SUKSHEMA
Facilitator's Manual
Volume: 2
Part C

Skilled Birth Attendance during Labour, Delivery and Postnatal Periods at 24/7 PHCs

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

KHPT
Karnataka Health Promotion Trust

Volume 2
Section A:

Skilled Birth Attendance during Labour, Delivery and Postnatal Periods at 24/7 PHCs

Sukshema

Nurse Mentors Tr

An overview of the On – Site mentoring intervention to institutionalize quality improvement strategy within 24/7 Primary Health Care centers in Karnataka state. The philosophy, design, The philosophy, design, implementation process and results are detailed herein.

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Government of Karnataka
Department of Health and Family Welfare
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PREFACE

Institutional deliveries in Karnataka have risen over recent years due to the efforts by the state health directorate which were strongly complemented by various innovations and schemes implemented under the National Rural Health Mission (NRHM) such as Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK), ASHA support, 108 ambulance services, etc. There has been a reduction in maternal and newborn mortality rates (MMR, NMR), but not enough to achieve the proposed state targets. With over 80% of pregnant women now delivering in facilities, it is critical that these deliveries are conducted as per the highest standards for quality of care. To accommodate this rising demand, government had prioritized upgradation of Primary Health Centres into 24/7 facilities to provide delivery services in rural areas and reduce the burden on district and larger hospitals enabling them to function more appropriately as first referral units (FRU) to provide emergency care. To achieve good quality of services provided in public health facilities it is important that the service providers working at these facilities are proficient in skills and practices that are appropriate particularly with reference to pregnant women, mothers and new-borns. To facilitate this, the need for dedicated teams to improve and monitor quality is crucial.

As a part of technical assistance to NRHM, Karnataka Health Promotion Trust and its consortium of partners developed an innovative nurse mentor led quality improvement program after detailed situation assessment and consultations with government. It was pilot tested in Bellary and Gulbarga during 2012-2013 where trained Nurse Mentors worked with 24/7 primary health centres (PHCs) staff to improve the quality of delivery and postpartum care. The mentoring programme integrated elements of clinical mentoring with facility-based quality improvement processes. Another critical component of the intervention was the use of revised case sheets by the staff that helped them in multiple ways, i.e. as job aid to adhere to standard practices, as a simple case documentation tool and as a tool to monitor and audit quality of care. The intervention results showed marked improvements in facility readiness and provider preparedness to deal with institutional deliveries and associated complications. Subsequently the program was scaled up in the remaining high priority districts of northern Karnataka and further taken up both within and outside the country.

As a part of this intervention, several technical products and training material were developed; they consist of 1) process documentation of the intervention that details the process of planning, implementing and monitoring the mentoring program, 2) Facilitator/ Trainer and Participant manuals. These materials have as annexures within them, various tools including the case sheets that were implemented under this initiative. We sincerely hope that these resources will be found useful by program managers in terms of gaining an in-depth understanding of the intervention and replicating it in their respective contexts.

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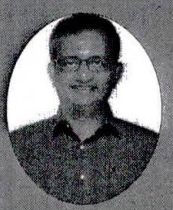

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Abbreviations

ABO	-	Blood groups A, B, O
A.M.M.A	-	Assessing and diagnosing, managing, measuring and advocating
AMTSL	-	Active management of the third stage of labour
ANC	-	Antenatal care
ANM	-	Auxiliary nurse midwife
APH	-	Antepartum hemorrhage
ASHA	-	Accredited social health activist
ART	-	Antiretroviral therapy
AWW	-	Anganwadi worker
AZT	-	Zidovudine
BCC	-	Behaviour change communication
BEmONC	-	Basic emergency obstetric and neonatal care
BM	-	Breast milk
BMV	-	Bag and mask ventilation
BPL	-	Below poverty line
CBO	-	Community-based organisation
CCT	-	Controlled cord traction
CEmONC	-	Comprehensive emergency obstetric and neonatal care
CHC	-	Community health centre
CBMWTF	-	Common bio-medical waste treatment facilities
CMO	-	Chief medical officer
COC	-	Combined oral contraceptive
CPD	-	Cephalopelvic disproportion
CVS	-	Cardiovascular system
DBF	-	Direct breast feeding
DDK	-	Disposable delivery kit
DHO	-	District health officer
DMPA	-	Depot medroxyprogesterone acetate
DNS	-	Dextrose normal saline
DPS	-	District programme specialist
EBM	-	Expressed breast milk
ECP	-	Emergency contraceptive pill
EDD	-	Expected date of delivery
FEFO	-	First expired, first out
FHR	-	Fetal heart rate
FHS	-	Fetal heart sound
FIFO	-	First in, first out
FRU	-	First referral unit
FS	-	Female sterilisation
GoI	-	Government of India
H/O	-	History of
Hb	-	Haemoglobin
HBV	-	Hepatitis B virus
HCP	-	Health care providers
Hg	-	Mercury
HBsAg	-	Hepatitis B surface antigen
HCG	-	Human chorionic gonadotrophin

HIV - Human immuno deficiency virus

HLD - High level disinfection

HMIS - Health management information system

HR - Heart rate

H_2O - Water

IM - Intramuscular

Inj - Injection

IV - Intravenous

ICTC - Integrated counselling and testing centre

IFA - Iron and folic acid (supplements)

IMNCI - Integrated management of neonatal and childhood illness

IUCD - Intrauterine contraceptive device

IUD - Intrauterine deat

IUGR - Intrauterine growth retardation

JSY - Janani Suraksha Yojana

JHFA - Junior health female assistant

KMC - Kangaroo mother care

LAM - Lactational amenorrhea method

LBW - Low birth weight

LHV - Lady health visitor

LMP - Last menstrual period

$MgSO_4$ - Magnesium sulfate

MM - MNCH mentor

MMR - Maternal mortality ratio

MNCH - Maternal neonatal and child health

MO - Medical officer

MoHFW - Ministry of Health and Family Welfare

MoWCD - Ministry of Women and Child Development

MPHW - Multipurpose health worker

MRP - Manual removal of placenta

MTP - Medical termination of pregnancy

MVA - Manual vacuum aspiration

NFHS - National Family Health Survey

NGO - Non-governmental organisation

NRHM - National Rural Health Mission

NS - Normal saline

NSSK - Navjaat Shishu Suraksha Karyakram

NSV - No-scalpel vasectomy

PEP - Post-exposure prophylaxis

PHC - Primary health centre

PIH - Pregnancy induced hypertension

PIP - Project implementation plan

PNC - Postnatal check-up

POC - Products of conception

PPE - Personal protective equipment

PPH - Postpartum hemorrhage

PPTCT - Prevention of parent-to-child transmission

PPV - Positive pressure ventilation

PRI - Panchayati Raj Institution

PROM - Premature or pre-labour rupture of membranes

P/A - Per abdomen

P/S - Per speculum

P/V - Per vaginum

QI - Quality improvement

RCH - Reproductive and child health

RDK - Rapid diagnostic kit
Rh - Rhesus factor
RL - Ringer lactate
RPR - Rapid plasma reagin
RR - Respiratory rate
RTI - Reproductive tract infection
SBA - Skilled birth attendant
SC - Sub-centre
SDM - Standard days method
SN - Staff nurse
STI - Sexually transmitted infection
TBA - Traditional birth attendant
TT - Tetanus toxoid
UTI - Urinary tract infection
VDRL - Venereal Disease Research Laboratory
VHND - Village health and nutrition day
WBC - White blood cell
WHO - World Health Organization
3TC - Lamivudine

Units of measurement

@ - At the rate of – to measure speed
% - Percent – to compare anything to 100
°C - Degree celsius – for temperature
cc - Cubic centimetre – to measure volume
cm - Centimetre – to measure length
dl - Decilitre – to measure volume
°F - Degree Fahrenheit – for temperature
gm - Gram – to measure weight
hrs - Hours - to measure time
IU - International units – to measure dose
KCal - Kilocalories- to measure energy produced
Kg - Kilogram - to measure weight
L - Litre to measure volume
lb - Pound to measure pressure
mcg - Microgram to measure weight
mg - Milligram to measure weight
min - Minute
ml - Millilitre to measure volume
mm - Millimetre to measure length
mmHg - Millimetre of mercury to measure BP
secs - Seconds
U - Units to measure dose

Glossary of Terminology

Abortion: Termination of pregnancy by the removal or expulsion of a foetus or embryo from the uterus before 20 weeks of pregnancy

Abscess: A localized collection of pus in any part of the body, with pain and redness.

Amniotic fluid: Fluid present in the uterus during pregnancy which protects the fetal inside

Amnionitis: Infection of the protective lining around the baby (amnion or inner lining); occurs in PROM

Anaemia: Condition caused by low hemoglobin in blood

ANC: Check up done during pregnancy to determine the condition of the woman and fetus

APGAR: The APGAR score indicates the newborn's well-being. It will be calculated at 1 minute and at 5 minutes after birth. An APGAR score of more than 7 is considered satisfactory. Less than 7 APGAR babies need referral to a higher centre for further management

APH: Bleeding in pregnancy (before delivery)

Asphyxia: Condition in a newborn due to severely deficient supply of oxygen to the body when the baby is unable to breathe normally

Atonic: Lack of muscle tone; loose or soft

Assisted deliveries: Vaginal delivery when the baby's delivery has to be assisted/helped out by using forceps or vacuum extraction applied to the baby's head

Blurred vision: Unclear or hazy vision, associated with high blood pressure, weakness

Breech presentation: When the buttocks of the fetus are in the lower area of the uterus

Chorioamnionitis: Infection of the protective lining around the fetus (amnion or inner lining and chorion or outer lining); occurs in premature rupture of membranes (PROM)

Clammy skin: When the skin is cool, moist, and pale. Sign of emergency such as shock, dehydration

CPD: Size or space of pelvis is narrow and does not allow baby to pass through

CVS: System related to heart and circulatory system

Diastolic blood pressure: Lower reading of blood pressure

Depressed/depression: Sadness, no interest in surroundings; may be seen in postnatal period

DMPA: Injectable contraceptive whose action lasts for 6 months

ECP: To be taken by a woman within 72 hours of unprotected, unplanned sexual contact to prevent a pregnancy

Effacement: Thinning of cervix at the time of labour

Endometritis: Infection of uterus; after PROM, repeated per vaginal (PV examination, unsterile conditions, after abortion/ MTP done in unsterile conditions

Engorgement: Filling up/ swelling

Flank pain: Pain in the side of the abdomen below the ribs

Fluctuant: Moving

Floppy: Poor muscle tone, limp

Fetal: Developing unborn baby inside the uterus

Fetal distress: Condition when the fetus is having some problem inside the uterus; detected by abnormal heart rate (FHR more than 160/min or less than 120/min), or irregular FHR

Fundal height: Height of the uterus which increases with pregnancy and decreases after delivery; measuring the upper border of the uterus and comparing with the standard in weeks of pregnancy gives the approximate duration of pregnancy

Gestation: Pregnancy / the period of development of the fetus in the uterus from conception until birth

Gestational age: Age of an embryo or fetus; calculated in weeks

Gravidity/gravid: The number of times the woman has been pregnant

Icterus: Jaundice or yellowish discolouration of sclera (white part of eye) in adult or skin in newborn

Infant: Baby from one month after birth to one year of age

IUGR: Inadequate/ slow growth of a fetus inside the uterus

Jerky movement: Fast movements which are not controlled and that have no purpose. Seen in fits

KMC: Care given to small baby by placing over the chest of mother/parent to provide extra warmth to the baby

LAM: Used as a traditional temporary method of contraception, when a woman does not have her monthly periods due to breast feeding

Latent: Developing or present but not visible

LBW: When the baby weight is below 2500gms (standard weight)

Lump: A localised swelling; may be hard or soft

Lochia: Discharge from the vagina from delivery up to a week

Liquor: Same as amniotic fluid

LMP: First day of last menstrual period a woman had before pregnancy, used to calculate EDD

Madilu kit: This is a postnatal kit given to mothers after delivery under a government scheme for postnatal care of mother and baby

Mastitis: Infection of breast; seen as pain and redness

Meconium: Yellow or green coloured stools passed by the fetus inside uterus or by newborn at birth

MRP: Done by removing the placenta by hand in condition of retained placenta

Murmur: An abnormal sound of the heart

MVA: Method of performing MTP where suction is created by a manual pump to remove contents in uterus

Misoprostol: Drug used to cause contraction of uterus and thereby prevent or treat postpartum hemorrhage; available as tablets of 200mcg; not given to women with asthma

Magnesium sulfate: An anti-convulsant drug used for preventing/treating eclampsia/severe pre eclampsia without causing sedation in mother or baby

Monitoring: Observe and check the progress or quality over a period of time

Nasal flaring: An increase in nostril size due to any difficulty in breathing

Newborn: A recently born baby

Obstetric: Related to pregnancy

Obstructed: Blocked; unable to come out

Oedema: Swelling due to accumulation of water

Outcome: End result

Pallor: Lack of colour especially in the face; seen in anaemia and long standing diseases

Parity/Para: Total number of deliveries and abortions a woman has had till present pregnancy

Pelvis: Cavity formed by joining together of the two hip bones and sacrum; contains, protects, and supports the intestines, bladder, and internal reproductive organs

Perineum: Area around vagina and the anus in females

PIH: Increased blood pressure (more than 140/90 mmHg) without proteinuria in a woman after 20 weeks gestation

Preterm: Pregnancy less than 37 completed weeks gestation

Pre-referral management: Activities carried out to stabilise the complicated cases before referring to a higher centre

Presentation: That part of the fetal lying over the pelvic inlet which would be first to come out at delivery

P/S: Using the speculum to view the vagina and cervix

P/V: Vaginal examination

Prolonged: Long duration/delayed

PROM: Rupture of membranes (bag of waters) before labour has begun; can be before 37 weeks – premature or before delivery – term or mature

Puerperal: The period immediately after delivery to 42 days

Purulent: Containing pus

Pustule: A small boil over skin filled with pus; a pimple

Retained: To hold in a particular place; not coming out

RPR: A newer blood test to screen routinely for syphilis in pregnant women

RR: Rate of breathing in one minute

Respiratory distress: Condition in which patients are not able to breathe properly and get enough oxygen

SBA: Person (doctor, nurse, ANM) trained in pregnancy, delivery, postnatal and newborn care

SDM: Used as a traditional temporary method of contraception where a woman tracks the days of her menstrual cycle and avoids unprotected sexual contact on fertile days of the cycle

Sepsis: Condition where infection from any site spreads throughout the body

Seizures: Convulsions, fits

Spontaneous: Without any effort or natural

Sterilization: A procedure to make free from live bacteria, virus or other microorganisms, used for cleaning needles and surgical instruments

Stillbirth: Birth of a dead fetus any time after the completion of 20 weeks of gestation.

Syphilis: A sexually transmitted disease which in pregnancy may cause congenital defects in the fetus

Systolic blood pressure: The upper level of blood pressure

Tender/tenderness: Pain felt if touched

Term: State of pregnancy which has completed 37 weeks

Transverse: Lying across

Traction: Pulling force

Tubectomy: It is a female sterilization procedure where a part of the fallopian tubes is cut. It is a permanent method of female sterilization

Umbilicus: A scar where an umbilical cord was attached

Unconsciousness: Person not responding to calls, stimulus

Uterine massage: Gently rubbing the uterus after the delivery of placenta to help the uterus contract and become hard

Uterine tone: Tightness of uterine muscles

Vasectomy: A surgical procedure performed on males in which the vas deferens (male tubes) are cut. It is a permanent method of male sterilization

VDRL: Blood test done routinely for syphilis in pregnant women; similar to RPR test

Vertex: Normal presentation of the fetus in which the head lies at the opening of the uterus

Voiding: Emptying the urinary bladder

Methods used for Training

Several participatory methods will be used for training. This is necessary since all participants are adults and thus following the principles of learning, it will be experiential and thus presumably more permanent.

Method	What is it	When to use	Other important points
Case Scenarios/ Case studies	Participants study briefly a situation that either describes a problem and then develop possible steps to solve the problem Participants discuss related issues that arise from the case scenario	To encourage participants to apply their knowledge and skills to similar problems and situations that they may encounter on the job or elsewhere	The situation presented in the case scenarios is comparable to one experienced by participants. Details in the scenario should be just enough to enable participants to recommend solutions/ discuss related issues or actions Generally case scenarios are more extensive than hypothetical situations and raise more issues. Give them enough time to exhaust the discussion as much as possible within the predetermined objectives

Demonstration	Facilitator or another volunteer participant demonstrates or models the steps of a procedure in an artificial situation, using mannequins or models to familiarise participants with it.	To improve the skills or competencies of the participants	This method follows the principle – learning by doing is more permanent. A major part of the training is dependent on demonstration of how to do certain procedures on the mother, new born or how to document information on the case sheets. It is important that time is given to participants to practice the same so that they are confident in doing the procedure especially if it is a new skill. Checklists could be used to assist them to monitor their own progress.
Discussion	Facilitators and participants or small groups of participants exchange ideas for the purpose of reaching a specified set of objectives	To increase knowledge To improve communication skills To test progress towards learning objectives	This method could be most useful if predetermined objectives are made. It could allow the participants to openly express their opinions on a subject as well as listen to the opinions of others thus facilitating learning through exchange of ideas This method is one of the commonest methods used in training. It is important to ensure that all participants take part in the discussion. This is best done by dividing the whole lot into smaller groups.

Mini lecture / presentation	Facilitator or a volunteer participant speaks to a group from prepared notes or using slides	To increase knowledge and to convey information, facts or concepts	Mini lectures are an efficient way to deliver information. It usually is for a short period of 10-15 minutes and thus takes note that attention span of a person is limited to 20 minutes. It also is advantageous over the traditional lecture method since several volunteers can be asked to prepare for a session and present it. The biggest disadvantage of this method is that communications is usually one way – flowing from the facilitator to the participants. The participation of the participants is limited. It is used when a new concept is introduced to the participants.
Question answer session / brainstorming / quiz	Facilitator prepares questions pertaining to a topic; then asks questions in a series to the participants in order to reach the predefined objectives	To increase the participants introspection and internal inquiry To increase the participants ability to collect information through analysis	This is an efficient way to encourage self- learning and participation. It helps to generate ideas quickly and fluidly while permitting freedom to express any idea or thought. It could have a snowball effect as one person's thought may help another person's thought process and thus increase learning. It is important to pay attention to every response of participants as this will encourage their participation

Role plays	This is a simulation technique and involves participants to imitate or act out a situation	To increase one's own awareness of one's thought processes To encourage participants to apply their knowledge and skills to problems like those they may encounter in the real life To sensitise participants to issues that they may be uncomfortable to address To provide an opportunity for participants to practice how they would communicate on the job to the patients	It allows participants to practice and thus think about situations even before they encounter such situations in real life. It could be interesting to participants. It may take time and thus clear guidelines must be given to participants of what is expected of them (preferably a day before the role play is to be enacted) and how much time is allotted for the role play. It is best if feedback is taken from the participants who enacted as well as from those who observed the role play on what worked well and what could be improved.
Videos	Facilitator uses videos to help participants comprehend a concept / procedure better	To sensitise participants on issues / demonstrate procedures that are best learnt by seeing and hearing	It is an efficient way to get participants to reflect on concepts that seem abstract or difficult to comprehend or to reinforce steps of a procedure that is vital. It is important to check for sound and need for other equipment such as DVD player, speakers, etc to be effective It is also important to be familiar with the video for it to be used efficiently.

Reflective exercises	Facilitator prompts reflection or internal inquiry in participants	To facilitate participants to perform an internal inquiry or examine or think of their own perceptions , thoughts or characteristics To facilitate participants to reflect and evaluate their own practice environment	This is efficient way to help participants first feel comfortable with how they feel about a topic and then share their experiences with others in a non-threatening environment. Ways to perform this is through role plays, think-pair-share, idea sheet, goals statement etc Discussion after the reflective exercise is important to help participants consolidate their own and others learnings.

Organisation of Training

Time	Topic	Resource
WEEK 1	DAY:1	
9:00-10:30	Arrival and registration of participants	
10:30-11:30	Introduction of participants	
11:30-12:00	TEA	
12:30-13:30	Pretest: Knowledge questionnaire Participant profile	
13:30-14:15	Lunch	
14:15-15:30	Inauguration	
15:30-16:00	TEA	
Day 2,3,4,5 and 6: QUALITY IMPROVEMENT: APPROACH, PRINCIPLES AND TOOLS IN MNH MENTORING INTERVENTION		
OBSTETRIC CONTENT AND DOCUMENTATION USING CASE SHEET		
WEEK 2	DAY:1	
9:00-10:15	Session 1: History Taking including specific details of HR factors to be considered	
10:15-10:30	TEA	
10:30-11:30	Session 2: Investigations with focus on essentials and high risk factors	
11:30-12:15	Session 3: General examination with focus on identification of high risk factors	
12:15-13:30	Session 4: Abdominal examination with focus on identification of high risk factors	
13:30-14:30	LUNCH	
14:30-19:30	Clinical posting in antenatal ward, postnatal ward, labour room (groups not more than 5 with 1 facilitator)	
WEEK 2	DAY:2	
9:00-11:00	Session 5: Pelvic exam with focus on identification of high risk factors	
11:00-11:15	TEA	
11:15-13:30	Session 6: Monitoring progress of labour including prolonged / obstructed labour and rupture of membranes plus use of partograph	
13:30-14:30	LUNCH	
14:30-19:30	Clinical posting in antenatal ward, postnatal ward, labour room (groups not more than 5 with 1 facilitator)	
WEEK 2	DAY:3	
9:00-10:00	Session 7: Preparation of labour room including emergency kits for emergencies (PIH, PPH, Sepsis)	

10:00-10:45	Session 8: Conducting normal delivery with focus on prevention of PPH	
10:45-11:00	TEA	
11:00-11:30	Session 9: AMTSL	
11:30-12:00	Session 10: Assessment and management of 4th stage of labour	
12:00-13:30	Session 11: Assessment and management of postnatal period including counselling on danger signs and family planning	
13:30-14:30	LUNCH	
14:30-19:30	Clinical posting in antenatal ward, postnatal ward, labour room (groups not more than 5 with 1 facilitator)	
WEEK 2	DAY:4	
9:00-11:30	Session 12: Complications PPH – identification and management of atonic uterus or retained placenta	
11:30-11:45	TEA	
11:45-12:30	Session 12: PPH contd – identification and management of tears or rupture of uterus and due to thrombosis	
12:30-13:30	Session 13: Complication infection – identification and management	
13:30-14:30	LUNCH	
14:30-19:30	Clinical posting in antenatal ward, postnatal ward, labour room (groups not more than 5 with 1 facilitator)	
WEEK 2	DAY:5	
9:00-11:30	Session 14: Complications PIH – identification and management	
11:30-11:45	TEA	
11:45-12:30	Session 15: APH – identification and management	
12:30-13:30	Session 16: Complication preterm labour – identification and management	
13:30-14:30	LUNCH	
14:30-19:30	Clinical posting in antenatal ward, postnatal ward, labour room (groups not more than 5 with 1 facilitator)	
WEEK 2	DAY:6	
9:00-11:30	Session 17: Discharge counselling or preparation for referral	
11:30-11:45	TEA	
11:45-12:30	Session 18: Questions and Answers on all sessions	
12:30-13:30	LUNCH	
13:30-18:30	Clinical posting in antenatal ward, postnatal ward, labour room (groups not more than 5 with 1 facilitator)	
NEWBORN CONTENT AND DOCUMENTATION USING CASE SHEET		
WEEK 3	DAY:1	
9:00-9:30	Session 1: Introduction	
9:30-10:30	Session 2: Classification of a newborn and its implications	
10:30-10:45	TEA	
10:45-12:30	Session 3: Routine care from birth to 1 hour including do's and don'ts	

12:30-13:30	Session 4: Preparation of newborn corner including kits for emergency	
13:30-14:30	LUNCH	
14:30-19:30	Clinical posting in NICU ward, postnatal ward, labour room (groups not more than 5 with 1 facilitator)	
WEEK 3	DAY:2	
9:00-9:30	Session 5: Introduction on NB resuscitation	
9:30-10:30	Session 5 contd: Newborn resuscitation – routine care	
10:30-10:45	TEA	
10:45-11:30	Session 5 contd: Initial steps of resuscitation	
11:30-12:30	Session 5 contd: Bag and mask resuscitation	
12:30-13:30	Session 5 contd: Chest compressions and drugs	
13:30-14:30	LUNCH	
14:30-19:30	Clinical posting in NICU, postnatal ward, labour room (groups not more than 5 with 1 facilitator)	
WEEK 3	DAY:3	
9:00-10:30	Session 6: Introduction on Breast feeding (initiation, preparation)	
10:30-11:30	Session 6 contd: Breast feeding – benefits, physiology, ten steps for successful breast feeding, position and attachment	
11:30-11:45	TEA	
11:45-12:30	Session 6 contd: Breast feeding – problems and its management	
12:30-13:30	Session 6: Expressed breast milk and indications for alternative methods of giving EBM	
13:30-14:30	LUNCH	
14:30-19:30	Clinical posting in NICU, postnatal ward, labour room (groups not more than 5 with 1 facilitator)	
WEEK 3	DAY 4	
9:00-10:30	Session 6: Care of a newborn 1hr till 48 hrs of birth	
10:30-11:30	Session 7: Thermal control of a newborn	
11:30-11:45	TEA	
11:45-12:30	Session 8: KMC	
12:30-13:30	Session 9: Care of LBW baby including feeding	
13:30-14:30	LUNCH	
14:30-19:30	Clinical posting in NICU, postnatal ward, labour room (groups not more than 5 with 1 facilitator)	
WEEK 3	DAY 5	
9:00-10:30	Session 10: Discharge counselling including problems of newborn (danger signs)	
10:30-11:30	Session 11: Referral of a sick newborn	
11:30-11:45	TEA	
11:45-12:30	Questions and answers on NB	
12:30-13:30	LUNCH	
13:30-18:30	Clinical posting in NICU, postnatal ward, labour room (5/gp)	

WEEK 3	DAY 6	
9:00-10:30	Session 12: IMNCI approach to care of a sick child	
10:30-11:30	Session 13: IMNCI approach to care of child with diarrhea	
11:30-11:45	TEA	
11:45-12:30	Session 14: IMNCI approach to a child with ARI	
12:30-13:30	LUNCH	
13:30-18:30	Clinical posting in NICU, postnatal ward, labour room (groups not more than 5 with 1 facilitator)	
Clinical Posting		
WEEK 4	DAY:1 – DAY:6 (GROUPS OF 5 EACH IN NICU-2 DAYS/ LABOUR ROOM-2 DAYS/PN-1 DAY/AN-1DAY) IN ROTATION	
Systems Strengthening		
WEEK 5	DAY:1	
9:00-10:30	Session 1: Infection control	
10:30-11:30	Session 2: Documentation	
11:30-11:45	TEA	
11:45-13:30	Session 2 contd: Documentation(registers to be maintained, reports, audits, anecdotes, observations etc.)	
13:30-14:30	LUNCH	
14:30-15:30	Session 2 contd: Documentation(registers to be maintained, reports, audits, anecdotes, observations etc.)	
15:30-16:30	Session 2 contd: Documentation(registers to be maintained, reports, audits, anecdotes, observations etc.)	
WEEK 5	DAY:2	
9:00-10:30	Session 3: : Drugs	
10:30-11:30	Session 4: Referral and transport	
11:30-11:45	TEA	
11:45-13:30	Session 5: Self assessment tools – use	
13:30-14:30	LUNCH	
14:30-15:30	Session 5 contd: Self assessment tools	
15:30-16:30	Session 5: Additional roles and responsibilities of mentors	
WEEK 5	DAY:3	
9:00-10:30	Posttest	
10:30-11:30	OSCE – Rapid assessment exercise - OB	
11:30-11:45	TEA	
11:45-12:45	OSCE – Rapid assessment exercise - OB	
12:45-14:00	LUNCH	
14:30-15:30	OSCE – Rapid assessment exercise - NB	
15:30-16:30	OSCE – Rapid assessment exercise - OB	
16:30-17:30	Valedictory	

Nurse Mentors Training Program Sessions Essential Care at labour, Delivery and Early Postnatal Period

INITIAL ASSESSMENT AT ADMISSION

This has five sessions as listed below

Session 1: History taking

Session 2: Previous investigations

Session 3: General examination

Session 4: Abdominal examination

Session 5: Pelvic examination.

Learning objectives

By the end of the session 1-5 the participants will be able to

- Recall the importance of doing a complete initial assessment of pregnant mothers after 20 weeks of gestation, presenting at the PHC
- List and discuss the relevance of the components of a good initial assessment
- Demonstrate how to do a comprehensive assessment
- Demonstrate documentation in the case sheet, the details of a complete initial assessment of the woman in labour
- Demonstrate mentoring skills for complete initial assessment of the pregnant mother

Refer to participants' manual chapter 1 for details and few additional case studies.

Session 1 Initial Assessment at Admission – History Taking

Materials: LCD, PowerPoint slides, SBA guidelines 2010(Page 13-15), new case sheets, Antenatal care/Thayi cards, 1 case study, 2 exercises for LMP calculation

Session time: 55minutes.

Training methods: Case studies and group activity, interactive lecture, case sheet demonstration

Session Objectives:

By the end of this session participants will be able to

- ✓ Discuss the importance of taking complete relevant history of the pregnant women admitted to the facility, in labour
- ✓ Demonstrate how to take a comprehensive history of the pregnant women admitted to the facility, in labour
- ✓ Demonstrate the documentation of comprehensive history using the new case sheet

	Teaching Steps	Duration
Introduction	1. Discuss the objectives of the session and its relevance	2 minutes
General history	2. Case study and group activity: (Slide 4) ❖ Divide the team into groups of 3-4 members eachand ask them to refer to Volume 2 – Case study 2.1(Part 1)for history taking, 2 exercises to calculate EDD- Case study 2.2-2.4 (See Volume 2 - Ch 2: pg 25-26) ❖ Ask each group to discuss what parameters they would ask in history and write down points. 3. Emphasize the need for the following during history-taking (Slide 5) ❖ Maintaining privacy ❖ Checking the antenatal card for previous history 4. Ask participants to present their points of discussion, on Case study 2.1- part 1. Refer to new case sheet and summarize the gaps, re-emphasize the positives using slides (Slide 6-8) ❖ Explain the importance of collecting details to provide identification data as well as any possibility of risk factors such as given below	15 minutes

	○ Age if less than 18 or more than 35 could be an indication of possible problems for mother and baby ❖ Present pregnancy history or presenting complaints: Ask participants to list the symptoms a woman in labour may come with, those that are normal and those that indicate complications. Reinforce about the need to ask about specific complaints during the present history ○ Normal signs: contractions, abdomen pain, watery discharge, rupture of membranes ○ Signs that might indicate a problem: fever, swelling of face, headache, blurred vision, vomiting, fits/seizures , decreased foetal movement, bleeding per vagina, foul discharge per vagina, difficulty in passing urine/ less urine, any other Demonstrate documentation on case sheet mode of delivery	
Obstetric history	5. Obstetric history (Slide 9-13) ❖ Explain that it is important to ask about GPAL, calculate gestational age of fetus and determine if she knows if it is a single/multiple pregnancy, since these details could flag a possible risk factor. ❖ Review case study 2.3-2.4 on calculation of GA and ensure they know how to calculate the GA especially when cycles are not regular. 6. Past obstetrical history ❖ Explain that it is important to ask about any complications in the previous pregnancies and labour, and outcome of these pregnancies since they could flag a possible risk factor in the present pregnancy	20 minutes
Past medical or surgical history	7. Past medical history (Slide 14-15) ❖ Explain the importance of enquiring about past medical history or surgical history	5 minutes
Summarise	8. Check if they have any doubts. Clarify them 9. Conclude with key points (Slide 16-17)	3 minutes

Case Study 2.1- History Taking And Examination (Facilitator's Copy)

Use this case study as a way to promote discussion around the important components that need to be done on history and physical examination. All participants should have a copy of the case and questions. You can then read the case out loud and ask the first question. For each question make sure that the points listed below are mentioned. Also make sure that during the discussion you reinforce why these questions or examinations are important to do and how it relates to good patient care. In all cases try to avoid directly giving the answers – rather probe around the topic to see if the participants can come up with the responses. At the end ask if there are any questions from the participants.

PART 1: Normal Pregnancy Case Study - Part One: History and Investigations

A 24 year G2 P1 presents to the PHC complaining of contractions.

What important information would you like to ask her about on history?

Use this question to have members of the groups discuss what they would want to ask the woman and why they think this is important. The following should be mentioned. In discussion explain why. If they do not mention all steps probe by asking, "Is there anything else you would want to ask, why or why not?"

The following points should be discussed:

Socio-demographics

This information helps you to create rapport with the patient before asking more personal questions. It can also help provide you with some information regarding possible risk in pregnancy or access to care (i.e. young or old age, marginalized groups).

- Name
- Husband's name
- Age
- Contact number
- Caste

Obstetrical history

This information determines the gestational age of the fetus and the type of pregnancy. This is important because it helps determine if the labour is preterm (before 37 weeks) or term, if there is more than one baby present and if the woman has had regular access to care.

- LMP
- EDD

- Gestational age of fetus
- Single or multiple
- ANC and number

History of presenting complaints

This information determines why the woman has come to the PHC to be seen. In this case it would be important that in addition to asking about contractions, other possible complications of pregnancy are ruled in or out. These include:

- Fever (sign of infection)
- Blurred vision/ swelling of face/ headache/ difficulty in passing urine/less urine (these are all signs of preeclampsia)
- Fits/seizures (this is a sign of possible eclampsia if greater than 20 weeks)
- Watery discharge per vagina/rupture of membranes
- Foul discharge per vagina (sign of amnionitis/uterine infection)
- Pain in abdomen (sign of abruption)
- Foetal movement (informs us about fetal status)
- Contractions - frequency, strength, and onset (help us to determine if the woman is in labour)

Past obstetrical history

This information determines if the woman had any previous complications in her previous pregnancy and labour. This may help us to assess her risk in this labour and to help plan if she should stay to deliver at the PHC or if she needs to go to an FRU. For example, a woman with a previous classical cesarean section should be referred as this is a contraindication to normal delivery and she will need another cesarean section. A woman who had a previous mild postpartum hemorrhage could still deliver at the PHC but staff should have this information at their back of their minds so that they can be prepared to ensure that active management of the third stage of labour is done and that she receives close attention in the immediate postpartum period.

- Year
- Mode
- Place
- Complication
- Outcome

Past medical and surgical history

This information determines if the woman had any pre-existing medical conditions or surgeries that would be important to know about in pregnancy/labour.

Allergies and medications

It is important to always ask if the woman is allergic to any medications, to know which medications you can use safely in pregnancy/labour. It is also important to know if the woman is also on any regular medications that she actually should avoid during pregnancy or that she may need to continue to take in pregnancy.

Previous investigations/tests (will be covered in Session 2)

Certain tests should be done on all pregnant woman as these tests help diagnose certain medical conditions that may require additional treatment in pregnancy or labour, especially related to anemia, infections or hypertensive diseases of pregnancy.

- HIV
- Syphilis
- Hepatitis B
- Urine dipstick for protein/sugar
- Haemoglobin and Blood group

All patients who present for care should have these 7 components asked about as they form the basics of good history taking and patient care and provide you with useful information to determine diagnosis and management. With practice they become quick and easy to do.

Case Scenario-Calculation Of EDD

Please read out the cases and ask the participants to calculate EDD. Ask 2 participants to read out their answers

Case study 2.2: LMP known

Laxmi, who is 18 years old, says she got her last period on January 21st, 2011. She wants to know when she will deliver. Calculate her due date.

Answer: 9 calendar months + 7 days, i.e. October 28th, 2011

Case study 2.3: LMP not known

Seema, who is 30 years old, comes to you and says that she has not got her period for the past three months. She last got her period on the day before Holi, i.e. March 10. Calculate her due date.

Answer: 9 calendar months + 7 days, i.e. December 16

Optional -

Case Study 2.4: Irregular cycles

Mrs. Rekha, 24 years old primigravida comes to OPD with 6 months amenorrhea (October 2013). This is her first visit to you on 25th April 2014

How will you calculate the EDD with regular (once every 28 days) and irregular cycles (length of cycle between 30-35 days)?

Answer Key

- H/o regular periods – add 9 months and 7 days to the LMP
- Cycles > 28 – 30 days
- Add the extra number of days to arrive at EDD
- Cycles < 28 days
- Subtract the number of days from the EDD.

Hand-Out 1.1: Case Study 2.1- History Taking And Examination

(Participant's copy)

Case Study 2.1: PART 1

Normal Pregnancy: History and Investigations

A 24 year G2 P1 presents to the PHC complaining of contractions. What important information would you like to ask her about on history?

HAND-OUT 1.2: CASE SCENARIO-CALCULATION OF EDD

(Participant's copy)

Please read out the cases and ask the participants to calculate EDD. Ask 2 participants to read out their answers

Case study 2.2: LMP known

Laxmi, who is 18 years old, says she got her last period on January 21st, 2011. Calculate her due date.

Answer

Case study 2.3: LMP not known

Seema, who is 30 years old, comes to you and says that she has not got her period for the past three months. She last got her period on the day before Holi, i.e. March 10. Calculate her due date.

Answer:

Optional -

Case Study 2.4: Regular and Irregular cycles

Mrs. Rekha, 24 years old primigravida comes to OPD with 6 months amenorrhea (October 2013). This is her first visit to you on 25th April 2014

How will you calculate the EDD with regular (once every 28 days) and irregular cycles (length of cycle between 30-35 days)?

Answer:

Session 2 Initial Assessment at Admission - Previous investigations

Materials: PPT slides, SBA guidelines 2010(Pg 23), new case sheets, Antenatal care/Thayi cards

Session time: 40 minutes

Training methods: Interactive lecture and guided discussion

Session Objectives:

By the end of this session participants will be able to

- ✓ Explain the relevance of previous laboratory investigations at the time of assessment of a pregnant woman or woman in labour
- ✓ Demonstrate documentation of previous investigations on the case sheet and assess requirement of repeat investigations and referral

Teaching Steps		Duration
Introduction	1. Introduce the topic and session objectives (Slide 1-2) .	3 minutes
Previous investigations	2. Facilitate discussion on the various investigations performed in pregnancy (Slide 3) and why it is important to check them at the time of taking the history of a woman during pregnancy or in labour (Slide 4) ❖ Common complications can be picked up ❖ Provider can be alert about the findings 3. Present slides (Slide 5-12) to explain the relevance of specific blood tests done during ANC period as recorded in ANC card; or for a woman labour, and its documentation on the case sheet. Explain that not all investigations are done at PHCs. However importance of doing investigations need to be discussed as given below ❖ Blood haemoglobin test: low haemoglobin levels (anemia), could be a risk for PPH and LBW. It could also compromise the heart resulting in problems during labour. Referral of a woman to a higher centre would be required ❖ Blood group and type: ABO incompatibility if a woman is O group and the baby is either A or B group or if the mother is Rh negative blood group. Health care personnel need to be alert for jaundice in newborns presenting before 24 hours. ❖ VDRL syphilis positive is a flag for signs of anomalies in newborns and also infection in the newborn	15 minutes

	❖ HIV positive test could alert to refer a woman and newborn later for either ART or ARV prophylaxis ❖ Urine test: positive for infection, if proteinuria is present one must be aware of presence of pre-eclampsia or eclampsia 4. Highlight the next steps required ❖ Repeat tests after assessing present situation, if required - for Hb (if done before 3 months), Urine test for proteinuria (if not checked and BP is raised)	
Demonstration or Review of Tests	5. Review with participants how to do the urine test for protein and HIV rapid test. Inform participants that they will learn how to perform the HIV rapid test during their clinical posting.	10 minutes
Summarize	6. Brainstorm with participants (Slide 13) when a referral must be made? Wait for responses and then explain when referral must be done to FRU for those women with abnormal test findings: 1. Hb below 7gm/dl, 2. Urine test positive for protein, 3. Rh negative, 4. VDRL positive, 5. HIV positive 6. Ultrasound findings 7. Check for and clarify any doubts. Review key points (Slide 14-15).	5 minutes 2 minutes

Session 3 Initial Assessment at Admission –General Examination

Materials: PPT slides, SBA guidelines 2010(page 17-18), new case sheets, weighing scale, BP apparatus, stethoscope

Session time: 30 minutes

Training methods: Lecture, Case sheet demonstration, Case study part 2

Session Objectives:

At the end of this session participants will be able to

- ✓ Discuss the important of general physical examination and significance of abnormal findings
- ✓ Demonstrate the documentation of general examination on a case sheet

	Teaching Steps	Duration
Introduction	1. Introduce the topic, session objectives (Slide 1-2)	2 minutes
General examination	2. Reinforce the relevance of examination and review of Case study and group activity (Slide 3-4) ❖ Divide the team into groups and administer CASE STUDY 2.1: PART 2 for examination of woman in pregnancy or labour ❖ Ask each group to discuss what parameters they would check for during general examination of a woman in labour and present their findings. ❖ Reinforce key parameters to check during a general examination (Slide 5-7)	10 minutes 5 minutes
	3. Reinforce that for any abnormalities detected (Slide 8-10), the woman must be monitored and might require further tests and referrals if the facility cannot manage the same. ❖ Raised temperature - infection ❖ Weak pulse may be shock ❖ Rapid pulse could be fever, also shock ❖ Low BP could be shock ❖ High BP could be PIH ❖ Weight – low gain could be a flag for possible malnutrition and thus problems in fetus /newborn	5 minutes

	❖ Short stature (<140cms) – risk factor for obstructed labour due to contracted pelvis ❖ Pallor – maybe anaemia, shock ❖ Edema – swelling of face, hands, feet – maybe anaemia, PIH, heart or kidney or other problems ❖ Jaundice– hepatitis	
Summarize	4. Take participants through documentation of general examination on case sheet and ask them to also complete Handout 5.1 (General examination) 5. Clarify any doubts, if any on the sessionand then give them the key messages (Slide 11-12)	7 minutes

Session 4 Initial Assessment at Admission - Abdominal examination

Materials: PPT slides (11), SBA guidelines 2010(pg 19-22), new case sheets, stethoscope, mannequin

Session time: 50 minutes

Training methods: Demonstration on mannequin followed by interactive lecture, power-point and case sheet demo.

Session Objectives:

By the end of this session participants will be able to

- ✓ Explain the importance of abdominal examination in a woman with labour, how to diagnose abnormal findings
- ✓ Demonstrate how to conduct all steps of abdominal examination
- ✓ Demonstrate the documentation of abdominal examination on a case sheet

	Teaching Steps	Duration
Introduction	1. Introduce the topic and session objectives (Slide 1-2).	3 minutes
Abdominal examination	2. Reinforce importance of abdominal examination and do's and don'ts involved in it (Slide 3-4). 3. Highlight the components of an abdominal examination (Slide 5). 4. Demonstrate using mannequin and facilitate a discussion. Reinforce information using slides (Slide 6-11): ❖ The components of abdominal exam such as estimation of fundal height, abdominal grips 1, 2,3 ,4, to show lie, presentation, engagement of presenting part, FHR monitoring ❖ Divide the participants into 2 groups and ask 2-3 participants from each group to give return demonstration of abdominal examination on the mannequin. Ask participants to observe and comment.	20 minutes 20 minutes
Abnormal findings	5. Present slides to explain how to interpret few common abnormal findings (Slide 12) ❖ Fundal height does not match with weeks of pregnancy: if less - prematurity, wrong dates; if more – twins, increased liquor ❖ Presentation – breech, transverse	10 minutes

	❖ Engagement of presenting part – if not engaged, requires monitoring of labour and assessment. Could flag obstructed labour ❖ FHR – less than 120/min, more than 160/min, irregular – is fetal distress 6. Brainstorm with participants which of these would require a referral? ❖ Explain it is important to identify any abnormality at admission so as to start initial management and make a quick referral to a centre that can manage the situation appropriately.	
Summarize	7. Show participants where abdominal exam findings must be recorded on the new case sheet. Check if all are clear about the use of the new case sheets for initial assessment of a woman in labour. 8. Clarify doubts if any and conclude with key messages of the session (Slide 13-14).	7 minutes

Session 5 Initial Assessment at Admission – Pelvic Examination

Materials: PPT slides (15), SBA guidelines 2010(pg: 41-44), New case sheets, gloves, pelvic model, video on correct /wrong steps

Session time: 55 minutes

Training methods: Demonstration with pelvis model and facilitated discussions, Interactive lecture, Case sheet demo.

Session Objectives:

By the end of this session participants will be able to

- ✓ Explain the importance of vaginal examination in a labour patient and assessment of stages of labour
- ✓ Discuss how to diagnose abnormal findings, their initial management and need for referral
- ✓ Demonstrate the documentation of vaginal examination on a case sheet

	Teaching Steps	Duration
Introduction	1. Introduce the topic and session objectives (Slide 1-2).	3 minutes
Vaginal examination	2. Using slides explain the importance of vaginal examination and the components of vaginal examination such as dilatation of cervix; effacement of cervix; station of presenting part; status of membranes; status of liquor (Slide 3-4)	10 minutes
	3. Reinforce the points on preparation of a woman for pelvic exam and do's and don'ts when performing a pelvic exam (Slide 5-6).	32 minutes
	4. Demonstrate using pelvic model and skull and facilitate discussion (Slide 7-15) ❖ How to estimate cervical dilatation, practice using bangles; ❖ How to estimate cervical effacement ❖ How to estimate station of presenting part using fetal skull or doll with fetal skull and adequacy of pelvic outlet	
	5. Invite 1-2 participants to do a return demonstration of a pelvic exam. Ask the observers to comment. Ask participants to note steps that were correct and wrong. Facilitate a discussion	

Video on pelvic exam	6. Show video on pelvic exam. Inform them that more details will be dealt with in the session "Monitoring Labour" (Slide 16) ❖ Descent of presenting part delayed in the context of duration of active labour ❖ Abnormal presenting part-face, breech, limbs (transverse) ❖ Huge capput ❖ Dilatation not occurring as per the normal rate ❖ Cervical effacement delayed 7. Reinforce the need to do a vaginal examination at admission to detect stage of labour and determine any abnormality for initiation of management and referral.	5 minutes
Summarize	8. Ask participants to refer to the new case sheet and point out the place they will mark the vaginal examination findings. Reinforce the importance of these details and the need to document them on the case sheet. Ask a participant to highlight the key messages of the session (Slide 17-18). 9. Review Case Study 2.1: Part 2 with participants. Clarify any doubts of the participants.	5 minutes

Case Study 2.1: Part 2

PART TWO: Physical examination (Read the following section out and then proceeds as in the first section)

The woman is 39 weeks gestation. Her last delivery was 2 years ago. It was a normal vaginal delivery of a live born male infant, weighing 2700 gm at term. She had no complications in her pregnancy or labour. She has been having regular antenatal care. She is otherwise healthy, has never had surgery, is not taking any medications and does not have any allergies. Her contractions began 3 hours ago. They are every 5 minutes and are becoming closer together and stronger. She has not felt her water break and she can feel good fetal movement.

What would you like to do on physical examination? i.e. what do you think you should focus on when performing a physical examination on this woman.

Answer: The following should be mentioned. In discussion explain why. If they do not mention all steps probe by asking, "Is there anything else you would want to examine, why or why not?"

General examination

A general examination provides important information about the patient's overall health as well as possible medical conditions that may have developed due to pregnancy.

- Weight, Height (can indicate signs of malnourishment)
- Vital signs: Pulse, Blood pressure, Temperature (abnormalities can be sign of infections, high blood pressure of pregnancy, hemorrhage)
- Pallor (sign of anemia)
- Oedema (sign of pre - eclampsia)
- Jaundice (sign of severe - eclampsia, haemolysis, hepatitis infection)
- Heart sounds, any murmurs (sign of cardiac disease or physiologic murmur)
- Lungs (abnormalities can be sign of fluid overload in pre-eclampsia/eclampsia, cardiac disease or infection)

Abdominal examination

An abdominal examination is important to perform because it provides needed information about the size, position and heart rate of the baby, heart rate of the baby, if the woman had any previous surgeries and the tone of the uterus (contractions, abruption, or infection).

- Fundal height (in weeks) (abnormalities can be a sign of babies that are too large or too small for the gestational age)
- Presentation (determines if baby is in a position that can be delivered vaginally- i.e. vertex, complete or frank breech)

- Fetal heart sounds (determines if baby is alive, or if it is in distress)
- Contractions present, Contraction frequency, Contractions intensity (determines if labour is active or false)
- Is uterus tender (abnormalities can be a sign of infection, abruption)
- Previous cesarean scar (alerts you to ask about type of previous cesarean – classical and inverted T's are contraindications to vaginal deliveries)

Vaginal examination

A vaginal examination also provides important information about the baby (presentation, if membranes are ruptured) and helps us determine if the woman is in active labour or not.

- Cervical dilatation, cervical effacement (determines if in active labour and if labour is progressing normally)
- Status of membranes, date and time of rupture, colour of liquor (determines if there are any signs of infection or fetal distress)
- Presenting part(determines if baby is in a position that can be delivered vaginally- i.e. vertex, complete or frank breech)
- Station of presenting part (determines if descent is progressing normally in labour)

Can you think of any situations when you would not want to do a vaginal exam?

Answer: The following should be mentioned. In discussion explain why. If they do not mention both scenarios probe by asking, "Is there any other situation you can think of where you would not want to do a vaginal exam, why or why not?"

- If the membranes are ruptured and the woman is not in labour. The risk for an infection in the uterus (amnionitis) increases with the number of vaginal exams that the woman has. Therefore you want to avoid performing an exam until she is actually showing signs of active labour.
- If there is vaginal bleeding after 20 weeks and the location of the placenta is not known. Vaginal bleeding after 20 weeks in a pregnant woman (antepartum hemorrhage) can be due to placenta previa (when the placenta covers the opening to the cervix). You want to avoid doing a digital exam in these cases as this can make the bleeding worse.

Ask if there are any questions.

Key Points

- All women presenting to the PHC should have a relevant history and physical examination performed. This provides valuable information about the woman, the pregnancy, why she is presenting and if she can stay at the PHC or needs to be stabilized and referred.
- Pregnant women who present with PV bleeding after 20 weeks should not have a vaginal examination performed if the location of the placenta is not known (documented by Ultrasound).
- Pregnant women who present with prelabour rupture of membranes should not have a vaginal examination performed if there are no signs of labour.

Handout 5.1: Case Study 2.1: Part 2

PART TWO: Physical examination

(Read the following section out and then proceed as in the first section)

The woman is 39 weeks gestation. Her last delivery was 2 years ago. It was a normal vaginal delivery of a live born male infant, weighing 2700 g at term. She had no complications in her pregnancy or labour. She has been having regular antenatal care. She is otherwise healthy, has never had surgery, is not taking any medications and does not have any allergies. Her contractions began 3 hours ago. They are every 5 minutes and are becoming closer together and stronger. She has not felt her water break and she can feel good fetal movement.

What would you like to do on physical examination? i.e. what do you think you should focus on when performing a physical examination on this woman?

Labour And Delivery

This has the following sessions

Session 6: Monitoring and progress of labour, use of partograph and identification of complication – abnormal labour

Session 7: Normal delivery

Session 8: Third stage of labour and active management of third stage of labour

Session 9: Fourth stage of labour (Upto 2hours after delivery)

Learning objectives

By the end of this session (6-9) participants will be able to

- Recall the stages of labour, component of and how to do labour monitoring, the significant of using the partgraph.
- Demonstrate how to monitor progress of labour using the partograph in a woman admitted to the PHC and how to manage all four stages of labour.
- Demonstrate the correct documentation of the partograph and case sheet for all stages of labour for a woman admitted to the PHC.
- Demonstrate mentoring skills for use of partograph in first stage of labour, management of second to fourth stages of labour, including monitoring and progress of labour in a woman admitted to the PHC.

Session 6 Monitoring the Progress of Labour, Use of Partograph; Complication – Abnormal Labour

Materials: PPT slides, SBA guidelines 2010(pg 43-52), new case sheets, video, copies of Partograph, 2 exercises for partograph demonstration, 2 case scenarios for plotting of partograph, pelvic model and a doll with a placenta,cord

Session time: 1 Hour 50 minutes

Training methods: Interactive lecture, Case study and group discussion, partograph demonstration and practice sessions, Case sheet demonstration.

Session Objectives:

By the end of this session participants will be able to

- ✓ Recall the stages of labour, components of and how to do labour monitoring, significance of using partograph
- ✓ Demonstrate how to use of partograph for second stage of labour, monitor labour and estimate of progress of labour
- ✓ Describe how partograph could help in diagnosing obstructed or prolonged labour
- ✓ Demonstrate mentoring skills for use of partograph for first stage of labour, monitoring labour and estimation of progress of labour
- ✓ Demonstrate the documentation of partograph for first stage of labour, monitoring labour general examination on a case sheet,
- ✓ Demonstrate how to audit case sheets for partograph, monitoring labour for a patient admitted to the facility

Teaching Steps		Duration
Introduction	1. Introduce the topic and session objectives (Slide 1-2).	5 minutes
Monitoring of labour	2. Ask participants to explain about the stages of labour including latent and active stages and duration in a primigravida and multigravida woman (Slide 3-4).	10minutes
	3. Explain the significance of regular monitoring of labour sheet (Slide 5-7). Highlight the components of labour monitoring in latent and active stages using slides and recording the following on the case sheet. ❖ BP, temperature (every 4 hours, more often if indicated) ❖ Pelvic examination (every 4 hours unless otherwise indicated) ❖ Pulse, FHR and contractions (every 30min) ❖ Explain the DO'S and DONT's in monitoring	10 minutes

Use of partograph	4. Present slides (Slide 8-22) ❖ Explain the steps to plot a partograph and how to detect normal labour and abnormal labour (prolonged and obstructed labour). 5. Slide 23:Demonstrate how to plot a partograph using 2 Partograph exercises 1-2 (See Handout 6.1-6.2). Refer participants to additional exercises given in Mentors Manual Vol 2: Partograph Exercise 3.1-3.2 (pg 62 - 66) that could be used by mentors for practice or during mentoring sessions with the staff nurses. ❖ Divide participants into groups of 3-4 members. ❖ Distribute Partograph exercise 1-2 (Handout 6.1-6.2) on normal labour, not requiring any intervention as depicted by partograph findings to half the group. ❖ After 20 minutes review both exercises going through each step with the participants and helping them to complete it. ❖ Ask participants to interpret partograph findings and evaluate progress and when to refer. Discuss the findings. ❖ If time permits give them additional labour case studies (Handout 6.3-6.4) for practice of interpreting progress of labour using the partograph. 6. Discuss normal delivery process and do's and don'ts during delivery (Slide 24-27). 7. Clarify any doubts participants might have on the use of the partograph and how it is interpreted.	20 minutes 40 minutes
Prolonged and obstructed labour	8. Slide 28: Give the Case study – abnormal labour(Handout 6.5) on prolonged labour to all the participants. Ask them to read it and discuss with them the questions. Use the facilitators copy to lead the discussion. 9. Reinforce the meaning, causes, signs and symptoms and initial management of prolonged and obstructed labour as given in the slides (Slide 29-35).	20 minutes
Summarize	10. Ask a participant volunteer to point out the partograph in the new case sheet. 11. Check if they have any doubts on the use of partograph, and clarify them. Reinforce the key messages. Reinforce that the case sheet could be a tool for monitoring the progress of labour, it could also act like a teaching aid providing opportunities for mentors to choose one to one mentoring methods. (Slide 36-37).	5 minutes

Hand-Out 6.1: Partograph Exercise -1

Instructions:

This exercise is designed to allow you to learn while doing. Work along with the facilitator and complete the partograph. Interpret the plotting on partograph.

One of you read aloud the Steps 1-2, when instructed by the facilitator. Then plot on the partograph as you read information provided in Step 3. Wait till all complete the same. Then another one of you read Step 4. Go through the question and answers with the facilitator. Clarify any doubts.

Step 1:

- Mrs A was admitted at 5.00 a.m. on 12.5.2010
- Membranes ruptured 4.00 a.m.
- Gravida 3, para 2+0
- Hospital number 7886
- On admission the foetal head was 4/5 palpable above the symphysis pubis and the cervix was 2cm dilated.

Step 2:09.00 a.m.

- The cervix is 5 cm dilated.
- There are 3 contractions in 10 minutes, each lasting 20–40 seconds
- Foetal heart rate (FHR) 120/min
- Membranes ruptured, amniotic fluid clear
- Pulse 80 per minute
- Blood pressure 120/70 mm Hg
- Temperature 36.8°C

Step 3

Plot the following information on the partograph:

- 09.30 a.m. FHR 120/min, Contractions 3/10 each 30 sec, Pulse 80/min
- 10.00 a.m. FHR 136/min, Contractions 3/10 each 30 sec, Pulse 80/min
- 10.30 a.m. FHR 140/min, Contractions 3/10 each 35 sec, Pulse 88/min
- 11.00 a.m. FHR 130/min, Contractions 3/10 each 40 sec, Pulse 88/min
- 11.30 a.m. FHR 136/min, Contractions 4/10 each 40 sec, Pulse 84/min
- 12.00 noon FHR 140/min, Contractions 4/10 each 40 sec, Pulse 88/min
- 12.30 p.m. FHR 130/min, Contractions 4/10 each 45 sec, Pulse 88/min

Step 4:1.00 p.m.

- Cervix is fully dilated
- Contractions 4/10 each 45 sec
- FHR 140/min
- Amniotic fluid clear
- Pulse 90/min,
- Blood pressure 100/70
- Temp 37°C

Hand-Out 6.1: Partograph Exercise -1

Step	Question	Answer
1	What should be recorded on the partograph?	The woman is not in active labour. Record only the details of her history, i.e. first 4 bullets, not the cervical dilatation.
2	What should you now record on the partograph?	The woman is now in the active phase of labour. Plot the given information on the partograph.
3 and 4	What is your diagnosis? What steps should be taken? What do you expect to happen next?	Normal progress of labour; good foetal and maternal condition Routine monitoring of labour; reassure the woman; give her fluids to drink Looking at the progress, the woman is expected to have a normal delivery
5	Note: record on case sheet	1.20 p.m.: spontaneous delivery of a live female infant, Wt. 2,850g

Hand-out 6.2: Partograph Exercise 2

Instructions:

This exercise is designed to allow you to learn while doing. Work along with the facilitator and complete the partograph. Interpret the plotting on partograph.

One of you, read aloud the Steps 1, when instructed by the facilitator. Then plot on the partograph as you read information provided in Step 2. Wait till all complete the same. Compare your partographs with each other. Clarify any doubts you might have. Then another one of you read Step 3. Go through the question and answers with the facilitator. Clarify any doubts.

Step 1:

- Mrs B was admitted at 10.00 a.m. on 2.5.2010
- Membranes intact
- Gravida 1, para 0+0
- Hospital number 1443.

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

- Cervix is 4 cm dilated
- Contractions 2 in 10 minutes, each lasting 15sec
- FHR 140/min
- Membranes intact
- Pulse 80 per minute
- Blood pressure 100/70 mm of Hg
- Temperature 36.2°C

Step 2:

Plot the following information on the partograph:

- 10.30 a.m. FHR 140/min, Contractions 2/10 each 15 sec, Pulse 90/min, membranes intact
- 11.00 a.m. FHR 136/min, Contractions 2/10 each 15 sec, Pulse 88/min, membranes intact
- 11.30 a.m. FHR 140/min, Contractions 2/10 each 20 sec, Pulse 84/min, membranes intact
- 12.00 noon FHR 136/min, Contractions 2/10 each 15 sec, Pulse 88/min, membranes intact
- 12.30 p.m. FHR 136/min, Contractions 1/10 each 15 sec, Pulse 90/min, membranes intact
- 1.00 p.m. FHR 140/min, Contractions 1/10 each 15 sec, Pulse 88/min, membranes intact
- 1.30 p.m. FHR 130/min, Contractions 1/10 each 20 sec, Pulse 88/min, membranes intact

Step 3:

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

At 2.00 p.m.

- Cervix is 8 cm dilated
- Contractions 3/10 each 20 sec
- FHR 140/min
- Membranes intact.
- Pulse 90/min
- BP 120/80 mm Hg
- Temperature 36.2°C

Questions

Q: What is your diagnosis? What action should be taken now?

Key for Partograph Exercise -2

Step	Question	Answer
1	What is your diagnosis	Mrs B is in active labour
	What action will you take	Inform Mrs B of finding and what to expect Encourage her to move around Encourage her to drink and eat as desired
2	What is your diagnosis	Good progress Good fetal and maternal condition
	What action will you take	Inform Mrs B of findings and what to expect, Reassure her; Encourage her to move about; give her fluids to drink
3	What is your diagnosis	Normal labour; with good foetal and maternal condition.
	What action should be taken now?	Conduct delivery Refer the patient to a facility where augmentation or surgical intervention can be done if she fails to progress after 10am and remains 4 cms dilated

Hand-Out 6.3: Labour Case Study 1

Instructions:

This exercise is designed to allow participants to learn the use and interpretation of a partograph.

Give time to participants to read through the questions and then discuss the same with them Clarify any doubts.

Radha (wife of Gangaram), 26 years of age, third gravida, was admitted at 5:00 am on 11 June 2010 with complaints of full term pregnancy with labour pains since 2:00 am. Her membranes ruptured at 4:00 am. She has two children of the ages of 5 and 2 years. On admission, her cervix was dilated 2cm.

Plot the following findings on the partograph: At 9:00 am:

- The cervix was dilated 5 cm.
- She had 3 contractions in 10 minutes, each lasting 30 seconds.
- The FHR was 120 beats per minute.
- The membranes had ruptured and the amniotic fluid was clear.
- Her pulse was 80 per minute
- Her blood pressure was 120/70 mmHg.
- Her temperature was 36.8° C.

Plot the following findings on the partograph.

9:30 am: FHR 120/min, contractions 3/10 each 30 seconds, pulse 80/minute, amniotic fluid clear

10:00 am: FHR 136/min, contractions 3/10 each 35 seconds, pulse 80/minute, amniotic fluid clear

10:30 am: FHR 140/min, contractions 3/10 each 40 seconds, pulse 88/minute, amniotic fluid clear

11:00 am: FHR 130/min, contractions 3/10 each 40 seconds, pulse 88/minute, amniotic fluid clear

11:30 am: FHR 136/min, contractions 4/10 each 45 seconds, pulse 84/minute, amniotic fluid clear

12:00 noon: FHR 140/min, contractions 4/10 each 45 seconds, pulse 88/minute, amniotic fluid clear

12:30 pm: FHR 130/min, contractions 4/10 each 50 seconds, pulse 88/minute, amniotic fluid clear

At 1:00 pm:

- Cervix fully dilated
- Contractions 4/10 each 55 seconds
- FHR 140/min
- Amniotic fluid clear
- Pulse 90/minute,
- Blood pressure100/70 mmHg,
- Temperature 37° C

Questions:

1. What is your diagnosis after plotting the partograph at 1.00pm?

_____

_____

2. What can you predict about the outcome for this woman?

_____

_____

3. Why did you predict the above?

_____

_____

Hand-Out 6.4: Labour Case Study 2

Instructions:

This exercise is designed to allow participants to learn the use and interpretation of a partograph.

Give time to participants to read through the questions and then discuss the same with them Clarify any doubts.

Rubina (wife of Zarif), age 26 years, was admitted at 11: 00 am on 12 June 2009 with the complaint of full term pregnancy with labour pains since 4:00 am. Her membranes ruptured at 9:00 am. She has one child aged 3 years. She gave birth to a stillborn baby 5 years back.

Plot the following findings on the partograph: At 11:00 am:

- The cervix was dilated 4 cm.
- She had 3 contractions in 10 minutes, each lasting less than 20 seconds.
- The FHR was 140 per minute.
- The membranes had ruptured and the amniotic fluid was clear.
- Her blood pressure was 100/70 mmHg.
- Her temperature was 37° C.
- Her pulse was 80 per minute.

Plot the following findings on the partograph

11:30 am: FHR 130/min, contractions 3/10 each 35 seconds, pulse 88/minutes, amniotic fluid clear

12:00 noon: FHR 136/min, contractions 3/10 each 40 second, pulse 90/minutes, amniotic fluid clear

12:30 pm: FHR 140/min, contractions 3/10 each 40 seconds, pulse 88/minutes, amniotic fluid clear

1:00 pm: FHR 130/min, contractions 3/10 each 40 seconds, pulse 90/minutes, amniotic fluid clear

1:30 pm: FHR 120/min, contractions 3/10 each 45 seconds, pulse 90/minutes, amniotic fluid clear

2:00 pm: FHR 120/min, contractions 3/10 each 45 seconds, pulse 88/minutes, amniotic fluid clear

2:30 pm: FHR 118/min, contractions 3/10 each 45 seconds, pulse 90/minutes, amniotic fluid clear

Plot the following findings on the partograph

At 3: 00 pm:

- Cervix dilated 6 cm

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- Contractions 4/10 each 45 seconds
- FHR 100/minute
- Amniotic fluid meconium-stained
- Pulse 100/minute
- Blood pressure 120/80 mmHg
- Temperature 37.8°C

Questions:

1. What is your diagnosis after plotting the partograph at 3.00pm? (abnormal labour)

2. What is the action you will take?

3. What initial management should be provided to the woman if she is referred?

Case Study Abnormal Labour

(Facilitator's copy)

Facilitator instructions:

- Hand out the participant's case study copy.
- Please read out the following scenario to the participants and ask them to answer the questions.
- One option on how to do this is to go around in a circle and let everyone provide an answer or you can just let individual participants respond.
- The purpose of the case study is to get them to think through what steps need to be done and why they would or would not do something. In all cases try to avoid directly giving the answers – rather probe around the topic to see if the participants can come up with the responses.
- Review the key points and answer any questions at the end of the case study.

Case Study -

20 yrs. old Mrs. Lakshmi, who is a primigravida is admitted with labour pains at 5 am.

On examination at 5 am: (0 hour)

- Pulse 90/min., BP 120/80mmHg., Temp 37.4°C,
- P/A: 3 Contractions for 15-20 sec/10 minute, FHR 140/minute,
- P/V: Cervix 4 cm. dilated, membranes present

What will you do?

- Monitor for progress of labour

B) At 9.00 am (After 4 hours):

- Pulse 98/min., BP 120/70 mmHg., Temp 38°C
- P/A: 3 Contractions for 20-25 sec./10 min., FHR 126/min.
- P/V: Cervix 5 cm dilated, membranes present

Is the progress normal?

- The cervical dilatation is not as expected, i.e., 1 cm / hr., hence the progress is delayed

C) What are the signs of obstructed labour?

- Plotted cervical dilatation line in the partograph is to the right of Line A at the four hour and eight hour assessments
- No cervical change (secondary arrest) with repeat PV after 4 hours in active phase of labour
- Significant caput and moulding

- Cervix that is not well applied to presenting part
- Swollen, oedematous cervix
- Ballooning lower uterine segment
- Formation of retraction band felt over abdomen
- Foetal or maternal distress(Mother: tachycardia, signs of dehydration & fever, baby – Foetal distress)
- Labour that is longer than 24 hours duration

D) How will you refer?

Do the following

- Talk to the relatives about the condition of the patient
- Call and determine the nearest facility where a c-section can be done if necessary
- Arrange transport
- Keep the woman NPO
- Do not provide oxytocin

Give the following

- Insert 16-18 gauge IV and provide IV normal saline or ringer lactate @ 30 drops/min
- Insert Foley's catheter
- Start oxygen
- Give all the three following antibiotics
  - Ampicillin 1g either Oral or IV
  - Metronidazole either 400mg Oral or 500mg IV
  - Gentamicin 80mg either IM or IV

While in transport

- Keep the woman in left lateral position
- Continue fluid and carry extra bottles to last till she reaches the facility
- Provide oxygen
- Keep a delivery set and essential drugs handy
- SN accompanies the woman

Carry relevant documents

- Take the plotted partograph
- Take the filled up complication case sheet A for the patient

Hand-Out 6.5: Case Study Abnormal Labour

(Participants copy)

Case Study labour:

A. 20 yrs. old Mrs. Lakshmi, primigravida is admitted with labour pains at 5 am.

On examination at 5 am: (0 hour)

- Pulse 90/min., BP : 120/80 mmHg., Temp : 37.4°C,
- P/A : 3 contractions for 15-20 sec./10 min., FHR : 140/min.,
- P/V cervix 4 cm. dilated, membranes present

What will you do?

B. At 9.00am (after 4 hours):

- Pulse 98/min., BP 120/70 mmHg., Temp : 38°C
- P/A: 3 contractions for 20-25 sec./10 min., FHR 126/min.
- P/V: cervix 5 cm dilated, membranes present

Is the progress normal? (Note down the reasons for your answer).

C. What are the signs of obstructed labour?

D. How will you refer and what will you do before referring?

Session 7 Normal Delivery

Materials: PPT slides, SBA guidelines 2010 (pg 47-48), new case sheets, video, 5 case scenarios in printed copies, copies of Partograph, Pelvic model and a doll with a placenta, cord, mannequin, delivery kit, flip charts and markers

Session time: 50 minutes

Training methods: Lecture, Video, Demonstration on mannequin/pelvic model, Case sheet demonstration.

Session Objectives:

By the end of this session participants will be able to

- ✓ Recall the steps to conduct and manage the second stage of labour and normal delivery
- ✓ Demonstrate how to conduct and manage the second stage of labour and normal delivery
- ✓ Demonstrate documentation of managing the second stage of labour and conducting a normal delivery, in case sheets
- ✓ Demonstrate mentoring skills for conducting and managing the second stage of labour and normal delivery

	Teaching Steps	Duration
Introduction	1. Introduce the topic and session objectives (Slide 1-2).	2 minutes
Monitoring of labour	2. Ask participants to explain the components of delivery. Write main points of discussion on the flip chart.	3 minutes
	3. Show video of the stages of delivery of baby: head, shoulder and body. ❖ Pause video at o Crowning o Delivery of head o Delivery of shoulder o Delivery of trunk o Putting the baby over the mother's abdomen	10 minutes
	4. Present slides to explain do's and don'ts during labour; stages of labour and indications of episiotomy (Slide 3-8); also show slides on delivery of head, shoulders trunk; clamping cord (Slide 9-14).	10 minutes

	5. Demonstrate using the mannequin/pelvic model the stages of delivery. Divide the group in pairs and ask each to do the return demonstration using the pelvic model and fetus.	20 minutes
Summarize	6. Ask a volunteer to show where delivery notes and what must be included recorded in case sheets.	5 minutes
	7. Clarify if any doubts arise and highlight the key points (Slide 15-16).	

Session 8 Third Stage of Labour and Active Management of Third Stage of Labour (AMTSL)

Materials: PPT slides, SBA guidelines 2010 (pg 49-50), New case sheets, video, case scenarios in printed copies, Pelvic model and a doll with a placenta, cord, delivery kit and drug tray, PPT

Session time: 50 minutes

Training methods: Lecture, power point, demonstration –use of pelvic model or mannequin, baby and placenta.

Session Objectives:

By the end of this session participants will be able to

- ✓ Recall about the third stage of labour, the significance of active management of third stage and its components, examination of placenta
- ✓ Demonstrate how to manage third stage of labour - AMTSL, examination of placenta, estimation of blood loss
- ✓ Demonstrate documentation of managing the third stage of labour, in case sheets
- ✓ Demonstrate mentoring skills for managing third stage of labour

	Teaching Steps	Duration
Introduction	1. Introduce the topic and session objectives (Slide 1-2).	2 minutes
Third stage of labour, AMTSL	2. Ask participants how they conduct the third stage of labour. 3. Using slides explain the relevance of AMTSL and its importance to reduce maternal mortality, steps of AMTSL, Dos and Don'ts (Slide 3-11).	8 minutes
Demonstration of AMTSL	4. Demonstrate using pelvic model or mannequin how to perform AMTSL steps (uterotonic, controlled cord traction, uterine massage followed by examination of placenta, estimation of blood loss)- **Use checklist – Handout 7.1** 5. Divide participants into groups and ask one or two volunteer participants for return demonstration. Commend them for correct steps and correct any mistakes	30 minutes
Summarize	6. Ask a few participants to highlight the key learning of the session. Wait for responses. 7. Conclude with key messages and show the video on AMTSL (Slide 12-13). Encourage participants to mention points that are in line with SBA recommendations. Clarify any questions if they arise.	10 minutes

Hand-Out 7.1: Evaluation Checklist

Evaluation type: model (M) or clinical practice (C)

SINo	Steps	Done			Not done
	AMTSL Step 1: Administration of a uterotonic drug (2 points)				
1.	Palpates the uterus to make sure no other baby is present				
2.	If no other baby is present administers uterotonic drug (oxytocin 10IU IM or if a woman has an IV infusion an option of oxytocin 5IU IV bolus slowly within a minute of delivery				
	AMTSL Step 2: Does controlled cord traction (9 points)				
3.	Clamps and cuts the cord approximately 2-3 minutes after the birth				
4.	Places the palm of the other hand on the lower abdomen just above the woman's pubic bone				
5.	Keeps slight tension on the cord and awaits a strong uterine contraction				
6.	Applies gentle but firm downward traction to the cord during a contraction, while at the same time applying counter-traction abdominally				
7.	Waits for the next contraction and repeats the action if manoeuvre is not successful after 30-40 seconds of controlled cord traction				
8.	As the placenta delivers, holds it in both hands				
9.	Uses a gentle upward and downward movement or twisting action to deliver the membranes				
10.	If membranes tear, gently examine the upper vagina and cervix				
11.	Places the placenta in the basin available				
	AMTSL step 3: Uterine massage				
12.	Immediately massages the fundus of the uterus through the woman's abdomen until the uterus is contracted (firm)				
13.	Ensures the uterus does not become relaxed 9soft) after stopping uterine massage				
14.	If the uterus becomes soft after massage, repeats uterine massage				

15.	Teaches the woman how to massage the uterus				
	Immediate PP care				
16.	Inspects and repairs lacerations or tears /episiotomy if needed of the lower vagina and perineum				
17.	Examines the maternal surface of the placenta and membranes for completeness and abnormalities				
18.	Disposes the placenta in the appropriate bin				
20.	Removes the soiled bed linen and makes the woman comfortable				
21.	Estimates blood loss				
22.	Assists woman to start breast feeding				

Session 9 Management of Fourth Stage (Up to 2hrs after Delivery)

Materials: PPT slides, SBA guidelines 2010 (pg 51-52), new case sheets, watch, BP apparatus, stethoscope, gloves

Session time: 25 minutes

Training methods: Lecture, PPT, Case sheet demonstration

Session Objectives:

At the end of this session participants will be able to

- ✓ Explain the importance of care provided to the mother within the first 2 hours of delivery and steps of monitoring fourth stage of labour.
- ✓ Describe the steps of monitoring fourth stage of labour.
- ✓ Demonstrate documentation of fourth stage of labour in the case sheet.

	Teaching Steps	Duration
Introduction	1. Introduce the topic and objectives of the session (Slide 1-2)	2 minutes
Fourth stage of labour	2. Ask participants how they monitor patients soon after delivery (4th stage). Record the same on the flip chart.	3 minutes
Assess and Monitoring during fourth stage	3. Explain using slides the importance of management of the fourth stage, i.e. the first two hours after delivery of the placenta. Emphasise on the need to monitor pulse, BP, uterine tone and fundal height and bleeding PV and what any abnormality might indicate (Slide 3-8). 4. Discuss with participants any problems they face in monitoring this stage of labour.	15 minutes
Summarize	5. Check with participants if they know where they would record details of pulse, after BP uterine tone, fundal height and bleeding PV in the new case sheet. 6. Ask participants "how do you think you could use the case sheet as a mentoring tool?" 7. Clarify any doubts and conclude with key points (Slide 9-10).	5 minutes

Postpartum Or Postnatal Period

Learning objectives

By the end of the session participants will be able to

- Recall the importance of doing a relevant assessment for the women in the early postnatal period.
- List and describe the relevance of the components of a good postnatal assessment.
- Demonstrate how to do a comprehensive postnatal assessment and manage postnatal period appropriately.
- Demonstrate documentation of relevant early postnatal assessment and management of the women admitted to the PHC in the case sheet.
- Demonstrate mentoring skills for doing a relevant early postnatal assessment and management of the women presenting or admitted to the PHC.

Refer to Chapter 4 in the Participants manual for details of the session

Session 10

Postnatal Care at the Facility

Materials: PPT slides, SBA guidelines 2010, new case sheets,watch, BP instrument, thermometer, stethoscope, gloves, speculum/Cusco's speculum, flip charts, marker pens

Session time: 40 minutes

Training methods: Case studies, interactive lecture, power point presentation, Group activity, case sheet demonstration

Session Objectives:

By the end of this session participants will be able to

- ✓ Describe how postnatal care is to be provided to a recently delivered mother at the facility
- ✓ Demonstrate documentation of postnatal care provided to recently delivered mother at the facility

	Teaching Steps	Duration
Introduction	1. Introduce the topic and objectives of the session (Slide 1-2).	3 minutes
Postnatal care at facility - components	2. Group activity: Ask participants "will you monitor a recently delivered woman during the postnatal period", "what?" "why?"Facilitate discussion and note down the points on a flipchart.	7 minutes
	3. Explain and reinforce using slides (Slide 3-9): ❖ Significance of postpartum check up ❖ Frequency of postpartum monitoring during 48 hour stay ❖ Key components of postpartum care include o Monitoring vital signs: BP, HR, temperature o Examining the breast, abdomen to check if it is contracted, amount of bleeding PV, perineum to detect any tears	20 minutes
	4. Role play: Demonstrate with another facilitator how to counsel mothers regarding care of mother in the facility ❖ Preventing infection ❖ Danger signs to look for ❖ Diet she must take	5 minutes
Summarize	5. Ask participants to point out where they would record the details of postnatal check up on the new case sheet 6. Brainstorm with participants "how would you be able to assess the quality of postnatal care in the facility. Wait for responses and then tell them that it could be through audit of case sheets, exit interview of women at discharge or direct observation. 7. Clarify any doubts of the participants and conclude with key points (Slide 10-11).	5 minutes

Complications During Pregnancy, Labour, Delivery And Postnatal Period – Identification, Initial Management And Referral

Session 11 A: Identification, initial management and referral of haemorrhage (APH and PPH)

Session 11 B: Identification, initial management and referral of PIH

Session 11 C: Identification, initial management and referral of infection and preterm labour

Session 12: Preparation of labour room

Learning objectives

By the end of the sessions participants will be able to

- Recall how to identify obstetric complications during pregnancy, labour and delivery and in the postnatal period at the PHC.
- Explain the appropriate initial management before referral for complication identified.
- Demonstrate how to identify danger signs obstetric complications and provide the appropriate initial management.
- Demonstrate documentation of complications and appropriate initial management at the PHC.

Refer to Chapter 5 in Mentors' manual

Session 11A Complications of Labour, Delivery, Postnatal Period– Identification, Initial Management and Referral of Hemorrhage (PPH and APH)

Materials: PPT slides, SBA guidelines 2010(pgs 79-85), New case sheets, video, case scenarios in printed copies,pelvic modelandadollwitha placenta, government complication management protocols, emergency drug tray.

Session time: 60 minutes

Training methods: Case studies and group activity, interactive lecture using power point and Video, Demonstration on pelvic model, doll and placenta, use of government labour room protocols, Case sheet demonstration.

Session Objectives:

By the end of this session participants will be able to

- ✓ Discuss how to identify danger signs/ obstetric complications at initial assessment of labour, during labour and in postnatal period at the facility
- ✓ Explain the initial management of obstetric complications at first assessment of labour, during labour and in postnatal period at the facility
- ✓ Demonstrate documentation of complications at assessment of labour, in labour and in postnatal period at the facility on case sheets

Teaching Steps		Duration
Introduction	1. Introduce the topic and session objectives (Slide 1-2).	3 minutes
Identification of danger signs at initial assessment, initial management	2. Brainstorm with participants "what are the complications of labour, delivery and postpartum period?" After 5 minutes ask them to present their list and then project the list. ❖ PPH, Eclampsia, preterm labour, Infection/fever, APH. 3. Request one or two participant volunteers to describe their experience in handling any one of the complications 4. Get participants to refer to the case sheet and point out what aspect of the case sheet refers to danger signs. ❖ Reinforce that complications can be detected at any time – in initial assessment prior to labour, during labour, during delivery, third stage, fourth stage, postnatal period and thus a woman must be observed carefully during these periods. ❖ Emphasise the need to act quickly to manage the common complications such as	5 minutes

Care of a woman with APH	5. Ask participants: "have any of you seen a woman bleeding before delivery?" "what are some of the causes?" 6. Explain with slides causes and presenting features of APH, initial management before referral (Slide 3-10).	20 minutes
Care of a woman with PPH	**Use case study – (Handout 10A.1) either before or after this part** 7. Brainstorm with participants: "when would you suspect PPH?". Wait for responses and then tell them danger sign bleeding PV more than 500 cc at delivery, passage of clots. 8. Ask them what they would assess if a woman has bleeding. Reinforce the need to examine the abdomen and check for the following ❖ Findings : uterus may or may not be not contracted, bleeding PV heavy or very heavy, low BP, rapid pulse 9. Ask them further "what else will you look for once you know a woman is bleeding?: (Expected response – cause of bleeding) What investigations might be required? ❖ Causes of PPH - atonic PPH, incomplete placenta, tear, rupture uterus, retained placenta, infection in delayed PPH ❖ Identification of cause using the PPH protocol 10. Then ask them, "from your experience how do you think PPHcan be prevented and managed?" ❖ AMTSL, uterine massage, Injection Oxytocin 10 IUIM, 20 IU in 500ml IV drip, removal of placenta and placental fragments, ❖ Bimanual compression , ❖ repair of 1st and 2nd degree tears, ❖ Antibiotics (Ampicillin 1gm IV, Metronidazole 500ml IV, Gentamycin 80mg IM) in Manual removal of placenta (MRP), and delayed PPH ❖ Referral 11. Explain the causes, identification and initial management of PPH using slides (Slide 11-19). 12. Demonstrate how bimanual compression can be done on the mannequin. 13. Refer them to the case sheet. Ask them to identify information that they would need to record on the case sheet. Reinforce how the case sheet could be used to ❖ Audit practices of staff nurses. ❖ Teach staff on a one to one basis how PPH could be identified, assessed further and managed before referral	10 minutes 10 minutes 5 minutes 10 minutes 10 minutes 5 minutes
Summarize	14. Ask participants to point out three key learning's of the session. Clarify if there are any doubts. 15. Conclude with key messages (Slide 20)	2 minutes

Case Study – Early PPH

(Facilitator's Copy)

As the instructor, hand out the participants case study copy. Please read out the following scenarios to the participants and ask them to answer the questions. One option on how to do this is to go around in a circle and let everyone provide an answer or you can just let individual participants respond. The purpose of the case study is to get them to think through what steps need to be done and why they would or would not do something. In all cases try to avoid directly giving the answers – rather probe around the topic to see if the participants can come up with the responses. Review the key points and answer any questions at the end of the case study.

Scenario: Part A

You have just delivered Mrs. B, a 30 year old gravida 4 para 4 at the PHC. She had a vaginal delivery for a live born, 2.6 kg baby boy. What will you do to actively manage the third stage of labour and decrease the risk of postpartum hemorrhage in this woman?

Answer: Perform active management of the third stage of labour, which involves the following components. You do not want to give away the answers but probe to see if the participants can provide them. For example if they do not mention giving uterotonics -ask "would you give any medications, why or why not?" – this encourages them to actually think about the steps that need to be taken.

- Administration of a uterotonic drug (5-10 mg IV or IM of oxytocin, 600 micrograms rectally of misoprostol, or 0.2 mg IM of ergometrine). Mention that oxytocin is the preferred drug but that the others are also acceptable to use.
- Clamping of the cord
- Gentle, controlled cord traction with one hand over the symphysis pubis to provide counter traction and thus prevent uterine inversion
- Discuss that these 3 actions have been shown to decrease the risk of postpartum hemorrhage and should be performed on all women as routine care. This is especially important to do in the Northern Karnataka context since PPH is the leading cause of maternal deaths.

Scenario: Part B

Mrs. B. delivers the placenta. After delivery of the placenta what do you want to check for and why?

Answer: The following should be mentioned. In discussion explain why. If they do not mention all steps probe by asking, "Is there anything else you would want to do, why or why not?"

- Check that the placenta and membranes are complete, because retained placental tissue/ fragments can lead to ongoing bleeding and be a cause of PPH.
- You also want to check that the uterus is firm and contracted since uterine atony is the most common cause of PPH (it is responsible for 80% of all PPH cases).

- Examine the perineum, vagina and cervix for tears. This is because tears are the most likely cause of PPH if the uterus is firm and well contracted and the placenta is complete.
- Estimate if the amount of blood loss at delivery is normal or abnormal. This helps you get a sense of what is a normal amount of blood after delivery and what is too much bleeding after delivery.

Scenario: Part C

On examination the uterus is well contracted and there are no perineal tears. The placenta and membranes are intact. One hour later she begins to have heavy PV bleeding. What would you like to do on your initial assessment of Mrs. B and why?

Answer: All of the following points need to be mentioned and discussed. You want to reinforce that there needs to be a sequential order to doing things and that in reality if 2 health care providers are present at the same time many of these steps happen simultaneously. If they do not mention all steps probe by asking, "Is there anything else you would want to do, why or why not?"

- Call for help - this allows you to have additional help for managing the patient. If help is not available do not wait for help to come to assess the patient.
- An initial rapid assessment of Mrs. B should be done to look for signs of shock and if she is in need of emergency resuscitation. These signs include: pulse >110, systolic blood pressure less than 90 mmHg, sweatiness, cold, clammy skin, rapid breathing, altered level of consciousness, confusion. Temperature should also be done to rule out infection.
- The uterus should be immediately checked to see if it is contracted. Explain that this is done because 80% of all PPH is due to uterine atony and even though it was firm before it may have become atonic.
- The perineum, vagina and cervix should be carefully re-examined for tears. While this was done previously – now that the bleeding has started again you want to make sure that you did not miss anything on earlier examination.

Scenario: Part D

You have completed your initial rapid assessment of Mrs. B and your findings include the following: Her temperature is 36.8^0 C, her heart rate is 100 beats per minute, her blood pressure is 116/74 and her respirations are 18 per minute. She is alert and oriented. Her uterus is soft and boggy. There are no perineal, vaginal or cervical tears.

Based on these findings, what is Mrs. B's diagnosis and why?

Based on these findings do you think shock is present?

Answer: Uterine atony without signs of shock. Explain that the findings of a soft, boggy, uncontracted uterus are consistent with the diagnosis of uterine atony. Review again the signs of shock (pulse >110, systolic blood pressure less than 90 mmHg, sweatiness, cold, clammy skin, rapid breathing, altered level of consciousness, confusion).

How will you manage her and why?

Answer: All of the following points need to be mentioned and discussed. You want to reinforce that there needs to be a sequential order to doing things and that in reality if 2 health care providers

are present at the same time many of these steps happen simultaneously. You do not want to give away the answers but probe to see if the participants can provide them. For example if they do not mention starting an IV -ask "Would you start an IV, why or why not?" – This encourages them to actually think about the steps that need to be taken.

- Call for help/assistance as many things need to be done simultaneously. Mrs. B should not be left unattended nor should you delay caring for Mrs. B while help is on its way or if help is unavailable.
- Begin uterine massage and continue until the uterus is firm. This helps the uterus contract. You may also need to do a pelvic examination to remove any clot from the uterus. As long as there is clot in the uterus the uterus will not be able to contract.
- Immediately give an additional dose of Oxytocin 10 Units IM x 1. If oxytocin is not available then one of the following uterotonics can be given via an alternate route (800 micrograms of misoprostol rectally, 0.2 mg IM of ergometrine) to help the uterus contract. Explain that oxytocin is the preferred drug of choice, followed by misprostol, then ergometrine (ergometrine has more adverse effects such as increasing the blood pressure). Use this point to reinforce that the new case sheets will have information on dosages, repeat dosages and contraindications.
- Start an IV with a large bore needle (16 or 18 guage) and run 20 Units of injectable oxytocin in 500ml of Ringers Lactate or Normal Saline at 60 drops per minute then follow with an additional 20 units of injectable oxytocin in 500ml of IV fluids at 40 drops per minute (not more than 3L).
- If the woman continues to bleed and the uterus does not contract after performing the above steps then one of the following uterotonics can be given via an alternate route (800 micrograms of misoprostol rectally, 0.2 mg IM of ergometrine) to help the uterus contract. Use this point to reinforce that the new case sheets will have information on dosages, repeat dosages and contraindications.
- Start an IV and begin fluids of either NS or RL at 40-60 drops per minute. Explain that placing an IV ensures that you have access for more fluid administration and any additional medications if she continues to bleed. By giving fluids, you are making sure that the woman does not become volume depleted while you are managing the bleeding.
- Insert a Foley catheter will help keep the uterus contracted by making sure the bladder is empty. It is also is a useful way to measure urine output if the woman continues to bleed.
- Continue to recheck her vital signs. This will let you know if the patient is remaining stable or is beginning to deteriorate and show signs of shock.
- You do not need to cross-match her for blood since she is not in shock.
- Blood for haemoglobin does not need to be drawn immediately if she does not continue to bleed and if she responds to your initial management.

Scenario: Part E

You correctly diagnose uterine atony. You have performed uterine massage, removed all clots from the uterus, administered oxytocin 10 Units IM x 1, started an IV with and inserted a Foley. She has IV fluids of 500ml of NS with 20 units of oxytocin running at 60 drops per minute. Her uterus is now firm and well contracted. Repeat vital signs show a heart rate of 86, blood pressure of 108/72, temperature of 36.9^0 C and respiratory rate of 16. Her haemoglobin is 8g/dl. There is no further PV bleeding.

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

- Mrs. B.'s vital signs and blood loss should continue to be monitored, every 15 minutes for 1 hour, then every 30 minutes for 2 hours, every hour for 3 hours and then every 4 hours for 24 hours. Her uterus should be checked to make sure that it remains firm and well contracted. In addition, she should be encouraged to breastfeed her newborn. She needs to have this additional close monitoring because you want to make sure she does not start to bleed again. Breastfeeding releases oxytocin and this also help to keep the uterus contracted to prevent bleeding.
- Twenty-four hours after the bleeding has stopped, a haemoglobin or haematocrit should be done to check for anemia.
- If Mrs. B.'s hemoglobin is below 11 g/dL she should be given IFA tablets once daily for 6-9 months. This will help increase her iron stores and increase her hemoglobin.
- A blood transfusion is not needed if her vital signs are stable and no further bleeding occurs.
- She should be encouraged to express her concerns, listened to carefully, and provided continuing emotional support and reassurance.
- Mrs. B. should remain at the health center for an additional 24 hours, and before discharge counseling should be provided about danger signs in the postpartum period (bleeding, abdominal pain, fever, headache, blurred vision), compliance with iron/folic acid treatment and the inclusion in her diet of locally available foods rich in iron. In addition, counseling about breastfeeding and newborn care should be provided.
- If recovery continues to be unremarkable, Mrs. B. and her baby should be seen by a healthcare provider approximately 5 to 6 days after discharge.

Congratulations you have successfully managed a case of early postpartum hemorrhage.

Ask if there are any questions or points that require clarification.

Key points to review at the end of the case

- Active management of the third stage of labour should be performed on all women after delivery of the baby.
- Inspection of the placenta and membranes, perineum, vagina and cervix and uterine tone should be done routinely after all deliveries. Doing so routinely will help identify and/or prevent early PPH.
- Early PPH is defined as bleeding greater than 500 ml in the first 24 hours after delivery. What you really want to be able to determine is if the bleeding is much heavier than it should be (i.e. not a normal amount).
- The most common cause of early PPH is uterine atony (80% of all cases). Perineal, vaginal and cervical tears, followed by retained placenta or placental fragments are the next most common causes.
- Always perform an initial rapid assessment to determine if the patient is in shock or not and requires immediate resuscitation.
- Never leave a bleeding woman alone. Women who have had an immediate PPH need increased monitoring for the next 24 hours to make sure no further bleeding occurs.

Handout 10A.1: Case Study – PPH

(Participant's copy)

Scenario: Part A

You have just delivered Mrs. B, a 30 year old gravida 4, para 4 at the PHC. She had a vaginal delivery for a live born, 2.6 kg baby boy. What will you do to actively manage the third stage of labour and decrease the risk of postpartum hemorrhage in this woman?

Scenario: Part B

Mrs. B. delivers the placenta. After delivery of the placenta what do you want to check for and why?

Scenario: Part C

On examination the uterus is well contracted and there are no perineal tears. The placenta and membranes are intact. One hour later she begins to have heavy PV bleeding. What would you like to do on your initial assessment of Mrs. B and why?

Scenario: Part D

You have completed your initial rapid assessment of Mrs. B and your findings include the following: Her temperature is 36.8^0 C, her heart rate is 100 beats per minute, her blood pressure is 116/74 and her respirations are 18 per minute. She is alert and oriented. Her uterus is soft and boggy. There are no perineal, vaginal or cervical tears.

Based on these findings, what is Mrs. B's diagnosis and why?

Based on these findings do you think shock is present?

_____

_____

How will you manage her and why?

_____

_____

_____

_____

Scenario: Part E

You correctly diagnose uterine atony. You have performed uterine massage, removed all clots from the uterus, administered oxytocin 10 Units IM x 1, started an IV with and inserted a Foley. She has IV fluids of 500 ml of NS with 20 units of oxytocin running at 60 drops per minute. Her uterus is now firm and well contracted. Repeat vital signs show a heart rate of 86, blood pressure of 108/72, temperature of 36.9^0 C and respiratory rate of 16. Her haemoglobin is 80. There is no further PV bleeding.

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

_____

_____

Session 11B Complications of Labour, Delivery and Postnatal Period– Identification, Initial Management and Referral of Hypertensive Disorders of Pregnancy

Materials: PPT slides, SBA guidelines 2010 (pgs 79-85), New case sheets, video, case scenarios in printed copies,pelvic modelandadollwitha placenta, government complication management protocols, emergency drug tray.

Session time: 1 Hour 30 minutes

Training methods: Case studies and group activity, interactive lecture using power point and Video, Demonstration on pelvic model, doll and placenta, use of government labour room protocols, Case sheet demonstration.

Session Objectives:

By the end of this session participants will be able to

- ✓ Discuss how to identify hypertensive disorders of pregnancy initial assessment of labour, during labour and in postnatal period at the facility
- ✓ Explain the initial management of hypertensive disorders of pregnancy at first assessment of labour, during labour and in postnatal period at the facility
- ✓ Demonstrate documentation of hypertensive disorders of pregnancy at assessment of labour, in labour and in postnatal period at the facility on case sheets

	Teaching Steps	Duration
Reinforce information on hypertensive disorders of pregnancy	1. Use slides to explain classification, identification of, initial management and referral of a woman with PIH (Slide 21-27). 2. Encourage questions and if none if forthcoming, ask a few questions.	10 minutes
hypertensive disorders of pregnancy identified through a case scenario	3. Distribute the case study (Handout 11B.1) to each participant. Ask them to sit in their groups and read the case. Give them half an hour to complete it. 4. Discuss the questions with them 5. Encourage any participant to share their experience of taking of a woman with hypertensive disorders of pregnancy	40 minutes 10 minutes
Documentation	6. Request participants to go through the case sheet and check what information must be recorded in hypertensive disorders of pregnancy. 7. Reinforce how reviewing documents at a PHC, could help in identifying ❖ One to one mentoring encounters	10 minutes

Summarize	8. Brain storm with participants to review content ❖ How would you define hypertensive disorders of pregnancy? ❖ How is hypertensive disorders of pregnancy classified? ❖ What is Hypertension in pregnancy? ❖ What are some danger signs that could point to a hypertensive disorders of pregnancy? ❖ What is the drug of choice for Severe preeclampsia / eclampsia ❖ What are some possible complications of hypertensive disorders of pregnancy? 9. End with the key messages (Slide 28).Clarify any doubts	

Handout 10A.1: Case Study – PPH
(Participant's copy)

Facilitator's Instructions: Hand out case study participant copy. Please read out the following scenarios to the participants and ask them to answer the questions. One option on how to do this is to go around in a circle and let everyone provide an answer or you can just let individual participants respond. The purpose of the case study is to get them to think through what steps need to be done and why they would or would not do something. In all cases try to avoid directly giving the answers – rather probe around the topic to see if the participants can come up with the responses. When medications need to be given ask them the dose of the medication and how they would give it. Review the key points and answer any questions at the end of the case study.

Scenario: Part A

Mrs. B is a 16 year old gravid 1 para 0 referred to your PHC from the ANM at the Sub-Centre. She reports that at that visit she was told she had "high blood pressure" and to come to the PHC for further assessment. A review of her records shows that she has had three antenatal visits this pregnancy and that before this last visit all findings were within normal limits. At her last visit, it was found that her blood pressure was 140/90 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 is currently 37 weeks gestational age.

What do you think about the blood pressure measurement of 140/90? Is this normal or abnormal?

Answer: It is abnormal. Discuss normal blood pressure in pregnancy. Blood pressure of greater than or equal to 140/90 mm Hg after 20 weeks gestational age is not normal and is consistent with the diagnosis of hypertensive disorders of pregnancy.

Why is it important to know that the urine was negative for protein?

Answer: The absence of protein in the urine indicates that the patient only has pregnancy induced hypertension and not pre-eclampsia. If there was protein in the urine with a blood pressure of greater than or equal to 140/90 mm Hg after 20 weeks then the patient would have pre-eclampsia. Whenever someone presents with high blood pressure it is absolutely essential to determine if there is protein in the urine or not as this changes your diagnosis and management.

Based on this information from her last visit of a blood pressure of 140/90 mm Hg and no proteinuria what would your diagnosis have been then?

Answer: Mrs. B.'s signs and symptoms e.g., diastolic blood pressure 90–110 mm Hg after 20 weeks gestation and no proteinuria are consistent with pregnancy induced hypertension.

Now, at her visit with you, what would you like to include on your initial history when talking with Mrs. B and why?

Answer: The following should be mentioned. In discussion explain why. If they do not mention all steps probe by asking, "Is there anything else you would want to ask, why or why not?"

- Mrs. B. should be greeted respectfully and with kindness. This helps build rapport with the patient.
- She should be told what is going to be done and listened to carefully. In addition, herquestions should be answered in a calm and reassuring manner. This reassures the patient and also helps build rapport.
- Ask specifically about the following: has she had headache, blurred vision, upper abdominal pain or fits/seizures other problems since her last clinic visit. These are important questions to ask because they are symptoms of hypertensive disorders of pregnancy. They area also the danger signs that should be discussed with all pregnant women as indications to seek care immediately.
- She should be asked whether fetal activity has changed since her last visit. This is important to ask about because it provides an indication of fetal well being.

What would you like to do on physical examination and why?

Answer: The following should be mentioned. In discussion explain why. If they do not mention all steps probe by asking, "Is there anything else you would want to do, why or why not?

- Blood pressure should be measured. Blood pressure greater than or equal to 140/90 after 20 weeks gestational age is indicative of pregnancy induced hypertension. If protein is present in the urine then it is indicative or pre-eclampsia.
- An abdominal examination should be done to check fetal growth and to listen for fetal heart sounds. This is an indication of fetal wellbeing (in cases of pre-eclampsia/eclampsia reduced placental function may lead to low birthweight; there is an increased risk of hypoxia in both the antenatal and intrapartum periods, and an increased risk of abruptio placentae).

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

Urine should be checked for protein, since the presence of protein in the urine changes the diagnosis from pregnancy induced hypertension to pre-eclampsia.

Scenario: Part B

You have completed your assessment of Mrs. B., and your main findings include the following:

History: Mrs. B. is complaining of severe headache, and blurred vision. She denies any upper abdominal pain, convulsions or loss ofconsciousness. She reports normal fetal movement.

Physical Examination: Mrs. B.'s blood pressure is 170/120 mm Hg, and she has 4+ proteinuria.

The fetus is active and fetal heart rate is 136 per minute. Uterine size is consistent with dates.

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

Answer: Mrs. B.'s signs and symptoms e.g., blood pressure greater than 160/90 mm Hg after 20 weeks gestation, 4+ proteinuria, blurred vision and severe headache are consistent with severe pre-eclampsia.

Scenario: Part C

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

Answer: The following should be mentioned. In discussion explain why. If they do not mention all steps probe by asking, "Is there anything else you would want to do, why or why not?

- Explain to Mrs. B her condition and answer any questions she may have.
- She should be referred to the nearest FRU for further assessment. Prior to referral she should receive medication to stabilize her. She will need to be delivered.
- Antihypertensive medications should be given to help lower her blood pressure. You do not want to drop the systolic below 90 mm Hg as this can be too low for the fetus. Give Nifedipine 5 mg orally x 1. Providing this medication helps decrease the risk that she may have a stroke.
- Provide the first dose of prophylactic Magnesium sulfate prior to transfer. Women with severe pre-eclampsia are at risk of having seizures. Giving magnesium sulfate can prevent this from happening. Give 10 ml of Inj. Magnesium sulfate deep IM in each buttock (a total of 20 ml of magnesium sulphate) -this is the preferred choice.
- Tranquilizers and sedative should NOT be given. There is no benefit to give these – they may actually harm the woman and her baby.
- Call the FRU and speak with someone to let them know that Mrs. B is coming. A transfer note should be given to Mrs. B to take with her that contains the important information for the receiving facility (history, medications given, blood pressure, gestational age). This helps the health care providers at the referral facility know why the woman was referred, what her problem is and how she has been treated to date.
- She should not be sent alone. She has a high risk of seizure and needs to travel accompanied.

If Mrs. B had presented with convulsions what your diagnosis have been?

Answer: Eclampsia. All seizures in a pregnant woman from after 20 weeks up until 6 weeks postpartum are eclampsia until proven otherwise.

What would your plan of care be for Mrs. B if she was having convulsions?

Answer: The following should be mentioned. In discussion explain why. If they do not mention all steps probe by asking, "Is there anything else you would want to do, why or why not?

- Do not leave the woman on her own. Being with her helps to prevent from fall or injury.
- Protect the woman from fall or injury, but do not restrain her. Restraining the patient can actually harm her.
- Ensure a clear airway and breathing. If the woman is unconscious, keep her on her back with her arms at the side; tilt her head backwards and lift her chin to open the airway.
- After the convulsion is over, help her turn to a left lateral position. Keep the woman in this position throughout transportation.
- Keep a mouth gag between the upper and lower jaw to prevent tongue bite. (Do not attempt this during a convulsion.)
- Measure the BP of the woman. Maintain a record of these. Knowing the blood pressure will let you know if the woman will also need a dose of antihypertensive medications. If the

systolic is greater than 160 or the diastolic greater than 110 mmHg then she will need an antihypertensive. This prevents against the risk of her having a stroke.

- Give the first dose of Inj. magnesium sulphate. Give 10 ml of Inj. magnesium sulphate deep IM in each buttock (a total of 20 ml of magnesium sulphate). It is important to ensure that this is given deep because otherwise it can lead to the formation of an abscess at the injection site. Magnesium sulfate is the preferred drug of choice for treating seizures in pregnancy.
- Start an IV infusion, and give IV fluids slowly @ 30 drops/minute and insert a Foley catheter. This will prevent the women from becoming dehydrated, allow you to monitor urine output (which can decrease significantly in eclamptic women) and provides IV access if you need additional medication.
- Tranquilizers and sedative should NOT be given. There is no benefit to given these – they may actually harm the woman and her baby.
- Immediately arrange to refer the woman to an FRU. Eclampsia is a life threatening condition for the both the mother and baby and she needs to be transferred to a centre where they can deliver her immediately.
- Ensure that the woman reaches the referral centre within 2 hours of receiving the first dose of magnesium sulphate. This is because women with eclampsia need to be delivered within 12 hours from the onset of the seizure.
- She should not be sent alone. She should be transported via ambulance. This is because this is a life threatening condition and she needs to have help with her.

If magnesium sulfate were not available in your PHC what other drug would you use for treatment of seizures in pregnancy and how would you give it?

Answer: Diazepam 20 mg rectally in 10 ml syringe. This is second line and should be given only if magnesium sulfate is not available. Magnesium sulfate is the preferred drug since it is better and stopping seizures in and preventing them in cases of pre-eclampsia and eclampsia.

Congratulations you have successfully managed a case of severe- preeclampsia and eclampsia.

Ask if there are any questions or points that require clarification.

Key points to review at the end of the case

- Severe pre-eclampsia and eclampsia are life threatening conditions that need to be recognized and treated immediately.
- Blood pressure greater than or equal to 140/90 mm Hg in pregnancy is not normal.
- All women with increased blood pressure in pregnancy should have their urine checked for the presence of protein.
- Blood pressure greater or equal to 160 /110 requires a dose of antihypertensive before referral.
- Women with severe pre-eclampsia and eclampsia need to be stabilized before being referred to the FRU.
- Women with severe pre-eclampsia need a prophylactic dose of magnesium sulfate prior to transfer to the FRU. This helps prevent seizures.
- Magnesium sulfate is the drug of choice to treat seizures in pregnant women.
- Tranquilizers and /or sedatives should NOT be given to women with, pregnancy induced hypertension, severe- pre-eclampsia or eclampsia.
- Never leave a seizing woman alone.

Hand-Out 11B.1: Case Study: Hypertensive Disorder of Pregnancy (Participant's Copy)

Scenario: Part A

Mrs. B is a 16 year old gravida 1 para 0 referred to your PHC from the ANM at the Sub-Centre. She reports that at that visit she was told she had "high blood pressure" and to come to the PHC for further assessment. A review of her records shows that she has had three antenatal visits this pregnancy and that before this last visit all findings were within normal limits. At her last visit, it was found that her blood pressure was 140/90 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 is currently 37 weeks gestational age.

What do you think about the blood pressure measurement of 140/90? Is this normal or abnormal?

Why is it important to know that the urine was negative for protein?

Based on this information from her last visit of a blood pressure of 140/90 mm Hg and no proteinuria what would your diagnosis have been then?

Now, at her visit with you, what would you like to include on your initial history when talking with Mrs. B and why?

What would you like to do on physical examination and why?

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

Scenario: Part B

You have completed your assessment of Mrs. B., and your main findings include the following:

History: Mrs. B. is complaining of severe headache and blurred vision. She denies any upper abdominal pain, convulsions or loss of consciousness. She reports normal fetal movement.

Physical Examination: Mrs. B.'s blood pressure is 170/120 mm Hg, and she has 4+ proteinuria.

The fetus is active and fetal heart rate is 136 per minute. Uterine size is consistent with dates.

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

Scenario: Part C

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

If Mrs. B had presented with convulsions, what your diagnosis have been?

What would your plan of care be for Mrs. B if she was having convulsions?

Session 11C Complications of Labour, Delivery, Postnatal Period– Identification, Initial Management and Referral of Infection and Preterm Labour

Materials: PPT slides, SBA guidelines 2010 (pgs 79-85), New case sheets, video, case scenarios in printed copies, pelvic model and a dollwitha placenta, government complication management protocols, emergency drug tray.

Session time:1 Hour

Training methods: Case studies and group activity, interactive lecture using power point and Video, Demonstration on pelvic model, doll and placenta, use of government labour room protocols, Case sheet demonstration.

Session Objectives:

By the end of this session participants will be able to

- ✓ Discuss how to identify maternal sepsis during initial assessment of labour, during labour and in postnatal period at the facility
- ✓ Explain the initial management of maternal sepsis.
- ✓ Discuss how to identify Preterm labour and the initial management.
- ✓ Demonstrate documentation of maternal sepsis and preterm labourat assessment of labour, in labour and in postnatal period at the facility on case sheets

	Teaching Steps	Duration
Introduction	1. introduce the topic and session objectives 2. Ask participants "How many have seen women with infection during labour or in postnatal period?" Request anyone to share their experiences	5 minutes
Care of a woman with infection	3. Ask participants to discuss in their groups "What are the common causes of fever in a woman during labour, delivery, postnatal period?" 4. After 5 minutes ask participants to write their responses on the board. 5. Highlight the main causes of fever in mothers during delivery and postnatal period with the help of PPTs (Slide 29-34). 6. Ask participants to apply AMMA approach for a woman with fever and discuss the same in the group ❖ Assess: Fever and other associated symptoms ❖ Manage: based on the cause with antibiotics and antipyretics ❖ Measure: ❖ Advocacy: 5 cleans	15 minutes 10 minutes

	7. Distribute the case scenario (Handout 10C.1) to participants. Ask them to discuss it among the group members and then after 5 minutes request each group to take turns and answer the questions. Reinforce key points (Slide 35).	
Care of a woman with preterm labour	8. Present the slides on preterm labour, with or without rupture of membranes; with or without contractions (Slide 36-38). ❖ Causes ❖ Danger signs to watch for ❖ Initial management based on gestational age. 9. Discuss the significance of Dexamethasone for a woman in imminent preterm labour ❖ Route ❖ Dosage ❖ Indications ❖ Advantages	15 minutes
Documentation and audit	10. Tell participants to imagine that they were visiting the PHC. Ask them to discuss in their groups how they would monitor the practice of a staff in caring for a woman with infection or preterm labour 11. Reinforce on how infection could be prevented with the help of PPTs	10 minutes
Summarize	12. Ask participants to come out with 3 important messages 13. Project the key messages (Slide 39). 14. Clarify any doubts. Highlight the different case sheets (complication case sheets that will be used). Reinforce the key messages (slide 40-42).	5 minutes

Case Study – Fever
(Facilitator's copy)

Facilitator's Notes: As the instructor, hand out the case study participant copy. Please read out the following scenarios to the participants and ask them to answer the questions. One option on how to do this is to go around in a circle and let everyone provide an answer or you can just let individual participants respond. The purpose of the case study is to get them to think through what steps need to be done and why they would or would not do something. In all cases try to avoid directly giving the answers – rather probe around the topic to see if the participants can come up with the responses. Review the key points and answer any questions at the end of the case study.

Scenario: Part A

Mrs. B. is a 22-year-old para 1 who has come to the health centre complaining that she feel shot and unwell. Mrs. B. reports that she gave birth vaginally to a full-term newborn 3 days ago at the health centre. The newborn weighed 4 kg and Mrs. B. suffered a perineal laceration that required suturing. She was counselled about danger signs before leaving the health centre, including the need to seek care early if any danger signs occur.

Before you assess Mrs. B, what are the possible common illnesses that could be causing her fever today?

Answer: All of the following points need to be mentioned and discussed. You do not want to give away the answers but probe to see if the participants can provide them. For example if they do not mention one ask "Are there any other causes of fever you can think of, why or why not?" – This encourages them to actually think about the possible illnesses that could be causing the fever. Explain that it is important to think about what the common causes are because this helps direct you on what questions to ask on history and what to look at on physical exam.

All of the following are common causes of fever in the postpartum woman:

- Uterine infection (also called endometritis or puerperal sepsis)
- Wound infection – this could be either an infection of a perineal wound or a caesarean section wound
- Kidney infection (pyelonephritis)
- Breast engorgement
- Breast infection (this can be either a mastitis or a breast abscess)
- Viral infection causing diarrhoea or vomiting

What will you include in your initial assessment of Mrs. B., and why? This refers to both history and physical examination.

Answer: The following should be mentioned. In discussion explain why. If they do not mention all steps probe by asking, "Is there anything else you would want to do, why or why not?

- Mrs. B. should be greeted respectfully and with kindness. This helps build rapport with the patient.
- She should be told what is going to be done and listened to carefully. In addition, her questions should be answered in a calm and reassuring manner. This helps build rapport with the patient.
- A rapid initial assessment should be done to determine the degree of illness: her temperature, pulse, blood pressure and respirations should be noted. This is important to do because it quickly lets you know how sick Mrs. B is and if she has any signs of septic shock.
- On history you want to inquire specifically about the presence of other signs or symptoms, such as:
    - abdominal pain or tenderness (this is a sign of uterine infection/endometritis /puerperal sepsis),
    - bleeding, foul-smelling lochia (this also is a sign of uterine infection/endometritis / puerperal sepsis),
    - frequent or painful urination and flank pain (this is a sign of a kidney infection/ pyelonephritis),
    - swollen or red breasts (this can be a sign of breast engorgement or breast infection/ mastitis/abscess),
    - any vomiting or diarrhoea (this is a sign of a viral infection), and
    - any loss of consciousness (this can indicate sepsis).
- In addition to the initial rapid assessment on physical examination you want to perform the following:
    - examine the breasts for signs of swelling, pain and tenderness (these are a sign of engorgement), for any redness and swelling (this is a sign of an breast infection, mastitis), cracked nipples, and for the presence of a lump or mass (this indicates a breast abscess)
    - examine the perineal wound for any pain, tenderness, redness, discharge, swelling, abscess formation (these are signs of a wound infection or abscess),
    - examine the abdomen to see if there is any uterine tenderness (this is a sign of uterine infection), and
    - examine the lochia to see if there is any purulent fouls smelling lochia (this is also a sign of uterine infection).

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

None at this stage – she is stable.

Scenario: Part B

You have completed your assessment of Mrs. B., and your main findings include the following:

History: Mrs. B. denies abdominal pain, frequent or painful urination, abdominal tenderness, foul-smellinglochia, breast swelling or redness, vomiting or diarrhea or loss of consciousness. Physical Examination: Mrs. B.'s temperature is 38°C, her pulse rate is 88 beats per minute, her blood pressure is 120/80 and her respiration rate is 20 breaths per minute. There is no abdominal tenderness. Her lochia is ofnormal color and amount, and without offensive odour. Her breasts are normal with no swelling or redness. Her perineal wound is tender with redness and swelling present extending beyond the edge of the incision. There is no discharge or pus present.

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

Answer: Mrs. B.'s symptoms and signs (e.g., wound tenderness, redness and fever) are consistent with the diagnosis of perineal wound infection.

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

Answer: The following should be mentioned. In discussion explain why. If they do not mention all steps probe by asking, "Is there anything else you would want to do, why or why not?

- The steps taken to manage the complication should be explained to Mrs. B. In addition, she should be encouraged to express her concerns, listened to carefully, and provided emotional support and reassurance.
- You can perform one of 2 options: provide the first dose of antibiotic and refer to an FRU or if your MO is comfortable with managing as an outpatient you can proscribe a five day course of antibiotics and have her return for follow up.

Option one: referral.

- Provide the following antibiotics Cap Ampicillin 1 g, Tab Metronidazole 400 mg and Inj Gentamicin 80 mg IM stat. This will start to treat the infection immediately.
- Analgesia can be provided to help with the pain and the fever. Tab Paracetamol 500 mg to take as 3-5 times per day as needed, can be given.
- Make sure there is a good referral note including reason for referral, and medications given. This provides very helpful information for the people who will see Mrs. B at the next facility.

Option two: Outpatient management and follow up.

- Antibiotics should be prescribed. This should consist of Cap Ampicillin 500 mg orally four times a day for 5 days and metronidazole 400 mg orally three times a day for five days.
- Analgesia can be provided to help with the pain and the fever. Tab Paracetamol 500 mg to take as 3-5 times per day as needed can be given

- Mrs. B. should be counseled about the need for good hygiene, to change her perineal pad/cloth at least three times a day and to wear clean clothes. This will help keep the area clean.
- Mrs. B. should be asked to return the next day for followup and to have the perineal dressing changed. This will let you reassess Mrs. B's wound to make sure it is getting better and not worse.
- Mrs. B. should be followed up on a daily basis until the wound has healed satisfactorily. This is necessary to make sure that MRs B is improving and not getting worse. If she does not improve then she would require referral for further management.

Ask if there are any questions.

Key Points

- Uterine infection, breast engorgement and infection, wound infection and kidney infection are all common causes of fever in a postpartum woman. Anytime a postpartum woman presents with a fever you should be thinking about these possible causes.
- A careful history and physical examination focusing on these common causes will help provide the correct diagnosis.
- If the woman is managed as an outpatient, whatever the diagnosis is for the cause of the fever, follow up is always needed to make sure that the woman is getting better.
- If the woman is referred a good referral note should always be done and sent with the woman.

Hand-Out 11C.1: Case Study – Fever

(Participant's copy)

Scenario: Part A

Mrs. B. is a 22-year-old para 1 who has come to the health center complaining that she feels hot and unwell. Mrs. B. reports that she gave birth vaginally to a full-term newborn 3 days ago at the health center. The newborn weighed 4 kg and Mrs. B. suffered a perineal laceration that required suturing. She was counseled about danger signs before leaving the health center, including the need to seek care early if any danger signs occur.

Before you assess Mrs. B, what are the possible common illnesses that could be causing her fever today?

What will you include in your initial assessment of Mrs. B., and why? This refers to both history and physical examination.

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

Scenario: Part B

You have completed your assessment of Mrs. B., and your main findings include the following:

History: Mrs. B. denies abdominal pain, frequent or painful urination, abdominal tenderness, foul-smelling lochia, breast swelling or redness, vomiting or diarrhea or loss of consciousness. Physical Examination: Mrs. B.'s temperature is 38°C, her pulse rate is 88 beats per minute, her blood pressure is 120/80 and her respiration rate is 20 breaths per minute. There is no abdominal tenderness. Her lochia is of normal color and amount, and without offensive odor. Her breasts are normal with no swelling or redness. Her perineal wound is tender with redness and swelling present extending beyond the edge of the incision. There is no discharge or pus present.

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

_____

_____

_____

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

_____

_____

_____

_____

Session 12

Preparation of Labour Room

Materials: SBA handbook

Session Time: 60 minutes

Training methods: Discussion, demonstration

Session Objectives:

By the end of the session the participants should be able to

- ✓ Discuss the importance of preparing the labour room.
- ✓ Discuss and demonstrate the articles, drugs and equipments that is required in the labour room.
- ✓ Discuss the problems the staff may face in keeping the labour room prepared.

	Teaching Steps	Duration
Introduction	1. Introduce the session topic and objectives	5 minutes
Reason for being prepared	2. Brainstorm with participants, "why should you be prepared always in the labour room?" wait for responses 3. Ask participants, "What articles, drugs and equipment must be ready in the labour room?" Write their responses in the flip chart. Ask them to refer to Checklist 2.4 in SBA Handbook 2010. Reinforce requirements to conduct a delivery safely.	10 minutes
Articles needed to be kept ready	4. Ask participants to turn to SBA handbook and refer to their responses written on the flip chart. Request a volunteer to read aloud how the labour room must be prepared	10 minutes
Summarize	5. Discuss any problems they might face in keeping the labour room prepared always. 6. Encourage one or two volunteers to share how they have managed to be always ready for any woman in labour 7. Conclude with key messages and clarify any doubts.	15 minutes

Preparation For Discharge

Learning objectives

By the end of the session participants will be able to

- Demonstrate the counselling skills required before discharge including danger signs for mother and newborn, follow up and care and FP advice.
- Demonstrate documentation of discharge for mother and baby.
- Demonstrate mentoring skills for discharge.

Refer to Chapter 6 of Mentor's manul Vol 2 manual for details of the session.

Session 13

Preparation for Discharge or Referral

Materials: SBA guidelines 2010, new case sheets

Session time: 1 Hour

Training methods: Interactive lecture, Case sheet demonstration

Session Objectives:

By the end of the session the participants should be able to

- ✓ Discuss the importance of counselling the mother and family before discharge.
- ✓ Discuss the maternal and newborn danger signs that the mother needs to be educated on before discharge.
- ✓ Discuss the critical steps that the staff need to take to ensure timely referral of maternal / newborns with complications.

	Teaching Steps	Duration
Introduce the topic	1. Introduce the topic of the session and its objectives	5 minutes
Preparation for discharge	2. Group activity – counselling at discharge ❖ Ask participants the significance of counselling before discharge ❖ Ask participants to describe the counselling to be given mothers and their family about recognising danger signs in the postnatal period 3. Explain what advice to give families about when to seek care for danger signs, care, follow up, FP ❖ Bleeding in postnatal period ❖ Any kind of infection (Fever, breast pain, breathing difficulty, foul smelling lochia, difficulty in urination, pain in abdomen, pain in perineum) in postnatal period ❖ Regular postnatal checkups required at home/facility ❖ Types of contraceptive methods to be advised for recently delivered woman ❖ Supplementation of IFA, calcium and nutritious diet, their significance and compliance ❖ Personal care and hygiene for a mother before discharge	15 minutes 30 minutes

	4. Divide the participants into 5 groups. Ask each group to plan for a role play (5 minutes). Request two volunteer participants from each group to demonstrate how they would counsel a postnatal mother just before discharge on one of the assigned topics as given below ❖ Danger signs ❖ Follow up ❖ Family planning ❖ Nutrition ❖ Hygiene	
Transporting a pregnant woman with complications	5. **Brainstorm with participants** "what would you do if a woman is to be referred urgently to another center. Wait for responses , Highlight the key points to remember for referral: ❖ Call and determine the nearest facility where labour induction, augmentation, c-section and ICU are available if needed ❖ Arrange transport – 108 , Ambulance Govt., Ambulance Pvt, Any other form of transport ❖ In case of shock: Continue fluids and carry extra bottles to last till she reaches the facility; provide oxygen staff nurse to accompany the woman and monitors vital signs every 10 mins to adjust the IV drip ❖ If the woman is pregnant, keep a delivery set and essential drugs handy ❖ If delivered, ensure baby is kept warm, feedings continued	10 minutes
Summarize	6. Ask participants to turn to the part of the new case sheet where counselling provided for a woman at discharge could be recorded 7. Reinforce main points	5 minutes

Sukshema Mentor's Participant Profile

1. S.No..... Name: .....
2. Place:..... Mobile number:.....; email id:.....
3. Address: .....
   .....
4. Qualification: GNM/BSc/PcBSc/MSc;
5. Studied in an institution with attached hospital: YES / NO
6. Years of experience/ service.....
7. Years of service in last work place.....
8. Last position held:.....
9. Received training on MNCH (Maternal, neonatal, child health)

Type	NO	YES	Duration if Yes
SBA			
NSSK			
NRHM			
Any other			

10. Circle your level of confidence in performing the following on a scale of 1-5 where 1 means very low confidence and 5 means very high confidence

i. Taking a history of a woman in labour	1	2	3	4	5
ii. Checking BP of a woman in labour	1	2	3	4	5
iii. Doing an abdominal exam of woman in labour	1	2	3	4	5
iv. Doing a vaginal exam of woman in labour	1	2	3	4	5
v. Monitoring labour using partograph	1	2	3	4	5
vi. Conducting normal vaginal delivery	1	2	3	4	5
vii. Giving and suturing an episiotomy	1	2	3	4	5
viii. Administering inj$MgSO_4$ to a woman	1	2	3	4	5

ix. Starting an Iv for a woman	1	2	3	4	5
x. Monitoring a woman in postnatal period	1	2	3	4	5
xi. Assisting in newborn resuscitation	1	2	3	4	5
xii. Giving bag and mask resuscitation for NB	1	2	3	4	5
xiii. Giving chest compression to a NB if needed	1	2	3	4	5
xiv. Giving Inj Vitamin K to a NB	1	2	3	4	5
xv. Assisting a mother to breast feed her baby	1	2	3	4	5
xvi. Assisting a mother to give KMC	1	2	3	4	5
xvii. Checking the temperature of a NB	1	2	3	4	5
xviii. Using the radiant warmer for a NB	1	2	3	4	5
xix. Monitoring a NB from birth till discharge	1	2	3	4	5
xx. Counselling a woman on her care and NB care	1	2	3	4	5

11. In the last 1 year how many of the following you have done / performed (approximate number)

    i. Conducted normal vaginal deliveries .....
    ii. Given an episiotomy .....
    iii. Given magnesium sulphate injection .....
    iv. Done/Assisted - resuscitation for a newborn .....
    v. Given vitamin K for a newborn .....
    vi. Given antibiotic for a woman in labour .....
    vii. Sutured an episiotomy .....
    viii. Managed a woman with bleeding .....
    ix. Managed a woman with hypertension/eclampsia .....
    x. Managed a low birth weight baby .....

12. Give at least three expectations from present training

    i. .....
    ii. .....
    iii. .....

Pre-test/Post-test (Knowledge)

Sukshema - Nurse Mentors Training Program

Pre-test / Pos-test

Time 1 hour

Serial Number:.....

TOTAL MARK (70).....

Please write the alphabet of the single best option in box provided against each question for multiple choice questions or complete the question as indicated. Each expected answer carries "1" mark.

1. Which of the following is NOT an adult learning principle

a. Adults learn best when they accept responsibility for their own learning
b. Adults learn best when learning is applied immediately
c. Adults learn best when learning occurs in large groups
d. Adults learn best when the learning experience is active not passive

2. Which of the following is an open ended question

a. Are you feeling all right today?
b. Is there anything else I can do for you?
c. What do you think brings up these feelings for you?
d. How old is your partner

3. Feedback is most constructive when it

a. Is delivered a long time after the learner performs a skill
b. Is delivered using "you" statements ("you really need to.....")
c. Is descriptive but does not pass judgment on the learners intentions or skills
d. Does not target specific errors but rather is made up of general comments

4. After how many minutes does a learner's ability to retain and recall information significantly decline?

a. 10 minutes
b. 30 minutes
c. 50 minutes
d. 75 minutes

5. A good method to spontaneously get creative list of ideas, thoughts, problems, or solutions around a particular topic without regard to application of these ideas is called

a. Brainstorming
b. Role play
c. Practicum
d. Coaching

6. Which of the following is NOT a quality improvement principle

a. Promotion of client and provider rights
b. Mentoring
c. Self-assessment
d. Team work

7. Which of the following is a client right?

a. Standard operating procedures
b. Accessible, available services
c. Opportunity to practice skills
d. Awareness of range of services in the health care setting

8. Which of the following is a tool that could be used to ass individual staff clinical competence

a. Case sheets
b. Client and provider rights handout
c. PHC operating guidelines
d. Action plan

9. Which of the following behaviour would NOT reflect "attending" skill of a mentor

a. Leaning forward towards the mentee
b. Relaxed posture
c. Crossing arms while talking to mentee
d. Maintaining eye contact

10. Which of the following is an example of an evaluative question

a. You do understand this, don't you?
b. What are the main points that you have learnt?
c. How do you think this could be managed at the PHC level?
d. Did you have your breakfast?

11. An example of immediate response methods of clinical mentoring is

a. Case based discussion
b. Modelling
c. Mini lecture
d. Case sheet review

12. Distance mentoring makes use of the following tools EXCEPT

a. Telephone
b. Email
c. Letter
d. Face to face

13. Susheela is 24 years. She comes to the PHC in May 2012 and tells you that she is 7 months pregnant. She says that her last period started a day before Diwali (October 18). Her due date is

a. July 24
b. July 28
c. July 17
d. July 22

14. The second stage of labour begins with and ends with

a. onset of labour and half dilatation of the cervix
b. onset of labour pains and full dilatation of the cervix
c. full dilatation of the cervix and delivery of the baby
d. Full dilatation of the cervix and delivery of the placenta

15. Fetal distress is diagnosed with an FHR less than 120 beats per minute or more than 160 beats per minute

a. True
b. False
c. Not sure

16. A catheter is used to empty the bladder to manage a case of PPH

a. True
b. False
c. Not sure

17. If the blood pressure for a pregnant woman is more than 140/90mmHg and there is protein present in the urine. It is a case of

a. Proteinuria
b. Hypertension
c. Eclampsia
d. Pre-eclampsia

18. The appropriate order of steps in active management of third stage of labour include

a. Controlled tracton, fundal massage and oxytocin
b. Intravenous oxytocin, cord clamping and cutting and fundal massage
c. Cord clamping and cutting, controlled cord traction, ergometrine administration and inspection of placenta
d. Intramuscular injection of oxytocin, controlled cord traction with counter traction to the uterus and uterine massage

19. In the active stage of labour a vaginal examination must be done

a. Hourly
b. Two hourly
c. Four hourly
d. Not at all

20. The dose and route of oxytocin for the initial management of PPH before you refer the woman to the FRU are

a. 20 IU in 500ml of ringer lactate, intravenously
b. 15 IU, in 500 mL of ringer Lactate intravenously
c. 20 IU, intramuscular stat
d. 5 IU, intramuscular stat

21. Preterm labour is defined as labour before 40 weeks of gestation

a. True
b. False
c. Not sure

22. Normally, 6-7 cm dilatation of the cervix is considered full dilatation

a. True
b. False
c. Don't know

23. What is the dose and route of magnesium sulfate injection for the initial management of eclampsia

a. 5mL (2.5 g), deep IM in each buttock
b. 10mL (5 g), deep IM in each buttock
c. 15mL (7.5g), deep IM in each buttock
d. 20 mL (10 g), deep IM in each buttock

24. If a woman has good uterine contractions, but progress of labour is arrested it is called

a. Prolonged labour
b. Obstructed labour
c. Arrested labour
d. False labour

25. Active management of the third stage of labour must be practiced

a. Only for women with a history of PPH
b. Only for primipara
c. Only for the multipara
d. For all women

26. A woman with a ruptured uterus has which of the following signs and symptoms present

a. Rapid maternal pulse, low BP
b. Persistent abdominal pain and tenderness
c. Fetal distress
d. All of the above

27. Initial management of postpartum endometritis includes all EXCEPT

a. Discontinuation of breast feeding
b. Observation of colour and odour of lochia
c. Administration of antipyretic/analgesic
d. Administration of antibiotic

28. For a woman with 30 weeks pregnancy and sudden profuse watery discharge from vagina you will

a. Give antibiotics and send her home for home with follow up advice
b. Check maternal and fetal status and send her home
c. Give her antibiotics and refer to FRU with foot end raised
d. Do nothing and send her home since it is too early

29. During the first two hours after birth the health care provider must

a. Measure the woman's BP and pulse once and insert a catheter to empty her bladder
b. Measure the woman's BP and pulse and check the uterine tone every 15 minutes
c. Not disturb the woman if she is asleep as her rest is more important
d. Measure the woman's BP, temperature and pulse every 15 minutes

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30. Which of the following is a normal presentation in pregnancy

a. Breech
b. Vertex/cephalic
c. Face
d. Shoulder

31. Which of the following if detected on the partograph of a primigravida woman in labour at a PHC indicates need for urgent referral

a. Progressing to left of the alert line
b. Has reached the alert line
c. Has crossed the action line
d. Progressing to the right of the alert line (line A)

32. A baby whose birth weight is less than .....grams is a low birth weight baby

33. Breast feeding must be initiated within .....minutes of normal delivery

34. What are the signs of good attachment?

....

....

35. State any four danger signs in a newborn

....

....

36. List the three major causes of mortality in newborns

....

37. Name any four benefits of KMC

.....

.....

.....

38. What are the two indications for positive pressure ventilation in a neonate?

.....

.....

39. Expand the term STABLE in relation to transport of a sick neonate

.....

.....

.....

40. Four essential needs of a newborn in the first 48 hours include

.....

.....

.....

41. A baby whose weight is less than as expected for gestational age is called

.....

42. A baby born term, crying well must be given

a. Routine care
b. Special care
c. Resuscitation
d. Intensive care

43. The eye of the baby must be cleaned from ..... to .....

44. A baby with poorly developed breast bud, no sole creases is a ..... baby

45. A baby weighing less than .....grams must be referred to a higher centre

46. Breast feeding is contraindicated for a woman who is HIV positive

a. True
b. False
c. Not sure

47. The dosage of Vitamin k for a newborn baby weighing 1600gms is

a. 1mg
b. 0.5mg
c. 0.25mg
d. None at all

48. What is the local treatment for sore nipple

a. Antibiotics
b. Good attachment
c. Analgesics
d. Hind milk

49. Which of the following congenital anomalies is an emergency and requires immediate transfer

a. Diaphragmatic hernia

b. Anorectal anomaly

c. Spina bifida

d. Congenital heart defect

50. What are any two signs that a newborn is getting enough breast feed?

.....

.....

Pre-testPost-test (Knowledge) – Answer and Scoring Key

Category	Question No. and Content	Answer	Score
Mentoring and QI	1. Which of the following is NOT an adult learning principle	c	1
	2. Which of the following is an open ended question	c	1
	3. Feedback is most constructive when	c	1
	4. After how many minutes does a learner's ability to retain and recall information decline	b	1
	5. A good method to spontaneously get creative ideas, Which of the following is NOT an adult learning principle	a	1
	6. Which is not a quality improvement principle	b	1
	7. Which is a client right	b	1
	8. Which is a tool that could be used to assess individual staff clinical competence	a	1
	9. Which behaviour would not reflect "attending" skill of a mentor	c	1
	10. Which is an example of an evaluative question	c	1
	11. An example of immediate response methods of clinical mentoring is	b	1
	12. Distance mentoring makes use of the following tools except	d	1
	TOTAL		**12**
Obstetric content	13. Susheela is 24 years. She comes to the PHC in May 2012 and tells you that she is 7 months pregnant. She says that her last period started a day before Diwali (October 18). Her due date is	a	1
	14. The second stage of labour begins with and ends with	c	1
	15. Fetal distress is diagnosed with an FHR <120 or >160 beats per minute	a	0.5
	16. A catheter is used to empty the bladder in case of PPH	a	0.5
	17. If the BP is >140/90 in a pregnant woman and urine protein is positive	d	1
	18. The appropriate order of steps in AMTSL include	d	1
	19. In active stage of labour vaginal exam must be done	c	1

	20. The dose and route of oxytocin for initial management of PPH before referral	a	1
	21. Preterm labour is defined as labour before 40 weeks of gestation	b	0.5
	22. Normally 6 -7cm dilatation of the cervix is considered full dilatation	b	0.5
	23. What is the dose and route of Magnesium sulphate for initial management of eclampsia	b	1
	24. If a woman has good uterine contractions but progress of labour is arrested	b	1
	25. AMTSL must be practices	d	1
	26. A woman with ruptured uterus presents with	d	1
	27. Initial management of postpartum endometritis include all except	a	1
	28. For a woman with 30 weeks pregnancy and sudden profuse watery discharge from the vagina you will	c	1
	29. During the first 2 hrs after birth the HCP must	b	1
	30. Which of the following is a normal presentation in pregnancy	b	1
	31. Which of the following if detected on the partograph of a primi woman in labour indicates urgent referral	d	1
	TOTAL		**17**

	Qs no and Qs	Answer	Marks
Newborn content	32. Birth weight less than ……..is LBW	2500gm or 2.5kg	1
	33. Breast feeding must be initiated ……of birth	30 mins or ½ an hour	0.5
	34. Signs of good attachment	Mouth wide open More areola visible above than below mouth Chin touching breast Lower lip everted	0.5x4=2
	35. 4 danger signs in a newborn (Any)	Breathing difficulty Convulsions Discharge or redness from umbilicus Feeding difficulty Vomiting or blood in stools Hypothermia or pyrexia Icterus Stiff or floopy baby Irritability or lethargy Pustules>10 in skin	0.5x4=2

	36. Three major causes of mortality in NB	Asphyxia Sepsis Prematurity or LBW	0.5x3=1.5
	37. Four benefits of KMC	Temperature maintained Increases milk production Increased growth of baby Prevents sepsis and infection Baby more secure Bond between mother and baby	0.5x4=2
	38. Two indication for PPV	Apnea HR<100/min	0.5x2=1
	39. STABLE- expand	Sugar Temperature Airway Perfusion Lab report Emotional support	0.25x6=1.5
	40. Four essential needs of NB in 1st 48 hrs	Warmth Breast feeding Cord care and prevention of infection Hygiene	0.5x4=2
	41. A baby whose weight is less than as expected for gestational age is called	Small for date or GA	0.5
	42. A baby born term, crying well must be given	a	1
	43. The eye must be cleaned	Inner to outer canthus	0.2x2=0.5
	44. Baby with poorly developed breast bud, no sole creases is	Preterm	0.5
	45. A baby's whose weight is …..must be referred to a higher centre	1800 gm or 1.8 kgs	0.5
	46. Breast feeding is contraindicated for a HIV positive woman	b	0.5
	47. Dosage of Vitamin K for a NB weighing 1600gms	a	1
	48. Local treatment for sore nipple	d	1

	49. Which congenital anomaly is an emergency and requires immediate referral	a	1
	50. Two signs a newborn is getting enough breast feed (any two)	8-10 feed / day Satisfied with feed Passing urine 6-8 times Sleeps well	0.5x2=1
		TOTAL	**21**

Mentoring and QI = 12

OB content = 17

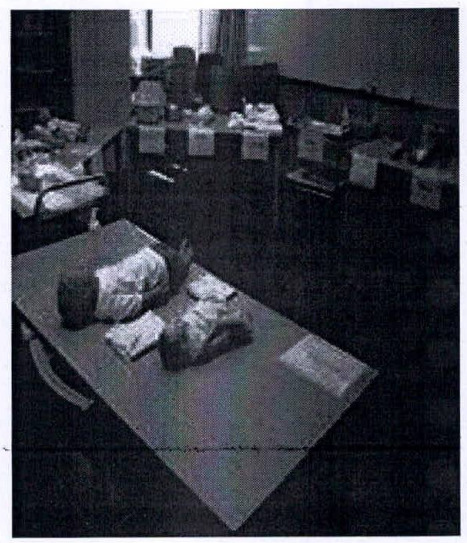
NB content = 21

TOTAL = 50

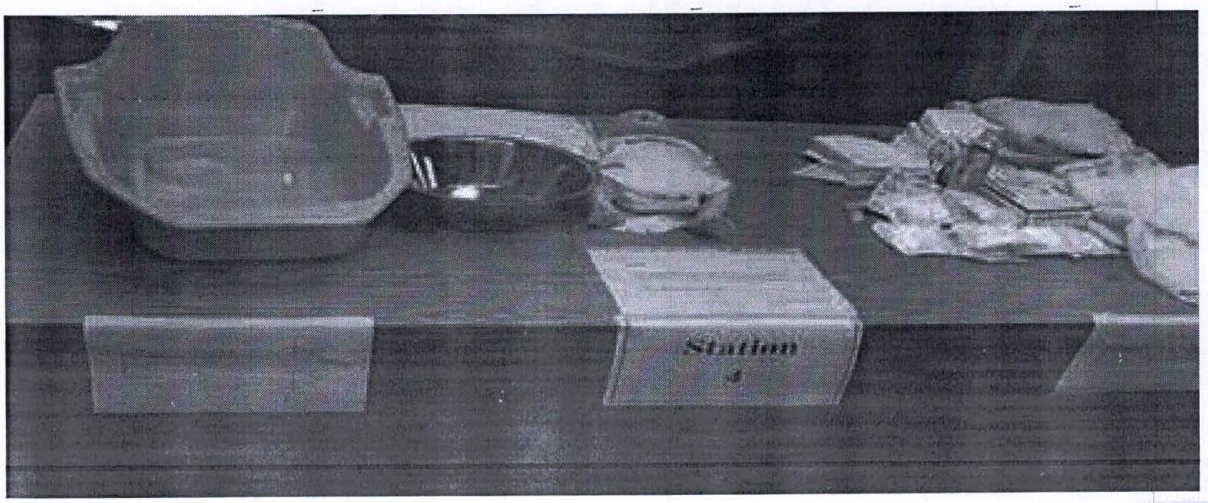
Rapid Assessment Exercise - OSCE (Clinical)

General Instructions to Trainers

- Select a room large enough to accommodate ten tables with chairs arranged in a circle with sufficient space between tables as given in the picture below.



- Collect all required articles / stationery / mannequins as listed.
- Laminate instructions for participants at each station, pictures that will be used, so that you can use it repeatedly for all trainings.
- Laminate station numbers (e.g. STATION 1) in a large font size so that it is visible from a distance.
- Arrange each station with articles / stationery as indicated an hour before the OSCE.
- Paste station number in each table so that it is easily visible to all participants.



- Make arrangements for one faculty for each of the observed stations and volunteers where indicated. Sometimes the faculty could also play the role of volunteer in an observed station.
- There must be an overall coordinator who will see that flow of participants goes smoothly, answer sheets are kept in box provided for unobserved stations
- Brief faculty and volunteers on their role and if faculty how to use the checklist during observation.
- Inform faculty/volunteers that their attention will be required completely during the OSCE.
- Make arrangements for tea and snacks during the OSCE.

OSCE FOR NURSE MENTORS SUKSHEMA PROJECT TRAINING PROGRAM

DATE

VENUE:

Osce Plan For Obstetrics-Intranatal and Immediate Postnatal

Station	Details	Marks	Observed /Not Observed	Faculty
1.	BP	3	Observed	
2.	Calculation of gestational Age	2	Unobserved	
3.	Abdominal Examination	8	Observed	
4.	Partograph	2	Unobserved	
5.	Postnatal counselling	6	Observed	
6.	Preparation of Labour room	4	Unobserved	
7.	Complication – PPH , fill in the blanks	5	Unobserved	
8.	$MgSO_4$	5	Unobserved	
9.	PV Mentoring	8	Observed	
10.	AMTSL	7	Observed	
	TOTAL	**50**		

General instructions to be given by one facilitator to all the participants

- Each one will go through 10 stations and 2 rest stations
- There are 5 observed and 5 unobserved stations
- In the observed station you will be expected to perform some activity. Complete the task within time given
- In the unobserved station you will be asked to write some information on the answer sheet. Write your name on the answer sheet and participant number. Once you complete it fold the answer sheet and place it in the box provided.
- The duration of each station will be 4 minutes. Two of the observed stations will be longer (6 minutes). Hence the rest stations will be 2 minutes.

- None of the facilitators will give any comments or assistance
- Three stations have volunteers to help in completing the station
- A bell will ring, each one go to the assigned station based on participant number.
- Do not face the station first
- When the bell rings again, each participant can turn and read participant instructions. Complete the task given.
- If you complete the task before time given, sit in the chair and wait
- When the bell rings again, you must switch to the next station.
- All participants will go through all the stations.
- The test will take approximately 50 minutes.
- No one will be allowed to go out of the room during the exam.

Candidates	OSCE Overall Evaluation - Stations												Grand Total (50)
	Observed						Unobserved						
	(3)	(8)	(6)	(8)	(7)	(32)	(2)	(2)	(4)	(5)	(5)	(18)	
	1	3	5	10	12	Total	2	4	7	8	9	Total	
1.													
2.													
3.													
4.													
5.													
6.													
7.													
8.													
9.													
10.													
11.													
12.													
13.													
14.													
15.													
16.													
17.													
18.													
19.													
20.													

Requirements For Each Station

General requirements

- ☐ Juice for volunteers and faculty
- ☐ Snacks
- ☐ Cellotape
- ☐ Instructions for each station
- ☐ Files to place the Key for each station – 10
- ☐ Bell, stopwatch

Station 1: Checking BP	**Station 7: Preparation of labour room**
☐ BP Apparatus ☐ Stethoscope ☐ Checklist for observer (2) ☐ Chair (3) ☐ Volunteer (1) ☐ Instructions for volunteer ☐ Table (1)	☐ Chair (1) ☐ Table (1) ☐ Answer sheet (25) ☐ Box to collect answer sheet
Station 2: Calculation of gestational age	**Station 8: Complications PPH**
☐ Case scenario with answer sheet ☐ Chair (1) ☐ Table (1) ☐ Box to collect answer sheet	☐ Chair (1) ☐ Table (1) ☐ MNCH Case sheet with all complication case sheets ☐ Answer sheet (25) ☐ Box to collect answer sheets

Station 3: Abdominal examination

- ☐ Mannequin with foetus
- ☐ Bed sheet/Sheet to cover mannequin with fetus in situ
- ☐ Stethoscope
- ☐ Fetoscope
- ☐ Hand Sanitizer
- ☐ Table (1)
- ☐ Chair (2)
- ☐ Checklist for observer (2)

Station 4: Partograph

- ☐ Laminated partograph
- ☐ MNCH Case sheet with all complication case sheets
- ☐ Answer sheet (25)
- ☐ Chair (1)
- ☐ Table (1)
- ☐ Box to collect answer sheet

Station 5: Postnatal counselling

- ☐ Volunteer
- ☐ Chair (3)
- ☐ Instructions for volunteer
- ☐ Table
- ☐ Observer checklist (2)

Station 6: Rest

- ☐ Chair (1)
- ☐ Table (1) Optional

Station 9: Magnesium Sulphate

- ☐ Chair (1)
- ☐ Table (1)
- ☐ Case scenario
- ☐ Answer sheet (25)
- ☐ Box-to collect answer sheets

Station 10: PV mentoring

- ☐ Chair (3)
- ☐ Table (1)
- ☐ Pelvis model, Sheet, Gloves, handrub, tray to discard gloves
- ☐ Volunteer to demonstrate procedure
- ☐ Instructions for volunteer
- ☐ Checklist for observer (2)

Station 11: Rest

Station 12: AMTSL

- ☐ Chair (2)
- ☐ Table (1)
- ☐ Mannequin, Placenta
- ☐ Gloves
- ☐ Hand rub
- ☐ Drug tray with - oxytocin, Methergine, $MgSO_4$ Misoprostol tablets, alcohol swabs
- ☐ Syringes with kidney tray
- ☐ Tray for placenta to be placed
- ☐ Observer checklist(2)

Checking BP

Key for Station 1:

			S. No											
S. No	Observations	Marks												
1.	Tells patient about the procedure	0.25												
2.	Ties cuff accurately	0.5												
3.	Checks palpatory BP	0.5												
4.	Deflates the cuff fully before checking Auscultatory BP	0.5												
5.	Places the diaphragm of the stethoscope in the cubital fossa while checking auscultatory BP	0.5												
6.	Deflates cuff at the rate of 2mm per second	0.25												
7.	Tells the patient whether the BP is normal or abnormal	0.5												
	Total	3												

Calculation of Gestation Age

Key for Station 2:

			S.No											
S. No	Observations	Marks												
1.	Correct Gestational age (32 weeks)	1												
2.	Gestation - Preterm	1												
	TOTAL	2												

			S.No											
S. No	Observations	Marks												
1.	Correct Gestational age (32 weeks)	1												
2.	Gestation - Preterm	1												
	TOTAL	2												

Abdominal examination

Key for Station 3:

			S.No											
S. No	Observations	Marks												
1	Explains about procedure	0.5												
2	Estimates fundal height accurately +/- 2 weeks	1												
3	Demonstrates 4 grips	4												
4	FHR method and site	0.5x2												
5	Reports lie correctly	1												
6	Thanks the lady	0.5												
	TOTAL	8												

			S.No											
S. No	Observations	Marks												
1	Explains about procedure	0.5												
2	Estimates fundal height accurately +/- 2 weeks	1												
3	Demonstrates 4 grips	4												
4	FHR method and site	0.5x2												
5	Reports lie correctly	1												
6	Thanks the lady	0.5												
	TOTAL	8												

Partograph

Key for Station 4:

			S.No											
S. No	Observations	Marks												
1	Cervical dilatation after 4 hours is on the right of Line A	1												
2	FHR below 120/min	1												
3	Amniotic fluid meconium stained	1												
4	Complication case sheet A	1												
	TOTAL	4												

			S.No											
S. No	Observations	Marks												
1	Cervical dilatation after 4 hours is on the right of Line A	1												
2	FHR below 120/min	1												
3	Amniotic fluid meconium stained	1												
4	Complication case sheet A	1												
	TOTAL	4												

Postnatal Counselling for excessive vaginal bleeding and Infection

Key for Station 5:

			S.No											
S. No	Observations	Marks												
1	Greets the lady	0.25												
	Content of counselling													
2	Passage of clots	0.5												
3	Excessive soakage of pads	0.5												
4	Fever	0.5												
5	Painful/ burning micturition/ loin pain	0.5												
6	Foul smelling discharge	0.5												
7	Painful swelling in the breast	0.5												
8	Tone of voice/ Body language/ Eye contact	0.75												
9	Asks if she has understood Clarifies doubts	0.5												
10	Thanks the mother	0.5												
	Total marks attained	6												

Preparation of Labour room

Key for Station 6:

S. No	Observations	Marks	S.No												
1	**Any 4 of these given below are correct** Artery forceps Scissors Bowl with antiseptic solution, betadine, savlon or dettol Episiotomy scissors Suture material Sterile pads Gloves Needle Kidney tray Sterile cotton balls Sterile gauze\	0.5 x4													
2	Match the following 1-b, 2-f, 3-d, 4-c	0.5x4													
	TOTAL	4													

Key for Station 6:

S. No	Observations	Marks	S.No												
1	**Any 4 of these given below are correct** Artery forceps Scissors Bowl with antiseptic solution, betadine, savlon or dettol Episiotomy scissors Suture material Sterile pads Gloves Needle Kidney tray Sterile cotton balls Sterile gauze\	0.5 x4													
2	Match the following 1-b, 2-f, 3-d, 4-c	0.5x4													
	TOTAL	4													

Complications - PPH

Key for Station 7:

			S.No											
S. No	Observations	Marks												
1	Case sheet F	1												
2	No	1												
3	Oxytocin	1												
4	Atonic Uterus	1												
5	True	1												
	TOTAL	5												

Key for Station 7:

			S.No											
S. No	Observations	Marks												
1	Case sheet F	1												
2	No	1												
3	Oxytocin	1												
4	Atonic Uterus	1												
5	True	1												
	TOTAL	5												

Magnesium sulfate

Key for Station 8:

			S.No											
S. No	Observations	Marks												
1	Diagnosis – Eclampsia	1												
2	Correct drug $MgSO_4$	1												
3	Correct route deep IM	1												
4	Correct site Gluteal/ Both sides	1												
5	10 gm of $MgSO_4$ or 20mL of $MgSO_4$	1												
	Total	**5**												

Key for Station 8:

			S.No											
S. No	Observations	Marks												
1	Diagnosis – Eclampsia	1												
2	Correct drug $MgSO_4$	1												
3	Correct route deep IM	1												
4	Correct site Gluteal/ Both sides	1												
5	10 gm of $MgSO_4$ or 20mL of $MgSO_4$	1												
	Total	**5**												

Mentoring a Staff for PV exam

Key for Station 9:

S. No	Observations	Marks	S.No											
1	Introduces self	0.25												
2	Starts with telling nurse the correct things she did	0.25												
3	Identifies the mistakes (5) ◆ Does not ask for history of ◆ bleeding ◆ Does not tell the patient ◆ Not washing hands ◆ Doesn't clean perineum ◆ Washes hands with gloves on	0.5x5												
4	Demonstrates correctly all the steps (8) ◆ Asks for history of bleeding and empty bladder ◆ Explains procedure ◆ Washes hands ◆ Cleans perineum ◆ Inserts 2 fingers and Finishes entire pelvic assessment ◆ Removes gloves ◆ Washes hands ◆ Notes findings	0.5x8												
5	Asks if nurse has understood	0.25												
6	Asks her to demonstrate and gives positive reinforcement	0.25												
8	Is gentle, non-threatening, non-judgmental	0.25												
9	Explains why it is important to do the procedure correctly	0.25												
	TOTAL	**8.0**												

AMTSL

Key for Station 10:

S. No	Observations	Marks	S.No											
1	Checks if there is another baby inside by palpating the abdomen	1												
2	Gives 10 U Oxytocin IM	1												
3	Controlled cord traction correctly (traction, counter traction)	1X2												
4	Uterine massage	1												
5	Examines placenta (cotyledons all there, membranes complete)	1x2												
	TOTAL	7												

Key for Station 10:

S. No	Observations	Marks	S.No											
1	Checks if there is another baby inside by palpating the abdomen	1												
2	Gives 10 U Oxytocin IM	1												
3	Controlled cord traction correctly (traction, counter traction)	1X2												
4	Uterine massage	1												
5	Examines placenta (cotyledons all there, membranes complete)	1x2												
	TOTAL	7												

Instructions for Station (Laminate for each Station)

Station 1

Check the BP for the volunteer. Assess whether the BP is normal.

Station 2

Mrs Kamala comes to the PHC with labour pains today. Her LMP is 19/4/2012.

1. Please calculate the gestational age: .....

2. Circle the correct answer

Mrs Kamala is term / preterm / post term

Station 3

Do a complete abdominal examination on the mannequin.

Tell / Report your findings to the examiner

Station 4

Name 3 problems seen in the given partograph

1. .....
2. .....
3. .....

Which complication case sheet will you use?

Station 5

Mrs Vimala is getting discharged.

Counsel the woman before she goes home

Station 6

Name 4 items that you would keep in the sterile tray in the labour room

1.
2.
3.
4.

Match the condition with the drug by drawing line

Condition	Drug
1. Peurperal sepsis	a. Magsulp
2. Lady in labour at 33weeks gestation	b. Antibiotics
3. Lady in shock at 25 weeks at gestation	c. Nifedipine
4. BP=140/96, no proteinuria, no convulsion	d. IV fluids
	e. Oxytocin
	f. Corticosteroid

Station 8

Ms shanty 30 years G4, P3. She gave birth to a healthy, full term baby weighing 2.6 kg. You gave oxytocin following the birth of the baby. The placenta was delivered 5 minutes later without complication. However, 30 minute after childbirth, Mrs Shanty complained of giddiness.

On assessment the finding are:

- She looks comfortable.
- Pulse 88/minute,
- Respiration rate 18/minute,
- BP 100/80,
- Temperature 37°C.

Per Abdomen:

- Uterus is soft.
- Vagina and cervix cannot be examined as she has heavy vaginal bleeding.

Questions:

1. Which complication case sheet would you use?_____
2. Is the lady in shock? Yes / No
3. Which is the drug you want to give this lady immediately? Circle the answer $MgSO_4$ / Oxytocin / Misoprostol / Ampicillin / Gentamicin
4. What is the cause of the heavy bleeding?_____
5. If her BP is 100/60 after one hour of your management, then is there worsening of her condition – True / False

Station 9

A staff nurse is doing a PV examination at the PHC. You have seen her doing the procedure. Mentor using modelling how a PV should be done

Station 10

Show how you would do AMTSL on the mannequin

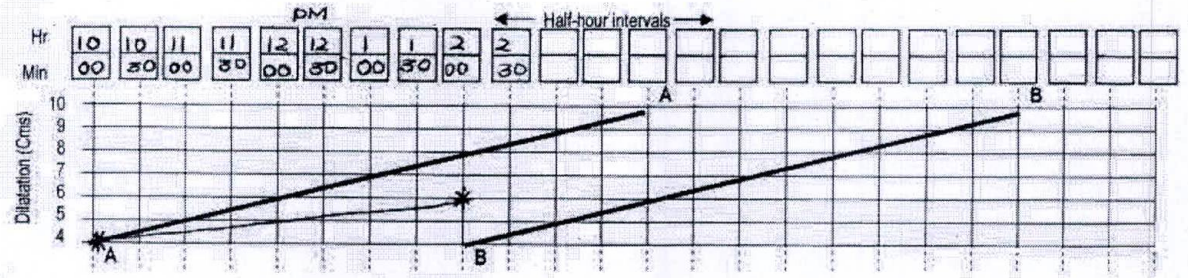
PHC - COPY

PARTOGRAPH (Start at 4 cms dilatation or more; plot always on vertical lines)

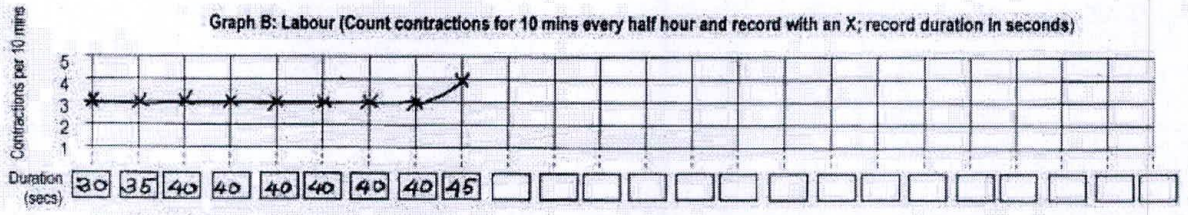
PHC Reg: 6639.

Name MRS CHITRA Parity G4P3 Date and time of rupture of membranes 9AM 12.5.2012

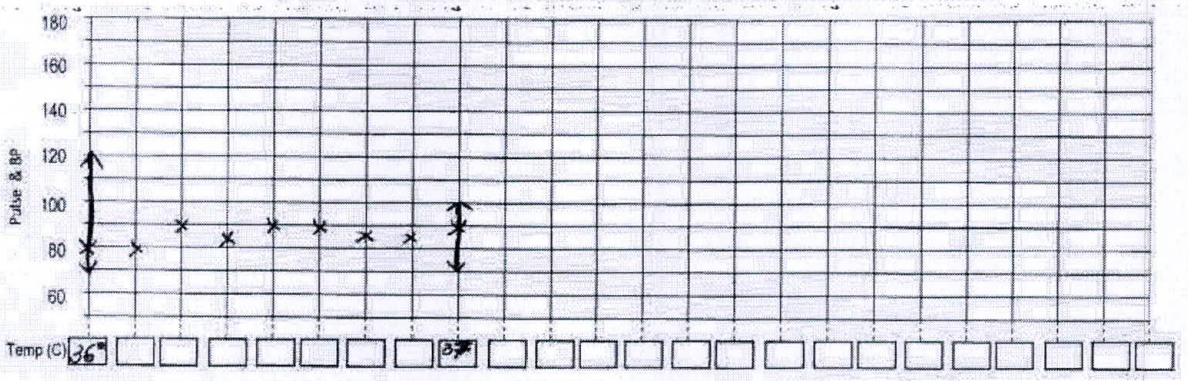
Graph A: Labour (Start plotting dilatation at 4 cms or more with an X on Line A, corresponding to the cervical dilatation at first evaluation. Note the time at the top, corresponding to the first plot. Measure and plot with an X every four hours. Line AA= ALERT LINE; Line BB = ACTION LINE)



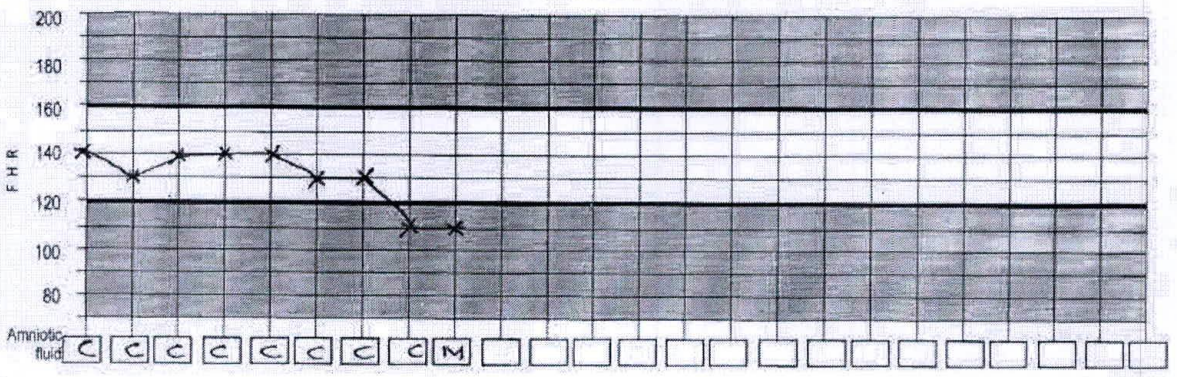
Graph B: Labour (Count contractions for 10 mins every half hour and record with an X; record duration in seconds)



Graph C: Maternal condition (Record pulse with an X every half hour; record BP every four hours using ↕ symbol, the top arrow denoting systolic BP and the lower arrow denoting diastolic BP; record temperature every four hours)



Graph D: Foetal condition (Record FHR with an X every half hour; record amniotic fluid (I, C, B, M) every half hour)



Log Book

Nurse Mentors Skill Training

Introduction

This log book is designed to assist you in completing the requirements for the training program. It will also be evidence to the experience that you will have in the obstetric or neonatal wards of selected hospitals.

The clinical / practical experience will be in the obstetric wards of selected tertiary level hospital. Considering that a registered nurse and mid wife is selected as a mentor although with limited experience in the field, it is assumed that each will have basic knowledge and skills on managing a woman during labour, at delivery and postnatal period. Given is the schedule of posting for practical experience.

Overall Aim of the Training Programs

By the end of the training program it is anticipated that you will have had opportunity to observe and or practice skills, develop the right attitudes, so that you become competent in providing efficient yet empathetic care to a woman in labour, at delivery, and in the postnatal period.

Mentor Training Program :Tentative Schedule for Practical Experience

	MENTORING Week 1							OBSTETRICS Week 2								
M/D	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1								LR	PN	AN	PH	PN (N)	LR			
2								LR	PN	AN (N)	PH	PN	LR			
3								LR	PN	AN	PH	PN	LR (N)			
4								LR	PN	PN	AN	PH	PN (N)	H		
5								AN	LR	PN	AN (N)	PH	PN	O		
6								AN	LR	PN (N)	AN	PH	PN	L		
7								AN	LR	PN	AN	PH	PN	I		
8								AN	LR (N)	LR	PN	LR (N)	PH	D		
9								PN	AN	LR	PN (N)	LR	PH	A		
10								PN	AN	LR (N)	PN	LR	PH	Y		
11								PN	AN (N)	LR	PN	LR	PH			

Please note: All will do 1 night in the OB 1 night in Neonatal (10pm to 6am) in St John's Hospital

								O B S T E T R I C	9-1 Classes = 24 hours 2-7 Practical experience in respective areas = 30+8 = 38 hours						N E O N A T A L	

M: Mentor D: Day LR: Labour Room PN: Postnatal ward

Mentor Training Program :Tentative Schedule for Practical Experience

NEONATAL					OBSTETRICS/NEONATAL							QIP / MENTORING						
Week 3					Week 4							Week 5						
17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
LR	PN	Ne (N)	LR	HOLIDAY	PH	LR	Ne	VISIT (2 PHCs)	EVALUATION - OB & NE	HOLIDAY								
LR	PN	Ne (N)	LR		PH	LR	Ne											
LR	PN	Ne	LR		PH	Ne	LR											
LR	Ne (N)	PN	LR		PH	Ne	LR											
PN	Ne (N)	LR	PN		LR	PH	Ne											
PN	Ne (N)	LR	PN		LR	PH	Ne											
PN	Ne	LR	PN		PN	PH	LR											
Ne (N)	Ne	LR	PN		PN	PH	LR											
Ne (N)	LR	PN	Ne		PN	PN	PH											
Ne	LR	PN	Ne (N)		Ne	PN	PH											
Ne	LR	PN	Ne (N)		Ne	PN	PH											
9-11 & 2-4 Classes = 24 hours 11-1 & 3-5 Practical = 24+8= 32 hours					COMBINED	8-4pm Pracs = 24 hrs												

AN: Antenatal ward PH: Philomena's Hospital – LR Ne: Neonatal N: Night

Objectives of the Obstetric Practical Training

By the end of the training program, you will

- Demonstrate how to do an initial assessment (history, previous investigations abdominal and vaginal exam) of a woman in labour
- Take blood for investigations such as Hemoglobin, VDRL, group and typing, malaria, Hepatitis and HIV
- Demonstrate confidence in assessing progress of labour (contractions, cervical dilatation, cervical effacement, FHR, status of membranes, descent of presenting part)
- Use the partograph correctly to assess a woman beyond 20 weeks and with 4cms dilated
- Demonstrate confidence in assessing a woman in postnatal period
- Interpret and identify danger signs based on initial assessment, assessment at labour or postnatal period
- Initiate initial management for a woman who presents with complications either during intranatal or postnatal period
- Counsel a woman during intranatal, postnatal period on various aspects concerning their care
- Complete referral procedure for a woman needing it.

Comments of supervisor of overall performance

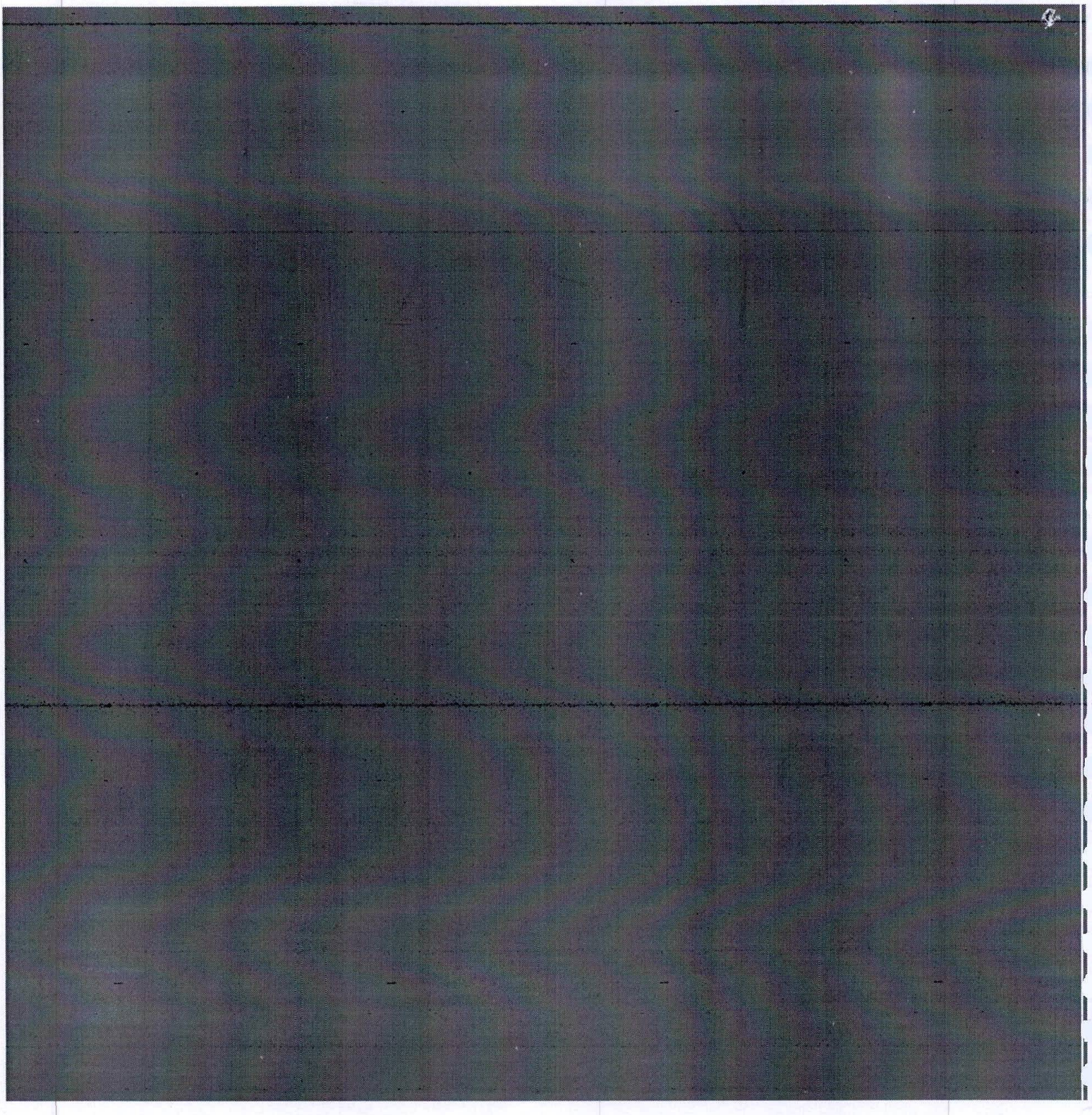
Details of procedures either observed or demonstrated in OB ward

S No	Competency	O/D	Details of the Woman
	Starting case sheet for the right person		
1.	Taking History (filled in case sheets)	1.	
	✓ Calculate gestational age correctly ✓ Check for presenting complaints	2.	
	✓ Check for danger signs	3.	
	✓ Check for any problems in the past	4.	
		5.	
		6.	
2.	Blood sampling for HB	1.	
		2.	
		3.	
		4.	
3.	Blood sampling for HIV	1.	
		2.	
		3.	
		4.	
4.	Interpret basic investigations for a woman	1.	
	✓ Hemoglobin	2.	
	✓ Blood group (?ABO incompatiability/ Rh-ve)	3.	
	✓ HIV test ✓ VDRL test result ✓ Malaria result ✓ Hepatitis result (Arrangements will be made for participants to visit the PPTCT center at selected tertiary hospital to observe and if possible perform rapid HIV test)	4.	

5.	Demonstrate general examination of a woman in labour ✓ Check general condition ✓ Check BP accurately ✓ Check pulse accurately ✓ Check temperature accurately ✓ Check for pallor	1. 2. 3. 4. 5. 6.	
6.	Demonstrate abdominal examination of a pregnant woman/woman in labour ✓ Check gestational age based on fundal height ✓ Check abdominal girth ✓ Check if breach is near fundus ✓ Check lie of fetus accurately ✓ Check if presentation part is engaged ✓ Check FHR correctly	1. 2. 3. 4. 5. 6.	
7.	Demonstrate vaginal examination of a woman in labour ✓ Check if membranes intact or ruptured ✓ Identify meconium stained liquor ✓ Check cervical dilatation ✓ Check if cervix is effaced ✓ Check the presenting part	1. 2. 3. 4. 5. 6.	
8.	Monitor labour using partograph and interpret the same ✓ Check if all details completely filled ✓ Check if participant interprets partograph ✓ Graph A ✓ Graph B ✓ Graph C ✓ Graph D	1. 2. 3. 4. 5. 6.	

9.	Conduct normal delivery ✓ Correct timing of bearing down , confirming full cervical dilatation ✓ Assists in crowning ✓ Gives perineal support when head bulging at perineum and delivery of anterior shoulder ✓ Wipes face ✓ Delivers shoulders ✓ Delivers body ✓ Places baby on warm clean towel mother's abdomen ✓ Cuts cord as specified ✓ Cleans perineum ✓ Places pad ✓ Helps mother hold baby	1. 2. 3. 4. 5. 6.	
	AMTSL ✓ Administers uterotonic ✓ CCT ✓ Uterine massage		
10.	Monitor a woman in postnatal period ✓ Check BP accurately, ✓ Check temperature accurately, ✓ Check if bleeding is normal, ✓ Check if uterus contracted ✓ Check for perineal tears ✓ Repair of perineal tears ✓ Check if woman is taking normal diet ✓ Check if woman has any danger signs	1. 2. 3. 4. 5. 6.	
	Post natal counselling ✓ Danger signs ✓ Personal Hygiene ✓ Breast feeding ✓ Care of the baby ✓ Family planning		

11.	Care of a woman with bleeding ✓ Identification of shock ✓ Assessment of quantity of bleeding (identify excess bleeding) ✓ Bimanual Compression of uterus ✓ Administration of appropriate IV fluid ✓ Administration of uterotonic ✓ Transport	1.	
12.	Care of a woman with sepsis Giving first dose of anti biotic	1.	
13.	Care of a woman with prolonged or obstructed labour or rupture of membranes> 12hrs	1.	
14.	Care of a woman with eclampsia/ pre-eclampsia/hypertension Administration of $MgSO_4$ / diazepam ✓ Transport ✓ Referral center	1.	



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Improved Maternal, Newborn & Child Health

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