproof container or plastic bag.					
2. Decontaminate instruments by placing in a plastic container filled with 0.5% chlorine solution for 10 minutes.					
3. Decontaminate or dispose of syringe and needle: • If reusing needle or syringe, fill syringe (with needle attached) with 0.5% chlorine solution and submerge in solution for 10 minutes for decontamination; • If disposing of needle and syringe, flush needle and syringe with 0.5% chlorine solution three times, then place in a puncture proof container.					
4. Immerse both gloved hands in 0.5% chlorine solution and remove gloves by turning them inside out: • If disposing of gloves, place in leakproof container or plastic bag; • If reusing surgical gloves, submerge in 0.5% chlorine solution for 10 minutes to decontaminate.					
5. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
6. Record procedure on woman's record.					

CHECKLIST 4.7.3: REPAIR OF 1ST AND 2ND DEGREE VAGINAL AND PERINEAL TEARS

(To be used by the **Facilitator** at the end of the module)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

PARTICIPANT_____ Date Observed_____

CHECKLIST FOR REPAIR OF 1st AND 2nd DEGREE TEARS (Some of the following steps/tasks should be performed simultaneously.)				
STEP/TASK	**CASES**			
GETTING READY				
1. Prepares the necessary equipment.				
2. Tells the woman what is going to be done and encourage her to ask questions.				
3. Listens to what the woman has to say.				
4. Makes sure that the woman has no allergies to lidocaine or related drugs.				
5. Provides emotional support and reassurance, as feasible.				
SKILL/ACTIVITY PERFORMED SATISFACTORILY				
REPAIRING THE TEARS				
1. Cleanses perineum with antiseptic solution.				
2. Administers local anesthetic.				
3. Uses a continuous suture from apex of tear downward to repair vaginal tear(s)				
4. At opening of vagina, brings together torn edges.				
5. Brings needle under vaginal opening and out through the tear and tie.				
6. Uses interrupted sutures to repair perineal muscle, working from top of perineal tear downward.				
7. Uses interrupted or subcuticular sutures to bring together skin edges.				
8. Washes perineal area and cover with a sterile sanitary pad.				

CHECKLIST FOR REPAIR OF 1st AND 2nd DEGREE TEARS (Some of the following steps/tasks should be performed simultaneously.)				
STEP/TASK	**CASES**			
SKILL/ACTIVITY PERFORMED SATISFACTORILY				
POST-PROCEDURE TASKS				
1. Before removing gloves, disposes of waste materials in a leakproof container or plastic bag.				
2. Decontaminates instruments by placing in a plastic container filled with 0.5% chlorine solution for 10 minutes.				
3. Decontaminates or disposes of syringe and needle: • If reusing needle or syringe, fills syringe (with needle attached) with 0.5% chlorine solution and submerges in solution for 10 minutes for decontamination; • If disposing of needle and syringe, flushes needle and syringe with 0.5% chlorine solution three times, then places in a puncture proof container.				
4. Immerses both gloved hands in 0.5% chlorine solution and remove gloves by turning them inside out: • If disposing of gloves, places in leakproof container or plastic bag; • If reusing surgical gloves, submerges in 0.5% chlorine solution for 10 minutes to decontaminate.				
5. Washes hands thoroughly.				
6. Records procedure on woman's record.				
SKILL/ACTIVITY PERFORMED SATISFACTORILY				

SKILLS PRACTICE SESSION 4-8: BREECH DELIVERY

PURPOSE

The purpose of this activity is to enable participant/students to practice breech delivery and achieve competence in the procedure

INSTRUCTIONS

This activity should be conducted in a simulated setting, using the appropriate models.
Participants should review Learning Guide 4.8 before beginning the activity

The facilitator should demonstrate the steps/tasks in the procedure of breech delivery for participant. Under the guidance of the facilitator, participant should then work in pairs to practice the steps/tasks and observe each other's performance, using Learning Guide 4.8

Participants should be able to perform the steps/tasks in Learning Guide 4.8 before skill competency is assessed by the facilitator in the simulated setting, using Checklist 4.8.
Finally, following supervised practice at a clinical site, the facilitator should assess the skill competency of each participant, using Checklist 4.8.

RESOURCES

- Childbirth simulator
- High-level disinfected or sterile surgical gloves
- Personal protective barriers
- Learning Guide 4.8: Breech Delivery
- Checklist 4.8: Breech Delivery

LEARNING GUIDE 4.8: BREECH DELIVERY

(To be completed by **Participant/students**)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently

3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR BREECH DELIVERY (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepare the necessary equipment.					
2. Tell the woman what is going to be done, listen to her and respond attentively to her questions and concerns.					
3. Provide continual emotional support and reassurance, as feasible.					
4. Review to ensure that the following conditions for breech delivery are present: • Complete or frank breech • Adequate clinical pelvimetry • Fetus is not too large estimated fetal weight is 3.5Kg or less • No previous cesarean section for cephalopelvic disproportion repaired uterine rupture, myomectomy and repaired perforation • Flexed head					
5. Put on personal protective barriers.					
PREPROCEDURE TASKS					
1. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.					
2. Put high-level disinfected or sterile surgical gloves on both hands.					
3. Clean the vulva with antiseptic solution.					
4. Put sterile drap under the women's buttock and one on her abdomen					
5. Catheterize the bladder, if necessary.					

LEARNING GUIDE FOR BREECH DELIVERY (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
BREECH DELIVERY					
Delivery of the Buttocks and Legs					
1. When the buttocks have entered the vagina and the cervix is fully dilated, tell the woman she can bear down with contractions.					
2. If the perineum is very tight, perform an episiotomy (see **Learning Guide 3.3: Episiotomy and Repair**).					
3. Let the buttocks deliver until the lower back and then the shoulder blades are seen.					
4. Gently hold the buttocks in one hand, but do not pull.					
5. If the legs do not deliver spontaneously, deliver one leg at a time: • Push behind the knee to bend the leg. • Grasp the ankle and deliver the foot and leg. • Repeat for the other leg.					
6. Hold the baby by the hips, but do not pull.					
Delivery of the Arms					
7. If the arms are felt on the chest, allow them to disengage spontaneously: • After spontaneous delivery of the first arm, lift the buttocks toward the mother's abdomen to enable the second arm to deliver spontaneously. • If the arm does not deliver spontaneously, place one or two fingers in the elbow and bend the arm, bringing the hand down over the baby's face.					
8. If the arms are stretched above the head or folded around the neck, use Lovset's maneuver: • Hold the baby by the hips and turn half a circle, keeping the back uppermost. • Apply downward traction at the same time so that the posterior arm becomes anterior, and deliver the arm under the pubic arch by placing two fingers on the upper part of the arm. • Draw the arm down over the chest as the elbow is flexed, with the hand sweeping over the face. • To deliver the second arm, turn the baby back half a circle while keeping the back uppermost and applying downward traction to deliver the second arm in the same way under the pubic arch.					

LEARNING GUIDE FOR BREECH DELIVERY (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
9. If the baby's body cannot be turned to deliver the arm that is anterior first, deliver the arm that is posterior: • Hold and lift the baby up by the ankles. • Move the baby's chest toward the woman's inner leg to deliver the posterior shoulder. • Deliver the arm and hand. • Lay the baby down by the ankles to deliver the anterior shoulder. • Deliver the arm and hand.					
Delivery of the Head					
10. Deliver the head by the Mauriceau Smellie Veit maneuver: • Lay baby face down with the length of its body over your hand and arm. • Place first and third fingers of this hand on the baby's cheekbones. • Place second finger in the baby's mouth to pull the jaw down and flex the head. • Use the other hand to grasp the baby's shoulders. • With two fingers of this hand, gently flex the baby's head toward the chest. • At the same time apply downward pressure on the jaw to bring the baby's head down until the hairline is visible. • Pull gently to deliver the head. • Ask an assistant to push gently above the mother's pubic bone as the head delivers. • Raise the baby, still astride the arm, until the mouth and nose are free.					
11. Manage immediate newborn care as in normal delivery ensuring assessing the baby's condition for breathing and complete AMTSL					
12. Check the birth canal for tears following delivery, and repair if necessary.					
13. Repair the episiotomy, if one was performed (see **Learning Guide 3.3: Episiotomy and Repair**).					
14. Provide immediate postpartum and newborn care, as required.					
POST-PROCEDURE TASKS					
1. Before removing gloves, dispose of waste materials in a leakproof container or plastic bag.					

LEARNING GUIDE FOR BREECH DELIVERY (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
2. Place all instruments in 0.5% chlorine solution for 10 minutes for decontamination.					
3. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out and place them in a leakproof container or plastic bag.					
4. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.					
5. Complete patient documentation					

CHECKLIST 4.8: BREECH DELIVERY

(To be used by the **Trainer/teacher** at the end of the module)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently

3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

PARTICIPANT/STUDENT _____ Date Observed _____

CHECKLIST FOR BREECH DELIVERY (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepares the necessary equipment.					
2. Tells the woman (and her support person) what is going to be done, listens to her and respond attentively to her questions and concerns.					
3. Provides continual emotional support and reassurance, as feasible.					
4. Ensures that the conditions for breech delivery are present.					
5. Puts on personal protective barriers.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
PREPROCEDURE TASKS					
1. Washes hands thoroughly and puts on high-level disinfected or sterile surgical gloves.					
2. Cleans the vulva with antiseptic solution.					
3. Puts sterile drape under the women's buttock and one on her abdomen					
4. Catheterizes the bladder, if necessary.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
BREECH DELIVERY					
Delivery of the Buttocks and Legs					
1. When the buttocks have entered the vagina and the cervix is fully dilated, tells the woman she can bear down with contractions.					
2. Performs an episiotomy, if necessary.					

CHECKLIST FOR BREECH DELIVERY (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
3. Lets the buttocks deliver until the lower back and shoulder blades are seen.					
4. Gently holds the buttocks in one hand.					
5. If the legs do not deliver spontaneously, delivers one leg at a time.					
6. Holds the baby by the hips.					
Delivery of the Arms					
7. If the arms are felt on the chest, allows them to disengage spontaneously.					
8. If the arms are stretched above the head or folded around the neck, uses Lovset's maneuver.					
9. If the baby's body cannot be turned to deliver the arm that is anterior first, delivers the arm that is posterior.					
Delivery of the Head					
10. Delivers the head using the Mauriceau Smellie Veit maneuver.					
11. Assesses the baby's condition for breathing and completes the delivery as in normal birth					
12. Following delivery, checks the birth canal for tears and repairs, if necessary. Repairs the episiotomy, if one was performed.					
13. Provides immediate postpartum and newborn care, as required.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
POST-PROCEDURE TASKS					
1. Before removing gloves, dispose of waste materials in a leakproof container or plastic bag.					
2. Places all instruments in 0.5% chlorine solution for decontamination.					
3. Removes gloves and discards them in a leakproof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.					
4. Washes hands thoroughly.					
5. Documents all relevant information					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

SKILLS PRACTICE SESSION 4-9: VACUUM EXTRACTION

PURPOSE

The purpose of this activity is to enable participant/students to practice vacuum extraction and achieve competency in the skills required.

INSTRUCTIONS

This activity should be conducted in a simulated setting, using the appropriate models. Participants should review Learning Guide 4.9 before beginning the activity. The facilitator should demonstrate the steps/task in the procedure of vacuum extraction for participants. Under the guidance of the facilitator, participants should then work in pairs to practice the steps/tasks and observe each other's performance, using Learning Guide 4.9.

Participant should be able to perform the steps/tasks in Learning Guide 4.9 before skill competency is assessed by the facilitator in the simulated setting, using Checklist 4.9.

Finally, following supervised practice at a clinical site, the facilitator should assess the skill competency of each participant, using Checklist 4.9.

RESOURCES

- Childbirth simulator
- High-level disinfected or sterile surgical gloves
- Personal protective barriers
- Vacuum extractor
- Learning Guide 4.9: Vacuum Extraction
- Checklist 4.9: Vacuum Extraction

LEARNING GUIDE 4:9 VACUUM EXTRACTION

(To be completed by **Participant/students**)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently

3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR VACUUM EXTRACTION (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepare the necessary equipment.					
2. Tell the woman what is going to be done, listen to her and respond attentively to her questions and concerns.					
3. Provide continual emotional support and reassurance, as feasible.					
4. Review to ensure that the following conditions for vacuum extraction are present: • Vertex presentation • Term fetus • Cervix fully dilated • Head at least at 0 station or no more than 2/5 palpable above the symphysis pubis					
5. Make sure an assistant is available.					
6. Put on personal protective barriers.					
PREPROCEDURE TASKS					
1. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.					
2. Put high-level disinfected or sterile surgical gloves on both hands.					
3. Clean the vulva with antiseptic solution.					
4. Place one sterile drapes below the woman's buttocks and one on her abdomen					
5. Catheterize the bladder, if necessary.					

LEARNING GUIDE FOR VACUUM EXTRACTION (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
6. Check all connections on the vacuum extractor and test the vacuum on a gloved hand.					
VACUUM EXTRACTION					
1. Assess position of fetal head by feeling the sagittal suture line and fontanelles.					
2. Identify the posterior fontanelle.					
3. Apply the largest cup that will fit, with the center of the cup over the flexion point ~2-3 cm anterior to the posterior fontanelle.					
4. Perform an episiotomy, if necessary, for proper placement of the cup (see **Learning Guide 9.3: Episiotomy and Repair**): • If episiotomy is not necessary for placement of cup, delay until the head stretches the perineum or the perineum interferes with the axis of traction.					
5. Check the application and ensure that there is no maternal soft tissue (cervix or vagina) within the rim of the cup: • If necessary, release pressure and reapply cup.					
6. Have the assistant create a vacuum of 0.2 kg/cm^2 negative pressure with the pump and check the application of the cup.					
7. Increase vacuum to 0.8 kg/cm^2 negative pressure and check application of cup.					
8. After maximum negative pressure has been applied, start traction in the line of the pelvic axis and perpendicular to the cup: • If the fetal head is tilted to one side or not flexed well, traction should be directed in a line that will try to correct the tilt or deflexion of the head (i.e., to one side or the other, not necessarily in the midline).					
9. With each contraction, apply traction in a line perpendicular to the plane of the cup rim: • Place a gloved finger on the scalp next to the cup during traction to assess potential slippage and descent of the vertex.					
10. Between each contraction check: • Fetal heart rate (by assistant) • Application of the cup					

LEARNING GUIDE FOR VACUUM EXTRACTION (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
11. With progress, and in the absence of fetal distress, continue the "guiding" pulls for a maximum of 30 minutes. • NOTE: Vacuum extraction is declared failed if: ▪ The head does not advance with each pull ▪ The fetus is undelivered after three pulls with no descent, or after30 minutes ▪ The cup slips off the head twice at the proper direction of pull with a maximum negative pressure					
12. When the head has been delivered, release the vacuum, remove the cup and complete the delivery as in normal birth.					
13. Check the birth canal for tears following delivery and repair if necessary.					
14. Repair the episiotomy, if one was performed (see **Learning Guide 9.3: Episiotomy and Repair**).					
15. Provide immediate postpartum and newborn care, as required.					
POST-PROCEDURE TASKS					
8. Before removing gloves, dispose of waste materials in a leak proof container or plastic bag.					
9. Place all instruments in 0.5% chlorine solution for 10 minutes for decontamination.					
3. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out and place them in a leak proof container or plastic bag.					
4. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.					
3. Complete documentation					

CHECKLIST 4:9: VACUUM EXTRACTION

(To be used by the **Trainer/teacher** at the end of the module)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

PARTICIPANT/STUDENT_____ Date Observed _____

CHECKLIST FOR VACUUM EXTRACTION (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	***CASES***				
GETTING READY					
1. Prepares the necessary equipment.					
2. Tells the woman what is going to be done, listens to her and responds attentively to her questions and concerns.					
3. Provides continual emotional support and reassurance, as feasible.					
4. Ensures that the conditions for vacuum extraction are present.					
5. Makes sure an assistant is available.					
6. Puts on personal protective barriers.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
PREPROCEDURE TASKS					
1. Washes hands thoroughly and puts on high-level disinfected or sterile surgical gloves.					
2. Cleans the vulva with antiseptic solution.					
3. Places one sterile drape under the women's buttock one over the women abdomen					
4. Catheterizes the bladder, if necessary.					
5. Checks all connections on the vacuum extractor and test the vacuum.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
VACUUM EXTRACTION					

CHECKLIST FOR VACUUM EXTRACTION (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	***CASES***				
1. Assesses the position of the fetal head and identifies the posterior fontanels.					
2. Applies the largest cup that will fit.					
3. Performs episiotomy if necessary for placement of the cup.					
4. Checks the application and ensures that there is no maternal soft tissue within the rim of the cup.					
5. Have assistant create a vacuum of negative pressure and checks the application of the cup.					
6. Increases the vacuum to the maximum and then applies traction. Correct the tilt or deflexion of the head.					
7. With each contraction, applies traction in a line perpendicular to the plane of the cup rim and assesses potential slippage and descent of the vertex.					
8. Between each contraction, checks -fetal heart rate (by assistant) -application of the cup.					
9. Continues the "guiding" pulls for a maximum of 30 minutes. Releases the vacuum when the head has been delivered.					
10. Checks the birth canal for tears following delivery, and repairs if necessary. Repairs the episiotomy, if one was performed.					
11. Provides immediate postpartum and newborn care, as required.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
POST-PROCEDURE TASKS					
1. Before removing gloves, disposes of waste materials in a leak proof container or plastic bag.					
2. Places all instruments in 0.5% chlorine solution for decontamination					
3. Removes gloves and discard them in a leak proof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.					
4. Washes hands thoroughly.					
5. Completes documentation					

ROLE PLAY 4-1: REASSURING THE WOMAN IN LABOR

DIRECTIONS

The facilitator will select two participants to perform the following roles: health care provider and woman in labor. The two participants taking part in the role play should take a few minutes to prepare for the activity by reading the background information provided below. The remaining participants, who will observe the role play, should at the same time read the background information.

The purpose of the role play is to provide an opportunity for participants to develop/practice effective interpersonal skills.

PARTICIPANT ROLES

Healthcare provider: The healthcare provider is an experienced SBA who has good interpersonal skills.

Woman in labor: Merima is16 years old. This is her first pregnancy.

SITUATION

Merima has come to the hospital because contractions started 3 hours ago. When the SBA asks Merima how she is feeling she grasps her abdomen with both hands as a contraction begins. She shuts her eyes tightly and cries out that she does not understand what is happening and is frightened.

FOCUS OF THE ROLE PLAY

The focus of the role play is the interpersonal interaction between the SBA and Merima and the appropriateness of the SBA's verbal and non-verbal communication skills.

DISCUSSION QUESTIONS

The facilitator should use the following questions to facilitate discussion after the role play.

1. How did the SBA demonstrate respect and kindness during her interaction with Merima?
2. How did the SBA provide emotional support and reassurance to Merima?
3. What non-verbal behaviors did the SBA use to encourage interaction between herself and Merima?

ROLE PLAY 4-2: PARENT EDUCATION AND SUPPORT FOR CARE OF THE NEWBORN

DIRECTIONS

The facilitator will select two participants to perform the following roles: healthcare provider and mother of newborn. The two participants taking part in the role play should take a few minutes to prepare for the activity by reading the background information provided below. The remaining participants, who will observe the role play, should at the same time read the background information.

The purpose of the role play is to provide an opportunity for participants to develop/practice effective interpersonal skills.

PARTICIPANT ROLES

Healthcare provider: The healthcare provider is experienced in the care of newborn babies and has good interpersonal communication skills.

Mother: The mother is from a village in a poor agricultural area; she is 27 years old and illiterate. This is her fourth baby.

SITUATION

Sosina gave birth to a healthy term baby 10 hours ago. The healthcare provider has noticed that the clothing Sosina has for her baby is not clean. She has also noticed that Sosina has wrapped a piece of unclean cloth tightly around the baby's abdomen, covering the cord stump.

FOCUS OF THE ROLE PLAY

The focus of the role play is the interpersonal interaction between the healthcare provider and the mother and the appropriateness of the health messages discussed with her.

DISCUSSION QUESTIONS

1. How did the healthcare provider demonstrate respect and kindness during her interaction with Sosina?
2. What key health messages related to hygiene and cord care did the healthcare provider discuss with Sosina?
3. What did the healthcare provider do to ensure that Sosina understood the health messages?

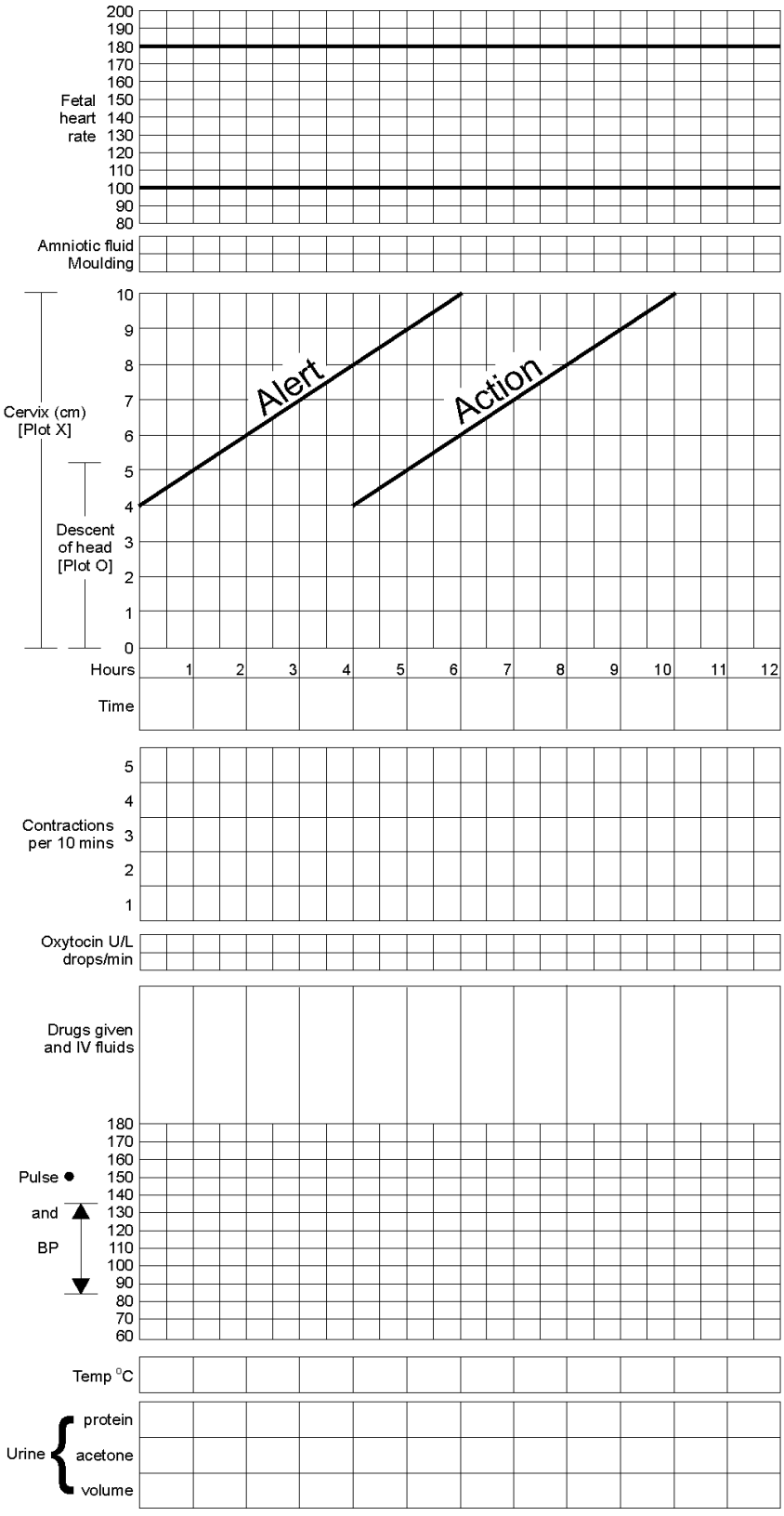
EXERCISE 4-1: USING THE PARTOGRAPH

PURPOSE
The purpose of this exercise is to enable learners to use the partograph to manage labor.

INSTRUCTIONS	RESOURCES
The facilitator should review the partograph form with participants before beginning the exercise.	The following equipment or representations thereof: • Partograph forms (three for each learner) • Poster-size laminated partograph • Exercise: Using the Partograph Answer Key
Each participant should be given three blank partograph forms. **Case 1**: The facilitator should read each step to the class, plot the information on the poster-size laminated partograph, and ask the questions included in each of the steps. At the same time, learners should plot the information on one of their partograph forms. **Case 2**: The facilitator should read each step to the class and have learners plot the information on another of their partograph forms. The questions included in each step should be asked as they arise. **Case 3**: The facilitator should read each step to the class and have learners plot the information on the third of their partograph forms. The questions should then be asked when the partograph is completed.	
Throughout the exercise, the facilitator should ensure that participants have completed their partograph forms correctly.	
The facilitator should provide learners with the three completed partograph forms from the Answer Key and have them compare these with the partograph forms they have completed. The facilitator should discuss and resolve any differences between the partographs completed by participants and those in the Answer Key.	

Name Gravida Para Hospital number

Date of admission Time of admission Ruptured membranes hours



PARTOGRAPH: CASE 1

STEP 1

- Saba was admitted at 05.00 on 19.9.2003
- Membranes ruptured 04.00
- Gravida 3, Para 2+0
- Hospital number 7886

- On admission the fetal head was 4/5 palpable above the symphysis pubis and the cervix was 2 cm dilated

Q: What should be recorded on the partograph?

Note: Saba is not in active labor. Record only the details of her history, i.e., first 4 bullets, not the descent and cervical dilation.

STEP 2

- 09.00:
  The fetal head is 3/5 palpable above the symphysis pubis
  The cervix is 5 cm dilated

Q: What should you now record on the partograph?

Note: Saba. is now in the active phase of labor. Plot this and the following information on the partograph:

- 3 contractions in 10 minutes, each lasting 20–40 seconds
- Fetal heart rate (FHR) 120
- Membranes ruptured, amniotic fluid clear
- Sutures of the skull bones are apposed
- Blood pressure 120/70 mmHg
- Temperature 36.8°C
- Pulse 80/minute
- Urine output 200 mL; negative protein and acetone

Q: What steps should be taken?
Q: What advice should be given?
Q: What do you expect to find at 13.00?

STEP 3

Plot the following information on the partograph:

09.30	FHR 120, Contractions 3/10 each 30 seconds, Pulse 80/minute
10.00	FHR 136, Contractions 3/10 each 30 seconds, Pulse 80/minute
10.30	FHR 140, Contractions 3/10 each 35 seconds, Pulse 88/minute
11.00	FHR 130, Contractions 3/10 each 40 seconds, Pulse 88/minute, Temperature37°C
11.30	FHR 136, Contractions 4/10 each 40 seconds, Pulse 84/minute, Head is 2/5 palpable
12.00	FHR 140, Contractions 4/10 each 40 seconds, Pulse 88/minute
12.30	FHR 130, Contractions 4/10 each 45 seconds, Pulse 88/minute
13.00	FHR 140, Contractions 4/10 each 45 seconds, Pulse 90/minute, Temperature37°C

- 13.00:
  - → The fetal head is 0/5 palpable above the symphysis pubis
  - → The cervix is fully dilated
  - → Amniotic fluid clear
  - → Sutures apposed
  - → Blood pressure 100/70 mmHg
  - → Urine output 150 mL; negative protein and acetone

Q: What steps should be taken?

Q: What advice should be given?

Q: What do you expect to happen next?

STEP 4

Record the following information on the partograph:

- 13.20: Spontaneous birth of a live female infant weighing 2,850 g

Answer the following questions:

Q: How long was the active phase of the first stage of labor?

Q: How long was the second stage of labor?

PARTOGRAPH: CASE 2

STEP 1

- Debritu was admitted at 10.00 on 19.9.2003
- Membranes intact
- Gravida 1, Para 0+0
- Hospital number 1443

Record the information above on the partograph, together with the following details:

- The fetal head is 5/5 palpable above the symphysis pubis
- The cervix is 4 cm dilated
- 2 contractions in 10 minutes, each lasting less than 20 seconds
- FHR 140
- Membranes intact
- Blood pressure 100/70 mmHg
- Temperature 36.2°C
- Pulse 80/minute
- Urine output 400 mL; negative protein and acetone

Q: What is your diagnosis?

Q: What action will you take?

STEP 2

Plot the following information on the partograph:

10.30 FHR 140, Contractions 2/10 each 15 sec, Pulse 90/minute
11.00 FHR 136, Contractions 2/10 each 15 sec, Pulse 88/minute
11.30 FHR 140, Contractions 2/10 each 20 sec, Pulse 84/minute
12.00 FHR 136, Contractions 2/10 each 15 sec, Pulse 88/minute, Temperature 36.2°C, Membranes intact

12.00:

- The fetal head is 5/5 palpable above the symphysis pubis
- The cervix is 4 cm dilated, membranes intact

Q: What is your diagnosis?

Q: What action will you take?

STEP 3

Plot the following information on the partograph:

12.30 FHR 136, Contractions 1/10 each 15 sec, Pulse 90/minute

13.00 FHR 140, Contractions 1/10 each 15 sec, Pulse 88/minute
13.30 FHR 130, Contractions 1/10 each 20 sec, Pulse 88/minute
14.00 FHR 140, Contractions 2/10 each 20 sec, Pulse 90/minute, Temperature 36.8°C, Blood pressure 100/70 mmHg

- 14:00:
  - The fetal head is 5/5 palpable above the symphysis pubis
  - Urine output 300 mL; negative protein and acetone

Q: What is your diagnosis?
Q: What will you do?

Plot the following information on the partograph:

- 14:00:
  - The cervix is 4 cm dilated, sutures apposed
  - Labor augmented with oxytocin 2.5 units in 500 mL IV fluid at 10 drops per minute (dpm)
  - Membranes artificially ruptured, clear fluid

STEP 4

Plot the following information on the partograph:

- 14.30:
  2 contractions in 10 minutes, each lasting 30 seconds
  Infusion rate increased to 20 dpm
  FHR 140, Pulse 90/minute

- 15.00:
  3 contractions in 10 minutes, each lasting 30 seconds
  Infusion rate increased to 30 dpm
  FHR 140, Pulse 90/minute

- 15:30:
  3 contractions in 10 minutes, each lasting 30 seconds
  Infusion rate increased to 40 dpm
  FHR 140, Pulse 88/minute

- 16.00:
  Fetal head 2/5 palpable above the symphysis pubis
  Cervix 6 cm dilated; sutures apposed
  3 contractions in 10 minutes, each lasting 30 seconds
  Infusion rate increased to 50 dpm
  FHR 144, Pulse 92/minute
  Amniotic fluid clear

- 16.30:
  3 contractions in 10 minutes, each lasting 45 seconds
  FHR 140, Pulse 90/minute
  Infusion remains at 50 dpm

Q: What steps would you take?

STEP 5

17.00 FHR 138, Pulse 92/minute, Contractions 3/10 each 40 sec, Maintain at 50 dpm
17.30 FHR 140, Pulse 94/minute, Contractions 3/10 each 45 sec, Maintain at 50 dpm
18.00 FHR 140, Pulse 96/minute, Contractions 4/10 each 50 sec, Maintain at 50 dpm
18.30 FHR 144, Pulse 94/minute, Contractions 4/10 each 50 sec, Maintain at 50 dpm

STEP 6

Plot the following information on the partograph:

- 19.00:
  Fetal head 0/5 palpable above the symphysis pubis
  4 contractions in 10 minutes, each lasting 50 seconds
  FHR 144, Pulse 90/minute
  Cervix fully dilated

STEP 7

Record the following information on the partograph:

- 19.30:
  - 4 contractions in 10 minutes, each lasting 50 seconds
  - FHR 142, Pulse 100/minute
- 20.00:
  - 4 contractions in 10 minutes, each lasting 50 seconds
  - FHR 146, Pulse 110/minute
- 20.10:
  - Spontaneous birth of a live male infant weighing 2,654 g

Answer the following questions:

Q: How long was the active phase of the first stage of labor?
Q: How long was the second stage of labor?
Q: Why was labor augmented?

CASE 3

STEP 1

- Amina was admitted at 10.00 on 19.9.2003
- Membranes ruptured 09.00
- Gravida 4, Para 3+0
- Hospital number 6639

Record the information above on the partograph, together with the following details:

- Fetal head 3/5 palpable above the symphysis pubis
- Cervix 4 cm dilated
- 3 contractions in 10 minutes, each lasting 30 seconds
- FHR 140
- Amniotic fluid clear
- Sutures apposed
- Blood pressure 120/70 mmHg
- Temperature 36.8°C
- Pulse 80/minute
- Urine output 200 mL; negative protein and acetone

STEP 2

Plot the following information in the partograph:

10.30 FHR 130, Contractions 3/10 each 35 sec, Pulse 80/minute
11.00 FHR 136, Contractions 3/10 each 40 sec, Pulse 90/minute
11.30 FHR 140, Contractions 3/10 each 40 sec, Pulse 88/minute
12.00 FHR 140, Contractions 3/10 each 40 sec, Pulse 90/minute, Temperature37°C, Head 3/5 palpable
12.30 FHR 130, Contractions 3/10 each 40 sec, Pulse 90/minute
13.00 FHR 130, Contractions 3/10 each 45 sec, Pulse 88/minute
13.30 FHR 120, Contractions 3/10 each 45 sec, Pulse 88/minute
14.00 FHR 130, Contractions 4/10 each 45 sec, Pulse 90/minute, Temperature37°C, Blood pressure 100/70 mmHg

- 14:00:
  - Fetal head 3/5 palpable above the symphysis pubis
  - Cervix 6 cm dilated, amniotic fluid clear
  - Sutures overlapped but reducible

STEP 3

14.30 FHR 120, Contractions 4/10 each 40 sec, Pulse 90/minute, Clear fluid
15.00 FHR 120, Contractions 4/10 each 40 sec, Pulse 88/minute, Blood-stained fluid
15.30 FHR 100, Contractions 4/10 each 45 sec, Pulse 100/minute
16.00 FHR 90, Contractions 4/10 each 50 sec, Pulse 100/minute, Temperature37°C
16.30 FHR 96, Contractions 4/10 each 50 sec, Pulse 100/minute
17.00 FHR 90, Contractions 4/10 each 50 sec, Pulse 110/minute

- 17:00:
  - Fetal head 3/5 palpable above the symphysis pubis
  - Cervix 6 cm dilated
  - Amniotic fluid meconium stained
  - Sutures overlapped and not reducible
  - Urine output 100 mL; protein negative, acetone 1+

STEP 4

Record the following information on the partograph:

- Cesarean section at 17.30, live female infant with poor respiratory effort and weighing 4,850 g

Answer the following questions:

Q: What is the final diagnosis?
Q: What action was indicated at 14.00, and why?
Q: What action was indicated at 15.00, and why?
Q: At 17.00, a decision was taken to do a cesarean section, and this was rapidly done. Was this a correct action?
Q: What problems may be expected in the newborn?

CASE STUDIES

CASE STUDY 4-1: CHILDBIRTH ASSESSMENT AND CARE

DIRECTIONS

Read and analyze this case study individually. When the others in your group have finished reading it, answer the case study questions. Consider the steps in clinical decision-making as you answer the questions. The other groups in the room are working on the same or a similar case study. When all groups have finished, we will discuss the case studies and the answers each group developed.

CLIENT PROFILE

Wosene is 30 years of age. She attended the antenatal clinic 2 weeks ago and has now come to the hospital with her mother-in-law because labor pains started 3 hours ago. Wosene reports that the pains start in her back and move forward, last 20 seconds, and occur about every 8 minutes. Wosene appears very anxious.

PRE-ASSESSMENT

1. Before beginning your assessment, what should you do for and ask Wosene?

ASSSESSMENT (information gathering through history, physical examination, and testing)

2. What history will you include in your assessment of Wosene and why?
3. What physical examination will you include in your assessment of Wosene and why?
4. What laboratory tests will you include in your assessment of Wosene and why?

DIAGNOSIS (interpreting information to identify problems/needs)

You have completed your assessment of Wosene and your main findings include the following:

History:

- Wosene is 39 weeks pregnant.
- This is her second pregnancy.
- Her first pregnancy and birth were uncomplicated, although she repeatedly states that labor was more painful than she had expected.
- She confirms that labor started 3 hours ago and that contractions seem to be growing increasingly longer and more frequent.
- All other aspects of her history are normal or without significance.

Physical Examination:

- Wosene kneels to the floor and cries out with each contraction.
- On measurement of vital signs: Respirations are 18 per minute, BP is 120/82, Pulse is 88 beats per minute, and Temperature is 37.8 º C.
- On abdominal examination:
  - Fundal height is 33 cm
  - Presenting part is four-fifths above the pelvic brim
  - Fetal heart tones are124 beats per minute
  - Contractions are irregular every 8-10 minutes and last 14-18 seconds
- On cervical examination:
  - Dilation of the cervix is 3 cm
  - Membranes are intact
  - Presentation is vertex and there is no molding
- Her physical exam reveals no abnormal findings.

Testing:

- Blood group is O Positive, RPR is negative, and blood was taken for HIV testing.

5. Based on these findings, what is Wosene's diagnosis (problem/need) and why?

CARE PROVISION (implementing plan of care and interventions)

6. Based on your diagnosis (problem/need identification), what is your plan of care for Wosene and why?

EVALUATION

- Wosene continues to have regular contractions; by 2 hours after admission, she is having 2 contractions in 10 minutes, each lasting 20-40 seconds.
- Maternal pulse remains between 80 and 88 beats per minute; fetal heart rate remains between 150 and 160 beats per minute.
- Wosene 's level of anxiety remains high and she continues to become agitated during contractions.

7. Based on these findings, what is your continuing plan of care for Wosene and why?

REFERENCES

BEmONC—Training manual

CASE STUDY 4-2: CHILDBIRTH ASSESSMENT AND CARE

DIRECTIONS

Read and analyze this case study individually. When the others in your group have finished reading it, answer the case study questions. Consider the steps in clinical decision-making as you answer the questions. The other groups in the room are working on the same or a similar case study. When all groups have finished, we will discuss the case studies and the answers each group developed.

CLIENT PROFILE

Beletech is 25 years of age. Her mother-in-law has brought her to the hospital and reports that she has been in labor for 8 hours and that her membranes ruptured 3 hours ago. You greet Beletech and her mother-in-law respectfully and with kindness. On arrival at the hospital, she had a strong contraction lasting 45 seconds. Because she is showing signs of labor, you complete the Quick Check to detect signs/symptoms of life-threatening complications and, finding none, quickly proceed to physical examination to determine whether birth is imminent. Although Beletech is not pushing, you find that she has a bulging, thin perineum.

ASSSESSMENT (information gathering through history, physical examination, and testing)

1. What history will you include in your assessment of Beletech and why?

2. What physical examination will you include in your assessment of Beletech and why?

3. What laboratory tests will you include in your assessment of Beletech and why?

DIAGNOSIS (interpreting information to identify problems/needs)

You have completed your assessment of Beletech and your main findings include the following:

History:

- Beletech is at term.
- This is her fourth pregnancy.
- Her previous pregnancies/deliveries were uncomplicated.
- All other aspects of her history are normal or without significance.

Physical Examination:

- Vital signs are as follows: Respirations are 20 per minute, BP is 130/82, Pulse is 88 beats per minute, Temperature is 37.8°C.
- On abdominal examination:
    - No scars are noted and uterus is oval-shaped

- Fundal height is 34 cm
- One set of fetal parts are palpable
- Fetus is longitudinal in lie and cephalic presentation
- Presenting part is not palpable above the symphysis
- Fetal heart tones are 148 per minute
- Bladder is not palpable
- Contractions are 3 per 10 minutes, 40–50 seconds in duration each

- On genital and cervical examination:
  - Her cervix is 10 cm dilated and fully effaced
  - Presentation is vertex and the fetal head is on the perineum
  - Visible amniotic fluid is clear
- All other aspects of her physical examination are within normal range.

Testing:

- Test results not yet back at this stage

4. Based on these findings, what is Beletech's diagnosis (problem/need) and why?

CARE PROVISION (implementing plan of care and interventions)

5. Based on your diagnosis (problem/need identification), what is your plan of care for Beletech and why?

EVALUATION

- Beletech has 3 contractions every 10 minutes, each lasting more than 40 seconds.
- After 15 minutes, she begins pushing spontaneously with each contraction.
- After another 15 minutes, she has a spontaneous vertex birth of a baby boy. The baby breathes immediately at birth.
- The third stage of labor has not yet been completed.

6. Based on these findings, what is your continuing plan of care for Beletech and why?

REFERENCES

BEmONC—

CASE STUDY 4-3: UNSATISFACTORY PROGRESS OF LABOR

DIRECTIONS

Read and analyze this case study individually. When the others in your group have finished reading it, answer the case study questions. Consider the steps in clinical decision-making as you answer the questions. The other groups in the room are working on the same or a similar case study. When all groups have finished, we will discuss the case studies and the answers each group has developed.

CASE STUDY

Gifti is an 18-year-old primigravida. She was brought to the health center in active labor at 10:00 am; the fetal head was palpable at 5/5 above the symphysis pubis; the cervix was 4 cm dilated; contractions were two in 10 minutes, each lasting less than 20 seconds. Membranes ruptured spontaneously at 12:00 pm, and amniotic fluid was clear. It is now 2:00 pm, and the fetal head is still 5/5 palpable above the symphysis pubis; the cervix is still 4 cm dilated and is now to the right of the alert line on Gifti's partograph; contractions continue at a rate of two in 10 minutes, lasting less than 20 seconds.

ASSESSMENT (History, Physical Examination, Screening Procedures/Laboratory Tests)

7. What will you include in your initial assessment of Gifti, and why?

8. What particular aspects of Gifti's physical examination will help you make a diagnosis or identify her problems/needs, and why?

9. What screening procedures/laboratory tests will you include (if available) in your assessment of Gifti, and why?

DIAGNOSIS (Identification of Problems/Needs)

You have completed your assessment of Gifti and your main findings include the following:

- Gifti has no symptoms or signs of cephalopelvic disproportion or obstruction.
- Her vital signs are within normal range, as is the fetal heart rate.
- She is not dehydrated.
- She has a high level of anxiety, however, and is finding it difficult to relax between contractions.
- On assessment, the cervix is found to be favorable.

10. Based on these findings, what is Gifti's diagnosis, and why?

CARE PROVISION (Planning and Intervention)

11. Based on your diagnosis, what is your plan of care for Gifti, and why?

EVALUATION

- At 6:00 pm, Gifti is having three contractions in 10 minutes, each lasting more than 40 seconds.
- Her partograph recordings show that her vital signs are normal; the fetal heart rate is within normal range, the cervix is 9 cm dilated, and the fetal head is 1/5 above the symphysis pubis.

12. Based on these findings, what is your continuing plan of care for Gifti, and why?

MODULE -5:

POSTPARTUM
MATERNAL (UP - TO 6 WEEKS) AND NEWBORN CARE

Participant learning objective: after completing this module, participants will be able to describe the aims and standards of postpartum care for both the mother and the newborn, based on the needs, evidences and challenges. It offers guidance on the way postpartum care could be organized. With respect to clinical problems, attention is focused on primary care, directed at the prevention, early diagnosis and treatment of disease and complications, and at referral to hospital if necessary. It introduces the basic components in the provision of care to the neonate who was born either in the institution or at home in the postnatal period.

Enabling objectives

1. Provide basic care to the woman in post-partum period.
2. Detect and provide care for diseases and complications in the post-partum period.
3. Recognize an emergency situation in the women during the postpartum period which requires immediate treatment and, in most cases, urgent referral to a higher level health facility.
4. Provide basic care to the neonate who presented to the health facility in the postnatal period.
5. Describe steps in rapid initial assessment and emergency management of a sick neonate presenting to the health facility.
6. Detect and provide care for sick neonates presenting to the health facility during the postnatal period.

SKILLS PRACTICE SESSION

SKILLS PRACTICE SESSION - 5.1: POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE

PURPOSE

The purpose of this activity is to enable participants to practice assessment of the woman during the postpartum period, including history and physical examination, and achieve competency in the skills required.

INSTRUCTIONS

The first part of this activity (history and physical examination) should be conducted in a simulated setting using the appropriate model(s). The provision of postpartum care should then be practiced in a postpartum clinic or postpartum ward.

Participants should review the Learning Guide 5.1 before beginning the activity. The facilitator should demonstrate the steps/tasks in taking a postpartum **history** for participants. Under the guidance of the facilitator, participants should then work in groups of three to practice the steps/tasks and observe each other's performance; while one participant takes a history from another, the third participant should use the relevant section of Learning Guide 5.1 to observe performance. Participants should then reverse roles until each has had an opportunity to take a history and be observed. Participants should be able to perform the steps/tasks relevant to taking a postpartum history before progressing to physical examination.

The facilitator should demonstrate the steps/tasks in **physical examination** of the postpartum woman for participants. Under the guidance of the facilitator, participants should then work in pairs and, using the appropriate model(s), practice the steps/tasks and observe each other's performance; while one participant does the physical examination, the second participant should use the relevant section of Learning Guide 5.1 to observe performance. Participants should then reverse roles. Participants should be able to perform the steps/tasks for postpartum history and physical examination before skills competency is assessed in the simulated setting by the facilitator, using Checklist 5.1.

The provision of postpartum care should be demonstrated in a postpartum clinic or ward and participants should then be supervised in the practice of postpartum assessment and care. Finally, following supervised practice at a clinical site, the facilitator should assess the skills competency of each participant using Checklist 5.1.

RESOURCES

- Pelvic model
- Sphygmomanometer and stethoscope
- Examination gloves
- 0.5% chlorine solution and receptacle for decontamination
- Leakproof container or plastic bag
- Postpartum record
- Learning Guide 5.1: Postpartum Assessment (History and Physical Examination) and Care
- Checklist 5.1: Postpartum Assessment (History and Physical Examination) and Care

LEARNING GUIDE 5-1: POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently

3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE **(Some of the following steps/tasks should be performed simultaneously.)**					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepare the necessary equipment.					
2. Greet the woman respectfully and acknowledge the newborn.					
3. Review the antenatal and birth records.					
4. Tell the woman (and her support person) what is going to be done, listen to her attentively, and respond to her questions and concerns.					
5. Provide continual emotional support and reassurance, as possible.					
HISTORY **(Ask the following questions if this is the first visit or the information is not available on the woman's record.)**					
Personal Information **(Every Visit for items followed with an "*"; First Visit for other items)**					
1. What is your name and age, and the name of your baby? • If the woman is less than 20 years old, determine the circumstances surrounding the pregnancy (e.g., unprotected sex, multiple partners, incest, sexual abuse, rape, sexual exploitation, prostitution, forced marriage, or forced sex).					
2. What is your address and phone number?					
3. Do you have access to reliable transportation?					
4. What sources of income/financial support do you/your family have?					
5. How many times have you been pregnant and how many children have you had?					

LEARNING GUIDE FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
6. How many of your children are still alive?					
7. Are you having a particular problem at present?* If Yes, find out what the problem is and ask the following additional questions: • When did the problem first start? • Did it occur suddenly or develop gradually? • When and how often does the problem occur? • What may have caused the problem? • Did anything unusual occur before it started? • How does the problem affect you? • Are you eating, sleeping, and doing other things normally? • Has the problem become more severe? • Are there other signs and conditions related to the problem? If Yes, ask what they are. • Have you received treatment for the problem? If Yes, ask who provided the treatment, what it involved, and whether it helped.					
8. Have you received care from another caregiver?* If Yes, ask the following additional questions: • Who provided the care? • Why did you seek care from another caregiver? • What did the care involve? • What was the outcome of this care?					
Daily Habits and Lifestyle **(Every Visit for items followed with an "*"; First Visit for other items)**					
9. Do you work outside the home?*					
10. Do you walk long distances, carry heavy loads, or do physical labor?*					
11. Do you get enough sleep/rest?*					
12. What do you normally eat in a day?*					
13. Do you smoke, drink alcohol, or use any other possibly harmful substances?					
14. Who do you live with?					
15. Has anyone ever prevented you from seeing family or friends, stopped you from leaving your home, or threatened your life?					
16. Have you ever been injured, hit, or forced to have sex by someone?					
17. Are you frightened of anyone?					

LEARNING GUIDE FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
Present Pregnancy and Childbirth (First Visit)					
18. When did you have your baby?					
19. Where did you have your baby and who attended the birth?					
20. Did you have any vaginal bleeding during this pregnancy?					
21. Did you have any complications during this childbirth, such as convulsions (pre-eclampsia/eclampsia), cesarean section or other uterine surgery, vaginal or perineal tears, episiotomy, or defibulation?					
22. Were there any complications with the baby?					
Present Postpartum Period (Every Visit)					
23. Have you had any heavy bleeding since you gave birth?					
24. What color is your vaginal discharge and how often do you need to change your pad/cloth?					
25. Have you had any problems with bowel or bladder function (e.g., incontinence, leakage of urine/feces from vagina, burning on urination, inability to urinate when urge is felt, and constipation)?					
26. Do you feel good about your baby and your ability to take care of her/him? If No, ask the following additional questions: • Are you feeling sad or overwhelmed? • Are you not eating or sleeping well? • Have you been crying or feeling more irritable than usual?					
27. Is your family adjusting to the baby?					
28. Do you feel that breastfeeding is going well?					
Previous Postpartum History (First Visit)					
29. Have you breastfed a baby before? If Yes, ask the following additional questions: • For how long did you breastfeed your baby(ies)? • Did you have any previous problems breastfeeding?					
30. Did you have any complications, such as convulsions (pre-eclampsia/eclampsia) or postpartum depression/psychosis following previous births?					
Contraceptive History (First Visit)					
31. How many more children do you plan to have?					

LEARNING GUIDE FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
32. Have you used a family planning method before? If Yes, ask the following additional questions: • Which method(s) have you used? • Did you like the method(s) and why? • Which method did you like the most and why? (if more than one method used) • Would you like information about other methods?					
33. Are you going to use family planning in the future?					
Medical History **(Every Visit for items followed with an "*"; First Visit for other items)**					
34. Do you have any allergies?					
35. Have you been tested for HIV? If Yes, ask whether the result was positive.					
36. Have you had anemia recently (within the last three months)? If Yes, obtain additional information about signs and symptoms and possible cause.					
37. Have you been tested for syphilis? If Yes, ask whether the result was positive and if and when and with what she was treated.					
38. Have you had any chronic illness/condition, such as tuberculosis, hepatitis, heart disease, diabetes, or any other chronic illness?					
39. Have you ever been in hospital or had surgery/an operation?					
40. Are you taking any drugs/medications, including traditional/local preparations, herbal remedies, over-the-counter drugs, vitamins, and dietary supplements?*					
41. Have you had a complete series of five tetanus toxoid immunizations?					
42. When did you have your last booster of tetanus toxoid?					
Interim History (Return Visits)					
43. Do you have a problem at present? If Yes, ask follow-up questions under "Personal Information" item 7, above.					
44. Have you had any problems since your last visit?					
45. Has your address or phone number changed since your last visit?					
46. Have your daily habits or lifestyle (workload, rest, dietary intake) changed since your last visit?					

LEARNING GUIDE FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
47. Have you received care from another caregiver since your last visit? If Yes, ask who provided the care, what care was provided, and what the outcome of care was?					
48. Have you taken drugs/medications prescribed and followed the advice/recommendations (plan of care) provided at your last visit?					
49. Have you had any reactions to or side effects from immunizations or drugs/medications given at your last visit?					
PHYSICAL EXAMINATION					
Assessment of General Well-Being (Every Visit)					
1. Observe gait and movements, and behavior and facial expressions. • If not normal for the woman's culture, ask if she has: - been without food or drink for a prolonged period; - been taking drugs/medications; - had an injury					
2. Observe general cleanliness, noting visible dirt and odor.					
3. Check skin, noting lesions and bruises.					
4. Check conjunctiva for pallor.					
Vital Signs Measurements (Every Visit)					
5. Have the woman remain seated and relaxed.					
6. Measure blood pressure, temperature, and pulse.					
Breast Examination (Every Visit)					
7. Explain the next steps in the physical examination to the woman and obtain her consent to proceed.					
8. Ask the woman to empty her bladder.					
9. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.					
10. Ask the woman to uncover her body from the waist up, and have her lie comfortably on her back.					
11. Check the contours and skin of the breasts, noting dimpling or visible lumps, scaliness, thickening, redness, lesions, sores, and rashes.					
12. Gently palpate breasts, noting tenderness and swelling, and areas that are red and hot.					

LEARNING GUIDE FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
13. Check nipples, noting pus or bloody discharge, cracks, fissures, or other lesions, and whether nipples are inverted.					
Abdominal Examination (Every Visit)					
14. Ask the woman to uncover her stomach.					
15. Have her lie on her back with her knees slightly bent.					
16. Look for old or new incisions on the abdomen: • If there is an incision (sutures) from cesarean section or other uterine surgery, look for signs of infection.					
17. Gently palpate abdomen between umbilicus and symphysis pubis, noting size and firmness of uterus.					
18. Check whether bladder is palpable above the symphysis pubis.					
Leg Examination (Every Visit)					
19. Grasp one of the woman's feet with one hand and gently but firmly move the foot upwards toward the woman's knee, and observe whether this causes pain in the calf.					
20. Repeat the procedure on the other leg.					
Vaginal Examination (Every Visit)					
21. Ask the woman to uncover her genital area and cover or drape her to preserve privacy and modesty.					
22. Ask the woman to separate her legs while continuing to bend her knees slightly.					
23. Turn on the light and direct it toward genital area.					
24. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.					
25. Put new examination or high-level disinfected gloves on both hands.					
26. Touch the inside of the woman's thigh before touching any part of her genital area.					
27. Separate labia majora with two fingers, and check labia minora, clitoris, urethral opening, and vaginal opening, noting swelling, tears, episiotomy, defibulation, sores, ulcers, warts, nits, lice, or urine or stool coming from vaginal opening.					
28. Palpate the labia minora, noting swelling, discharge, tenderness, ulcers, fistulas, irregularities, and nodules.					
29. Look at perineum, noting scars, lesions, inflammation, or cracks in skin, bruising, and color, odor and amount of lochia.					

LEARNING GUIDE FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
30. Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out: • If disposing of gloves (examination gloves and surgical gloves that will not be reused), place in a plastic bag or leakproof, covered waste container; • If reusing surgical gloves, submerge in 0.5% chlorine solution for 20 minutes for decontamination.					
31. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.					
CARE PROVISION **Note:** ***Individualize the woman's care by considering all information gathered during assessment.***					
HIV Counseling					
1. If the woman does not know her HIV status or has not been tested for HIV, provide HIV counseling and testing.					
Breastfeeding and Breast Care					
2. Based on the woman's breastfeeding history, provide information about the following: • Exclusive breastfeeding on demand; • Comfortable positions for breastfeeding and use of both breasts; • Adequate rest and sleep; • Extra fluid and food intake; • Breast care.					
Complication Readiness					
3. Review the woman's complication readiness plan with her (or develop one if she does not have one), covering: • Arrangements made since last visit; • Changes; • Obstacles or problems encountered.					
Mother-Baby-Family Relationships					
4. Encourage family involvement with the newborn and assist the family to identify challenges/obstacles and devise strategies for overcoming them.					
Family Planning					

LEARNING GUIDE FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
5. Introduce the concepts of birth spacing and family planning: • Discuss the woman's previous experience with and beliefs about contraception, as well as her preferences; • Discuss the lactational amenorrhea method and its benefits; • Advise on the availability and accessibility of family planning services.					
Nutritional Support					
6. Provide advice and counseling about diet and nutrition: • All postpartum women should eat a balanced diet and a variety of foods rich in iron and vitamin A, calcium, magnesium, and vitamin C; • Women who are breastfeeding should: - eat two additional servings of staple food per day; - eat three additional servings of calcium-rich foods; - drink at least eight glasses of fluid (two liters) each day (including milk, water, and juices); - eat smaller more frequent meals, if necessary; - avoid alcohol and tobacco; - try to decrease amount of heavy work and increase rest time.					
Self-Care and Other Healthy Behaviors					
7. Provide advice and counseling about: • Prevention of infection/hygiene • Rest and activity • Sexual relations and safer sex					
Immunizations and Other Prophylaxis					
8. Give tetanus toxoid (TT) based on woman's need.					
9. Dispense sufficient supply of iron/folate until next visit and counsel the woman about the following: • Eat food rich in vitamin C; • Avoid tea, coffee, and colas; • Possible side effects and management.					

LEARNING GUIDE FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
10. Dispense medications as follows: • Antimalarial tablets (based on region/population-specific need); • Mebendazole (based on region/population-specific need); • Vitamin A (based on region/population-specific need); • Iodine (based on region/population-specific need).					
Return Visits					
11. Schedule the next postnatal visit: • Make sure the woman knows when and where to come; • Answer any additional questions or concerns; • Advise her to bring her records with her to each visit; • Make sure she understands that she can return any time before the next scheduled visit if she has a problem; • Review danger signs and key points of the complication readiness plan; • Thank the woman for coming.					

CHECKLIST 5-1: POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE

(To be used by the **Facilitator** at the end of the module)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

PARTICIPANT _____Date Observed _____

CHECKLIST FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE **(Some of the following steps/tasks should be performed simultaneously.)**					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepares the necessary equipment.					
2. Greets the woman respectfully and with kindness.					
3. Tells the woman (and her support person) what is going to be done, listens to her attentively, and responds to her questions and concerns.					
4. Provides continual emotional support and reassurance, as possible.					
Skill/activity performed satisfactorily					
HISTORY **(Ask the following questions if the information is not available on the woman's record.)**					
Personal Information **(Every Visit for items followed with an "*"; First Visit for other items)**					
1. What is your name and age, and the name of your baby?					
2. What is your address and your phone number?					
3. Do you have access to reliable transportation?					
4. What sources of income/financial support do you/your family have?					
5. How many times have you been pregnant and how many children have you had?					
6. How many of your children are still living?					
7. Are you having a particular problem at present?*					
8. Have you received care from another caregiver?*					

CHECKLIST FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
Daily Habits and Lifestyle **(Every Visit for items followed with an "*"; First Visit for other items)**					
9. Do you work outside the home?*					
10. Do you walk long distances, carry heavy loads, or do physical labor?*					
11. Do you get enough sleep/rest?*					
12. What do you normally eat in a day?*					
13. Do you eat any substances such as dirt or clay?					
14. Do you smoke, drink alcohol, or use any other possibly harmful substances?					
15. Who do you live with?					
16. Has anyone ever prevented you from seeing family or friends, stopped you from leaving your home, or threatened your life?					
17. Have you ever been injured, hit, or forced to have sex by someone?					
18. Are you frightened of anyone?					
Present Pregnancy and Childbirth (First Visit)					
19. When did you have your baby?					
20. Where did you have your baby and who attended the birth?					
21. Did you have any vaginal bleeding during this pregnancy?					
22. Did you have any complications during this childbirth?					
23. Were there any complications with the baby?					
Present Postpartum Period (Every Visit)					
24. Have you had any heavy bleeding since you gave birth?					
25. What color is your vaginal discharge and how often do you need to change your pad/cloth?					
26. Have you had any problems with bowel or bladder function?					
27. Do you feel good about your baby and your ability to take care of her/him?					
28. Is your family adjusting to the baby?					
29. Do you feel that breastfeeding is going well?					
Previous Postpartum History (First Visit)					
30. Have you breastfed a baby before?					
31. Did you have any complications following previous childbirths?					

CHECKLIST FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
Contraceptive History (First Visit)					
32. How many more children do you plan to have?					
33. Have you used a family planning method before?					
34. Are you going to use family planning in the future?					
Medical History **(Every Visit for items followed with an "*"; First Visit for other items)**					
35. Do you have any allergies?					
36. Have you been tested for HIV?					
37. Have you had anemia recently?					
38. Have you been tested for syphilis?					
39. Have you had any chronic illness/condition, such as tuberculosis, hepatitis, heart disease, diabetes, or any other chronic illness?					
40. Have you ever been in hospital or had surgery/an operation?					
41. Are you taking any drugs/medications, including traditional/local preparations, herbal remedies, over-the-counter drugs, vitamins, and dietary supplements?*					
42. Have you had a complete series of five tetanus toxoid immunizations?					
43. When did you have your last booster of tetanus toxoid?					
Interim History (Return Visits)					
44. Do you have a problem at present?					
45. Have you had any problems since your last visit?					
46. Has your address or phone number changed since your last visit?					
47. Have your daily habits or lifestyle (workload, rest, dietary intake) changed since your last visit?					
48. Have you received care from another caregiver since your last visit?					
49. Have you taken drugs/medications prescribed and followed the advice/recommendations (plan of care) provided at your last visit?					
50. Have you had any reactions to or side effects from immunizations or drugs/medications given at your last visit?					
Skill/activity performed satisfactorily					
PHYSICAL EXAMINATION					
1. Observe gait and movements, and behavior and facial expressions.					

CHECKLIST FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
2. Observes general hygiene, noting visible dirt and odor.					
3. Checks skin, noting lesions and bruises.					
4. Checks conjunctive for pallor.					
5. Have the woman remain seated and relaxed, and measure her blood pressure, temperature, and pulse.					
6. Explains the next steps in the physical examination to the woman and obtains her consent to proceed.					
7. Asks the woman to empty her bladder.					
8. Washes hands thoroughly.					
9. Ask the woman to uncover her body from the waist up, have her lie comfortably on her back, and examines her breasts, noting any abnormalities.					
10. Asks the woman to uncover her stomach and lie on her back with her knees slightly bent.					
11. Looks for old or new incisions on the abdomen, and gently palpates abdomen between umbilicus and symphysis pubis, noting size and firmness of uterus, and checks whether bladder is palpable above the symphysis pubis.					
12. Examines the woman's legs, noting any calf pain.					
13. Asks the woman to uncover her genital area, covers or drapes her to preserve privacy and modesty, and asks her to separate her legs.					
14. Turns on the light and directs it toward genital area.					
15. Washes hands thoroughly and puts new examination or high-level disinfected gloves on both hands.					
16. Inspects/examines labia, clitoris, and perineum, noting lochia, scars, bruising, and skin integrity.					
17. Immerses both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out: • If disposing of gloves (examination gloves and surgical gloves that will not be reused), places in a plastic bag or leakproof, covered waste container; • If reusing surgical gloves, submerge in 0.5% chlorine solution for 20 minutes for decontamination.					
18. Washes hands thoroughly.					

CHECKLIST FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
Skill/activity performed satisfactorily					
CARE PROVISION **Note:** Individualize the woman's care by considering all information gathered during assessment.					
1. If the woman does not know her HIV status or has not been tested fro HIV, provides HIV counseling.					
2. Based on the woman's breastfeeding history, provides information about breast feeding and breast care.					
3. Reviews the woman's complication readiness plan with her (or develop one if she does not have one.					
4. Encourages family involvement with the newborn and assists the family to identify challenges/obstacles and devise strategies for overcoming them.					
5. Introduces the concepts of birth spacing and family planning.					
6. Provides advice and counseling about diet and nutrition.					
7. Provides advice and counseling about self-care.					
8. Gives tetanus toxoid (TT) based on woman's need.					
9. Dispenses sufficient supply of iron/folate until next visit and counsels the woman about taking the pills.					
10. Dispenses other medications based on need.					
11. Schedules the next antenatal visit.					
Skill/activity performed satisfactorily					

SKILLS PRACTICE SESSION – 5-2: ASSESSMENT OF THE NEWBORN

PURPOSE

The purpose of this activity is to enable participants to practice newborn assessment, including history and physical examination, and achieve competency in the skills required.

INSTRUCTIONS

This activity should be conducted in a simulated setting, using an appropriate model.

Participants should review Learning Guide 5.2, before beginning the activity.

The facilitator should demonstrate the steps/tasks in taking a newborn **history** for participants. Under the guidance of the facilitator, participants should then work in groups of three to practice the steps/tasks and observe each other's performance; while one participant takes a history from another, the third participant should use the relevant section of Learning Guide 5.2 to observe performance. Participants should then reverse roles until each has had an opportunity to take a history and be observed. Participants should be able to perform the steps/tasks relevant to taking a newborn history before progressing to physical examination of the newborn.

The facilitator should demonstrate the steps/tasks in physical examination of the newborn for participants. Under the guidance of the facilitator, participants should then work in pairs and, using the newborn doll, practice the steps/tasks and observe each other's performance; while one participant does the physical examination, the second participant should use the relevant section of Learning Guide 5.2 to observe performance. Participants should then reverse roles. Participants should be able to perform the steps/tasks in taking a newborn history and doing a newborn physical examination, as outlined Learning Guide 5.2, before skills competency is assessed in the simulated setting by the trainer, using Checklist 5.2.

Finally, following supervised practice at a clinical site, the facilitator should assess the skills competency of each participant using Checklist 5.2, including breastfeeding and mother-baby bonding.

Note: Observation of breastfeeding and mother-baby bonding should be practiced and assessed at the clinical site, under the guidance of the facilitator.

RESOURCES

- Newborn doll
- Cloth or baby blanket to wrap doll
- Baby weigh scale
- Thermometer
- Newborn record
- Learning Guide 5.2: Assessment of the Newborn
- Checklist 5.2: Assessment of the Newborn

LEARNING GUIDE – 5-2: ASSESSMENT OF THE NEWBORN

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

LEARNING GUIDE FOR ASSESSMENT OF THE NEWBORN (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepare the necessary equipment.					
2. Greet the woman respectfully and offer her a seat					
3. Tell the mother what you are going to do, encourage her to ask questions, and listen to what she has to say.					
HISTORY **(Ask the following questions if the information is not available on the mother's/baby's record.)**					
Personal Information (First Visit)					
1. What is your name, address, and phone number?					
2. What is the name and sex of your baby?					
3. When was your baby born?					
4. Do you have access to reliable transportation?					
5. What sources of income/financial support do you/your family has?					
6. How many times have you been pregnant and how many children have you had?					

LEARNING GUIDE FOR ASSESSMENT OF THE NEWBORN (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
7. Is your baby having a particular problem at present? If Yes, find out what the problem is and ask the following additional questions: • When did the problem first start? • Did it occur suddenly or develop gradually? • When and how often does the problem occur? • What may have caused the problem? • Did anything unusual occur before it started? • How does the problem affect your baby? • Is the baby eating, sleeping, and behaving normally? • Has the problem become more severe? • Are there other signs and conditions related to the problem? If Yes, ask what they are. • Has the baby received treatment for the problem? If Yes, ask who provided the treatment, what it involved, and whether it helped.					
8. Has your baby received care from another caregiver? If Yes, ask the following additional questions: • Who provided the care? • Why did you seek care from another caregiver? • What did the care involve? • What was the outcome of this care?					
The Birth (First Visit)					
9. Where was your baby born and who attended the birth?					
10. Did you have an infection (in the uterus) or fever during labor or birth?					
11. Did your bag of water break more than 18 hours before the birth?					
12. Were there any complications during the birth that may have caused injury to the baby (e.g., shoulder dystocia, breech birth, large baby, vacuum extraction, or forceps)?					
13. Did the baby need resuscitation (help to breathe) at birth?					
14. How much did the baby weigh at birth?					
Medical History (First Visit)					
15. Do you have diabetes?					
16. Have you had any infectious diseases such as hepatitis B, HIV, syphilis, or TB?					
17. Does the baby have a congenital malformation (a deformity at birth)?					
18. Has the baby received newborn immunizations such as for polio, TB, and hepatitis B?					
Newborn Period (Every Visit)					

LEARNING GUIDE FOR ASSESSMENT OF THE NEWBORN (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
19. Do you feel good about your baby and your ability to take care of her/him? If No, ask the following additional questions: • Are you feeling sad or overwhelmed? • Are you not sleeping or eating well? • Have you been crying or feeling more irritable than usual?					
20. Is your family adjusting to the baby?					
21. Do you feel that breastfeeding is going well?					
22. How often does the baby feed?					
23. Does the baby seem satisfied after feeding?					
24. How often does the baby urinate?					
25. Has the baby passed the first stool?					
26. When was the last time the baby passed stool? What was the color/consistency?					
Interim History (Return Visits)					
27. Is your baby having a problem at present? Has he/she had any problem since the last visit? If Yes, ask the follow-up questions under item 7, above.					
28. Has your baby received care from another caregiver since the last visit? If Yes, ask the follow-up questions under item 8, above.					
29. Have there been any changes in your address or phone number since the last visit?					
30. Have there been any changes in the baby's habits or behaviors since the last visit?					
31. Have you been able to care for the baby as discussed at the last visit?					
32. Has the baby had any reactions or side effects from immunizations, drugs/medications, or any care provided since the last visit?					
EXAMINING THE NEWBORN					
Assessment of Overall Appearance/Well-Being (Every Visit)					
1. Tell the mother what you are going to do, encourage her to ask questions, and listen to what she has to say.					
2. Wash hands thoroughly with soap and water and dry with a clean dry cloth or air dry.					
3. Wear clean examination gloves if the baby has not been bathed since birth, if the cord is touched, or if there is blood, urine, and/or stool present.					
4. Place the baby on a clean, warm surface or examine her/him in the mother's arms.					

LEARNING GUIDE FOR ASSESSMENT OF THE NEWBORN (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
5. Count the respiratory rate for one full minute and observe whether there is grunting or chest indrawing.					
6. Measure the temperature:					
7. Observe color, noting any central cyanosis, jaundice, or pallor.					
8. Observe movements and posture, noting any asymmetrical movements, convulsions, spasms, or opisthotonus.					
9. Observe level of alertness and muscle tone, noting response to stimuli, arousal from sleep, floppiness or lethargy, and irritability.					
10. Observe skin, noting any bruises, cuts, and abrasions.					
11. Weigh the baby.					
Head, Face and Mouth, Eyes					
12. Examine head, noting size and shape.					
13. Examine face, noting facial features and movements.					
14. Examine mouth, noting intactness of tongue, gums, and palate: • Use the little finger to feel the palate for any subcutaneous cleft.					
15. Examine eyes, noting any swelling, redness, or pus draining from them.					
Chest, Abdomen and Cord, and External Genitalia					
16. Examine chest, noting regularity and symmetry of movements.					
17. Examine abdomen and cord, noting shape of abdomen and whether blood is oozing from cord or whether there is any redness or hardened skin around the umbilicus, or an offensive odor.					
18. Examine genitals and anus (the urethral opening is at the end of the penis in term baby boys; term baby girls may have a mucoid or bloody vaginal discharge; genitals in both sexes may be swollen after birth; and patency of anus is confirmed when meconium is passed).					
Back and Limbs					
19. Examine back, noting any swelling, lesions, dimples, or hairy patches.					
20. Examine limbs, noting position and appearance, symmetrical movements, swelling over bone, or crying when arm, shoulder, or leg is touched.					
21. Immerse both gloved hands in 0.5% chlorine solution: • Remove gloves by turning them inside out; • If disposing of gloves, place in leakproof container or plastic bag; • If reusing gloves, submerge in 0.5% chlorine solution for 10 minutes to decontaminate.					
22. Wash hands thoroughly with soap and water and dry them with a clean, dry cloth or allow them to air dry.					

LEARNING GUIDE FOR ASSESSMENT OF THE NEWBORN (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
Breastfeeding (Every Visit)					
23. Help the woman feel relaxed and confident throughout the observation.					
24. Look for signs of good positioning: • Mother is comfortable with back and arms supported; • Baby's head and body are aligned and abdomen turned toward mother; • Baby's face is facing breast with nose opposite nipple; • Baby's body is held close to mother; • Baby's whole body is supported.					
25. Look for signs of good attachment: • Nipple and areola are drawn into baby's mouth; • Mouth is wide open; • Lower lip is curled back below base of nipple.					
26. Look for signs of effective suckling: • Slow deep sucks, often with visible or audible swallowing; • Baby pauses occasionally.					
27. Look for signs of finishing breastfeed: • Baby should release breast her/himself; • Feeding may vary in length from four to 40 minutes per breast; • Breasts are softer at end of feeding.					
Mother-Baby Bonding (Every Visit)					
28. Look for the following signs of bonding: • Mother appears to enjoy physical contact with baby; • Mother caresses, talks to, and makes eye contact with baby; • Mother responds with active concern to baby's crying or need for attention.					

CHECKLIST – 5-2: ASSESSMENT OF THE NEWBORN

(To be used by the **Facilitator** at the end of the module)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant/student does not progress from step to step efficiently
3. **Not Observed:** Step, task or skill not performed by participant during evaluation by trainer.

PARTICIPANT _____Date Observed _____

CHECKLIST FOR ASSESSMENT OF THE NEWBORN (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepares the necessary equipment.					
2. Tells the mother what you are going to do, encourages her to ask questions, and listens to what she has to say.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
HISTORY **(Ask the following questions if the information is not available on the mother's/baby's record.)**					
Personal Information (First Visit)					
1. What is your name, address, and phone number?					
2. What is the name and sex of your baby?					
3. When was your baby born?					
4. Do you have access to reliable transportation?					
5. What sources of income/financial support do you/your family have?					
6. How many times have you been pregnant and how many children have you had?					
7. Is your baby having a particular problem at present?					
8. Has your baby received care from another caregiver?					
The Birth (First Visit)					
9. Where was your baby born and who attended the birth?					
10. Did you have an infection (in the uterus) or fever during labor or birth?					
11. Did your bag of water break more than 18 hours before the birth?					

CHECKLIST FOR ASSESSMENT OF THE NEWBORN (Some of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
12. Were there any complications during the birth that may have caused injury to the baby?					
13. Did the baby need resuscitation (help to breathe) at birth?					
14. How much did the baby weigh at birth?					
Medical History (First Visit)					
15. Do you have diabetes?					
16. Have you had any infectious diseases such as hepatitis B, HIV, syphilis, or TB?					
17. Does the baby have a congenital malformation (a deformity at birth)?					
18. Has the baby received newborn immunizations such as for polio, TB, and hepatitis B?					
Newborn Period (Every Visit)					
19. Do you feel good about your baby and your ability to take care of her/him?					
20. Is your family adjusting to the baby?					
21. Do you feel that breastfeeding is going well?					
22. How often does the baby feed?					
23. Does the baby seem satisfied after feeding?					
24. How often does the baby urinate?					
25. Has the baby passed the first stool?					
26. When was the last time the baby passed stool? What was the color/consistency?					
Interim History (Return Visits)					
27. Is your baby having a problem at present? Has s/he had any problem since the last visit?					
28. Has your baby received care from another caregiver since the last visit?					
29. Have there been any changes in your address or phone number since the last visit?					
30. Have there been any changes in the baby's habits or behaviors since the last visit?					
31. Have you been able to care for the baby as discussed at the last visit?					
32. Has the baby had any reactions or side effects from immunizations, drugs/medications, or any care provided since the last visit?					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

CHECKLIST FOR ASSESSMENT OF THE NEWBORN (Some of the following steps/tasks should be performed simultaneously.)						
STEP/TASK	**CASES**					
EXAMINING THE NEWBORN						
Assessment of Overall Appearance/Well-Being (Every Visit)						
1. Tells the mother what you are going to do, encourages her to ask questions, and listens to what she has to say.						
2. Washes hands thoroughly and puts on clean examination gloves, if necessary.						
3. Places the baby on a clean, warm surface or examine her/him in the mother's arms.						
4. Weighs the baby.						
5. Measures respiratory rate and temperature.						
6. Observes color, movements and posture, level of alertness and muscle tone, and skin, noting any abnormalities.						
7. Examines head, face and mouth, eyes, noting any abnormalities.						
8. Examines chest, abdomen and cord, and external genitalia, noting any abnormalities.						
9. Examines back and limbs, noting any abnormalities.						
10. Immerses both gloved hands in 0.5% chlorine solution: • Removes gloves by turning them inside out; • If disposing of gloves, places in leakproof container or plastic bag; • If reusing gloves, submerges in 0.5% chlorine solution for 10 minutes to decontaminate.						
11. Washes hands thoroughly with soap and water and dries them with a clean, dry cloth or allow them to air dry.						
Breastfeeding (Every Visit)						
12. Helps the woman feel relaxed and confident throughout the observation.						
13. Looks for signs of good positioning and attachment						
14. Looks for signs of effective suckling.						
15. Looks for signs of finishing breastfeed.						
Mother-Baby Bonding (Every Visit)						
16. Looks for signs of bonding.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						

CASE STUDIES

CASE STUDY- 5.1: POSTPARTUM ASSESSMENT AND CARE

DIRECTIONS

Read and analyze this case study individually. When the others in your group have finished reading it, answer the case study questions. Consider the steps in clinical decision-making as you answer the questions. The other groups in the room are working on the same or a similar case study. When all groups have finished, we will discuss the case studies and the answers each group developed.

CLIENT PROFILE

Lili gave birth 2 weeks ago. Her pregnancy, labor, and birth were uncomplicated. This is her first postpartum clinic visit. Lili has one other child, who is three years of age. She does not want to become pregnant again for at least 2 years. Lili left her baby at home with her mother-in-law, but reports that the baby is well and had a routine check-up by the SBA when the baby was one week old.

PRE-ASSESSMENT

1. Before beginning your assessment, what should you do for and ask Lili?

ASSSESSMENT (information gathering through history, physical examination, & testing)

2. What history will you include in your assessment of Lili and why?
3. What physical examination will you include in your assessment of Lili and why?
4. What laboratory tests will you include in your assessment of Lili and why?

DIAGNOSIS (interpreting information to identify problems/needs)

You have completed your assessment of Lili and your main findings include the following:

History:

- Lili is feeling well.
- Lili reports no complications or problems during this pregnancy labor/childbirth, or postpartum period. Her medical history is not significant: she is taking no medications, nor does she have any chronic conditions or illnesses.
- Lili's first child is well and was breastfed for 6 months.
- She is exclusively breastfeeding her baby and intends to do so for at least 6 months.
- She wants to know whether she should start using contraception now, as she does not want to become pregnant again for at least 2 years.

- All other aspects of her history are normal or without significance.

Physical Examination:

- Lili's general appearance is healthy.
- Vital signs are as follows: BP is 120/76, Pulse is 78 beats per minute, and Temperature is 37.6°C.
- Her breasts appear normal.
- Her abdominal exam is without significant findings and involution is proceeding normally.
- Her lochia is a pale, creamy brown in color
- All other aspects of her physical examination are within normal range.

Testing:

HIV test is negative.

5. Based on these findings, what is Lili's diagnosis (problem/need) and why?

CARE PROVISION (implementing plan of care and interventions)

6. Based on your diagnosis (problem/need identification), what is your plan of care for Lili and why?

EVALUATION

- Lili returns to the clinic at 6 weeks postpartum.
- She is well.
- She tells you that she is still breastfeeding exclusively/on demand and her menses have not returned.
- She also says she has decided to return to work, on a part-time basis, when her baby is 4 months of age, and will only be partially breastfeeding from then on.
- She asks whether she should start taking a contraceptive.

7. Based on these findings, what is your continuing plan of care for Lili and why?

REFERENCES

BEmONC—

CASE STUDY – 5.2: FEVER AFTER CHILDBIRTH

DIRECTIONS

Read and analyze this case study individually. When the others in your group have finished reading it, answer the case study questions. Consider the steps in clinical decision-making as you answer the questions. The other groups in the room are working on the same or a similar case study. When all groups have finished, we will discuss the case studies and the answers each group has developed.

CASE STUDY

W/O Bosena is a 35-year-old para three mother who gave birth at home 48 hours ago. Her pregnancy was term and her birth was attended by a trained birth attendant (TBA). Labor lasted 2 days and the TBA inserted herbs into W/O Bosena's vagina to help speed up the birth. The baby breathed spontaneously and appears healthy. W/O Bosena's mother-in-law has brought her to the health center today because she has had fever and chills for the past 24 hours.

ASSESSMENT (History, Physical Examination, Screening Procedures/Laboratory Tests)

What will you include in your initial assessment of W/O Bosena, and why?

1. What particular aspects of W/O Bosena's physical examination will help you make a diagnosis or identify her problems/needs, and why?
2. What screening procedures/laboratory tests will you include (if available) in your assessment of W/O Bosena, and why?

DIAGNOSIS (Identification of Problems/Needs)

You have completed your assessment of W/O Bosena and your main findings include the following:

- W/O Bosena's temperature is 39.8º C, her pulse rate is 136 beats/minute, her blood pressure is 70/40 mm Hg and her respiration rate is 24 breaths/minute.
- She is pale and lethargic and slightly confused.
- She has lower abdominal pain, her uterus is soft and tender, and she has foul-smelling vaginal discharge.
- It is not known whether the placenta was complete.
- W/O Bosena is fully immunized against tetanus.

3. Based on these findings, what is W/O Bosena's diagnosis, and why?

CARE PROVISION (Planning and Intervention)

4. Based on your diagnosis, what is your plan of care for W/O Bosena, and why?

EVALUATION

Thirty-six hours after initiation of treatment, you find the following:

- W/O Bosena's temperature is 38º C, her pulse rate is 96 beats/minute, her blood pressure is 110/70 mm Hg and her respiration rate is 20 breaths/minute.
- She is less pale and no longer confused.

5. Based on these findings, what is your continuing plan of care for W/O Bosena, and why?

CASE STUDY - 5.3: COMMON NEWBORN PROBLEMS

DIRECTIONS

Read and analyze this case study individually. When the others in your group have finished reading it, answer the case study questions. Consider the steps in clinical decision-making as you answer the questions. The other groups in the room are working on the same or a similar case study. When all groups have finished, we will discuss the case studies and the answers each group developed.

CLIENT PROFILE

Biritu is 30 years of age and gave birth to her third baby at home 5 days ago. Her pregnancy, labor, and birth were uncomplicated. Biritu noticed yesterday that her baby's cord stump had an offensive smell. She has brought Baby Alemayehu to the health center for the first time today because she is concerned that the cord may be infected.

PRE-ASSESSMENT

1 Before beginning your assessment, what should you do for and ask Biritu and Baby Alemayehu?

ASSSESSMENT (information gathering through history, physical examination, and testing)

2 What history will you include in your assessment of Baby Alemayehu and why?

3 What physical examination will you include in your assessment of Baby Alemayehu and why?

4 What laboratory tests will you include in your assessment of Baby Alemayehu and why?

DIAGNOSIS (interpreting information to identify problems/needs)

You have completed your assessment of Baby Alemayehu and your main findings include the following:

Quick Check:

No danger signs or other significant findings except for foul smelling cord.

RIA:

No significant findings or need for resuscitation.

History:

- Baby weighed 3 kg at birth
- Biritu reports that she had no infection during pregnancy, labor, or birth. There were no other complications for her or her baby at labor or birth.
- The birth was attended by a doctor in a primary healthcare center.
- Baby Alemayehu is reportedly breastfeeding well.
- Biritu denies covering cord or putting any substance on the cord.
- All other aspects of her history are normal or without significance.

Physical Examination:

- Baby Alemayehu weighs 3 kg.
- Vital signs are as follows: Respirations are 40 per minute, Temperature is 37.0°C.
- Baby Alemayehu has a moist cord stump that has an offensive smell.
- None of the following are observed: draining pus, redness and swelling of the skin extending more than 1 cm beyond umbilicus, skin lesions, red hard surrounding skin, or distended abdomen.
- You observe that Baby Alemayehu is breastfeeding well
- All other aspects of her physical examination are within normal range.

1. Based on these findings, what is Baby Alemayehu's diagnosis (problem/need) and why?

CARE PROVISION (implementing plan of care and interventions)

2. Based on your diagnosis (problem/need identification), what is your plan of care for Baby Alemayehu and why?

EVALUATION

- Biritu and Baby Alemayehu return to the clinic the next day because her mother-in-law has instructed her to not continue the treatment, not wash the cord, and keep the cord bound with a piece of cloth.
- You find that the cord stump and umbilicus have improved only slightly.
- There are no other significant findings or signs of sepsis. The baby continues to feed well and have normal temperature. There is no draining pus, redness and swelling of the skin extending more than 1 cm beyond umbilicus, skin lesions, red hard surrounding skin, or distended abdomen.

3. Based on these findings, what is your continuing plan of care for Biritu and why?

REFERENCES

BEmONC—BEmONC Training manual

CASE STUDY - 5.4: COMMON NEWBORN PROBLEMS

DIRECTIONS

Read and analyze this case study individually. When the others in your group have finished reading it, answer the case study questions. Consider the steps in clinical decision-making as you answer the questions. The other groups in the room are working on the same or a similar case study. When all groups have finished, we will discuss the case studies and the answers each group developed.

CLIENT PROFILE

Tiberih is 20 years of age and gave birth to her first baby at home 12 days ago. Both she and Baby F were seen at the health center 6 days after the birth. No problems were detected at that time. Tiberih lives in a small hut in a local village and does not have easy access to clean water. She has come to the health center today because her baby has a skin rash and she is concerned about this.

PRE-ASSESSMENT

1. Before beginning your assessment, what should you do for and ask Tiberih and Baby Kiros?

ASSSESSMENT (information gathering through history, physical examination, and testing)

2. What history will you include in your assessment of Baby Kiros and why?

3. What physical examination will you include in your assessment of Baby Kiros and why?

4. What laboratory tests will you include in your assessment of Baby Kiros and why?

DIAGNOSIS (interpreting information to identify problems/needs)

You have completed your assessment of Baby Kiros and your main findings include the following:

History:

- Record review reveals that Tiberih has no running water in her home and must carry water for household use from a river that is known to be polluted.
- Tiberih reports that the rash began 3 days ago.
- She denies putting any substance on the baby's skin.

- She reports that the baby is feeding well.
- All other aspects of the baby's history are normal or without significance.

Physical Examination:

- Baby Kiros's temperature is 37.0°C.
- Baby Kiros has 7–8 skin pustules on her left arm and upper chest. There is no localized swelling or redness, fluctuant lesions, generalized edema, or rash on palms or soles.
- The baby is wearing soiled clothing and is wrapped in a soiled cloth.
- The baby is breastfeeding well and shows no other signs of systemic sepsis as mentioned above.
- All other aspects of her physical examination are within normal range.

5. Based on these findings, what is Baby Kiros's diagnosis (problem/need) and why?

CARE PROVISION (implementing plan of care and interventions)

6. Based on your diagnosis (problem/need identification), what is your plan of care for Baby Kiros and why?

EVALUATION

- Tiberih returns to the clinic in 2 days.
- You find that the skin pustules have improved and the baby is wearing clean clothes.
- Tiberih reports that she is boiling water that is used for drinking and for bathing the baby.

7. Based on these findings, what is your continuing plan of care for Baby Kiros and why?

ANNEX

BEmONC - Clinical Logbook

Skills Practice Sessions

Skills practice sessions provide participants with opportunities to observe and practice clinical skills, usually in a simulated setting and at a clinical site. The first step in a skills practice session requires that participants review the relevant learning guide. Next, the trainer demonstrates the steps/tasks, several times if necessary, for the particular skill or activity and then has participants work in groups of two or three to practice the steps/tasks and observe each other's performance, using the relevant learning guide. The trainer should be available throughout the session to observe the performance of participants and provide guidance. Participants should be able to perform all of the steps/tasks in the learning guide before the trainer assesses skill competency using the relevant **checklist**.

The learning guides contain the steps or tasks relevant to the skills for managing maternal or newborn care or problems and correspond to the information presented in the reference manuals for the course to ensure standardisation.

- Initially, participants can follow the learning guide as the trainer demonstrates the steps or tasks for a particular procedure.
- Subsequently, during classroom and clinic practice sessions, they serve as step-by-step guides for the participant as s/he performs the skills. During this phase, participants work in groups of two or three, using the learning guides to rate each other's performance or prompt each other as necessary. The clinical trainer(s) will provide guidance to each group to ensure that learning is progressing and that participants are following the steps outlined.
- The checklists are then used by the clinical trainer to evaluate each participant's performance in providing care.

Criteria for assessment are included at the beginning of the checklists. Assessment of clinical skills will usually take place at the end of the classroom part of the training course. It is important that each participant demonstrates the steps or tasks at least once for feedback and coaching before the final assessment. If a step or task is not performed correctly, the participant should repeat the entire skill or activity sequence, not just the incorrect step. In addition, it is recommended that the trainer not stop the participant at the incorrect step unless the safety of the client is at stake. If it is not, the trainer should allow the participant to complete the skill/procedure before providing coaching and feedback on her/his overall performance.

All of the skills below are included in the training and the following record will be used to track progress towards skill competency.

BASIC EMONC COURSE

RECORD OF SKILLS **Name:** _____

Checklist	Skill	Case Number									
		1	2	3	4	5	6	7	8	9	10
	Antenatal care										
	Birth planning										
	Management of severe pre-eclampsia/eclampsia										
	Assessment of the woman in labor										
	Assist normal birth, including active management of third stage and immediate essential newborn care										
	Vacuum extraction										
	Breech delivery										
	Perineal/episiotomy repair										
	Newborn resuscitation										
	Assessment of the mother and baby in the first 24 hours after birth										
	Post abortion care (MVA)										
	Manual removal of placenta										
	Bimanual compression of uterus										
	Adult resuscitation and management of shock										
	Use of partograph										

Note: The trainer or clinical preceptor will initial case number and note level of competency:

M = performed competently with models;

S = performed with client/patient under supervision of trainer or clinical preceptor;

C = performed competently with client/patient.