

# Basic Emergency Obstetric Care

*A Trainer's Guide*



*Supported by*



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Department of Health  
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# Foreword

The past decade was marked by a slow progress in the field of maternal and child health. Of the 1.6 to 2 million babies born annually, over 3 to 4% of them die during the first month, and nearly two-thirds of deaths occur in the critical first week after birth – the perinatal period. In like manner, maternal mortality ratio continues to be a major public health concern at 172 per 100,000 live births. Most of these deaths are a result of poor maternal health brought about by poor nutritional status coupled with low quality care before pregnancy, during pregnancy, childbirth and immediately after birth.

Recent improvements in medical knowledge and advances in health technology have caused a change in the way services to pregnant women are provided. The previous paradigm utilized the “risk approach” where high-risk pregnancies were first identified and referred for closer attention during the prenatal period. Now, in contrast, every pregnant woman is considered at risk and should have access to a skilled attendant before, during and after pregnancy.

For the strategy to succeed, the “three delays” of deciding to seek care, reaching appropriate care, and receiving care at appropriate health facilities must be addressed. One critical pathway according to JICA, WHO, UNICEF and UNFPA is to improve the accessibility, utilization, and quality of services for the treatment of complications during pregnancy and childbirth. This is based on evidence that at least 15% of all pregnant women will develop serious complications and require life-saving access to quality obstetric services. Thus, the single most critical intervention is to ensure the presence of a health worker with midwifery skills at every birth, and transportation to a more comprehensive level of 24-hour quality obstetric care in case of emergency. The UN system has recommended the setting up of a facility with capability to provide comprehensive obstetric care (CEmOC) in an area with at least 500,000 population and a facility with capability to provide basic emergency obstetric care (BEmOC) in an area with at least 125,000 population.

In response to the global call of effecting substantial improvement in maternal and child health, as defined in the Millennium Development Goals, the Department of Health has reaffirmed its commitment to invest in women and children's health by adopting specific goals, targets, strategies and interventions to reduce maternal and infant mortality. It is against this background that this Trainer's Guide on Basic Emergency Obstetric Care is developed. This will serve as the national standard for training doctors, nurses and midwives in the field of emergency obstetrics at primary level facilities. This Trainer's Guide provides a full range of concepts and strategies that enable master trainers to give high quality training to health workers on pregnancy, childbirth, postpartum and newborn care. It is hoped that this Guide becomes a useful tool for decision-makers, program managers and health care providers in charting out roadmaps toward meeting the health needs of women and children.



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Secretary of Health

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Finally, the Department of Health acknowledges the technical assistance provided by the Center for Reproductive Health Leadership and Development, Inc. (CRHLD) in the finalization and production of this guide.

# Acronyms

BEmOC	— Basic Emergency Obstetric Care	LR	— Labor Room
BP	— Blood Pressure	MMR	— Maternal Mortality rate
CD	— Compact Disc	NB	— Newborn
CPR	— Contraceptive Prevalence Rate	OPD	— Out-patient Deployment
DR	— Delivery Room	OHP	— Overhead Projector
ER	— Emergency Room	PCPNC	— Pregnancy, Childbirth, Postpartum and Newborn Care
GP	— Gravida Para	POGS	— Philippine Obstetrical and Gynecological Society
IE	— Internal Examination	PR	— Pulse Rate
IM	— Intramuscular Injection	RAM	— Rapid Assessment and Management
IV	— Intravenous Injection or Infusion	RR	— Respiratory Rate
LBW	— Low Birth Weight	TNA	— Training Needs Assessment
LCD	— Liquid Crystal Display	TOCT	— Training of Core Trainers
LGU	— Local Government Unit		

# Introduction

## **A. The Situation of Maternal and Newborn Care in the Philippines**

The Philippines registered a Maternal Mortality Rate (MMR) of 172 per 100,000 in 1998 compared to 180 per 100,000 in 1995 (National Demographic Health Survey, 1998). Despite the decrease in MMR, the reduction of maternal deaths due to pregnancy related complication remains a challenge. The 1998 NDHS indicated that postpartum hemorrhage is the leading cause of deaths followed by hypertensive complications, sepsis, obstructed labor and unsafe abortion. In the same survey, perinatal death was placed at 18 per 1000 livebirths. Compared with Malaysia and Singapore (9.1 per 1000 livebirths & 4.1 per 1000 livebirths, respectively), the Infant Mortality Rate (IMR) in the country is 36 per 1000 livebirths. In the latest 2003NDHS, the percentage of LBW babies (<2500 gms) is high at 13%, not including those that were not weighed. This is a reflection of the intrauterine growth retardation brought by maternal deprivation during pregnancy. Stillbirths or infant deaths, on the other hand, can be avoided especially in the critical first week of life if essential care is available during pregnancy, childbirth and

the immediate postpartum period.

As explained in the Three Delays Model, maternal deaths occur due to delays in: (1) deciding to seek care for perceived obstetrical complications; (2) identifying and reaching the appropriate facility; and (3) receiving appropriate and adequate care in the facility.

The World Health Organization (2002) pointed out that although most pregnancies and births are uneventful, approximately 15% of all pregnant women develop a potentially life-threatening complication that calls for skilled care and some will require a major obstetrical intervention to survive. If Emergency Obstetric Care is available, and women can access it in time, women's lives can be saved.

The establishment or upgrading of strategic health facilities on Basic Emergency Obstetric Care (BEmOC) aims to avert death and disability among pregnant women and newborn babies. BEmOC refers to the functions that can be provided by a team of experienced and trained skilled birth attendants composed of licensed doctor, nurse

and midwife who act as a team at the primary level in providing basic emergency care to mothers and babies to avert maternal and newborn morbidity and mortality. The WHO recommends a ratio of one BEmOC facility per one hundred twenty five thousand (1:125,000) population.

The following are the six (6) basic functions of a BEmOC facility:

1. administer parenteral antibiotics ( initial loading dose)
2. administer parenteral oxytocic drugs (for active management of the 3rd stage of labor only)
3. administer parenteral anticonvulsants for pre-eclampsia and eclampsia (initial loading dose)
4. perform manual removal of placenta
5. perform removal of retained products
6. perform assisted vaginal delivery

## **B. The Safe Motherhood Policy**

The Philippines is committed to pursuing the principles enunciated in the Cairo and Beijing Conferences on Population and Women respectively for the promotion of safe motherhood and women's health, and to ensure healthy newborns. Hence, the enactment of the Department of Health's Administrative Order No. 79s.2000, otherwise known as the Safe Motherhood Policy on August 28, 2000.

It is restating its commitment to the aspiration of a healthy nation through a more vibrant and vigorous Safe Motherhood Initiatives. The following principles form the basis for programming the reduction of maternal and perinatal mortality and morbidity in the country:

- ▶ Promotion of women's rights and gender

sensitivity;

- ▶ Access to quality health and nutrition services;
- ▶ Focusing on health promotion, education and advocacy;
- ▶ Establishing linkages and developing collaboration to ensure sustainability;
- ▶ Mobilizing families and communities to address family planning and maternal and newborn care;
- ▶ Empowering communities to recognize and correct gender discrimination and prevent violent and abusive behavior towards women and girls; and
- ▶ Reporting and reviewing all maternal deaths

## ***Goal, Coverage and Scope***

The Safe Motherhood Policy embraces the goal of ensuring safe motherhood and healthy newborns, hence, its main objective is to reduce maternal and perinatal morbidity and mortality. Under this policy, all women of reproductive age (15-49) and newborns up to 28 days of life are target of interventions and services. Special attention shall be given to indigenous women, women among highly marginalized groups (fisher folks, farmers, urban slums, etc.) and teenage/adolescent groups. Approaches or strategies shall be culture-based and gender-sensitive.

## ***Guidelines and Procedures***

### **1. Ensuring Quality Maternal and Newborn Care**

Good quality maternal and newborn health services:

- ▶ Are accessible and available as close as possible to where the women live, and at the lowest possible facility that can provide the services

safely and effectively.

- ▶ Are acceptable to potential users and responsive to local cultural and social norms, such as preferences for privacy, confidentiality and care by female health workers.
- ▶ Have on hand all essential supplies and equipment.
- ▶ Provide comprehensive care and linkages to other reproductive health services;
- ▶ Provide for continuity of care and follow-up;
- ▶ Are staffed technically competent health care providers who rely on clear guidelines/protocols for treatment;
- ▶ Are staffed by workers who provide respectful and non-judgmental care that is responsive to women's needs;
- ▶ Involve the client in decision-making, and see the client as partners in health care and active participants in protecting their own health; and
- ▶ Offer economic and social support to health care providers that enable them to do the best job they can;
- ▶ Encourage partner as well as family and community involvement in pre-natal and post-natal services.

## 2. Elements of Quality Maternal and Newborn Care

### ▶ Prenatal

Pregnant Women should have at least four (4) prenatal visits for:

- Health promotion: advice on nutrition (e.g iodized salt utilization) and health care, breastfeeding, newborn care as well as counseling to alert women to danger signs and help plan for birth;
- Assessment: history taking, physical exami-

nation and screening test like hemoglobin/hematocrit determination, urinalysis using the *Home Based Mother's Record (HBMR)*, dental check-up and prophylaxis. (Note: The HBMR has been updated and replaced by the *Mother and Child Book*)

- Prevention: Tetanus Toxoid immunization, Micronutrient supplementation (low dose Vitamin A, Multiple micronutrient supplementation, ferrous sulfate) and early detection and management of complications.
- Treatment: Management of sexually transmitted infections, anemia, toxemia, or other risk conditions.

### ▶ Natal/ Delivery Care

All deliveries should be attended by a "skilled attendant" and is within two hours from first level referral or well-equipped hospital that can handle emergency obstetric cases and should have the following services:

- Provide good quality care that is hygienic, safe and sympathetic on an on-going basis;
- Recognizes and manage complications, including instituting life-saving measures for mother and baby when called for;
- Monitor progress of labor using partograph;
- Refer promptly and safely when higher-level care is needed; and
- Ensure the support/presence of husband/partner.

### ▶ Postpartum and Newborn Care

The postpartum mother together with her newborn should have at least 2 postpartum visits one month apart for the following services:

- Newborn screening for 8 congenital metabolic disorder
- Apgar scoring, proper cord care
- Identification and management of problems in mothers and newborn in the 1st 24 hours
- Immediate and safe referral cases needing higher level care
- Initiate exclusive breastfeeding
- Counseling and health promotion on exclusive breastfeeding, follow-up immunization, family planning, micronutrient supplementation, personal hygiene and care of newborn.
- BCG immunization and complete assessment of the newborn using Growth Monitoring Chart (GMC)

units (LGUs) in the country. This local version serves as the main reference book for the Skills Training in BEmOC. This will guide service providers in their clinical decision-making through a systematic collection, analysis, classification and use of relevant information by suggesting key questions, essential observations and/or examinations and recommending/applying appropriate evidenced-based interventions.

### **C. The Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC) Manual**

One of the strategies adopted to enable the service providers become competent in the management of women and their newborns was the development of the *Pregnancy, Childbirth, Postpartum and Newborn Care: A Guide for Essential Practice* by the World Health Organization. It aims to guide health care professionals in the management of women and newborns in said periods as well as its application through an intensive skills training course.

The WHO-PCPNC Manual was adopted to the Philippine settings based on consultations with technical groups, academe, Philippine Obstetrical and Gynecological Society (POGS), Midwives Association and on the results of the pilot testing of the manual in the five areas of local government

# About the Trainer's Guide

## **Background of the Trainer's Guide**

The WHO document -- *Pregnancy, Childbirth, Postpartum and Newborn Care: A Guide for Essential Practice (PCPNC)* was adopted as a reference manual for health care providers responsible for the care of women during pregnancy and childbirth, and their newborns. To facilitate the conduct of training, this training guide was developed in collaboration with various partner organizations that have a stake on reducing maternal deaths in the Philippines.

A multi-sectoral PCPNC Task Force was created, composed of representatives from the Dr. Jose Fabella Memorial Hospital, Midwives Associations, WHO, UNICEF, JICA and UNFPA with DOH-NCDPC as chair and convenor. Several meetings were conducted with support from UNICEF and WHO to brainstorm on how best the training can improve the health providers' capability on managing emergency complications of pregnancy and childbirth.

A meeting hosted by the WHO was conducted to generate more technical inputs and solicit

endorsement of the Guide from other partners like the Philippine Pediatric Society, Philippine Obstetrics and Gynecology Society, and three groups from the midwives' associations. The last three series of meetings to finalize the Trainer's Guide and the pre-testing was funded by the UNFPA. A total of 23 health service providers from lying-in or birthing facilities, Provincial Health Offices from six UNFPA assisted provinces, and from the Center for Health Development participated and gave a comprehensive assessment of the training.

With support from JICA, a two-day consultative workshop was conducted by DOH to provide the different stakeholders with the opportunity to further review the draft and recommend ways to improve it. An additional off-shoot of this workshop was an agreement to come up with a DOH Administrative Order entitled "Implementing Guidelines for Basic Emergency Obstetric Care" that will guide decision makers and implementers of BEmOC in the country.

## How to Use the Trainer's Guide

This Trainer's Guide shall provide facilitators and resource persons the standard technical content and design of BEmOC training. It promotes the team approach in the delivery of BEmOC. The overall objective of the training is to enhance the skills of birth attendants (doctors, nurses, midwives) in assessing and managing conditions related to pregnancy, childbirth, postpartum and newborn care.

It is an 11-day training with 4-day didactic sessions and 7-day clinical practice. The objectives of the didactic phase are as follows:

- ▶ apply the principles of good care;
- ▶ enhance clinical judgment by identifying and prioritizing patients through the application of Quick Check and RAM;
- ▶ discuss the impact of doing an immediate general assessment of the woman upon consultation at the health facility;
- ▶ perform an assessment and management of a woman during labor, after delivery and discharge from the health facility;
- ▶ recognize and respond to observed signs or volunteered problems of mothers;
- ▶ show how to care for the newborn;
- ▶ demonstrate counseling skills on the essential routine and emergency care of women and newborn during pregnancy, childbirth, postpartum and post-abortion;
- ▶ identify community support mechanisms for maternal and newborn health.

The didactic part covers nine (9) modules, namely: (1) Overview of BEmOC and the PCPNC Manual; (2) Principles of Good Care; (3) Quick Check and

Rapid Assessment and Management; (4) Antenatal Care; (5) Labor, Delivery and Immediate Postpartum; (6) PostPartum Care; (7) Newborn Care; (8) Counseling; and (9) Mobilization of Community Support.

The practicum phase covers two (2) practicum activities for clinical skills on BEmOC. It aims to enhance the competencies of service providers in applying basic emergency obstetric care to all women and their babies. Its sessions include: (1) Orientation for the Practicum; and (2) Practicum Activities for Clinical Skills in BEmOC. The practicum session shall take place in an accredited training hospital: at the outpatient department, emergency room, maternity ward, labor and delivery room and wherever trainees can practice their skills. Nearby lying-in clinics and birthing homes, health centers and rural health units may also serve as practicum sites provided they are accredited as training units.

The training team shall be composed of: (1) a training director; (2) at least five core trainers; and (3) a finance/administrative officer. To ensure a common understanding on the Trainer's Guide and PCPNC Manual, a two-day facilitator's meeting before the training proper will be conducted for the team and other invited resource persons. The resource persons or facilitators for the training will be selected based on their experience/expertise in the area of maternal and newborn care, orientation on PCPNC, exposure to conduct of training activities and willingness to be part of the team.

***The Trainer's Guide is organized in three parts:***

**Part 1** provides checklist on pre-training preparation. It consists of the technical and administrative requirements which need to be prepared to ensure smooth implementation of the training, such as: (1) organization of the training team; (2) selection of resource; (3) persons and training-of-trainers; (4) identification of partner institutions and facilities; (5) selection of participants and training needs assessment; (6) setting of schedule; (7) development of course schedule and preparation of training materials; (8) conduct of facilitators' meeting; and (9) fulfillment of administrative requirements.

**Part 2** presents the nine modules of the didactic phase and two modules of the practicum phase. Each module and session includes presentation of the objectives, topics, duration, methodology and materials needed. This part also provides practical tips on how to monitor and evaluate before, during and after the course, including the preparation of an action plan.

**Part 3** provides an overview of post-training activities which the trainers and participants can undertake collaboratively. This part includes discussion of outcome indicators for the training, the need for continuing communication, how to monitor and evaluate training outcomes and the importance of documenting experiences.

The introductory part walks the trainer or reader into the context of the guide which includes the situation of maternal and newborn care in the Philippines, the Safe Motherhood Policy and the context of the PCPNC which serves as the main reference book of the Trainer's Guide.

To facilitate the use of this book, especially finding information, the three major parts and the Annex which includes the Trainer's Notes are color coded:

Part 1	Pre-Training Activities	Yellow
Part 2	Conduct of the Training Course	
	A. Didactic Phase	Blue
	B. Practicum Phase	Pink
	C. Monitoring, Evaluation and Action Plan	Orange
Part 3	Post-Training Activities	Green
Annex		Violet

A **Glossary** is also included in page 87 to aid the trainers and readers in understanding the meanings of words/terms used in the guide.

The **Annex Portion** includes the trainer's notes, guide to the powerpoint presentation, and sample training schedule for the didactic phase. The trainer's notes contain the various reference and presentation materials. Sample forms and tools are also included in this section.

Together with this Trainer's Guide are the instructional materials such as the Compact Disk of PowerPoint Presentations, a set of transparencies of selected presentation materials and the PCPNC Manual as main resource book.



Prior to conducting the skills training on BEmOC, certain preparations need to be done to ensure its smooth implementation.

# Technical Preparation

## Organization of the Training Team

A Training Team needs to be organized to lead the following responsibilities:

- ▶ Management of the training which includes planning, organizing and running the training sessions in an effective and collaborative manner;
- ▶ Mentoring by providing guidance and support to individual participants;
- ▶ Planning how the newly gained competencies can be applied by the participants in their work place;
- ▶ Motivating participants by supporting them in meeting their learning objectives; and
- ▶ Conducting Training of Core Trainers (TOCT) among resource persons/facilitators for the different sessions in the didactic phase and area facilitators for the practicum phase.

The composition of the team includes:

- ▶ Training Director
- ▶ Core Trainers
- ▶ Administrative and Finance Officer

## Selection of Resource Persons and Training of Core Trainers (TOCT)

The selection of resource persons/facilitators should take into consideration appropriate matching of their qualifications with the training objectives and methodology, as well as the characteristics of the participants. The recruitment process should be guided by selection criteria.

The TOCT aims to level-off understanding among the Training Team, resource persons/facilitators for the didactic phase and area facilitators for the practicum phase about the goals, objectives and mechanics of the BEmOC skills training. The discussions/meetings will focus on the following:

- ▶ Context of IMPAC on Safe Motherhood
- ▶ Context of the PCPNC as a Reference Guide
- ▶ Modules for the BEmOC Skills Training
- ▶ Orientation on the Trainer's Guide, particularly:
  - **Didactic Phase** - session objectives, group activities, expected outputs and materials/resources needed.

- **Practicum Phase**
  - objectives
  - hospital departments/areas that will be involved
  - hospital personnel/staff/area facilitators who will be involved
  - requirements of the practicum and the expected technical assistance from the area facilitators
  - determine schedule of rotation to approximate completion of requirements (may use as basis results of Training Needs Assessment (TNA) to address the gaps/skills required by the participants on BEmOC)
  - forms/checklists to be filled-up by the participants
  - forms/monitoring tools to be accomplished by the area facilitators to aid in facilitating application of skills
  - conduct of mid-practicum assessment
  - how to effectively provide technical assistance and monitoring of the participants including proper feedbacking of observations
  - proper conduct and decorum during practicum
- **Monitoring and Evaluation of the Training** (during and after)

Criteria for the Selection of Resource Persons:

- ▶ Experience/expertise in the area of maternal and newborn care
- ▶ Orientation on PCPNC
- ▶ Exposure to conduct of training activities
- ▶ Willingness to be part of the team

## Identification of Partner Institutions and Facilities

Institutions and facilities that will be involved in the delivery of the training course should be identified early on. The identification process should consider the following criteria:

- ▶ Training Institution for Practicum
  - Accredited by Philippine Obstetrical and Gynecological Society (POGS) or Department of Health for teaching/training
  - Can be government (as covered by DOH Administrative Order) or private institutions that will meet the criteria (covered by MOA with Local Government Unit)
- ▶ Health Facilities for Practicum
  - With Business Plan (according to PhilHealth Accreditation scheme)
  - Accessibility of the facility
  - Capability of the personnel to model correct service provision and assist participants during practice
  - With adequate caseload for clinical procedure (BEmOC)
  - Availability of essential supplies and equipment
- ▶ Training Venue for the Didactic
  - Adequate space for the number of participants and activities that will be conducted, including break-out groups
  - Availability of equipment and supplies
  - Availability of facilities for communication
  - Comfortable/well-appointed accommodation

In identifying partner institution and facilities, bear in mind that “the training scenario should be as close as possible to the work environment of the

participants” (WHO, 1997:40). In this way, there is greater chance of putting into practice the new skills learned in their own work sites (McInerney et al., 2001; JHPIEGO, 2001).

## **Selection of Participants and Training Needs Assessment**

The success of the BEmOC skills training course will also depend on a careful selection of participants. Criteria for selecting participants may include:

### **LGU Participant**

- ▶ LGUs/provinces with high Maternal Mortality Rate (MMR), neonatal death and low Contraceptive Prevalence Rate (CPR)
- ▶ Available BEmOC facilities of LGU
- ▶ Adequate support of LGU in terms of upgrading facilities, availability of supplies and allocation of budget
- ▶ LGU with Investment Plan and resource management capability
- ▶ Available human resources for team composition
- ▶ Private institutions willing to be trained
- ▶ Level of competencies of participants

### **Individual Participant**

- ▶ Team of doctors, nurses and midwives who serve as skilled birth attendants at the birthing facilities that are capable of providing BEmOC
- ▶ At least with experience in handling birth deliveries
- ▶ Background in basic OB-GYN and Pediatrics

Once the participants have been selected, a TNA

designed to determine the skills which the participants would like to learn or improve during the training, as well as their level of knowledge and attitudes regarding BEmOC. The participants will be asked to complete a TNA form which will be used by the Training Team in improving the delivery of the course.

## **Setting of Schedule**

The schedules for TOCT among the resource persons, dry-run for the course and actual training should be discussed and agreed upon early enough to prepare them accordingly. Inform them immediately as soon as the schedules are finalized.

## **Development of Course Schedule and Preparation of Training Materials**

A schedule of all the activities that will take place during the BEmOC skills training course should be developed by the Training Team. This includes information about the objectives, methodology, time allotted to each activity and the resources/materials needed. It is both a planning tool and a guide for the trainers. The course schedule aims to ensure that the flow of training is logical, the participants are able to effectively acquire and apply new knowledge and skills and stay focused and interested.

Together with the course schedule, training materials such as handouts, computer-generated presentations (PowerPoint) using computer and LCD or overhead projectors, flipchart paper, photographs and models (e.g. dolls, chicken breast, etc.) have to be prepared.

## List of Training Materials/Resources

- ▶ Metacards
- ▶ Pentel pens
- ▶ Masking tape
- ▶ Board
- ▶ LCD and computer
- ▶ Overhead projector
- ▶ PCPNC Manual
- ▶ Handouts on BEmOC
- ▶ Manila paper
- ▶ Transparencies of presentation materials
- ▶ CD of PowerPoint presentations
- ▶ Chalk
- ▶ Prizes for games
- ▶ 5 drill exercises
- ▶ Case study handouts
- ▶ Arm model
- ▶ IV butterfly/canula
- ▶ Chicken breast
- ▶ Drugs and supplies (magnesium sulphate, oxytocin, ergometrine, diazepam, IV/IM antibiotics, arthemeter or quinine IM)
- ▶ Quick Check and RAM chart
- ▶ Crayola
- ▶ Paste
- ▶ Assorted art papers
- ▶ Observation tool
- ▶ Partograph and Labor chart
- ▶ Examination chart for mothers (after discharge)
- ▶ Slide presentations
- ▶ Undressed doll
- ▶ Mannequin
- ▶ Self-inflating bag

- ▶ Mask size 0 & 1
- ▶ Suction tube/suction device
- ▶ 2 towels
- ▶ Clock
- ▶ Skills requirement handout
- ▶ Practicum forms
- ▶ Patients
- ▶ Hospital/birthing/lying-in facilities

## Conduct Facilitators' Meeting for the Trainers Course

A two-day facilitator's meeting should be conducted with core trainers to ensure that all requirements of training for the didactic and practicum phases have been prepared. The result of the meeting should serve as basis for doing the necessary adjustments or improvement in the training course.

# Conduct of the Training Course

This section consists the didactic phase, practicum phase and monitoring and evaluation of the actual skills training on BEmOC. The objectives and topics of the three main parts, modules and specific sessions are laid out to guide the trainers and participants during the conduct of the training course. An appropriate mix of training methods that were used in pre-testing this trainers' guide was adopted to ensure that participants realize the course objectives.

# Didactic

## Objectives

By the end of the didactic phase, participants will be able to:

- ▶ apply the principles of good care;
- ▶ enhance clinical judgment by identifying and prioritizing patients through the application of Quick Check and RAM;
- ▶ discuss the impact of doing an immediate general assessment of the woman upon consultation at the health facility;
- ▶ perform an assessment and management of a woman during labor, after delivery and discharge from the health facility;
- ▶ recognize and respond to observed signs or volunteered problems of mothers;
- ▶ show how to care for the newborn;
- ▶ demonstrate counseling skills on the essential routine and emergency care of women and newborn during pregnancy, childbirth, postpartum and post-abortion; and
- ▶ identify community support mechanisms for maternal and newborn health.

## Duration

The didactic phase will be conducted in four (4) days.

## Methodology

Different methods and activities shall be employed to meet the objectives of the didactic phase, particularly participatory and hands-on methods. These include: lecture/ interactive-discussions, brainstorming/case studies, group work/ experiential sharing, demo-return demo, plenary sessions and clinical exposure. The participants will be provided with the opportunity to describe the skill, demonstrate the skill, practice the skill and verify whether the task is being performed proficiently.



# Module 1

## Overview of BEmOC and the PCPNC Manual

### Objective

To enable participants to understand BEmOC and the use of the PCPNC Manual.

### Topics

- ▶ Overview of BemOC
- ▶ Use of the PCPNC Manual

### Duration

1 hour and 30 minutes

### Session 1

BEmOC and the Use of PCPNC Manual

### Specific objective

At the end of the session, the participants will be able to understand BEmOC and the importance of PCPNC Manual and its use.

### Methodology

Warm-up exercise	10 min
Lecture-discussion	30 min
Reinforcement	10 min
Drill	40 min

### Materials needed

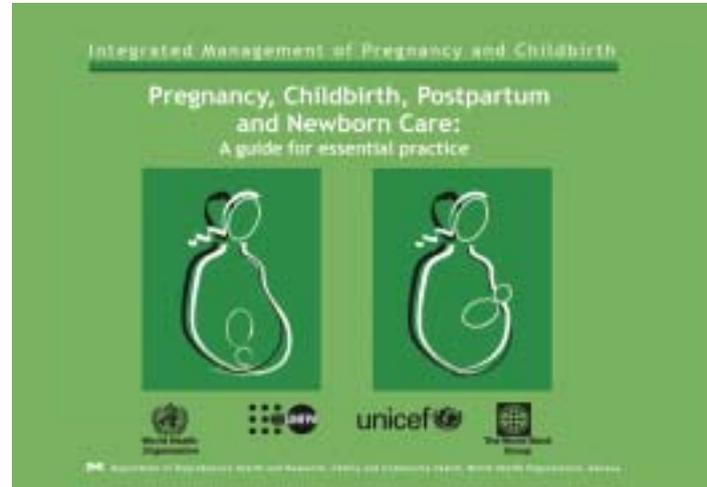
Metacards, pentel pens, masking tape, board, LCD/OHP, presentation materials and handouts on BEmOC and PCPNC Manual.

### Procedure

- ▶ Explain the objectives and mechanics of the session to the participants;
- ▶ Provide each participant with 2 metacards, and ask all of them to write their ideas about BEmOC and post their cards in the board;
- ▶ Summarize the contents of the metacards by identifying patterns of responses;
- ▶ After the summary of participants' ideas, proceed with the lecture-discussion on BEmOC and rationale and design of the BEmOC skills training course;

- ▶ Proceed with the Drill on the PCPNC Manual by explaining the importance of knowing how to navigate the contents of the manual, letting the participants go over the guide, and asking sample topics to identify pages and clarify contents; and
- ▶ Synthesize the contents of the session and link it with Module 2.

*Refer to pages 91-98 of the Trainer's Notes*



# Module 2

## Principles of Good Care

### Objective

To provide participants with the opportunity to apply the principles of good care to all contacts between the skilled attendant and all women and their babies.

### Topics

- ▶ Communication
- ▶ Workplace and administrative procedures
- ▶ Universal precautions and cleanliness
- ▶ Organizing a visit

### Duration

1 hour

### Session 1

Principles of Good Care

### Specific objective

At the end of the session, the participants should be able to improve skills in applying the principles of good care.

### Methodology

Lecturette 10 min  
Workshop 20 min  
Plenary 30 min

### Materials needed

4 pcs. manila papers, pentel pens, masking tape, board, LCD/OHP, PCPNC Guide, handouts and CD/transparencies of presentation materials on the Principles of Good Care.

### Principles of Good Care

The principles of good care apply to all contacts between the skilled attendant and all women and their babies. These principles concern:

- ▶ Communication
- ▶ Workplace and administrative procedures
- ▶ Universal precautions and cleanliness
- ▶ Organizing a visit

## Procedure

- ▶ Explain the objectives and mechanics of the session to the participants.
- ▶ Divide the participants into 4 groups. Ask each group to list down the principles of good care to all contacts between all women and babies on 4 concerns:
  - Communication;
  - Workplace and administrative procedures;
  - Universal precautions and cleanliness; and
  - Organizing a visit;
- ▶ Instruct the groups to write their inputs on the manila paper and post them on the wall/board for presentation;
- ▶ Each group will be given 2 minutes to present their outputs. While a group is presenting, other groups will act as observers and commentators. Each group should come up with a summary of their presentation; and
- ▶ Synthesize the workshop outputs and connect them with the next module's topics.



*Refer to page 99 of the Trainer's Notes*

# Module 3

## Quick Check and Rapid Assessment and Management (RAM)

### Objective

To enhance the clinical judgment of a health worker by identifying and prioritizing patients through the application of Quick Check and RAM.

### Topics

- ▶ Quick check
- ▶ RAM
- ▶ Referral system
- ▶ Emergency treatment for the woman (repair of Laceration, IV insertion, butterfly, IV cannulation, bleeding, eclampsia and pre-eclampsia and infection)

### Duration

2 hours and 30 minutes

### Session 1

Quick Check

### Specific objective

At the end of the session, the participants should be able to identify and prioritize patients from the group.

### Methodology

Lecture-discussion	15 min
Contest/reinforcement	5 min/20 min

### Materials needed

3 pcs manila papers with three headings namely: SIGN, CLASSIFY and TREAT, metacards with descriptive words, LCD, chalk, board and 1 prize.

### Procedure:

- ▶ Explain the objectives and mechanics of the session to the participants;
- ▶ For the Contest Activity: Divide the participants into 3 groups and distribute to them pink, yellow and green metacards with descriptive words of patients;
- ▶ Ask each group to post the cards on the corre-

sponding heading in the manila paper. The fastest group with the correct answers wins a prize. Everybody participates in checking the answers;

- ▶ For the Lecture-Discussion Activity: Discuss things that need to be considered during the initial contact with the woman and child seeking care. Ask the participants to share their own experiences or what they want clarified in the discussion; and
- ▶ End the session by synthesizing the topics covered and connect them with the next session.

*Refer to page 99 of the Trainer's Notes*

## Session 2

Rapid Assessment and Management (RAM)

### Specific objective:

To enable the learners to:

- ▶ Perform RAM to all women of childbearing, labor and postpartum stages;
- ▶ Assess emergency and priority signs, and give appropriate treatment; and
- ▶ Refer women to hospital.

### Methodology

Lecture-discussion	20 min
Drill on RAM	10 min/drill (5 drills)/30 min

## Materials needed

RAM chart, LCD, 5 drill exercises, manila papers, pentel pens, masking tape, and board.

## Procedure

- ▶ Explain the objectives and mechanics of the session and link it to the previous session;
- ▶ For the Lecture-Discussion: Present the RAM chart by discussing each item and clarifying questions/queries from the learners;
- ▶ For the Drill/Exercise: Check participants' comprehension by posing situations, and ask them to step by step solve a specific problem following the RAM procedure; and
- ▶ Ask the participants to summarize what they have learned from the session; and then proceed to the next session.

*Refer to page 99 of the Trainer's Notes*

## Case Study 1

### *Problem*

A young woman named Fatima, who is obviously pregnant, arrives at the health facility with an older woman. Fatima is complaining of severe abdominal pain. What action would you take?

### *Additional Data Obtained During the RAM*

Fatima has the following abnormal signs:

- ▶ Cold moist skin
- ▶ Pulse >120/minute
- ▶ Severe abdominal pain

### *What does this mean?*

Further assessment reveals that her blood pressure is 90/50 and the temperature is 40°C. How will you manage her?

### Case Study 2 Quick Check and RAM

#### *Problem*

A woman named Umi arrives at the health facility with her mother-in-law. She is obviously in advanced pregnancy and appears distressed with intermittent abdominal pain, which she says occurs about every 5 minutes. What action would you take?

#### *Additional Data Obtained during RAM*

No emergency signs are detected and her vital signs are the following: BP 100/70, PR 85, RR 20, temperature 36.8°C. Umi is found to be in labor. What will you do next?

- ▶ After the sharing, explain the correct process of referring patients based on the referral system. Request a participant to describe how she/he fills up the referral form. The discussion should lead to the correct way of filling up of form. Highlight important points in the referral system. Let participants' discuss their management system before referring patients. Assist in the discussion by providing additional inputs. Also, ask participants to enumerate sample cases needing referral.
- ▶ Sum-up the discussion by emphasizing important points in the referral system. Give assignment for the next session.

### Session 3

#### Referral System

#### Specific objective

At the end of the session, the participants should be able to refer patients correctly.

#### Methodology

Interactive discussion 20 min

#### Materials needed

Short notes of own experiences, chalk, board, LCD/OHP

#### Procedure

- ▶ Recapitulate the previous session and link it with the objectives and mechanics of Session 3.
- ▶ For this Interactive Discussion: Ask participants to share their own experiences in the field regarding referral of patients;

### Session 4

#### Emergency Treatment for the Woman

#### Specific objective

To provide the participants with the opportunity to practice the details on emergency treatment identified during Quick Check and RAM.

#### Methodology

Lecture-discussion	30 min
Demonstration/Return Demo	1 hr/1 hr & 30 min

#### Materials needed

Arm Model, IV Butterfly/Cannula, Chicken Breast, drugs, and supplies



With eclampsia and pre-eclampsia – instruct the participants to give magnesium sulphate, diazepam (if  $MgSO_4$  is not available), appropriate antihypertensive drug, appropriate IV/IM antibiotics, arthemeter or quinine IM (for malaria, and glucose IV);

- ▶ During the Reinforcement Activity: Supported with actual samples, familiarize the participants with the different drugs. To check their comprehension, ask participants to identify active drugs;
- ▶ Let the participants do the Exercise on Correct Amputation and Regulation of Fluid; and
- ▶ Synthesize the contents of the session.

*Refer to pages 99-102 of the Trainer's Notes*

## Procedure

- ▶ Start the session by asking participants to share their experiences in the work place. Then link these experiences with the objectives and mechanics of the session;
- ▶ For the Lecture-Discussion, discuss the following:
  - anatomy of female genital tract including;
  - degrees of laceration; and
  - anatomy of the arm.
- ▶ In the Demonstration/Return Demonstration Activity: With bleeding – instruct the participants to demonstrate the management of emergency treatment for the woman (massage uterus and expel clots, apply bimanual uterine compression, apply aortic compression, give oxytocin, give ergometrine, remove placenta and fragments manually, after manual removal of the placenta, repair the tear and empty bladder).

# Module 4

## Antenatal Care

### Objective

To enhance the knowledge, attitudes and practices of skilled health attendants on quality antenatal care.

### Topics

- ▶ Process flow of antenatal care;
- ▶ Skills necessary during antenatal care;
- ▶ Importance of General Assessment of a Pregnant Woman during a Visit

### Duration

1 hour and 15 minutes

#### Session 1

General Assessment of a Pregnant Woman During a Visit

At the end of the session, the participants should be able to understand the importance of doing an immediate general assessment of the pregnant woman upon consultation at the facility.

#### Methodology

Drawing	15 min
Plenary	30 min
Lecturette	30 min

#### Materials needed

Quick Check and RAM Chart, manila paper, pentel pen, masking tape, crayola, board, LCD and handouts.

#### Procedure

- ▶ Recapitulate the previous session and link the contents to the next topic's objective;
- ▶ Introduce the Game Activity: Tell the participants that they will be grouped into 3-5 members where each group represents their areas or health facility. The groups are given manila paper where they will make a symbolic drawing of the new lesson;

- ▶ After 15 minutes, ask them to post their outputs on the board. A member of each group will explain their work in relation to the new lesson during the plenary; and
- ▶ For the lecturette: Give additional inputs that were not discussed during the plenary presentations. Then synthesize the session emphasizing the salient aspects of the topic.

*Refer to pages 103-104 of the Trainer's Notes*

## Session 2

### Process Flow of Antenatal Care

#### Specific objective

At the end of the session, the participants should be able to improve their ability in explaining the process flow of providing quality antenatal care.

#### Methodology

Lecturette-discussion	20 min
Reinforcement	25 min
Role Play	20 min
Workshop	15 min/1 hr 20 min

#### Materials needed

35 metacards (pink, yellow & green), printed handouts, 25 pcs. manila papers, pentel pen, masking tape/paste, board, assorted art papers, 2 scenarios, observation tool, OHP/LCD, Quick Check and RAM Chart, case studies,

#### Procedure

- ▶ Recapitulate the previous session with the use of metacards to check on the participants' comprehension of Process Flow (e.g. emergency signs encountered during visit; assessment of a pregnant woman, pregnancy status, birth and emergency plan; screening the pregnant woman/ checking and proper management of condition; and response to observed or volunteered problems).
- ▶ Ask them to comment on the process of: a) elaboration, and b) classification. The posted metacards represent the phases to be followed in the discussion of the antenatal care (e.g. B1 – Quick Check and RAM; B8 – Emergency Treatment for the Woman; and C0-C1 – Antenatal Care). After everything has been explained, let a participant make a brief summary of the activity;
- ▶ Proceed to the Reinforcement Activity for Quick Check and RAM and Emergency Signs Encounter during Antenatal Care: Review first the conditions relevant to antenatal care. Then divide the participants into 3 groups and assign each to work on a specific topic:
  - Airway and breathing (e.g. circulation/ shock and convulsions/ unconscious);
  - Vaginal bleeding (bleeding in early pregnancy, severe abdominal pain, not in labor);
  - Dangerous fever (other danger signs).
- ▶ Provide the groups with the printed information on the metacards – emergency signs (white), measure (blue), and treatment (pink). Let participants work for 15 minutes. Instruct them to arrange the information materials accordingly (for example: Emergency sign – what signs, what will be done to measure it, how to manage it) and paste the outputs in the manila paper. The assigned leader of each group will

### Case Study 3 Antenatal Care

Ita is on her 6th month of pregnancy. She feels warm and unwell. Her sister-in-law accompanies her to the clinic. What would you do?

#### *Additional Data during Quick Check*

You elicit the information that Ita has burning urination and is febrile. Ita also looks very ill. What will you do next?

#### *During RAM*

Ita's blood pressure is 110/70 and her temperature is 38.6°C. She is ambulatory. No other signs were noted. How will you manage her?

explain their output. Ask other groups to observe and comment on the presentation.

- ▶ Congratulate the participants for their work. Then summarize the topics discussed by highlighting the salient features. Provide the participants with reading assignments for the next topic.
- ▶ Introduce the Role Play Activity on the topic “Assessment of a Pregnant Woman, Pregnancy Status, Birth and Emergency Plan”. Tell the participants that they will be divided into 3 groups. The 2 groups will work on a scenario while the third group acts as observers. The observers will give their comments on: good points; what have been missed; and areas for improvement.
- ▶ Lead the discussion to the expected outputs of the presentations. After the presentation, ask a volunteer to sum up the activity. Provide a synthesis of the topic discussed.
- ▶ Proceed to the Workshop on Development of a Birth and Emergency Plan. Instruct the participants that same groups will work together to come up with a birth and emergency plan. Each group will present their outputs written in

a manila paper. After the presentations, summarize the outputs and link them with the next topic for discussion.

- ▶ Facilitate the next topic, “Screening the Pregnant Woman”, a Lecture-Discussion. Ask the participants to share their own experiences, and then answer/clarify questions. Request a participant to summarize. Provide a synthesis of the discussions and then proceed to the next topic.
- ▶ Explain that Lecture-Discussion and Reinforcement Activities will be employed in the topic, “Response to Observed Signs or Volunteered Problems”. Begin the discussion by using the

### Case Study 4 Antenatal Care

#### *Problem*

Effie finds the antenatal clinic for the first time on her seventh month of pregnancy. She looks thin and pale. Explain the care you would give.

#### *Additional Data during Quick Check*

No emergency or priority signs are revealed so Effie is asked to wait in line. Her blood pressure is 100/80 and her temperature is 36.7°C. What will you do next?

#### *Data Obtained during Antenatal Care*

Effie is 29 years old. She has 6 previous pregnancies, including one miscarriage and one stillbirth. One pregnancy was also complicated by postpartum hemorrhage and a manual removal of the placenta. Where will you recommend the delivery of the present pregnancy?

On further check, Effie is noted to have conjunctival pallor and her hemoglobin is 70 g/l. How will you manage her?

Tactful questioning on HIV status reveals that Effie has recently been tested positive for HIV, following a positive test result for her husband.

What will you do next?

Quick Check and RAM. After this, instruct the participants to work in pairs in doing a case study. Let them write their outputs in the manila paper and explain them during the plenary presentation. Other participants will observe and comment on the presentation. End the discussion by providing a synthesis.

- ▶ Proceed with the last topic in this session, “Preventive Measures” by explaining the objectives and mechanics of the Lecture-Discussion and Reinforcement Activities. Discuss the topic focusing on how to:
  - give preventive measures;
  - advise and counsel on nutrition and self-care;
  - advise on labor and danger signs; conduct routine and follow-up visits
  - do newborn screening; and
  - undergo home delivery without a skilled attendant.
- ▶ In the Reinforcement Activity, divide participants into 5 groups where each group will employ a methodology, e.g. role-play, simulation, demonstration, lecturette, etc. Instruct them to demonstrate their understanding of the topic with the use of a selected methodology. Each group will be given 10 minutes for preparation and 15 minutes for presentation. Ask other groups to observe and comment on the presentation. Summarize the outputs.
- ▶ End the session by synthesizing major learnings from the different topics discussed, gaps in the discussion and areas for improvement.

*Refer to pages 103-104 of the Trainer’s Notes*

### Case Study 5 Antenatal Care

#### *Problem*

Yani is 15 years old. She goes to the health facility for the first time with her mother on her 3rd month of pregnant complaining of fresh vaginal bleeding. What will you do next?

#### *Additional Data during Quick Check and RAM*

The only abnormality found is light vaginal bleeding with no clots. After 6 hours, the bleeding decreases and Yani’s vital signs are stable. How will you manage her?

## Session 3

Skills Necessary during Antenatal Care

### Specific objective

To enable learners to perform the procedures and skills correctly and easily.

### Methodology

Lecture-discussion	10 min
Demonstration/Return Demo	20 min/30 min

### Materials needed

LCD

### Procedure

- ▶ Recapitulate the previous topic and link it with the next topic. After explaining the objectives of the session, proceed with the Lecture-Discussion on “Complete PE of a Pregnant Woman, Leopold’s Maneuver & Fetal Heart Beat;
- ▶ Summarize the discussion and proceed to the

Demonstration/Return Demonstration Activity.  
Let the participants work in pairs wherein each skill is performed by one learner to his/her partner, and afterwards, exchange roles.

- ▶ Once the skills have been performed, randomly ask the participants about their experiences while performing the skills and following the procedure.
- ▶ The session ends with a synthesis.

#### Case Study 6 Antenatal care

Teresa is 23 years old, G 2 P1 on her 8 month age of gestation, with companion. She had an adequate prenatal check up (all normal). Had a traumatic experience during her last delivery, doesn't want to deliver in a hospital. However, she is new in the area, doesn't know any skilled attendant, wants a home delivery or a birthing home. What is your advise?

#### Case Study 7 Antenatal Care

Martha is 38 years old G8 P7, went to visit the facility because of dizziness and severe anemia. All her deliveries according to her, were all normal and at home. Upon examination: BP 160/90, with blurring of vision, with her condition she is still insisting to have a home delivery (all her deliveries were handled by a Hilot). What is your advise for a birth or emergency plan?



# Module 5

## Labor, Delivery and Immediate PostPartum

### Objective

To improve participants' skills in assessing and managing a woman in labor, during and after delivery, and until her discharge from the health facility.

### Topics

- ▶ Stages of labor
- ▶ First stage of labor
- ▶ Second stage of labor
- ▶ Third stage of labor

### Duration

5 hours and 20 minutes

### Session 1

Stages of Labor

### Specific objective

At the end of the session, the participants should be able to:

- ▶ recognize and assess the woman's and fetal status at the time of admission; and
- ▶ decide stage of labor after complete rapid assessment on admission.



## Methodology

Lecture-Discussion 30 min

## Materials needed

LCD/OHP, CD/transparencies of presentation materials, white board marker, board, slides presentation and PCPNC Guide

## Procedure

- ▶ Present the objectives of the session and link it with Module 4.
- ▶ Proceed with the Lecture-Discussion on the topics “Examine the Woman in Labor or with Ruptured Membranes and Decide the Stage of Labor”. This is an interactive discussion where participants are enjoined to ask questions or clarify gray areas, while randomly asking participants with questions to check their comprehension.
- ▶ The session ends with a summary of the discussions.

*Refer to pages 105-107 of the Trainer’s Notes*

## Session 2

First Stage of Labor

## Specific objective

At the end of the session, the participants should be able to:

- ▶ identify abnormal findings in a woman while assessing pregnancy and fetal status on admission;
- ▶ manage identified abnormal findings in a woman during labor;

- ▶ provide supportive care for a woman in labor; and
- ▶ review and develop skills needed while attending to a woman in labor.

## Methodology

Pre-Test/Game	15 min
Lecture	30 min
Case Study	30 min
Small Group Discussion	30 min
Plenary	10 min/1 hr & 55 min

## Materials needed

QC and RAM Chart, 4 big cards with letters A-D, prize, OHP/LCD, N4-N5 of PCPNC, 2 case studies, Partograph and Labor, record acetate (4 sets), manila paper, pentel pens, masking tape and board

## Procedure

- ▶ Introduce the new topic with the use of Quick Check and RAM Chart.
- ▶ In the Pre-Test/Game Activity on the topic “First Stage of Labor – Respond to Obstetrical Care and Provide Supportive Care, tell participants that they will be divided into 4 groups. Each group is given 4 big letter cards A-D. Once the groups have been provided their cards, give a situation and mention 4 choices (A-D) wherein one of these is the best course of action to take. The groups will raise the corresponding letter they think is the correct answer. The fastest group with the correct answer wins a point, and the group with the most number of points wins the game.

## Pre-Test Game

### Topics from:

- ▶ 1st Stage of Labor
- ▶ Respond to OB problems
- ▶ IE, Partograph and Labor Records

### Q1. Classification of > 4 cm cervical dilatation late active phase

- a. early active phase\*
- b. early labor
- c. not yet in labor

### Q2. If a woman is not in active labor, discharge her and advise her to return if, EXCEPT:

- a. vaginal bleeding
- b. discomfort\*
- c. membranes rupture
- d. uterine contraction

### Q3. Signs of obstructive labor, EXCEPT:

- a. horizontal ridge across lower abdomen
- b. continuous contraction
- c. moderate abdominal pain\*
- d. labor > 24 hours

### Q4. Considered as obstetrical complication, EXCEPT:

- a. abdominal pain\*
- b. FHT = 100x2 determinations
- c. Pulsation felt during IE
- d. 2 fetal heart tones

### Q5. All are correct regarding supportive care throughout labor, EXCEPT:

- a. tell the woman what position to take to relieve discomfort or pain during labor\*
- b. a birth companion should be around to watch the woman in labor\*
- c. encourage the woman to eat and drink as she wishes throughout the labor
- e. explain all procedures to be done to the woman

### Q6. During active labor

- a. monitor the woman every 30 minutes
- b. do not do vaginal exam more frequently than every 4 hours unless indicated
- c. both a and b\*
- d. none of the above

- ▶ Proceed with the topics on “IE, Partograph and Labor Record” employing lecture-discussion, small group discussion and plenary presentations. In the Lecture-Discussion Activity, introduce the procedures and forms. While explaining the procedure on Leopold’s Maneuver, demonstrate it to one of the participants. Questions and clarification are elicited during the demonstration, afterwards, proceed to the discussion of a Partograph and Labor Record.
- ▶ For the Small Group Discussion, divide participants into 4 groups, where 2 groups work separately on one case and the other 2 groups work on the other case. Instruct the groups to analyze the cases relating them with the topics being discussed in 30 minutes.
- ▶ In the Plenary, the leader of each group will present the outputs, while other groups observe and give comments on the presentation. Ask one of the learners to summarize the discussion.
- ▶ End the session by providing additional inputs and synthesizing the different topics covered.



*Refer to pages 108-109 of the Trainer's Notes*

### **Session 3**

Second Stage of Labor

#### **Specific objective**

At the end of the session the participants should be able to:

- ▶ describe the course and conduct of normal delivery; and
- ▶ review and describe steps in the management of breech delivery, stuck shoulder, multiple fetuses and cord prolapse.

#### **Methodology**

Lecture-Discussion

20 min

Lecture-Demonstration 30 min/50 min

#### **Materials needed**

OHP/LCD, AVP

#### **Procedure**

- ▶ Explain the objectives of the session and link it with the previous topic by recapitulating the contents of the discussion;
- ▶ For the Lecture-Discussion on “Delivery of the Baby”, discuss the topic using illustrations from audio-visual production. This is an interactive discussion where questions and sharing of own experiences are encouraged from participants. Summarize the discussion and explain that Immediate Care of Newborn will be discussed in Module 7.
- ▶ Proceed with the Lecture-Demonstration on normal vaginal delivery, breech delivery, stuck shoulder, dystocia, multiple births and cord prolapse by first introducing the important skills needed. Explain the principles while demonstrating the procedure. This is an interactive activity where sharing of own experiences and questions are encouraged from the participants.
- ▶ The session ends with synthesis and explanation that skill enhancement will be done during the clinical period.

*Refer to pages 110-115 of the Trainer's Notes*

### **Session 4**

Third Stage of Labor

#### **Specific objective**

At the end of the session, the participants should be able to:

- ▶ describe steps in the delivery of placenta;
- ▶ determine active management of the 3rd stage of labor;
- ▶ assess and manage the mother during and after the 1st hour of complete delivery of the placenta until discharge from the health facility;
- ▶ identify and manage problems encountered in the mother immediately postpartum; and
- ▶ provide preventive measures to the mother after delivery.

## Methodology

Lecture-Discussion	30 min
Lecture-Demonstration	30 min
Case Study	30 min
Plenary	20 min
Didactic with Illustrations	15 min/2 hrs & 5 min

## Materials needed:

AVP, LCD/OHP, 2 case studies, manila papers, pentel pens, masking tape and board

## Procedure:

- ▶ Recapitulate the previous session, explain the objectives of the new session and link it with past topics;
- ▶ For the Lecture-Discussion on the “Delivery of the Placenta”, discuss the topic with the use of visuals. Tell participants to share their own experiences and ask questions to enrich the discussion. Ask one of the participants to summarize the discussion;
- ▶ Proceed to the next topics:
  - Care of the mother and newborn within first

- hour of placenta delivery;
- Care of the mother 1 hour after delivery of placenta; and
- Assessment of the mother after delivery and before discharge through Lecture-Discussion.
- Discuss the topic with the aid of illustrations, and sharing of experiences from the participants.
- Ask one of the participants to summarize the discussion;
- ▶ Continue with the next topic, “Respond to Problems Immediately Postpartum.” Using the case study method, the participants are divided into 4 groups where 2 groups work separately on 1 case study, and the other 2 groups work separately on another case. Let the groups work for 30 minutes and ask them to put their outputs in the manila paper;
- ▶ During the Plenary, tell the first 2 groups with the same case to present their outputs. Ask the other groups to observe and give comments. After the presentations, ask the next 2 groups to present their case study outputs. The other groups observe and give comments. Summarize the outputs of the 4 groups;
- ▶ Proceed with the last activity, Didactic Illustrations on:
  - management of abnormal stage of labor; and
  - active management of 3rd stage of labor.
- ▶ The discussion of the topic starts with an explanation of the important skills needed by the participants. Explain the principles while demonstrating the procedure. This is an interactive activity where sharing of own experiences and questions are encouraged from participants.



- ▶ During the summary, mention that skill enhancement will be done during the clinical period and the abnormal 3rd stage of labor will be discussed in emergency measures.
- ▶ The session ends with the synthesis of all the topics covered.

*Refer to pages 116-119 of the Trainer's Notes*

### Case Study 8 (Groups 2 and 4)

Christine M. 18 years old G2 P1 came in because of lumbo-sacral and abdominal pain which started 1 hour ago. No other associated signs and symptoms.

During ASK, CHECK RECORD, it was found out that Christine is single, no prenatal check-up done because she claimed her baby is moving throughout the pregnancy. She expects to deliver anytime this week.

You now perform the physical examination. Vital signs are normal including fetal heart rate. The abdomen is term size, uterine contraction is mild, 1-2x/10 min. You now perform vaginal examination which revealed: cervix 1 cm dilated, not effaced, no vaginal bleeding nor watery discharge. So you sent her home since she is living 5 minutes away. However, 8 hours later, she returned to your clinic with bloody-mucoid vaginal discharge, mild to moderate uterine contractions 2x/10 min., IE - cervix 4 cm dilated, cephalic, station -2, (+) BOW. You monitored her every hour.

4 hours later, IE - cx 7-8 cm, BOW spontaneously ruptured, thin-meconiumstained AF. She voided urine = 120 cc, uterine contraction 2-3x/10 mins. mod-strong.

2 hours later, IE - 9 cm, st +1, vital signs still normal.

30 minutes later, you noticed that the vulva was gaping, you did an IE - fully dilated, station +2 to +3.

### **Case Study 9** (Groups 1 and 3)

Cheska O. 32y/o G3 P2 came to the health facility at 3:00 AM, few minutes apart, she told you that uterine contractions occurred 2x in 10 minutes, 40-60 sec. Duration, moderate strong. On PE, vital signs were all normal, she claimed that she has not voided urine for 6 hours now, no urge to void till now.

IE -4 cm cervical dilatation, cephalic, BOW (-) with clear amniotic fluid admixed with scanty bloody-mucoid material. Still unable to void, you did bladder catheterization obtaining 200 cc.

At 7:00 AM, IE - cervix was 8-9 cm dilate, station 0, clear AF, FHR - 156 / min. BP - 140/100, uterine contraction now strong, 3x in 10 min. Patient voluntarily voided amounting to 130 cc, vital signs remains within normal limits, BP now = 130/80.

At 8:00 AM, patient complained that something was about to come of her vagina. IE revealed that full cervical dilatation, fully effaced, cephalic, station +2, clear AF.

#### **Materials to use**

1) Labor Record 2) Partograph.

# Module 6 Postpartum Care

## Objective

To enhance participants' capability in recognizing and responding to observed signs or volunteered problems of mothers so they can provide preventive measures and additional treatment.

## Topics

- ▶ Postpartum examination of the mother up to six weeks;
- ▶ Respond to observed signs or volunteered problems; and
- ▶ Preventive measure and additional treatment

## Duration

1 hour and 10 minutes

### Session 1

PostPartum Examination of the Mother Up to Six Weeks

### Specific objective

At the end of the session, the participants should be able to:

- ▶ assess and examine the mother after discharge from the facility; and
- ▶ conduct complete history and physical examination of a mother after discharge from a facility.

### Methodology

Lecture-Discussion 15 min

### Materials needed

Examination Chart for mothers after discharge and powerpoint presentation/transparencies

### Procedure

- ▶ Recapitulate the previous session, link it to the next topic by explaining the objectives of the new session;
- ▶ During the Lecture-Discussion, present the first side of the chart (Ask, Check Record, Look, Listen, Feel) to be used for examining the

mother after discharge from a facility or after a home delivery. This is an interactive discussion where participants share actual experiences and relate these with the session's topic; and

- ▶ End the session by providing synthesis of the topic discussed.

*Refer to pages 120-121 of the Trainer's Notes*

## Session 2

Respond to Observed Signs or Volunteered Problems

### Specific objective

At the end of the session, the participants should be able to:

- ▶ differentiate abnormal from normal signs and manage appropriately and accordingly; and
- ▶ recognize volunteered problems of a woman after discharge from a facility and to properly manage them accordingly.

### Methodology

Lecture-Discussion	10 min
Workshop/Pyramiding	30 min
Critiquing/Plenary	30 min

### Materials needed

Handouts/PCPNC Manual, OHP/LCD, Chart, paper, pencil, manila paper, pentel pen and masking tape

## Procedure

- ▶ Recapitulate the previous session, link it with the new topic by discussing the session's objectives;
- ▶ During the Lecture-Discussion on Observed Signs or Volunteered Problems, explain the Ask, Check Record/Look, Listen, Feel part of the chart. Encourage participants to ask questions or clarify gray areas in the discussion;
  - In the Workshop Activity, divide participants into 4 and let the groups analyze the problems, and based on their experiences answer the following:
    - what problematic signs will they observe on postpartum mothers;
    - how do they classify the problematic signs observed;
    - what treatment do they give and the possible advise regarding the problematic signs.
- ▶ Provide participants with the format in preparing their responses (Chart). After 30 minutes, let each group present outputs, while other groups provide comments or additional inputs;
- ▶ Ensure that the discussion results to the expected output from the manual for faster Teaching-Learning process. Ask participants about their reasons for the responses given, and after the discussion summarize the important points covered in the session;
- ▶ For the postpartum sessions, synthesize pregnancy from antenatal to postpartum care through simulation or role play by the participants.

*Refer to page 121 of the Trainer's Notes*

#### Observed Signs or Volunteered Problems

- ▶ If Elevated Diastolic Blood Pressure
- ▶ If Pallor (Check for Anaemia)
- ▶ If Signs Suggesting HIV
- ▶ If Heavy Vaginal Bleeding
- ▶ If Fever or Foul-Smelling Lochia
- ▶ If Dribbling Urine
- ▶ If Pus or Perineal Pain
- ▶ If Feeling Unhappy or Crying Easily
- ▶ If Vaginal Discharge 4 Weeks After Delivery
- ▶ If Breast Problem
- ▶ If Cough or Breathing Problem
- ▶ If Taking Anti-TB Drug

#### Procedure

- ▶ Recapitulate the previous session, link it with the new topic by discussing the session's objectives;
- ▶ During the Lecture-Discussion, explain the preventive measures that need to be considered for the women. This is an interactive discussion encouraging sharing of own experiences and clarification of important points.
- ▶ At the end of the discussion, ask one of the participants to summarize the discussion.
- ▶ End the session with a synthesis of the topic covered in the discussion.

*Refer to pages 121-122 of the Trainer's Notes*

### Session 3

#### Preventive Measures and Additional Treatments

#### Specific objective

To enable participants to provide preventive measures and additional treatments to a woman after discharge from a facility including immunization, vitamin K, folic acid, ebendazole, antimalarial treatment, etc.

#### Methodology

Lecture-Discussion                      15 min

#### Materials needed

OHP/LCD, handouts and PCPNC Manual

# Module 7 Newborn Care

## Objective

To enable health workers care for the newborn baby by developing the appropriate skills and needed knowledge.

## Topics

- ▶ Care of the newborn at the time of birth;
- ▶ Newborn resuscitation;
- ▶ Examination of the newborn baby; and
- ▶ Care of the normal and small babies until discharge from the health facility.

## Duration

6 hours and 40 minutes

### Session 1

Care of the Newborn at the Time of Birth

#### Specific objective

At the end of the session, the participants should be able to describe and carry out routine care of the newborn at the time of birth.

#### Methodology

Interactive Discussion  
Demonstration

50 min  
10 min/1 hour

#### Materials needed

board and chalk/white board and pen, LCD and computer/OHP, undressed doll, and bed

#### Procedure:

- ▶ Recapitulate the previous session, link it with the new topic by discussing the session's objectives;
- ▶ Lead an interactive discussion on the following topics:
  - basic needs of the newborn
  - preparing to meet the baby's needs
  - universal precautions
  - initial care of the baby at birth
  - keeping the baby warm
  - cord care



- eye care
  - Vitamin K injection
  - keeping the mother and baby together after delivery
  - baby's first breast feed.
- ▶ With the undressed doll on the table, ask participants about the basic needs of the newborn at the time of birth. Accept all the responses and show the appropriate card on the table as each of the 4 main points are mentioned. Then ask participants what they should do to prepare for and what to do during the delivery of the baby and why. The responses of the participants are written on the board, after which, the trainer compares their responses with the recommendations in the manual.
- ▶ The session ends with a synthesis.

*Refer to pages 123-135 of the Trainer's Notes*

## Session 2

### Newborn Resuscitation

#### Specific objective

At the end of the session, the participants should be able to:

- ▶ assess and identify newborns needing resuscitation;
- ▶ perform resuscitation of the newborn using standard guidelines; and
- ▶ provide after care if a baby requires help with breathing.

#### Methodology

Lecture-Discussion	1 hour
Lecture-Demonstration	1 hour/2hours

#### Materials needed

OHP/LCD and computer, PCPNC Manual/ Handout, Maniquin, self-inflating bag, mask size 0 & 1, suction tube/suction device, 2 towels and clock

#### Procedure

- ▶ Recapitulate the previous session, link it with the new topic by discussing the session's objectives;
- ▶ During the Lecture-Discussion on "Preparing for Birth and Essential Items for Resuscitation of the Newborn", discuss things to be considered in preparing for birth and explain the necessity of the items needed in resuscitation of newborn. Ask participants relevant questions to check their comprehension of the topic and summarize the discussion once finished;



- ▶ For the Lecture-Demonstration on “Steps in Resuscitation and Care After Resuscitation”, demonstrate the steps and ask learners whether they comprehend the discussion. Summarize the topic and link it with the next activity.
- ▶ Proceed with the Workshop Activity: Tell participants that they will be divided into 4 groups. Each group will be given the same scenario to enhance decision-making skills on when to start, continue or stop resuscitation. Instruct participants to demonstrate the proper techniques in resuscitation using the appropriate equipment to be assisted by facilitators. During group presentation, the other groups observe, give comments and provide additional inputs to the presentation.
- ▶ The session ends by asking participants if they have questions, and provide synthesis to all the topics discussed.

*Refer to pages 135-155 of the Trainer’s Notes*

## **Session 3**

### Examination of the Newborn Baby

#### **Specific objective**

At the end of the session, the participants should be able to:

- ▶ describe and carry out an examination of the baby soon after birth, before discharge from the hospital, during the first week of life at routine, follow-up and sick newborn visit; and
- ▶ assess, classify and treat a newborn using the Examine the Newborn chart.

#### **Methodology**

Lecture-Discussion	30 min
Workshop	15 min
Plenary	15 min/1 hr

#### **Materials needed**

LCD and computer, 3 case studies, manila paper, pentel pens and masking tape and powerpoint presentation/transparencies

#### **Procedure**

- ▶ Recapitulate the previous session, link it with the new topic by discussing the session’s objectives;
- ▶ In the Lecture-Discussion on “Examination of the Newborn”, discuss the chart, give ideas on what questions to ask the mother regarding her baby and explain how to examine the baby and what things should be observed on the baby until discharge. Ask participants questions during the discussion to determine comprehension, summarize the topic and link it with the

next activity.

- ▶ For the Workshop Activity, group participants into 3 where each group is given a case to work on. Using the chart, the groups will classify the baby's condition and give the appropriate treatment and advise. After 15 minutes, ask the groups to post their outputs on the board.
- ▶ During the Plenary, ask the leader of each group to present their outputs while other groups act as observers and give comments or additional inputs on the presentation. Ask for a volunteer to summarize the discussions.
- ▶ The session ends with a short input and synthesis of the discussion.

*Refer to page 156 of the Trainer's Notes*

### **Case Study 10**

Rosie is a preterm baby who was delivered an hour ago at about 35-week gestation weighing 1800g. At birth she started breathing spontaneously. She has not suckled at the breast, although her mother tried to feed her about half an hour ago.

The health worker assesses Rosie at one hour of life. She checks the maternal record to determine if Rosie needs any special treatment and finds that the mother did not have any problems or illnesses during pregnancy. Her membranes ruptured 1 hour before delivery. She also asks the mother if she has any concerns.

She learns that the mother is anxious because Rosie does not want to suck. On examination, she finds that Rosie's temperature is 36°C. No abnormal findings noted.

**Q: Based on these findings, how do you classify Rosie and how will you proceed?**  
After 1 hour Rosie's temperature is 36.8°C. Her mother

was able to feed Rosie breast milk which was dripped into her mouth as she only made a feeble attempt to suckle the breast. After short periods of suckling at the breast, breast milk is expressed into Rosie's mouth to ensure that she has an adequate intake of milk.

Although Rosie's mother is healthy and could go home, she arranges with her family to take care of the other children so that she can stay with Rosie in the hospital. Breastfeeding gradually improves during the next 2 to 3 days and special support is given. The mother is encouraged to breastfeed exclusively. Rosie is fed two times hourly and by the 3rd day of life, she no longer requires additional breast milk expressed into her mouth. Rosie is weighed daily and loses 10% of her birthweight (180 g) in the 1st three days of her life. On the 4th day her weight is static and thereafter she starts to gain weight daily.

**Q: How do you know if the baby is gaining weight?**

**Q: When should Rosie receive vaccinations? What vaccinations should be given?**

Rosie is ready for discharge on the 7th day after birth. She is now breastfeeding exclusively and has gained weight and now weighs 1700 g. Health worker carries out pre-discharge examination again. Rosie is examined for local infection and jaundice. There is no jaundice nor other complications.

**Q: How will you classify Rosie at this point?**

**What will be the criteria for discharge?**

**Q: How would you follow up this baby after discharge?**

### Case Study 11

Joe was born 6 hours ago by vacuum extraction for fetal distress. His weight is 2500 g. He required resuscitation at birth but started to breathe spontaneously after 4 minutes. At 1 hour of life he made feeble attempt to suckle at the breast but has had breast milk expressed into his mouth on two occasions. Now the mother is calling the health worker urgently because Joe is having convulsion. The health worker goes to the mother immediately but by the time she gets there Joe has stopped convulsing but looks very pale. On examination, it was found that Joe is not able to feed; he is cyanosed around his mouth, looks very pale and feels stiff.

### Case Study 12

Daisy is brought to the health facility by her mother and grandmother when she was 4 days old because she will not feed and is very fretful. She had a normal birth at term, breathed immediately and weighed 2700g. On discharge from the health facility 12 hours after birth she was a well baby and breastfeeding well. The mother has had 2 previous live children, but her second baby was about 4 weeks preterm and died at home at the age of 3 weeks. The only record for cause of death is failure to thrive.

The health worker checks the records and finds it unremarkable. Upon query, it was found out that Daisy has been fretful and not feeding well for the last 2 days. Daisy was breastfeeding 6 times a day and to try to settle her, she has been given mashed banana and pacifier when she cries. She has lost 300g since discharge from the health facility 3 days ago. The umbilicus and surrounding skin are red. The mother denies having put any substances on the umbilicus.

Hygiene is poor and Daisy has erythematous papular rashes on her buttocks.

Q: What are the medical problems can you identify using the flow chart? What should be done?

## Session 4

Care of the Normal and Small Babies Until Discharge from the Health Facility

### Specific objective

At the end of the session, the participants should be able to describe and carry out the everyday care of the baby.

### Methodology

Interactive Discussion	20 min
Lecture-Demonstration	40 min/1 hour

### Materials needed

board, chalk, whiteboard pen, PCPNC Manual, LCD and computer, and powerpoint presentation

### Procedure

- ▶ Recapitulate the previous session, link it with the new topic by discussing the session's objectives;
- ▶ During the Interactive Discussion, tell participants to write important points in the board based on the following questions:
  - how long do mothers and babies stay in the health facility;
  - what reasons may delay a baby from being

- discharged from the health facility; and
- when is the best time to teach the mother how to take care of her baby.
- ▶ Enumerate the responses, provide additional inputs, sum up the discussion and link it with the next activity; and
- ▶ For the Lecture-demonstration, introduce the activity by asking participants what they need to teach the mother how to take care of her baby. Proceed to discuss and demonstrate cord care, hygiene, eye care, and keeping the baby warm.
- ▶ End the session with a synthesis of all the topics covered.

*Refer to pages 156-159 of the Trainer's Notes*



# Module 8 Counseling

## Objective

To enable health workers to develop counseling skills to communicate effectively with women, their partners and families on the essential routine and emergency care of women and new-born during pregnancy, childbirth, postpartum and post-abortion periods.

## Topics

- ▶ Basic facts about counseling; and
- ▶ Applying the counseling skills.

## Duration

2 hours and 30 minutes

### Session 1

Basic Facts about Counseling

#### Specific objective

At the end of the session, the participants should be able to:

- ▶ Define counseling and interpersonal communication; and
- ▶ Discuss principles of counseling and interpersonal communication.

#### Methodology

Interactive Discussion 40 min

#### Materials needed

OHP/LCD and computer, metacards, pentel pens, masking tape, board, powerpoint presentation/transparencies

#### Procedure

- ▶ Recapitulate the previous session, link it with the new topic by discussing the session's objectives;
- ▶ During the Interactive Discussion Activity, provide participants with metacards and ask them to write all the things they know about counseling based on the guide questions. Participants will be made to work on their responses for 10 minutes, after which they will paste their cards on the board.

- ▶ After all the participants have pasted their cards, the trainer categorizes the responses according to:
  - what they know;
  - why there is a need for counseling;
  - how to counsel mothers, partners and families; and
  - characteristics of good counseling.
- ▶ End the session by providing additional inputs, synthesizing the discussion and linking it with the next topic.

*Refer to page 160 of the Trainer's Notes*

## Session 2

### Applying the Counseling Skills

#### Specific objective

At the end of the session, the participants should be able to:

- ▶ Demonstrate effective communication skills; and
- ▶ Demonstrate appropriate counseling techniques in the different maternal health situations.

#### Methodology

Lecture-Discussion	1 hr and 15 min
Role Play	40 min
Observation/Plenary	30 min
Group Work	10 min/2 hrs & 35 min

#### Materials needed

LCD and computer, slides, PCPNC Manual, observation tool, board and chalk

#### Procedure

- ▶ Recapitulate the previous session, link it with the new topic by discussing the session's objectives;
- ▶ During the Lecture-Discussion, provide inputs on the following issues:
  - HIV;
  - family planning;
  - post-abortion;
  - adolescent pregnancy; and
  - violence against women/VAW.
- ▶ Participants will be encouraged to ask questions or share own experiences with regards to the issues being discussed. Sum up the discussion and proceed to the next activity;
- ▶ Ask for a volunteer from the participants who will act as the mother or relative of the mother. Demonstrate critical skills.
- ▶ For the Role Play, instruct participants to group themselves into 4 where each group portrays a scenario or a counseling session on the following:
  - HIV;
  - woman with special needs;
  - family planning; and
  - post abortion.
- ▶ Participants will be asked to prepare for their presentation in 15 minutes and after which present a 10 minute play; and
- ▶ During the Plenary, select 4 participants to serve as observers/critique. They will look into the strong points and areas for improvement of the counseling session. After all the groups have presented, the 4 observers will present their

comments for 10 minutes while you write the important points on the board, and provide additional inputs for clarification during the discussion. A participant will be asked to summarize the outputs.

- ▶ End the session by synthesizing the discussions.

*Refer to pages 161-162 of the Trainer's Notes*

### Case study 13

**Client:**

"I am worried what my husband will say when he finds out I have lost the baby, and whether he will blame me or think I did something."

**Counselor:**

What is the worst thing that your husband can do to you?"

### Case study 14 Post Abortion and Family Planning

A 35 year old woman had recent completion curettage (cc) on her fifth pregnancy. She had an incomplete abortion 5th month of gestation. She felt guilty because her fetus happens to be a boy, for she had a daughter. However, her recent cc happens to be an emergency one. She had a blood transfusion and was advised not to get pregnant in 3 years time. Her husband is very quiet.

What will be your appropriate counseling?

### Case Study 15 HIV

A 28-year old G2 P1, 12 weeks AOG, went to your facility for the first time with her husband, an overseas worker who just arrived from Saudi Arabia.

Feeling guilty, the husband admitted to his wife that he has been diagnosed to be HIV+3 years ago while abroad. They are now very worried about the baby being infected and are thinking of terminating the pregnancy?

What will be your appropriate counseling?



# Module 9

## Mobilizing Community Support

### Objective

To enable participants establish community support mechanisms for maternal and newborn health.

### Topic

Establishing Links

### Duration

40 minutes

#### Session 1

Establishing Links

#### Methodology

Interactive Discussion  
Lecturette

30 min  
10 min

#### Specific objective

At the end of the session, the participants should be able to:

- ▶ Identify partners and members of the community who can become part of the support group; and
- ▶ Develop strategies/mechanisms to encourage active community participation in supporting maternal and newborn health.

#### Materials needed

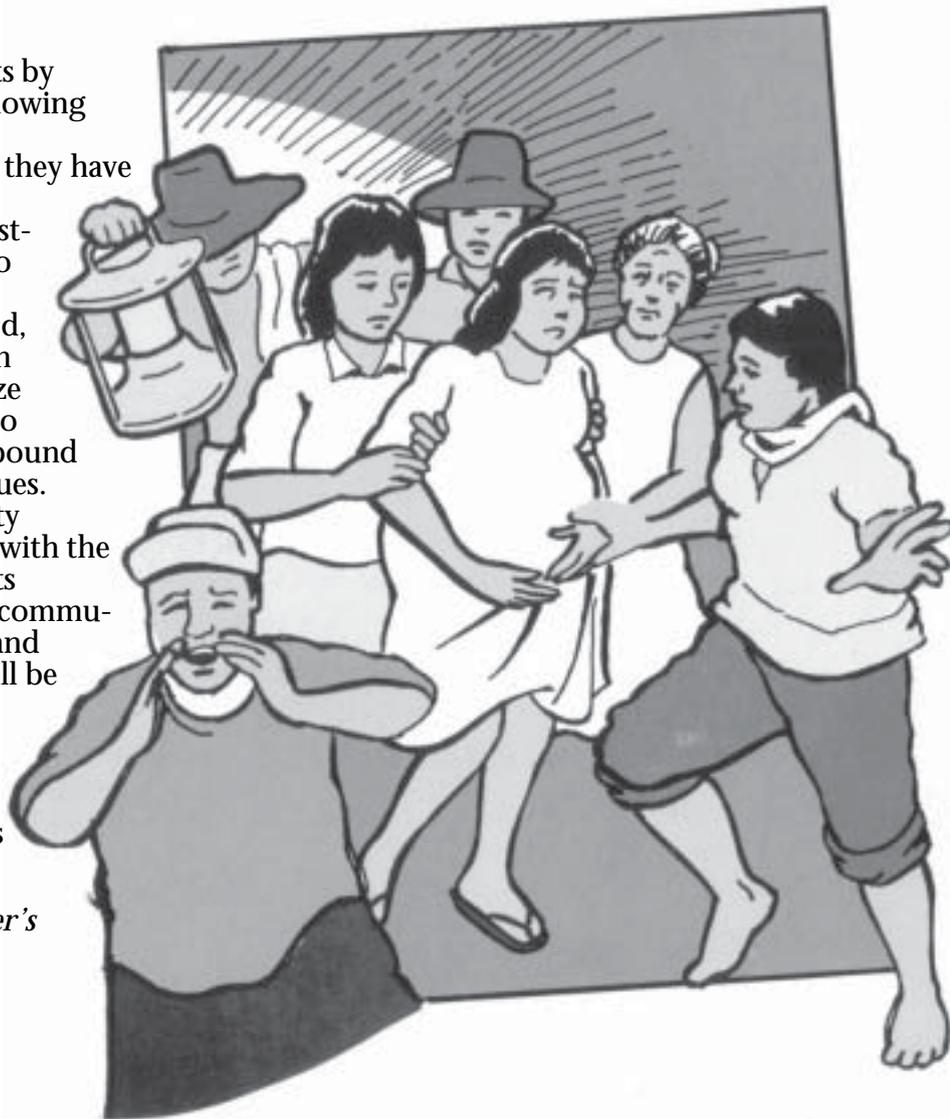
LCD and computer, powerpoint presentation, chalk and board

#### Procedure

- ▶ Recapitulate the previous session, link it with the new topic by discussing the session's objectives.

- ▶ The Interactive Discussion starts by asking participants with the following questions:
  - what groups/organizations they have in their own areas; and
  - what kind of services or assistance these groups provide to the communities.
- ▶ Write the responses on the board, and after all responses have been noted, categorize and summarize these for the learners. Proceed to provide additional inputs to expound on the discussion and clarify issues.
- ▶ In the lecturette on “Community Participation/Support”, begin with the discussion by asking participants “whether it is necessary for the community to be involved in maternal and newborn health”. Responses will be written on the board, and after which you summarize the outputs and provide additional inputs on the topic.
- ▶ End the session with a synthesis of the discussion.

*Refer to pages 163-164 of the Trainer’s Notes*



*Image from Midwives' Manual on Maternal Care, Department of Health, 2000*

# Practicum

## **Objective**

To enhance the competencies of participants in applying basic emergency obstetric care to all women and their babies.

## **Duration**

The practicum activities will be conducted in seven (7) days. This period includes on-site orientation, clinical work in the areas of assignment and mid-practicum assessment.

## **Methodology**

A mix of methods such as observation, hands-on/experiential learning and coaching will be employed during the practicum phase.



# Module 1

## Orientation on the Practicum

### Objective

To familiarize participants with the overall objectives and mechanics of the practicum phase.

### Topics

- ▶ Objectives and mechanics of the practicum
- ▶ Expected outputs from the participants
- ▶ Areas for exposure

### Duration

2 hours

### Session 1

Pre-Practicum Orientation

### Specific objective

At the end of the session, the participants will be able to understand the objectives of the practicum, methodology, schedule of activities and know the hospital heads, area facilitators and preceptors.

### Methodology

Lecturette

Interactive Discussion

30 min

1 hr & 30 min

### Materials needed

Forms, Skills requirements handouts, board and chalk/whiteboard pen

### Procedure

- ▶ Explain the objectives of the session and link it with the didactic phase;
- ▶ Divide the participants into teams of 4 (physician, nurse, midwife and MCH Coordinator as monitoring officer). Explain to the teams the objectives, methodology, schedule of activities and the personnel they will be working with at the hospital/health facility (e.g. hospital heads, area facilitators and preceptors); Discuss the areas for exposure (e.g. OPD, ER, LR, DR,

Ward and Post-discharge) and the expected outputs from the participants. Explain that they have to go on duty to see and experience the real situation, especially in handling a patient from the emergency room;

- ▶ Provide them with the forms containing the skills requirement and explain the process of filling-up and submission. Allow time for comments and questions. Encourage the participants to voice out their apprehensions or fears if there are any;
- ▶ Instruct the participants to refer to the PCPNC manual when necessary; and
- ▶ End the session by synthesizing the topics covered.



#### Practicum Requirements

- ▶ Scrub suit
- ▶ Smock gown
- ▶ Cap and masks
- ▶ Slippers
- ▶ Colored ID picture (2x2)
- ▶ Completion of requirements
- ▶ Evaluation test
- ▶ “Full attention and cooperation”

Example of Team Schedule for Area Assignments during Practicum Phase

Area	Mon (Aug 2)		Tue (Aug 3)		Wed (Aug 4)		Thu (Aug 5)	
	AM	PM	AM	PM	AM	PM	AM	PM
ER	1	2	3	4	5	6		
LR	2	3	4	5	6	1		
DR	3	4	5	6	1	2		
Ward	4	5	6	1	2	3		
OPD	5	6	1	2	3	4		
Post-discharge (2 <sup>nd</sup> F/OPD)	6	1	2	3	4	5		

Note: Sample schedule was used during the pre-test of this BEmOC Skills Training Guide on July 26-August 6, 2004.

### Skills Requirements per Category of Service Provider per Facility

Skills Requirements	No. of Requirements per Category of Service Provider Per Team		
	MD	PHN	RHM
ER			
1. IV Insertion	3	3	3
2. Skin testing	2	2	2
3. Intravenous (IV push) to include antibiotics	2	2	3
4. IM injection of Mag sulfate loading with monitoring of vital sign	1	2	1
5. Internal exam	3	5	5
DR			
6. Normal spontaneous delivery	1	3	1
7. Perineal repair	2	3	3
8. Manual extraction of placenta	3		
9. Recognition of case for assisted delivery	1	1	1
10. Removal of retained placenta	1		
11. Intramuscular injection	2		
12. Vitamin K injection	1	1	1
OPD			
13. TT Immunization	3		
14. Catherer insertion	1	1	1
15. Uterine abdominal compression	1	1	1
16. Partograph	3 (new); 2 (old)	3 (new); 2 (old)	3 (new); 2 (old)
17. Complete physical examination to include: Leopold's FHT, BP, etc.	3	3	3
PP			
18. Eye care	3	3	3
19. Cord care	3	3	3
20. Breastfeeding latching	3	3	3
OPD/ER/DR/LR			
21. Recognition of danger signs	3	3	3

#### Legend

Orange box = Participants are already competent

Green box = Not provided by law

# Module 2

## On-Site Team Activities for Clinical Skills in BEmOC

### Objective

To practice BEmOC skills learned during the didactic phase

### Topics

- ▶ Quick Check and Rapid Assessment and Management (RAM)
- ▶ Routine Care to Mothers and Newborns
- ▶ Management of Emergency during Antenatal, Labor, Delivery and PostPartum
- ▶ Accomplishment of Records and forms on PCPNC

### Duration

7 days

#### Session 1

On-site Practicum Orientation

#### Specific objective

At the end of the session, the participants will be able to execute their practicum assignments.

#### Methodology

Interactive Discussion 1 hour

Tour of the hospital/facilities 1 hour

#### Materials needed

Forms, guidelines for practitioners (from the facility where practicum will be held), rotation schedule

#### Procedure

- ▶ Tell the teams that they will proceed to the hospital/facility and pay a courtesy call to the head of the institution/agency;

- ▶ The head of the hospital/facility or any staff assigned to orient the participants will brief them on relevant matters concerning the practicum site or facility and the personnel.
- ▶ After the briefing, the participants will undergo a tour of hospital departments and facilities;
- ▶ The area facilitator assigned for each group will supervise the participants during the practice of skills learned.
- ▶ Each team will be assigned a person who will monitor and observe the practicum activities in the areas of assignment, as well as look into the administrative needs of the team;
- ▶ Tell the teams that with the briefing given they can now proceed to their area rotation/assignments.

## Session 2

Performance of Area Rotation/Assignments

### Specific objective

At the end of the session, the participants will be able to apply to:

- ▶ Apply quick check and RAM
- ▶ Perform routine care to mothers and newborns
- ▶ Manage emergency during antenatal, labor, delivery and postpartum periods
- ▶ Accomplish records and forms on PCPNC

### Methodology

Hands-on application of skills

### Materials/resources

Patients, equipment, supplies and forms

## Procedure

- ▶ The participants will perform the skills required on rotation to the areas of assignment;
- ▶ Instruct the participants to fill up the forms for the skill requirements that they need to accomplish during the practicum and submit these at the end of the period; Ask them to document their personal observations, experiences and lessons learned in their practicum journal;
- ▶ Facilitators will fill in the monitoring sheet/tool for each team assigned in their areas. They will also report during the mid-practicum assessment;
- ▶ The team observer/monitoring person will provide daily feedback to the facilitators and Training Team during the entire duration of the practicum period; and
- ▶ A mid-practicum assessment meeting will be conducted for completion of requirements, identification of issues and problems encountered, and possible solutions or adjustments that could still be done during the practicum period.

*Refer to pages 165-166 of the Trainer's Notes*



## Checklist for Facilitators during Mid-Practicum Assessment

1. **Feedback on:**
  - a. daily accomplishment
  - b. individual skills
  - c. areas for improvement
2. **Problems identified:**
  - a. area of assignment
  - b. provision of technical assistance
  - c. individual trainee
3. **Recommendations**



FACILITATORS MONITORING TOOL DURING PRACTICUM ON BE=00					
Name of Facilitator: _____					
Area Facilitator: _____					
Team Assignment: _____					
Members of the Team: _____					
_____					
_____					
Date	Area of Assignment	# of Cases Handled		Problems encountered/issue & concerns	Recommendations
	OPD/ER	MD	PHN	RNM	
	Labor Room				
	Delivery Room				
	Core Dressing Room				
	Ward				
Date: _____		Facilitator's signature _____			

## Group Checklist for Addressing Gaps during Practicum

Area	Concern/issue	Action to be Taken	Person responsible

# Monitoring, Evaluation and Action Plan

Monitoring and evaluating (M & E) training is necessary to determine the effectiveness of the course. By monitoring and evaluating the didactic and practicum activities of the participants, trainers can measure whether they are able to describe the skill, demonstrate the skills, practice the skills or verify whether the skills are being completed correctly. Evaluation can also gauge the satisfaction of the participants and provide information on how to improve the BEmOC skills training course.

Besides M & E, the preparation of an action plan is also an important component of a training course. Training can only be considered successful if the participants are able to apply their newly acquired skills and knowledge in their own work place, and eventually transfer the learnings to other health workers.

This section provides practical tips on how to monitor and evaluate before, during and after the course, including the preparation of an action plan. To contextualize the discussion, the roles and responsibilities of the BEmOC Team and the indicators for monitoring and evaluation are described.

# Roles and Responsibilities of the BEmOC Team

The BEmOC Team is composed of a physician, nurse and midwife. Their specific duties and responsibilities are as follows:

- ▶ Physician
  - Team leader
  - Perform all six (6) BEmOC functions
  - Supervisory function
  - Networking and referral
- ▶ Nurse
  - Assistant team leader
  - Does IV administration of 1-3 signal functions
  - Administrative function
  - Health education
  - Networking & referral for community & institutional support
- ▶ Midwife
  - Can do 1-3 signal functions
  - Assist in 4-6 signal functions
  - Health education
  - Prenatal & postnatal care
  - Networking & referral for community support

## Indicators for M & E

The indicators for the participant's level of competency will be measured in terms of:

- ▶ % of targeted service providers (participants/trainees) who performed appropriately 6 signal functions



- ▶ Average score is pre and post-tests in terms of KAS (TNA/competency and capability) which will be administered through the following:
  - K – written exam (case study)
  - A – self assessment; observer checklist
  - S – observer checklist

### What Can Evaluation Measure?

Evaluation can provide trainers with information about:

- ▶ Learner satisfaction: Were learners' expectations and needs met? Were learners satisfied with the performance of the trainers, the materials and the training process in general?
- ▶ The training process: Were the training activities conducted effectively and as planned?
- ▶ The results of the training: By the end of the training course, did learners experience the expected changes in their attitudes, knowledge and skills? To what extent did learners meet the training objectives?
- ▶ Transfer of the training: Are learners implementing their new attitudes, knowledge and skills after the training? What are some of the barriers that learners encounter when they try to use their new knowledge and skills? Do learners experience problems with the retention of new knowledge and skills over time?

Wegs, Cristina, et.al, (2003:73)

# Monitoring and Evaluation Processes

## Pre and Post-Tests

Before the course, the trainers should administer a pre-test to assess the participants' knowledge, attitudes and skills/competency in BEmOC. After the training, trainers should do a post-test to determine what KAS the participants have acquired or learned during the training. A sample of the pre and post-tests questionnaire which has been used during the pre-testing of this trainers' guide is shown below.



## Skills Training On BEmOC

### Pre-Test and Post-Test Questionnaire

#### I. True or False

Write letter T if the statement is true and F if the statement is false. Write your answers on the space provided.

- \_\_\_\_\_ 1. Internal examination can be done on a patient with vaginal bleeding late in pregnancy.
- \_\_\_\_\_ 2. Oral Rehydration solution is given to a patient whose blood pressure is <90/60.
- \_\_\_\_\_ 3. Pregnant patient is imminent delivery with a blood pressure of 150/100 cannot deliver in a primary health facility.
- \_\_\_\_\_ 4. Tetanus Toxoid should not be given to a pregnant woman if she has already received 3 doses during her last pregnancy 1 year ago.
- \_\_\_\_\_ 5. Oxytocin should be given after placental delivery.
- \_\_\_\_\_ 6. As a health worker, you should give antibiotics when the membranes has been ruptured for >8 hours.
- \_\_\_\_\_ 7. Blurred vision, epigastric pain and severe headache are signs of pre-eclampsia.
- \_\_\_\_\_ 8. Good counseling requires an interactive process which allows for two-way exchange of information.
- \_\_\_\_\_ 9. Counseling is the same as giving advice.
- \_\_\_\_\_ 10. Violence against women by their intimate partner affects her physical, mental, including reproductive health status.
- \_\_\_\_\_ 11. It is particularly important to give adolescents whether married or unmarried, information on birth planning prevention of STI, HIV / AIDS and FP.
- \_\_\_\_\_ 12. Bathing the newborn baby is the

most important task to do within the first 2 hours of life.

- \_\_\_\_\_ 13. A body temperature of 37 C is not a danger sign in a new born baby.
- \_\_\_\_\_ 14. A newborn baby does not require resuscitation if the baby is gasping.
- \_\_\_\_\_ 15. Small baby is synonymous with pre-term baby.

#### II. Multiple Choice

Please encircle the letter of the correct answer.

1. One of the following is NOT a major cause of maternal mortality
  - a. Abortion
  - b. Hemorrhage
  - c. Hypertension
  - d. Teenage Pregnancy
2. This skills training is intended for a health facility based providers. One of the following is not considered as a skilled attendant
  - a. Doctor
  - b. Hilot
  - c. Midwife
  - d. Nurse
3. The following are criteria of a good communication, except:
  - a. Use simple and clear language.
  - b. Encourage her to ask questions
  - c. Ask and provide information related to her needs
  - d. Make the woman feel welcome

4. Which of the following is NOT a criteria of confidentiality and privacy
- Ensure a private place for the examination and counseling
  - Make sure you have the woman's consent before discussing with her partner/family
  - Ensure, when discussing/transmitting necessary messages, that you cannot be overheard.
  - Never discuss confidential information about clients with other providers, or outside the health facility

5. The following are emergency signs seen in a pregnant patient requiring immediate referral, except:
- fever
  - vaginal bleeding
  - headache and visual disturbance
  - severe pallor

6. Which of the following is NOT an emergency sign in a baby requiring immediate newborn care
- just born
  - convulsions
  - any maternal concern
  - eye discharge

7. A woman in the immediate postpartum period. The uterus few minutes ago was not soft. On her examination, her uterus is now hard. You observed that she has consumed 1 pad fully soaked. 4-5 minutes after, you found out that the uterus is soft again. What is your next step?
- observe
  - request for hemoglobin status
  - refer to hospital

d. consider it normal

8. The counseling environment should be:
- welcoming and comfortable
  - a place with few distractions and where privacy can be maintained
  - conducive to a counselor
  - both a and b

9. A good counselor is:
- non-judgmental
  - trustworthy
  - both a and b
  - none of the above

10. The characteristic of a good counselor is:
- both the counselor and the client explore options together
  - facilitate decision-making
  - both a and b
  - none of the above

11. In counseling a pregnant adolescent, it is important for the service provider to observe the following points:
- strict privacy and confidentiality
  - use of simple and clear language
  - not to discuss topics related to RH and sexuality
  - non-judgmental

12. The key role of health worker includes the linking of the health services with the following.
- community group, women's group and leaders
  - peer support group
  - TBA and other health service provider

13. When giving emotional support to adolescent girls and women living with violence, it is important to remember which of the following:

- a. create a comfortable environment
- b. overcome your own discomfort with her situation
- c. make sure you have time and space to talk privately
- d. be patient and pay attention only to things that is relevant to present situation

14. Which of the following statements is true:

- a. breastfeeding should be routinely assessed as part of the newborn examination
- b. the mother's breast should be examined if the mother complains of nipple or breast pain
- c. a mother with HIV /AIDS who chooses to breastfeed her baby should not be allowed to do so and must be encouraged to give milk formula
- d. a and b only

15. A very small baby:

- a. is a baby with birth weight <1500g and / or is a pre-term less than 22 weeks
- b. refers to twin babies
- c. requires urgent referral to a hospital
- d. a and b only



## **Monitoring Practicum Activities**

During the practicum period, the Training Team should carefully monitor the performance of the participants in their areas of assignments. It is important to assign a permanent monitor/observer per team throughout the practicum activities to ensure continuity of observations, provision of administrative/technical assistance and immediate feedback on the progress of each individual participant and the team as a whole. Tools for the practicum activities include the Monitoring Checklist for Implementation of PCPNC Instructions to Monitor and Observation Tool.

*Refer to pages 167-176 of the Trainer's Notes*

**SKILLS TRAINING ON BEmOC**  
Observation Tool

Please answer the following questions accurately. Your responses will serve as feedback to help enhance the participants' counseling skills.

Direction: Please put a check ( ) mark on the column that corresponds to your answer.

Legend:

- 1 – Needs improvement, tasks not performed correctly and/or out of sequence (of required) or is omitted
- 2 – Competently performed, tasks performed correctly in proper sequence (if required) but participant does not progress from step to step efficiency
- 3 – Proficiency performed, tasks efficiently and precisely performed in proper sequence (if required)
- NO – Tasks not performed by the participant during observation

TASK	1	2	3	NO
<b>Communication and Counseling Skill</b>				
1. maintain eye contact with the group				
2. use an appropriate tone of voice				
3. exhibit appropriate body language				
4. listen attentively				
5. use simple language				
6. ask open-ended, close and probing questions when required				
7. correct rumors and misinformation	1	2	3	NO
<b>Greet</b>				
1. greet the client and introduce her/himself				
2. offer the client a seat				
3. assure confidentiality				
<b>Ask</b>				
1. ask the client why she has come to the clinic				
2. obtain history problem				

TASK	1	2	3	NO
<b>Tell</b> 1. assess what basic facts does the client know in relation to his / her problem				
2. reassure the client about management of the problem				
<b>Help</b> 1. help the client make a decision by focusing on the advantages and disadvantages of the possible action to be made				
<b>Explain</b> 1. explain to client what to do				
2. ask the client to repeat all instructions in her words				
3. refer the client for services not offered at the place				
<b>Return</b> 1. discuss return visit and follow-up with the client				
2. encourage the client to return anytime if there are questions or problems				
3. politely say goodbye to the client and invite her / him to return again				



## Daily Evaluation of Training Activities

At the end of the day, trainers should conduct evaluation of training activities to identify problems and gaps in the knowledge and skills of the participants. By doing this on a daily basis, immediate feedback on areas requiring improvement can be elicited, particularly on the design and implementation of the training. Specifically, feedback should be solicited on participants' satisfaction with the session activities, methods use, resource persons, flow and pace of the training. An evaluation tool for resource persons is shown on the right.

### SKILLS TRAINING ON BEmOC Resource Speakers Evaluation

Please evaluate today's resource speaker honestly. Your responses will serve as feedback to help us improve the conduct of the next course.

**Direction:** Please put check (✓) mark on the column that corresponds to your answer.

TOPIC	Poor	Fair	Good	Very good	Excellent
1. Interesting to participants					
2. Relevant					
3. Appropriate					
4. Easy to understand					
5. Comprehensive					
Additional Remarks					

COMPETENCY	Poor	Fair	Good	Very Good	Excellent
1. Has mastery of the subject matter					
2. Presentation is clear					
3. Organized					
4. Promotes group interaction					
5. Flexible					
6. Approachable					
Additional Remarks					

To what extent were the following course objectives for participants achieved?

Legend: 1 – Not achieved 2- Fairly achieved 3 – Fully Achieved

Objective			
Session 1			
Session 2			
Session 3			
Session 4			
Session 5			
Session 6			
Session 7			
Session 8			
Session 9			
Additional Remarks			

## Process and Output Evaluation

This is done after the training to evaluate the implementation of the course and determine whether the objectives were achieved. In the pre-testing of this trainers' guide on BEmOC, a course evaluation tool was used by the trainers to solicit feedback from the participants about their overall satisfaction and recommendations for improvements. This tool is shown below.

### Sample Evaluation Process of BEmOC Skills Training

Participants were given metacards to write their difficulties, helps and insights during the two-week training period. After 15 minutes, they were asked to post their responses on the manila paper. Their responses were processed by asking them further explanation or citing their reasons. The Training Team gave their comments based on the responses.

Afterwards, the participants were divided into 4 and tasked to compose a song whose lyrics are the following: 1) most unforgettable experience in the two-week activity, 2) what lessons must be included in the course that were not included at present, or if they feel all important lessons were already included, which must be allotted more time, 3) the most important lessons they learned, and 4) descriptions of the facilitators and resource speakers. After 30 minutes, each group gave their best performance.

**SKILLS TRAINING ON BEmOC**  
Course Evaluation

Please answer the following questions accurately. Your responses will serve as feedback to help us improve the conduct of the next courses.

**Direction:** Please put a check (✓) mark on the column that corresponds to your answer.

Legend: **1** – Poor   **2** – Good   **3** – Excellent

<b>Concern</b>	1	2	3
<b>A. Handouts</b>			
1) Adequate Information			
2) Organization			
3) Relevance			
<b>B. Training Venue</b>			
1) Didactic			
a. Food			
b. Accommodation			
c. Ventilation			
d. Conducive to learning			
2) Practicum / Clinical			
a. Adequate equipment			
b. Accessible to target output			
c. Competent facilitator			
d. Ratio of Participants to facilitator			
<b>C. Facilitator / Support Staff</b>			
1) Friendly			
2) Approachable			
3) Flexible			
4) Sensitive to participants' needs			
<b>Additional Remarks</b>			

Legend: **1** – Too Short   **2** – Enough   **3** – Too Long

<b>Concern</b>	1	2	3
<b>D. Training Course</b>			
1) Length / Duration			
<b>Additional Remarks</b>			

## Action Plan

Trainers should aid the participants in applying their new knowledge and skills by assisting them in developing an action plan which they could implement upon return to their work place. Two examples of matrix for an action plan are shown below which the participants could use in planning their future activities.

### Effective Action Plans

- ▶ Divide activities into discrete steps that are realistic and measurable
- ▶ Identify roles and responsibilities for learners, as well as their community partners, co-workers and supervisors
- ▶ Identify the resources needed to successfully complete all steps
- ▶ Include a specific timeline for completing each step

## ACTION PLAN

General Objective:

Specific Objective	Strategy/Major Activities	Time Frame	Locus of Responsibility	Resource Requirement	Indicator

Action Plan Format used during the pre-test of this trainer's guide on July 26-August 6, 2004.

		ACTION PLAN		
Learner:		Training Course:		Date:
Actions I will take as a result of this training				
Anticipated barriers and strategies for overcoming them:				
Action Steps	Person (s) responsible	Resources needed	Timeline for completion	Outcome/ results
Step 1				
Step 2				
Step 3				
Step 4				
Step 5				
Commitment of partners/support team				
Signature of learner		Date		
Signature of partner (s)		Date		
Signature of partner (s)		Date		

(Adapted from Intrah/PRIME II Project and the JHPIEGO, 2002; cited in Wegs, Cristina, et.al, 2003:72)

# Post- Training Activities

The Training Team should conduct post-training activities such as monitoring and outcome evaluation based on identified indicators to assess the application of new knowledge and skills in BEmOC by the participants in their work place. These activities will be facilitated through sustained communication with the participants and documentation of experiences in BEmOC.

# Outcome Indicators

After three (3) months, the following outcomes of the training may be measured according to the following indicators:

## ► **Competency**

- % of deliveries in BEmOC facilities (normal and complicated)
- % of complicated deliveries managed properly (done in BEmOC facility & referred to CEmOC from BEmOC)
- Attendance of BEmOC team during delivery (methodology – exit interview; postpartum counseling, observation checklist)
- Patient satisfaction (exit interview; provider client interaction, e.g. respect of privacy, observation checklist)
- Total cost of deliveries from home to BEmOC facilities

## ► **Facilities**

- % of facilities experiencing stock-out supplies within the last 3 months
- % of equipment in BEmOC facilities which are functional/complete

## ► **Records keeping**

- Completeness of record

## ► **Budget**

- Amount of budget utilized for BEmOC services
- Source of funds
- SOPs within BEmOC
- MOA signed w/ CEmOC in LGUs covered
- Mechanisms in place (transportation, communication)

# Continuing Communication

Trainers should continue their communication with the participants to follow-up their progress in applying their new knowledge and skills in BEmOC. The content and process of communication can be both informative and motivational. These can be done through email exchanges, telephone conversations, site visits and text messages. It is also important to provide the participants with user-friendly reference materials and job aids which they can use after the course as guide in completing BEmOC procedures or tasks.

## How to Build Skillful Communication

- ▶ Encode messages in terms that are easily understood by the receiver;
- ▶ Use specific examples rather than vague generalizations;
- ▶ Use simple and clear language;
- ▶ Think about and construct the message before sending it;
- ▶ Check understanding with the receiver;
- ▶ When listening, concentrate and make mental summaries;
- ▶ Avoid evaluating the message until it has been completed;
- ▶ Occasionally summarize what is being said to check for accuracy (paraphrase); and
- ▶ Ask clarifying questions to check understanding  
(Felix, 1998:108-109)

# Monitoring and Evaluating Training Outcomes

After three months, the Training Team may conduct visits to the work place of the participants to monitor and evaluate the implementation of BEmOC services. During monitoring visits, a competency-based skills assessment of the team and members can be conducted to determine whether changes have occurred in the delivery of BEmOC services in the health facility. Also, the capability of the health facility in terms of its equipments, record keeping and budget allocation for BEmOC should be assessed. The outcomes of the training can be gauged through client exit interview, observation checklist, site visits, interviews with participants, community partners, supervisors and other colleagues/co-workers.



## Sample Survey for BEmOC Team Member's Application of the Principles of Quality Care

Health Worker _____					
<ul style="list-style-type: none"> <li>• Please do not write your name on this survey.</li> <li>• Please complete this survey after you have seen the health worker.</li> <li>• Your health team would appreciate honest feedback</li> </ul>					
Please rate each of the following areas by circling ONE number on each line:					
	Poor	Fair	Good	Very Good	Excellent
1. My overall satisfaction with this visit to the health facility is...					
2. The reception/greeting afforded to me by the health worker was...					
3. On this visit I would rate the health worker ability to explain to me my condition as...					
4. The health worker's patience in providing information related to my needs...					
5. The extent to which I felt my privacy during examination and counseling was observed by the health worker...					
6. The extent to which I felt reassured by the health worker that all the information I gave to them will be treated with utmost confidentiality...					
7. The opportunity the health worker gave me to express my fears or concerns and ask questions...					
8. My confidence in the ability of the health worker to respond to our health care needs (mother and new born baby)...					
9. The amount of time given by the health worker in explaining to me what the treatment is and why it should be given...					
10. The health worker's ability to make me understand the procedure for examination and treatment...					
11. The health worker's concern for me as a person in this visit was...					
12. The recommendation I would give to my friends about the health worker would be...					
How can this health worker improve his/her service?					

## Sample Competency-Based Skills Assessment Checklist

Checklist for Post-abortion Family Planning Counseling Skills (To be completed by clinical trainer)		
<p>Directions: Mark your assessment of the individual in the box to the right of each question.</p> <p>Place a <input type="checkbox"/> in the box marked <b>Score</b> if the task was performed satisfactorily            Place an X in the box marked <b>Score</b> if the task was not performed satisfactorily            Write the letters <b>N/O</b> if you did not observe the individual perform the task.</p> <p><b>Satisfactory:</b> Performs the task according to standard procedure or guidelines  <b>Unsatisfactory:</b> Does not perform the task according to standard procedure or guidelines  <b>Not Observed:</b> Step or task not performed by participant during evaluation by trainer</p>		
<p>Participant _____ Course Dates _____</p>		
	Task	Score
<b>INITIAL INTERVIEW</b>		
1. Greets woman respectfully and with kindness.		
2. Assesses whether counseling is appropriate at this time (if not, arranges for her to be counseled at another time).		
3. Ensures necessary privacy.		
4. Obtains biographic information (name, address, etc.).		
5. Ask if she was using contraception before she became pregnant. If she was, finds out if she:		
<ul style="list-style-type: none"> <li>• Used the method correctly</li> <li>• Discontinued use</li> <li>• Had any trouble using the method</li> <li>• Has any concerns about the method</li> </ul>		
6. Provides general information about family planning.		
7. Explores any attitudes or religious beliefs that either favor or rule out one or more methods.		
8. Gives the woman information about the contraceptive choices available and the risks and benefits for each:		
<ul style="list-style-type: none"> <li>• Shows where and how each is used</li> <li>• Explains how the method works and its effectiveness</li> <li>• Explains possible side effects and other health problems</li> <li>• Explains the common side effects</li> </ul>		
9. Discusses client's needs, concern and fears in a thorough and sympathetic manner.		
10. Helps client begin to choose an appropriate method.		
<b>SKILL/ACTIVITY PERFORMED SATISFACTORILY</b>		
<b>CLIENT SCREENING</b>		
1. Screen client carefully to make sure there is no medical condition that would be a problem (completes Client Screening Checklist)		
2. Explains potential side effects and makes sure that each is fully understood.		
3. Performs further evaluation (physical examination), if indicated. (Non-medical counselors must refer client for further evaluation.)		
4. Discusses what to do if the client experiences any side effects or problems.		
5. Provides follow-up visit instructions.		
6. Assures client she can return to the same clinic at any time to receive advice or medical attention.		
7. Ask client to repeat instructions.		
8. Answer client questions.		
Trainer's Signature _____		Date _____

# Documentation of Experiences

It is important that the participants are able to document their experiences in handling BEmOC cases, particularly the application of knowledge and skills acquired from the training and mobilization of institutional and community support for maternal and newborn care. By documenting their experiences, the participants and the trainers will be able to identify areas for improvement which can be inputted in redesigning the training course or guide in determining follow-up activities for the participants. Below is a sample documentation form which can help the participants in systematizing their experiences with BEmOC in their work place.

Sample BEmOC Experience (s) Documentation Form

Trainee/Participant _____				
Date/Time Frame _____				
Subject/Topic _____				
Documentation objective: _____				
Activity/Case	Date(s)	Actions/ Steps Taken	Outputs	Lessons Learned

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# Glossary

Anaemia — low hemoglobin in the blood and is seen as pallor of the conjunctiva, mouth, tongue and nail beds

Antenatal care — a care for the woman and fetus during pregnancy

Cervix — the part of the uterus that is in the vagina

Cord prolapse — when umbilical cord presents itself outside of the uterus while the fetus is still inside

Dystocia — literally means difficult labor and it is characterized by abnormally slow progress of labor

Eclampsia — hypertensive disease of pregnancy resulting in convulsions

Glucose — a major nutrient of fetal growth and energy

Labor — the last few hours of human pregnancy characterized by uterine contractions that effect dilation of the cervix and force the fetus through the birth canal.

Lochia — sloughing of decidual tissue results in a vaginal discharge of variable quantity early in the puerperium

Partograph — a tool that helps the management of labor

Placenta — tissue within a woman's uterus (womb) that is created during pregnancy to feed the growing fetus

Pre-eclampsia — hypertensive disease of pregnancy associated with pitting edema but without convulsions

Shock — a general body disturbance caused by hemorrhage, trauma, dehydration and sepsis characterized by a fall in blood pressure, rapid pulse, cold, clammy skin, vomiting and restlessness

Uterus — an organ within a woman's body that support the growth of a fetus



# Annexes

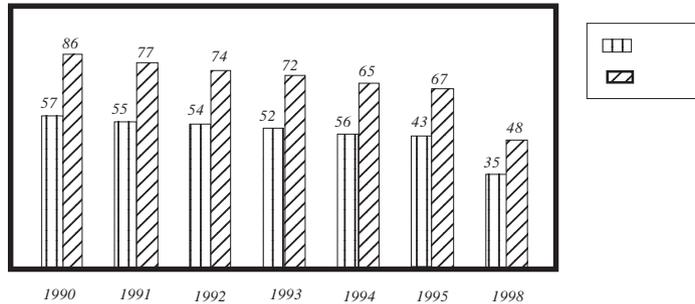


# Trainer's Notes

## Didactic Phase

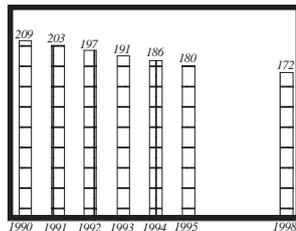
### Module 1: Overview of BEmOC and PCPNC Manual Session 1a: Overview of BEmOC

#### Infant and under Five Mortality (1990-1998)



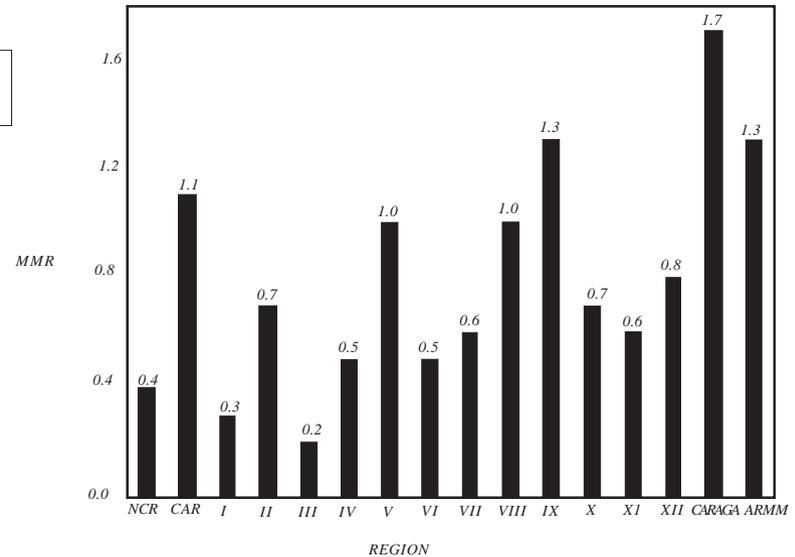
Source: UNICEF, PPAC Report 1997 & State of the World's Children 1997; NSO, 1998 NDHS

#### Maternal Mortality Rate in the Philippines: 172 / 100,000



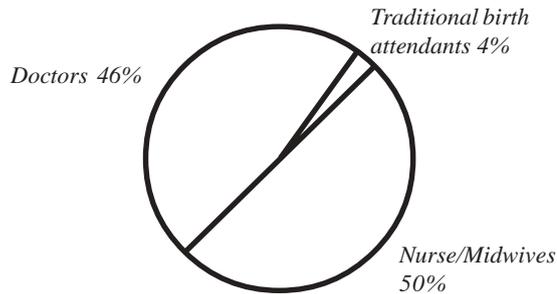
Source: NDHS 1998, Philippines

10 women die every 24 hours from causes related to pregnancy and childbirth.  
or 3650 maternal deaths/year, most are in the rural areas.



Source: FHSIS, 2000

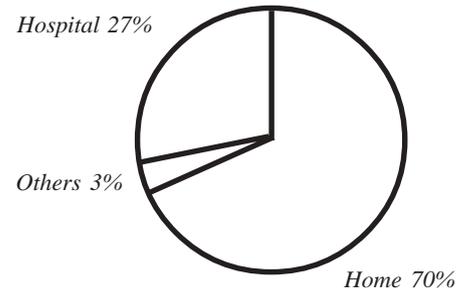
**More than 90 percent of the total births received pre-natal care from a trained birth attendant (nurses and midwives 50%; doctors 45.5%; and trained hilots 4.4%)**



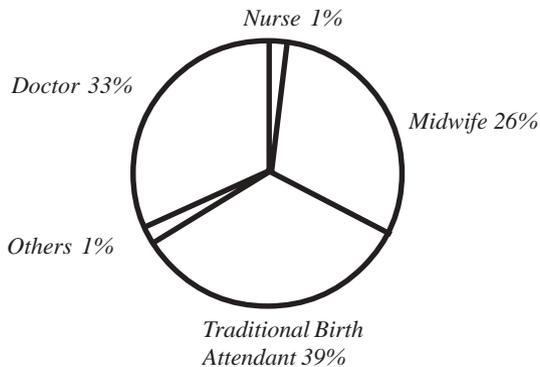
Source : MCHS-PNSO, Philippines 2002

### Deliveries by Place

70% of births were delivered in the home

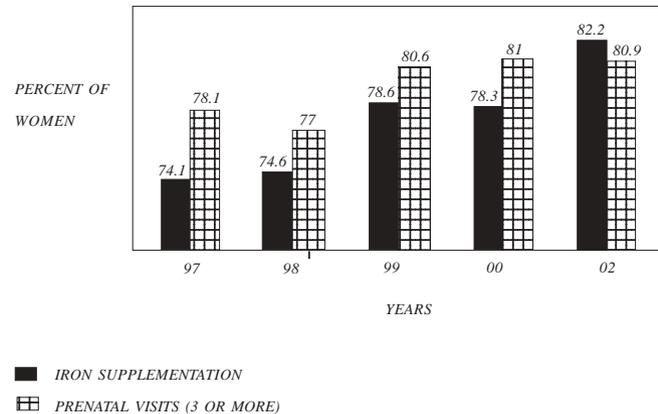


**Only 60 percent of births were attended by a health care professional (doctor or trained nurse/midwife)**



Source: MCHS-PNSO Philippines 2002

### Iron Supplementation and Pre-natal Visits



## Maternal Mortality by Main Cause

CAUSE	NUMBER OF CASES	RATE	%
1. Complications related to pregnancy occurring in the course of labor, delivery and puerperium (ICD 021-099)	603	0.4	38.19
2. Hypertension (complicating pregnancy, childbirth and puerperium; ICD 010-016)	425	0.3	26.92
3. Postpartum Hemorrhage (ICD 072)	286	0.2	18.11
4. Pregnancy with abortive outcome (ICD 0000-008)	144	0.1	9.12
5. Hemorrhage related to pregnancy (ICD o20;045;047)	121	0.1	7.66

### Constraints/Problems in Improving Safe Motherhood and Perinatal Health

- ▶ Decreasing health budget
- ▶ High cost of facility-based health services
- ▶ Human resource and facilities concentrated in highly urbanized cities/areas and limited resources in rural areas.
- ▶ Health is not main concern of Local Government Unit
- ▶ Insufficient obstetric equipment and supplies
- ▶ Advocacy of Safe Motherhood policy does not reach implementors
- ▶ Unavailability of skilled professional

### Policy Directions-Maternal Care

- ▶ RA 7322 - Increase in maternity benefits for women workers
- ▶ RA 8187 - Grant of Paternity leave
- ▶ RA 7600 - Rooming-in and breastfeeding
- ▶ DOH Circular 69-A - Authority for trained 'hilots' to attend to normal deliveries
- ▶ DOH Circular 187-A - Protocol for home deliveries

- ▶ AO 79 series 2000: Safe Motherhood Policy
- ▶ Reproductive Health Program Framework
- ▶ AO 34-A series 2000: Adolescent and Youth Policy
- ▶ AO 45-B series 2000: Prevention and Management of Abortion and Its Complications

### On Family Planning

- ▶ AO 50 series 2001: National FP Policy
- ▶ AO 125 series 2002: National Natural FP Strategic Plan
- ▶ AO 153 series 2000: National Strategy for VS and Implementing Guidelines for Itinerant Teams

### STD/HIV/AIDS

- ▶ National STD Strategy/National Policy Guidelines for the
- ▶ Prevention and Management of STDs
- ▶ AO No. series of 57-A, 1989: Policies In Abating Spread of HIV/AIDS
- ▶ AO 57-A, Expansion to National AIDS-STD Prevention and Control Program (NASPCP)
- ▶ EO No. 39: Framework for the Operations of PNAC

### Policy Directions-Child Care

- ▶ Policies on EPI, CDD and CARI
- ▶ AO 3-A series 2000: Guidelines on Vitamin A and Iron Supplementation
- ▶ IMCI
- ▶ ECCD Law
- ▶ CHILD 21

### Support Policies

- ▶ Food Fortification Law
- ▶ EO 51 - Milk Code
- ▶ HSRA
- ▶ Sentrong Sigla Certification
- ▶ PHIC Circular #6 - Maternity Package for normal spontaneous vaginal delivery in non-hospital facilities

## **Standards/Protocol Development - Maternal Care**

### **DOH**

Guidelines for birthing homes (draft)  
MCHS quality standards embodied in SS Certification  
Protocols on Home Deliveries  
Midwife's Manual on Maternal Care  
(Partograph)

### **WHO**

Manual on Essential Care Practice Guidelines for Pregnancy,  
Childbirth and Newborn (IMPAC)  
Managing Complications in Pregnancy and  
Child Birth (IMPAC)

### **UNICEF**

Maternal Death Review Guide

### **UNFPA**

RH Service Protocols By Level of Health Facility

### **WHSMP**

Comprehensive Emergency OB Manual (CEOBM) focusing  
on effective management of emergency OB cases up to  
hospital level  
Referral framework for emergency OB cases and protocols  
for transporting patients  
Revision of DOH guidelines on pap-smear cervical screening  
Strategy Development-Pregnancy Tracking and Birthing Plan  
Protocol

### **POPCOM**

Pre-Marriage Counseling Manual

## **Standards/Protocol Development - Child Care**

### **DOH**

AO 3-A series 2000: Guidelines on Vitamin A and Iron  
Supplementation  
Assessment Checklist for Essential Child Health Services  
Essential Child Health Visits  
Integrated Management of Childhood Illnesses Chart Booklet  
Expanded Program on Immunization Manual  
Manual on EPI Disease Surveillance

## **Both Child and Mother**

### **DOH**

Upang Higit Pang Makapaglingkod Manual for Public Health  
Midwives  
**UHNP**  
Integrated Maternal and Child Health Manual for Health  
Workers

## **Capability Building/Training - Maternal Care**

### **UNFPA**

Integrated Approach in Counseling and Basic RH Services  
(RH Training Course)  
Peer Educators Training on Counseling

### **UNICEF**

Maternal Death Review; Midwife's Manual

### **JICA**

Reproductive Health Training Supplementary Kit  
Male Family Planning/Reproductive Health Motivator  
Program

### **WHSMP**

Training in Partography  
Cyto-Screening Training of PGH MedTechs  
Pap Smear Preparation Training of PHC staff  
Training on Syndromic Case Management of STD

### **DOH**

Orientation on use of Midwives Manual  
Partograph Training at regional and local level  
Regular post-graduate course on Suturing of Perineal  
Laceration and Intravenous Fluid Insertion for Midwives  
Orientation on Integrated Management of Pregnancy and  
Childbirth (IMPAC) – MCPC and PCPNC  
Training of BHWs on Life Cycle Approach

## **Capability Building/Training-Child Care**

### **UNFPA**

Integrated Approach in Counseling (RH Training Course)  
**UNICEF and WHO**  
IMCI

**HKI**

IMCI; Training on Advocacy Skills

**DOH**

IMCI Training

**WHSMMP**

Training in Partography

Cyto-Screening Training of PGH MedTechs

Pap Smear Preparation Training of PHC staff

**ECCD**

Community IMCI Training

IMCI Training of health workers

Basic EPI Skills Training and Cold Chain Management Training

**IEC/Advocacy****UHNHP**

Development of an IMCH Manual for Health Workers

**DOH**

Guidebook on Adolescent Health

Teen-agers Guide to a Healthy Life Style

**JICA**

MCH Record Book

Series of video dramas (TV 99 Program- Adolescent VTR)

ARH Promotion Program

Booklet *“Pangangalaga sa Kalusugan ng Ina at Sanggol”* A

Counseling Guide for Health Workers and Information for Mothers

Teatro 99 Program Puppet Show

**UNFPA**

Video on ARH; community and facility-based IEC interventions

**HKI**

Integrated MCH Basic Learning Package

Vitamin A Supplementation IEC Materials

20-minute documentary – Vit. A, A Cause for Action

IMCI Behavior Change Communication Plan

National Advocacy Plan for Food Fortification and Supplementation

Comprehensive Iron Communication Plan

Nutrition Bulletin

**ECCD**

Mother and Child Book (draft)

**USAID**

Flip Charts on “Integrated Counseling Cards for MCH CBMIS to identify mothers’ unmet needs on FP and TT and children’s unmet needs for immunization and Vitamin A supplementation

**Service Delivery****UNICEF**

Birthing rooms for aseptic deliveries by skilled birth attendants

**JICA**

Established Under Five Clinic Program in Region 3

(upgrading of health facilities and provision of equipment in Region 3)

Reproduction of mother and child book

IMaCH Package

Tosang-Making Project

Botika Binhi

**ECCD**

EPI - distribution of cold chain equipment

IMCI - reproduction of modules, manuals, IMCI patient record and ECCD cards

**WHSMMP**

ECPG being pilot-tested in NCR and Eastern Samar

Renovation/construction of delivery rooms

Distribution of disposable OB kits (colposcopes, pap smear supplies, LEEP machines procurement, etc.)

Social hygiene clinics

Partnership among LGU, community, NGOs for referral and services

**UNICEF**

Child-Friendly Integrated Childhood Care and Development

**UNFPA**

Teen Centers in pilot areas; RH service provision in 9 project sites

**HKI**

Routine distribution of Vitamin A capsules

## **MIS/Monitoring and Research**

### **WHSMP**

KAP Survey on RTI/STD

### **HKI**

Evaluation of IMCI approach (baseline and end-line survey)

Developed monitoring system for LGUs on Vitamin A availability and coverage

### **FHI**

Conducted enhanced STI Control in Angeles City and a prevalence survey of RTI/STD in the Philippines

### **MSH**

Community-Based Management Information System

### **WHSMP II**

Technical studies to be conducted on FP, adolescents, maternal mortality and STI control and HIV prevention

### **UNFPA**

Quality Care Survey (pipeline)

## **Financing/Private Sector**

### **PhilHealth**

Developed maternity package by which the first two deliveries are paid by PHIC provided these occur in accredited facilities or are attended by accredited midwives. Only midwives attached to an accredited institution are eligible for accreditation.

### **JSI**

Establishments of Well Midwife Clinics primarily for FP services; now beginning to expand to providing child health services

### **FCFI**

Establishment of clinics providing maternal and child health services, with focus on Family Planning

## **Issues and Concerns (Challenges)**

- ▶ Policy and Structure
- ▶ Service Protocols and Guidelines
- ▶ Service Delivery
- ▶ Recording/Monitoring

- ▶ Issues and Concerns

## **Policy and Management Structure**

- ▶ Policies and frameworks exist but on individual programs (e.g. Safe Motherhood, Child's Health, RH Framework, FP Policies, etc.)
- ▶ Overarching framework on family health where maternal and child health belongs not yet in place
- ▶ Office structure at national level still on a program-specific assignments
- ▶ Life-cycle Approach - Interface between maternal care, family planning, and RTI/STD not yet clear
- ▶ Finalization of the TBA policy
- ▶ Allowing midwives to do intravenous injection

## **Issues and Concerns**

### **Standards and Service Protocols**

- ▶ Service protocols on maternal and child health developed and packaged by program
- ▶ Core maternal and child health services to be made available per level of facility not that clear yet (e.g. what midwives or the BHSs should provide)
- ▶ Several reference materials abound - consistency of standards across references in doubt

### **Service Delivery**

- ▶ Service provision is seldom client-oriented, but rather programmatic; child consultation most probably include mother's concern; but mother's consultation does not necessarily include child's concerns, resulting to missed opportunities for the client and other members of the family
- ▶ Lack of a single package of guidelines for health workers to use as reference at the facility level
- ▶ Manpower

### **MIS/Monitoring**

- ▶ Proliferation of different recording forms (e.g. ITRs, FP Form 1, ECCD/GMC, HBMR, etc.)

- ▶ Home-Based Maternal Record (HBMR) is not utilized to the fullest and remains to record only prenatal care. Often times, the care provided is not recorded or the card is not updated. In most hospitals, HBMR is not honored as a record of care already provided.
- ▶ ECCD card/UFC is often times used to record immunization only

### **Health Sector Reforms**

- ▶ While private-public partnership (through market segmentation) is important in the operationalization of ILHZs), the DOH has not been able to exert strong influence on the private sector and the practitioners outside DOH
- ▶ Referral system – community component not yet designed
- ▶ Some LGUs not convinced nor motivated to participate in the ILHZ
- ▶ Investment for public health very low

### **Integrated Management of Pregnancy and Childbirth (IMPAC)**

#### **Components:**

- ▶ Standardization of care by setting norms and standards
- ▶ Improving health system response
- ▶ Improving family and community participation, practices and response
- ▶ Integrated Management of Pregnancy and Childbirth

## **Module 1: Overview of BEmOC and PCPNC Manual**

### **Session 1b: Overview of Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC)**

#### **Pregnancy, Childbirth, Postpartum and Newborn Care: (A guide for essential practice)**

WHO recommendations for the skilled attendant providing routine and emergency care for women and newborn during pregnancy, delivery, postpartum and post abortion at primary health care.

#### **PCPNC...**

- ▶ A manual formulated by WHO Headquarters in Geneva and introduced by the World Health Organization-Western Pacific Regional Office in Manila
- ▶ Endorsed by the following organization World Health Organization (WHO) United Nations International Children's Educational Fund (UNICEF), United Nations Population Fund (UNFPA) and the World Bank
- ▶ It was reviewed and endorsed by the Federation International in Gynecology and Obstetrics (FIGO)
- ▶ Technical and editorial assistance was provided by the John Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO)

#### **What is PCPNC**

- ▶ Guides clinical decision-making.
- ▶ Promotes the early detection of complications and the initiation of early and appropriate treatment, including timely referral.
- ▶ Helps reduce high maternal and perinatal mortality and morbidity
- ▶ Used as a training and advocacy tool
- ▶ Adaptable to local circumstances and settings (needs, resources, local beliefs systems)

## **Content**

- ▶ Quick check, emergency management and referral
- ▶ Post abortion care
- ▶ Antenatal care
- ▶ Labour and delivery
- ▶ Postpartum care
- ▶ Newborn care

## **Structure and Presentation**

- ▶ Content is presented in a framework of colored flow charts supported by information and treatment charts
- ▶ Framework is based on syndromic approach
- ▶ Severity is marked in color:
  - red for emergencies
  - yellow for less urgent conditions
  - green for normal care

## **Format of PCPNC**

- ▶ Information boxes, illustrations
- ▶ Disease model for assessment, classification and management of complications
- ▶ With overview for each chapter or component

## **Format of PCPNC (5 area columns)**

- ▶ What to ask
- ▶ What to look for
- ▶ What to expect to see
- ▶ How to classify
- ▶ What to do/ treat

## **Basic EmOC: 6 functions (PCPNC)**

- ▶ Injectable antibiotics
- ▶ Injectable oxytocics
- ▶ Injectable anticonvulsants
- ▶ Manual removal of placenta
- ▶ Assisted vaginal delivery
- ▶ Removal of retained products

## **Comprehensive EmOC (MCPC) the same as above plus the following:**

- ▶ Caesarean Section
- ▶ Safe Blood Transfusion

## **MCPC**

- ▶ For midwives and doctors at the district hospital who are responsible for the care of women with complications of pregnancy and childbirth or the immediate postpartum period, including immediate problems of a newborn.
- ▶ The interventions described in these manual are based on the latest available scientific evidence.

## **Integration Approach of PCPNC and MCPC**

- ▶ Pregnancy, childbirth, postpartum
- ▶ Pregnancy related complications and endemic conditions / diseases and preventive measures
- ▶ Care at the facility, community and home care
- ▶ Mother, newborn, partner, family, community and facility
- ▶ Routine and emergency
- ▶ Primary and referral care
- ▶ Different vertical programs

## **Next Steps**

- ▶ Advertise the manuals and encourage governments, international agencies and NGOs to use it.
- ▶ Provide financial and technical support to government to translate and adapt the manual
- ▶ Provide technical support on adaptation and training

## **Module 2: Principles of Good Care**

### **Principles of Good Care**

- ▶ Communication
- ▶ Workplace and Administrative Procedures
- ▶ Universal Precautions and Cleanliness
- ▶ Organizing a Visit

### **Communication**

- ▶ Make the woman (and her companion) feel welcome
- ▶ Uses simple and clear language
- ▶ Encourage her to ask questions
- ▶ Ask and provide information related to her needs
- ▶ Support the woman in understanding her options and making decisions
- ▶ Seek permission from the patient when examining
- ▶ Summarize the most important information, including the information on routine laboratory tests and treatments.

### **Organizing a Visit**

- ▶ Emergency care visit
- ▶ Care of woman or baby referred for special care to secondary level facility
- ▶ Routine visit for the woman and/or the baby

### **Workplace and Administrative Procedures**

- ▶ Set-up and preparation of the Workplace
- ▶ Daily and occasional administrative activities
- ▶ Record keeping
- ▶ International conventions

### **Universal Precautions and Cleanliness**

- ▶ Wash hands
- ▶ Wear gloves
- ▶ Protect yourself from blood and other body fluids during deliveries
- ▶ Practice safe sharps disposal
- ▶ Practice safe waste disposal

- ▶ Deal with contaminated
- ▶ Ensure clean laundry
- ▶ Clean and sterilize contaminated equipment
- ▶ Clean and disinfect gloves
- ▶ Sterilize gloves

## **Module 3: Quick Check and Rapid Assessment and Management**

### **Session 1: Quick Check**

Please refer to Sec. B2 of PCPNC.

## **Module 3: Quick Check and Rapid Assessment and Management**

### **Session 2: Rapid Assessment and Management**

Please refer to Sec. B3-B7of PCPNC.

## **Module 3: Quick Check and Rapid Assessment and Management**

### **Session 3: Emergency Treatment for the Woman**

### **How to prepare a syringe for an injection**

- ▶ Wash your hands
- ▶ Take the syringe and needle out of the package
- ▶ Hold the syringe at the end of the plunger and hold the needle at the base
- ▶ Attach the syringe and needle
- ▶ If using a vial of ready to use medicine eg. Gentamicin, clean the vial and then carefully break the top off
- ▶ Put the needle into the vial. Draw up a little more of the medicine than required
- ▶ Hold the syringe upright with needle facing up
- ▶ To remove bubbles from the medicine, tap the syringe lightly on the side. Push the plunger until the air comes out and the medicine begins to spill from the tip of the needle.

- ▶ Push the plunger until you have the correct dose in the syringe.

### **How to prepare a syringe for an injection**

(For medicine that needs to be mixed with sterile water, e.g. Ampicillin)

- ▶ Clean the vial containing the sterile water and break the top off
- ▶ Fill the syringe with the amount of water you require according to the instructions
- ▶ Remove the bubbles if any
- ▶ Clean the rubber top of the medicine vial with alcohol swab
- ▶ Inject the sterile water into the bottle with the powdered medicine.
- ▶ Shake the bottle until the medicine is well mixed with the water
- ▶ Holding the vial upside down, put the needle inside and fill the syringe with a little more than the medicine required
- ▶ Remove the bubbles and push the medicine out until the correct dose is obtained.
- ▶ Cover the needle until you are ready to give the injection

## **Module 3: Quick Check and Rapid Assessment and Management**

### **Session 4: Emergency Treatment for the Woman- Anatomy of the Female Reproductive Tract**

#### **Classification**

- ▶ External Organ
  - copulation
- ▶ Internal Organ
  - ovulation
  - site of fertilization
  - blastocyst transport
  - implantation
  - development and birth of fetus

#### **Internal Generative Organs**

- ▶ (visible externally from the pubis to the perinium)

#### **Mons Pubis/Veneris**

- ▶ Fat-filled cushion at the anterior surface of the symphysis pubis

#### **Escutcheon**

- ▶ Female - triangular shape
- ▶ Male - diamond-like

#### **Labia Majora**

- ▶ two rounded folds of adipose tissues covered with skin extending downward and backward from the mons pubis
- ▶ homologue-scrotum
- ▶ vary in appearance (fat content):
  - ▶ nullipara
    - close apposition
    - moist inner surface (mucus membrane)
  - ▶ multipara
    - gape widely
    - skin like inner surface

### **Labia Minora**

- ▶ two flat reddish folds of tissues beneath the labia majora
- ▶ homologue-penile urethra and part of skin of penis
- ▶ nullipara-not visible
- ▶ multipara-project beyond the labia majora
- ▶ two lamellae
- frenulum            -lower pair
- prepuce            -upper pair

### **Clitoris**

- ▶ short cylindrical erectile organ located near the superior extremity of the vulva
- ▶ projects between the prepuce and prenulum parts:
- glans
- body/corpus
- crura
- principal erogenous organ

### **Vestibule**

- ▶ almond shaped area enclosed by labia minora laterally extending from the clitoris to the fourchette
- ▶ functionally mature female structure of the urogenital sinus of the embryo
- ▶ perforated by six openings:
- urethra
- vagina
- ducts of bartholin gland
- ducts of paraurethral gland

### **Bartholin Gland**

- ▶ major vestibular gland located beneath the fascia at 4 and 8 o'clock position
- ▶ homologue -cowpers gland
- ▶ ducts open on the sides of the vestibule just outside the lateral margin of the vagina orifice

### **Urethral Opening/Meatus**

- ▶ membranous conduit for urine from the urinary bladder to the vestibule

### **Skene/Paraurethral**

- ▶ branched tubular gland adjacent to distal urethra
- ▶ ducts open on the vestibule on either side of the urethra
- ▶ homologue -prostate gland

### **Vestibular Tubes**

- ▶ almond shaped aggregations of veins
- ▶ homologue -bulb of penis
- ▶ liable to injury and rupture
- ▶ vulvar hemotoma/hemorrhage

### **Hymen**

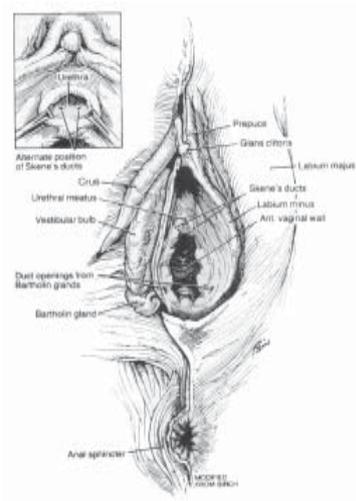
- ▶ thin perforated membrane at the entrance of the vagina, hidden by labia minora
- ▶ newborn -vascular/redundant
- ▶ pregnant -thick epithelium  
-rich in glycogen
- ▶ menopause -thin epithelium  
-with focal cornification
- ▶ hymenal opening
- crescentic/circular
- cribriform
- septate/fimbriated
- ▶ imperforate hymen
- ▶ myrtiform caruncle
- cicatrized nodules/tissue remnants of the hymen

### **Vagina**

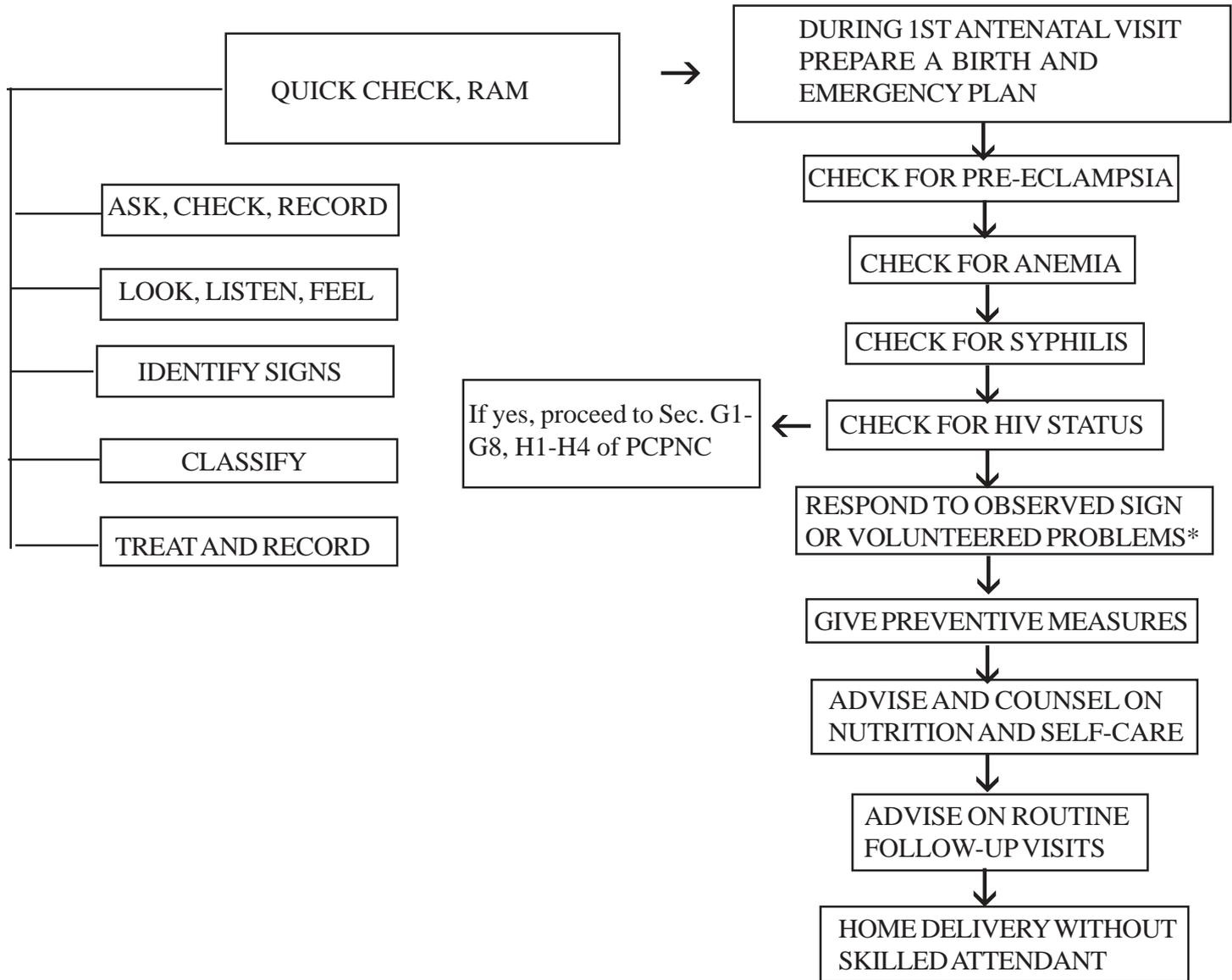
- ▶ tubular, musculomembranous structure extending from the vulva to the uterus, interposed anteriorly and posteriorly between the bladder and rectum
- ▶ functions-excretory canal of the uterus  
-organ of copulation

- ▶ portions
  - part of the birh canal
  - upper mullerian sucts
  - lower urogenital sinus
- ▶ nullipara -with numerous rugae
- ▶ multipara -smooth wall
- ▶ vaginal inclusion cyst

-remnants of mucosal tags buried during repair of vaginal laceration after childbirth



**Module 4: Antenatal Care**  
**Session 1&2: Process Flow of Antenatal Care**



## Antenatal Care

- ▶ Always begin with RAM  
(If the woman has no emergency or priority signs).
- ▶ Use the Pregnancy Status and Birth Plan Chart. C2;C14
- ▶ Check all women for pre-eclampsia, anemia, syphilis and HIV status C3-C6
- ▶ Use chart on 'Respond to Observed Signs or Volunteered Problems' to classify the condition and identify appropriate treatments

## Respond to Observed Signs or Volunteered Problems

- ▶ No fetal movement C7
- ▶ Ruptured membranes C7
- ▶ With fever or burning on urination C8
- ▶ With vaginal discharge C9
- ▶ With signs suggestive of HIV infection C10
- ▶ Smoking, on alcohol or drug abuse or with history of violence C10
- ▶ With cough or breathing difficulty C11
- ▶ On anti-tuberculosis treatment C11
- ▶ Give preventive measures due C12
- ▶ Develop a birth and emergency plan C14-C15
- ▶ Advise on nutrition, family planning, labor signs, danger signs, routine and follow-up visits C13 using Information and Counselling Sheets
- ▶ Record: positive findings, birth plans, treatment given, next scheduled visit
- ▶ If HIV positive, adolescent, or has special needs G1-G8; H1-H4

ANTENATAL RECORD	
FAMILY # _____	
DATE: _____	
NAME: _____ AGE: _____ WEIGHT: _____ kg Temp: _____ °C BP: _____	
HUSBAND NAME: _____ Initial Visit? _____ Follow-Up Visit? _____ Blood Type: _____	
ADDRESS: _____	
ADDRESS: _____	CLASSIFY
<p><b>QUICK CHECK (1-3)</b></p> <p>• <b>LOOK, LISTEN and FEEL</b></p> <p>Is the woman being wheeled or carried or</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> breathing vigorously</li> <li><input type="checkbox"/> sweating</li> <li><input type="checkbox"/> looking very ill</li> <li><input type="checkbox"/> in severe pain</li> <li><input type="checkbox"/> in labour</li> <li><input type="checkbox"/> delivery is imminent</li> </ul>	
<p><b>RAPID ASSESSMENT MANAGEMENT (LIMITED)</b></p> <p>• <b>CHECK AIRWAYS and BREATHING</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> very difficult breathing or</li> <li><input type="checkbox"/> normal responses</li> </ul> <p>• <b>CHECK CIRCULATION (SHOCK)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> cold/cool skin or</li> <li><input type="checkbox"/> weak and fast pulse</li> <li><input type="checkbox"/> check blood pressure</li> </ul> <p>• <b>CHECK FOR THE FOLLOWING</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> fever (10)</li> <li><input type="checkbox"/> Cervicitis (10)</li> <li><input type="checkbox"/> Vaginal Bleeding (14)</li> <li><input type="checkbox"/> Severe abdominal pain (10)</li> </ul>	
<p><b>ANY PRIORITY SIGNS? YES NO</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> labor pain or ruptured membranes</li> <li><input type="checkbox"/> severe pain</li> <li><input type="checkbox"/> systemic pain / abdominal pain</li> <li><input type="checkbox"/> severe headache</li> <li><input type="checkbox"/> blurred vision</li> <li><input type="checkbox"/> breathing difficulty</li> </ul>	
<p><b>ASK, CHECK, RECORD - (A2)</b></p> <p><b>FIRST VISIT</b></p> <p>How many months pregnant are you? _____ months/weeks * Look for consistent size</p> <p>When was your last period? LMP: _____ * T.T.</p> <p>When do you expect to deliver? EDC: _____ * F10</p> <p>Have you had a baby before? If yes:</p> <p>Check record for prior pregnancies or if there is no record ask about:</p> <ul style="list-style-type: none"> <li>- Prior cesarean section, breech, or vacuum</li> <li>- Prior fetal death or loss</li> <li>- Heavy bleeding during or after delivery</li> <li>- Complications</li> <li>- Stillbirth or death in first day</li> </ul> <p>• Do you smoke/drink alcohol/use any drugs? _____</p>	
<p><b>ALL VISITS</b></p> <p>Check duration of pregnancy work</p> <p>When do you plan to deliver? _____ * First for trimester of pregnancy</p> <p>Any vaginal bleeding since last visit? _____ * T.T.</p> <p>Is the baby moving? (ask 4 weeks) _____ * F10</p> <p>Check record for previous complications &amp; Treatment received during this pregnancy</p> <p>Do you have any concerns? _____ * First for presentation</p>	
<p>• <b>THIRD TRIMESTER</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Has the been discussed on family planning? If yes, when she want child again or IUD? _____</li> </ul>	<p>* First for obvious multiple pregnancy</p> <p>* First for concerns for breath</p> <p>* Listen to fetal heart</p>

**Module 5: Labor, Delivery, Immediate Postpartum Period**  
**Session 1: Stages of Labor-Overview**

**Labor**

- ▶ sequence of uterine contractions
- ▶ cervical dilatation
- ▶ bearing down
- ▶ delivery of the baby

**Delivery**

- ▶ expulsion of the baby

**Immediate Postpartum Period**

- ▶ Equally important as labor and delivery
- ▶ Most complications occur

**Role of physician, nurse & midwife**

- ▶ To anticipate
- ▶ To assess or identify problems
- ▶ To treat or manage problems of the woman

**Module 5: Labor, Delivery, Immediate Postpartum Period**  
**Session 1: Stages of Labor-Rapid Assessment and Management**

- ▶ Rapid Assessment and Management B3-B7
- ▶ Examine Woman in Labor or With Ruptured Membranes D2 – D3. Then decide the stage of labor.
- ▶ If an abnormal sign is identified, use the charts on Respond to Observed Signs or Volunteered Problems D4-D5
- ▶ For supportive care throughout labour and delivery, use Supportive Care chart D6
- ▶ Record findings continually on Labor record and partograph

**Respond to problems during labour and delivery pp. D14 – D18**

- ▶ Observe mother and baby in the labor room one hour after delivery. Use charts on Care of the Mother and Newborn Within the First Hour of Delivery of the Placenta Sec. D19 of PCPNC
- ▶ For immediate postpartum management until delivery, use Care of the Mother After the First Hour Following Delivery of the Placenta Sec. D20 of PCPNC
- ▶ To advise on danger signs, when to seek routine and emergency care, and family planning, use Preventive Treatment and Advise on Postpartum Care pp. D26 – D28
- ▶ Examination of the mother for discharge
- ▶ Do not discharge the mother before 12 hours.
- ▶ If mother is HIV Positive or Adolescent or has Special Needs
- ▶ If attending a delivery at the woman's home, see Sec. D29 of PCPNC.

PARTOGRAPH	
DATE TIME AND SIGNATURE: _____	
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**Look, listen and feel:**

- ▶ Response to contractions
- ▶ Check abdomen
- ▶ Feel abdomen
- ▶ Listen to the FHB
- ▶ Measure VS
- ▶ Look for pallor, dehydration

**Decide the Stage of Labor**

**Ask, check record:**

- ▶ Explain to the woman that you will give her a vaginal examination
- ▶ Ask for her consent

**Look, listen & feel:**

- ▶ Observe the vulva
- ▶ Perform vaginal examination
- ▶ DO NOT perform vaginal examination if currently bleeding or at any time after 7 months of pregnancy

**Module 5: Labor, Delivery, Immediate Postpartum Period**

**Session 1: Stages of Labor**

**Contents:**

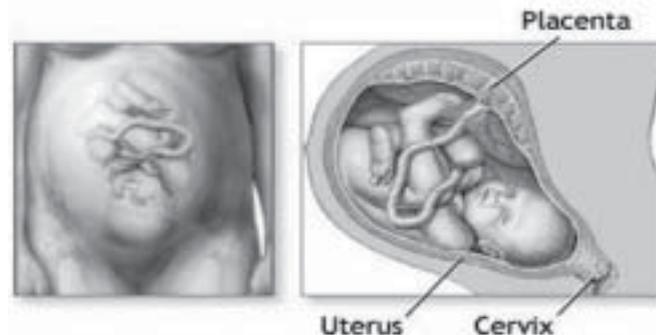
- ▶ Examine the woman in labor or with ruptured membranes
- ▶ Decide stage of labor

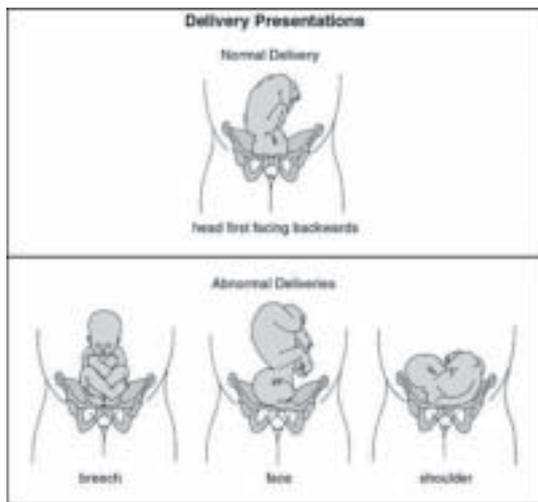
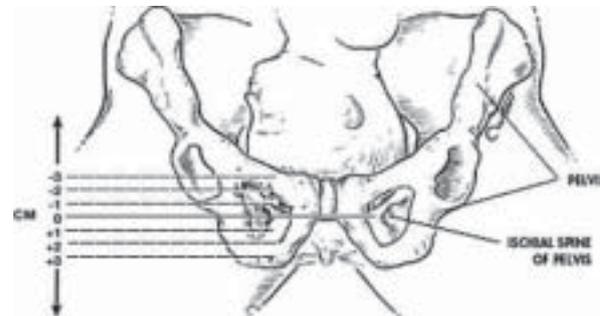
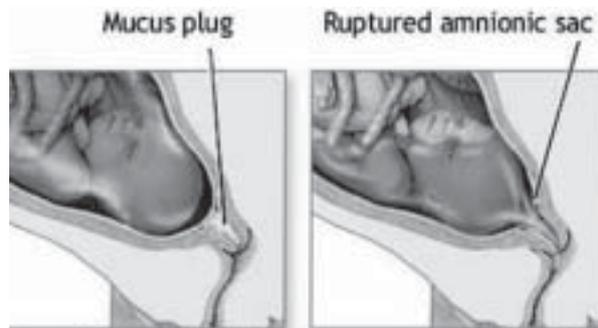
**Examine the woman in labor or with ruptured membranes**

**Ask, check record:**

- ▶ History of this labor
- ▶ Check record, or if no record
- ▶ If prior pregnancies
- ▶ Current pregnancy

Normal anatomy at full term (40 weeks)



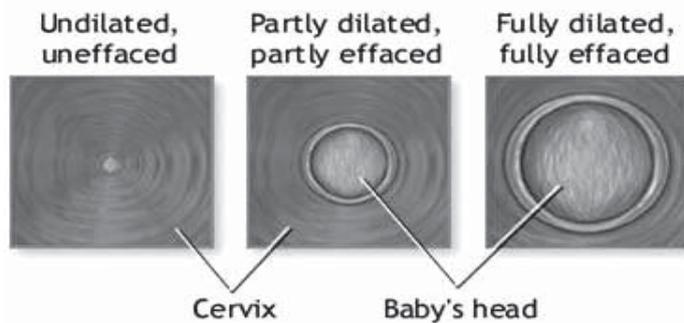


### Signs — Classify — Manage

- ▶ Imminent Delivery
- ▶ Late active labor
- ▶ Early active labor
- ▶ Not yet in active labor

### Review

- ▶ First do RAM (B3 – B7)
- ▶ Assess the status of the woman and her fetus status (D2)
- ▶ Decide stage of labor (D3)



**Module 5: Labor, Delivery, Immediate Postpartum Period**

**Session 2: First Stage of Labor**

**Contents:**

- ▶ First stage of labor
- not in active labor
- in active labor
- ▶ Respond to obstetrical problems
- ▶ Supportive care
- ▶ Skills: IE, Partograph, Labor record

Fontanelles:

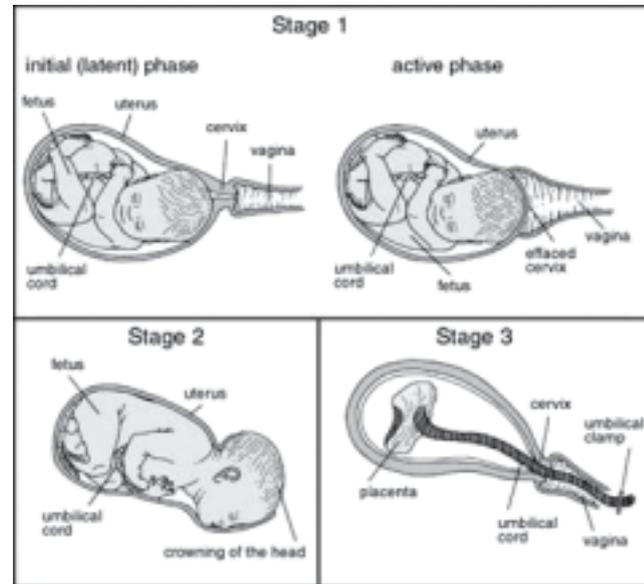
- Mastoid
- Posterior
- Sphenoid
- Anterior

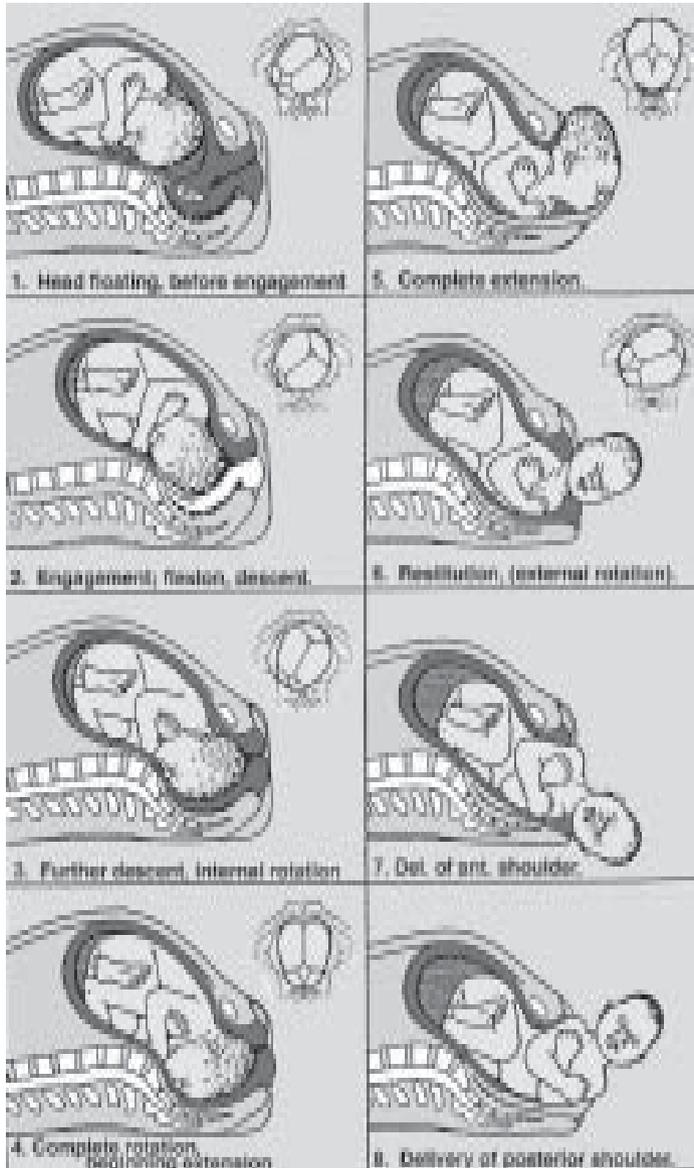


#ADAM

Uterus between contractions

Uterus during contractions





### Supportive Care throughout Labor

► To provide a supportive, encouraging atmosphere for birth, be respectful of the woman's wishes.

- Communication
- Cleanliness
- Mobility
- Urination
- Eating, drinking
- Breathing technique
- Pain and discomfort relief
- Birth companion

If woman is distressed or anxious, investigate the cause (D2 - D3)

If pain is constant (persisting between contractions) and very severe or sudden onset (D4)

## Module 5: Labor, Delivery, Immediate Postpartum Period

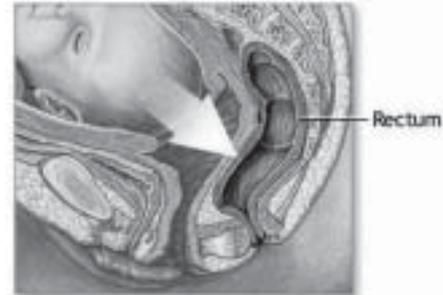
### Session 3: Second Stage of Labor

#### Second Stage of Labor

- ▶ Cervix dilated 10 cm
- ▶ Bulging thin perineum
- ▶ Head visible

#### Contents:

- ▶ Delivery of the baby
- ▶ Skills:
  - Normal vaginal delivery
  - Breech delivery
  - Stuck shoulder
  - Multiple birth
  - Cord prolapse



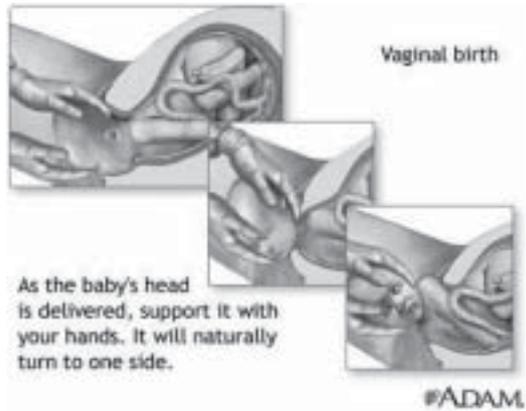
Urge to have bowel movement is due to pressure of baby's head against rectum.

#### Second Stage of Labor

Monitor every 5 minutes:

- ▶ For emergency signs using RAM (B3–B7)
- ▶ Frequency, intensity and duration of contractions
- ▶ Fetal Heart Rate (D14)
- ▶ Perineum thinning or bulging
- ▶ Visible descent of fetal head or during contraction
- ▶ Mood and behavior: distressed, anxious (D6)
- ▶ Record findings regularly in Labor Record and Partograph (N4 – N6)
- ▶ Never leave the woman alone

- ▶ All delivery equipment and supplies, including newborn (NB) resuscitation equipment are available, and place of delivery is clean and warm (25°C) (L3);
- ▶ Empty bladder (B12);
- ▶ Assist to choose a comfortable position, upright as possible;
- ▶ Stay with mother and offer emotional and physical support (D10–D11)
- ▶ Allow her to push as she wishes with contractions. Do not urge her to push.
- ▶ Wait until head visible and perineum distending
- ▶ Refer urgently to hospital if 2<sup>nd</sup> stage lasts for 2hrs or more without visible steady descent of the head. (B17)
- ▶ Do not perform episiotomy routinely.
- ▶ Wash hands w/ clean water and soap.
- ▶ Put on gloves just before delivery.
- ▶ See universal precautions during labor and delivery A4.
- ▶ Ensure controlled delivery of the head
- ▶ Feel gently around baby's neck for the cord.
- ▶ Await spontaneous rotation of shoulders and delivery within 1–2 minutes (D17– managing STUCK SHOULDERS).



- ▶ Exclude 2<sup>nd</sup> baby.
- ▶ Palpate mother's abdomen.
- ▶ Give 10 IU oxytocin IM to the mother.
- ▶ Watch for vaginal bleeding.
- ▶ Change gloves or wash gloved hands.
- ▶ Clamp and cut the cord.
- ▶ Encourage initiation of breastfeeding. K2

## Module 5: Labor, Delivery, Immediate Postpartum Period

### Session 3: Second Stage of Labor- Perineal Repair

#### Episiotomy

- ▶ Or perineotomy
- ▶ Is an incision into the perineum to enlarge the space at the outlet, thereby facilitating the birth of the child.

#### Maternal benefits:

- ▶ A straight incision is simpler to repair and heals better than a jagged, uncontrolled laceration;
- ▶ Strength of the pelvic floor can be preserved and the incidence of uterine prolapse, cystocele and rectocele reduced;
- ▶ Structures in front and rear are protected;
- ▶ Less stretching of and less damage to the anterior vaginal wall, bladder, urethra and periclitoral tissues;
- ▶ Tears into the rectum can be avoided;
- ▶ Second stage of labor is shortened.

#### Fetal benefits:

- ▶ Lessens pounding of the head on the perineum so helps prevent brain damage;
- ▶ Makes birth easier.

#### Indications:

- ▶ Prophylactic: To preserve the integrity of the pelvic floor;
- ▶ Arrest of progress by resistant perineum (thick and heavily muscled tissue, operative scars, and previous well-repaired episiotomy);
- ▶ To obviate uncontrolled tears, including extension into the rectum;
- ▶ Fetal reasons (premature babies, large babies, abnormal positions, and fetal distress).

#### Timing of Episiotomy:

- ▶ If made too late, procedure fails to prevent lacerations;
- ▶ If made too early, the incision leads to loss of blood;
- ▶ Is made when the perineum is bulging, when 3 to 4 cm diameter of the fetal scalp is visible during contraction;

#### Lacerations of the Perineum

##### Maternal causes:

- ▶ Precipitate, uncontrolled or unattended delivery (most common cause);
- ▶ The patient's inability to stop bearing down;
- ▶ Hastening the delivery by excessive fundal pressure;
- ▶ Edema and friability of the perineum;
- ▶ Vulvar varicosities weakening the tissue;
- ▶ Narrow pubic arch with outlet contraction, forcing the head posteriorly;
- ▶ Extension of episiotomy.

##### Fetal causes:

- ▶ Large baby;
- ▶ Abnormal positions of the head (OP, face);
- ▶ Breech deliveries;
- ▶ Difficult forceps extractions;
- ▶ Shoulder dystocia;
- ▶ Congenital anomalies (hydrocephalus).

#### Classification of Lacerations of the Perineum

**First degree laceration** involves the fourchette, perineal skin and vaginal mucosa membrane BUT NOT the underlying fascia and muscle.

**Repair** aims reapproximation of the divided issue and hemostasis. A simple interrupted suture is enough. If bleeding is profuse, figure-8 sutures may be used.

**Second degree laceration** involves, in addition to the skin and mucous membrane, the muscles of the perineal body BUT NOT the rectal sphincter.

**Repair:**

- ▶ Interrupted, continuous or lock stitches are used to approximate the edges.
- ▶ The deep muscles of the perineal body are sutured together with interrupted sutures.
- ▶ A running subcuticular suture or interrupted sutures, loosely tied, bring together the skin edges.

**Third degree laceration** extends through the skin, mucous membrane, perineal body AND INVOLVE the anal sphincter.

**Repair** - Similar to repair of fourth degree laceration except that the reapproximation starts with the torn ends of the anal sphincter.

**Fourth degree laceration** – extends through the rectal mucosa to expose the lumen of the rectum.

**Repair:** (repaired in layers)

- ▶ The anterior wall of the rectum is repaired with fine 000 or 0000 chromic catgut on a fused needle. Starting at the apex, interrupted sutures are placed submucosally so that the serosa, muscularis and submucosa of the rectum are apposed. Others approximate edges with continuous suture going through all layers.
- ▶ The line of repair is oversewn by bringing together the perirectal fascia and the fascia of the rectovaginal septum. Interrupted or continuous sutures are used.
- ▶ The torn ends of the rectal sphincter are identified, grasped with allis forceps and approximated with interrupted sutures or two figure-8 sutures.
- ▶ The vaginal mucosa is then repaired as a midline episiotomy with continuous or interrupted sutures.
- ▶ The perineal muscles are sewn together with interrupted sutures.
- ▶ The skin edges are sewn together with a continuous subcuticular suture loosely tied interrupted sutures.

**Disruption of Episiotomy or Laceration Repair:**

- ▶ Poor healing powers (nutritional deficiencies, anemia, exhaustion after a long and difficult labor).
- ▶ Failure of technique (careless approximation of the wound, incomplete hemostasis leading to hematoma formation, failure to obliterate dead space).
- ▶ Devitalization of tissue (use of crushing instruments, strangulation of tissue by tying sutures too tightly, employment of heavy catgut).
- ▶ Infection

**Aftercare**

- ▶ Maintain cleanliness
- ▶ Use of antiseptic after each urination or bowel movement
- ▶ No alcohol
- ▶ Perilight may be used
- ▶ Daily shower and washing using soap and water
- ▶ Use of stool softener for those who had third or fourth degree lacerations
- ▶ Well balanced diet

**Other locations of lacerations**

- ▶ Tissue on either urethra
- ▶ Labia minora
- ▶ Lateral walls of the vagina
- ▶ Area of the clitoris
- ▶ Cervix
- ▶ Urethra
- ▶ Bladder

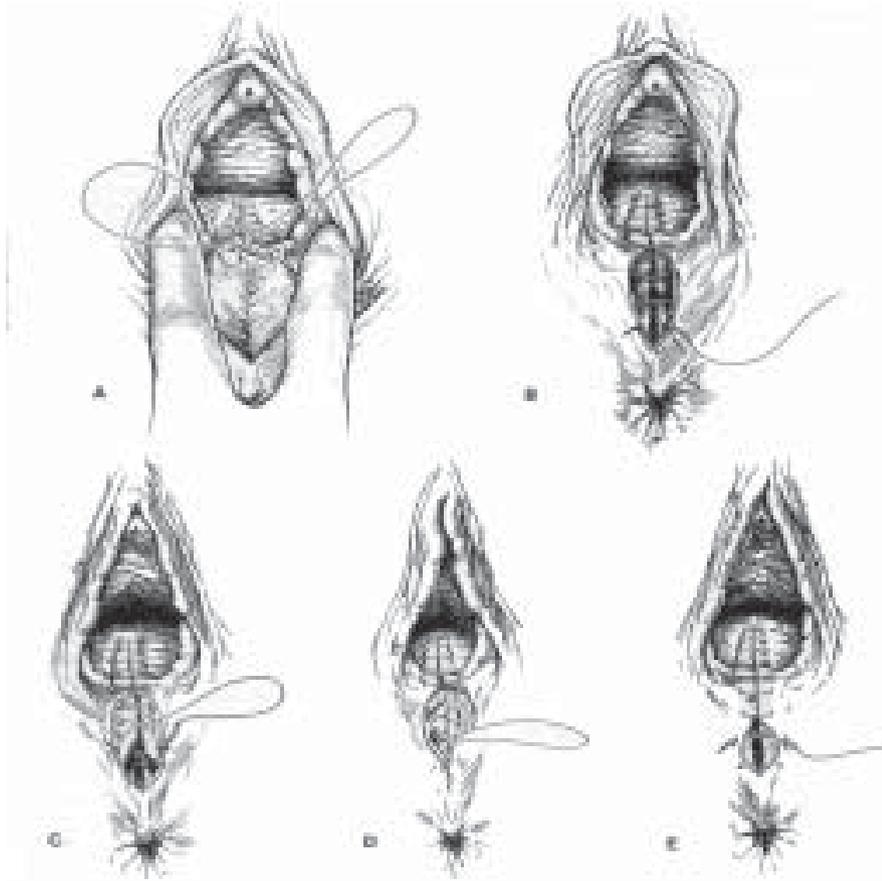
Repair of median episiotomy.

**A.** Chromic 2-0 or 3-0 suture is used as a continuous suture to close the vaginal musoca and submucosa. **B.** After closing the vaginal incision and reapproximating the cut margins of the hymenal ring, the suture is tied and cut.

Next, three or four interrupted sutures of 2-0 or 3-0 chromic are placed in the fascia and muscle of the incised perineum. **C.** A continuous suture is carried downward to unite the superficial fascia. **D.**

Completion of repair. The continuous suture is carried upward as a subcuticular stitch. (An alternative method of closure of skin and subcutaneous fascia is illustrated in E.)

**E.** Completion of repair of median episiotomy. A few interrupted sutures of 3-0 chromic are placed through the skin and subcutaneous fascia and loosely tied. This closure avoids burying two layers of suture in the more superficial layers of the perineum.



### Labor and Delivery: Episiotomies

Intervention	Supporting Research
<ul style="list-style-type: none"><li>• Selective use of episiotomy rather than routine episiotomy leads to a lower risk of morbidity.</li></ul>	<ul style="list-style-type: none"><li>• A systematic review of six randomized controlled trials found that selective use of episiotomy shows a lower risk of clinically relevant morbidity, including posterior perineal trauma, a reduced need for suturing perineal trauma, and fewer healing complications at seven days. The only advantage found in the selective use of episiotomy is an increased risk of anterior perineal trauma. There was no difference in the incidence of major complications, such as severe vaginal or perineal trauma or in pain, dyspareunia (difficult or painful sexual intercourse), or urinary incontinence (Carroli and Belizan, 2000).</li><li>• A study of 62 women found that episiotomy was significantly associated with the length of perineal laceration. Twenty-seven (44%) of the women had episiotomies performed; they had significantly larger perineal lacerations when compared with those who did not undergo the procedure (4.9 cm vs. 1.1 cm). All of the third and fourth degree lacerations occurred in women who had episiotomies. The study suggests that episiotomies performed during vaginal deliveries rather than protecting the perineal floor cause it more damage. A multivariate analysis that controlled for other factors revealed that only episiotomy was significantly associated with the length of the perineal laceration (Nager and Helliwell, 2001).</li></ul>

## Module 5: Labor, Delivery, Immediate Postpartum Period

### Session 3: Second Stage of Labor- Third Stage of Labor

#### Contents:

- ▶ Delivery of the placenta
- ▶ Care of the Mother and NB WITHIN 1<sup>st</sup> hour of placental delivery
- ▶ Care of the Mother 1hour AFTER delivery of the placenta
- ▶ Assessment of the Mother after delivery and Before Discharge
- ▶ Respond to Problems Immediately Postpartum
- ▶ Skills

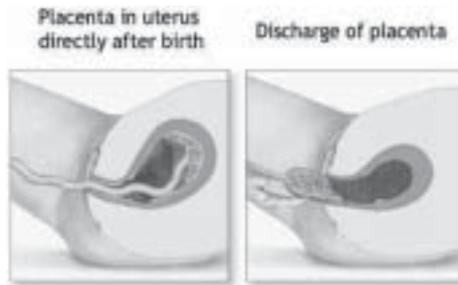
-Management of abnormal 3<sup>rd</sup> stage

-Antepartum Hemorrhage

-Active management of 3<sup>rd</sup> stage

#### Delivery of the Placenta

- ▶ Monitor Mother every 5 mins:
- ▶ For emergency signs using RAM (B3-B7)
- ▶ Feel if uterus is well-contracted
- ▶ Mood and behavior (distressed or anxious) (D6)
- ▶ Time since 3<sup>rd</sup> stage begun (time since birth)



- ▶ Record findings, treatment and procedures in *Labor Record and Partograph* (N4-N5)

#### Deliver the Placenta - Treat & Advise If Required

- ▶ Ensure 10 IU oxytocin IM is given
- ▶ Await strong contraction (2-3mins) and deliver by controlled cord traction.
- ▶ 30mins undelivered -empty bladder, encourage breastfeeding, repeat controlled cord traction
- ▶ 1hr undelivered - manual delivery (doctor), IM/IV antibiotic

#### Another 1hr undelivered — refer to hospital

- ▶ DO NOT exert excessive traction on the cord.
- ▶ DO NOT squeeze or push the uterus to deliver the placenta.
- ▶ Check the placenta and membranes if complete. If incomplete — remove fragments manually (doctor), IM/IV antibiotic B11, B15
- ▶ Check uterus if well contracted and no bleeding. Repeat check every 5 mins.

#### If heavy bleeding

- ▶ Massage uterus to expel clots if any, until it is hard B10
- ▶ 10 IU Oxytocin IM
- ▶ Call for help
- ▶ IV line B9, add 20 IU oxytocin x 60 drops/min
- ▶ Empty bladder

#### If bleeding persists and uterus soft —

- ▶ Continue massage
- ▶ Bimanual or aortic compression B10
- ▶ Continue IVF with 20 IU oxytocin x 30 drops/min
- ▶ Refer urgently to hospital B17
- ▶ Examine perineum, lower vagina and vulva for tears. If 3<sup>rd</sup> degree refer to hospital
- ▶ Collect, estimate and record blood loss throughout the 3<sup>rd</sup> stage and immediately afterwards.

### **Care of the Mother and NB within 1<sup>st</sup> hour of delivery of the Placenta**

- ▶ Monitor mother every 15 mins
- ▶ Monitor baby every 15 mins

### **Care of the Mother and NB**

- ▶ Assess amount of bleeding. Less than 5mins soaked or constant trickle of blood — B10

-if bleeding from a perineal tear, repair if required — B10 or Refer to hospital B17

- ▶ Ask the companion to stay with the mother
- ▶ Encourage the woman to pass urine

### **Care of the Mother 1HR after Delivery of the Placenta**

Use chart for continuous care of the mother until discharge.

### **Monitor mother at 2, 3 and 4 hrs, then every 4 hrs:**

- ▶ For emergency signs using RAM
- ▶ Feel uterus if hard and round
- ▶ Record findings, treatments and procedures in *Labor Record* and *Partograph* N4-N5
- ▶ Never leave the woman and baby alone
- ▶ DO NOT discharge before 12 hrs.

### **Care of the Mother — Interventions if Required**

- ▶ Advise on *Postpartum Care and Hygiene, Nutrition* D26
- ▶ Advise when to seek care D28
- ▶ Counsel on Birth Spacing and other Family Planning Methods D27
- ▶ Repeat examination of the mother before discharge using Asses the mother after delivery D21. For baby J2-8.

### **Assess the Mother after Delivery**

Use chart to examine the mother the first time after delivery (at 1 hr after delivery or later) and for discharge.

### **Ask, Check record:**

- ▶ Bleeding >250 ml
- ▶ Completeness of placenta and membranes
- ▶ Complications during delivery and postpartum
- ▶ Needs tubal ligation or IUD
- ▶ Others

### **Look, Listen and Feel:**

- ▶ Temperature
- ▶ Feel the uterus
- ▶ Vaginal bleeding
- ▶ Perineum: tear, swelling, pus
- ▶ Pallor

### **Signs – Classify – Treat & Advise**

- ▶ Give Preventive Measures D25
- ▶ Ensure that all are given before discharge.

### **Assess, Check records – Treat & Advise D25**

- ▶ RPR status. If none — do RPR test L5
- ▶ If (+) administer Benzathine Penicillin (F6)
- ▶ Tetanus toxoid status -give if due (F2)
- ▶ Give 500mg of Mebendazole to every woman once in 6 months (F3)
- ▶ Check woman's supply of iron/folate, vitamin A
- ▶ Give 3 months supply of iron and counsel on compliance (F3), give vitamin A if due (F2)
- ▶ Ask whether mother and baby are sleeping under insecticide bednet. F4
- ▶ Record all treatment given using Postpartum Record (N6)

### **Advise on Postpartum Care D26**

- ▶ Companion for the 1<sup>st</sup> 24hrs
- ▶ Not to insert anything in the vagina
- ▶ Rest and sleep
- ▶ Importance of washing
- ▶ Avoid sexual intercourse until perineal wound is healed

### **Counsel on Nutrition**

- ▶ Greater amount of variety of nutritious and healthy foods
- ▶ Ensure she can eat any normal foods
- ▶ More nutrition counseling on thin mothers and adolescents
- ▶ No to myths and fallacies about foods
- ▶ Seek help from family members about proper nutrition of the mother

### **Counsel on Birth Spacing and Family Planning D27**

- ▶ Importance of Family Planning
- ▶ Include partner of family member to be included in the counseling
- ▶ Explain non-breastfeeding can make her pregnant again
- ▶ Ask desired family size
- ▶ 2-3 years gap is healthy to the mother and child
- ▶ Give info on when to start a method after delivery will vary on whether the woman is breastfeeding or not
- ▶ Make arrangement on when to see a FP counselor, or counsel directly
- ▶ Advise correct and consistent use of condoms for dual protection against STIs or HIV and pregnancy. Promote their use (G2)
- ▶ For HIV (+) women see G4 for FP considerations
- ▶ Ask choice for Vasectomy of partner

### **Lactation Amenorrhea Method (LAM)**

- ▶ A breastfeeding woman is protected from pregnancy only if:
  - ▶ Not > 6 months postpartum
  - ▶ Breastfeeding exclusively (8 or more times/day)
  - ▶ Can also choose additional FP method

### **Method Options for the Non-breastfeeding Woman**

#### **Can be used immediately postpartum:**

- ▶ Condoms
- ▶ Progesterone-only pills

- ▶ Progesterone- only injectable
- ▶ Implant
- ▶ Spermicide
- ▶ Female sterilization (w/in 7 days or delay 6 weeks)
- ▶ IUD (w/in 48 hrs of delay 4 weeks)

#### **Delay 3 weeks:**

- ▶ Combined OCPs
- ▶ Combined injectables
- ▶ Diaphragm
- ▶ Fertility awareness method

#### **Delay 6 Weeks:**

- ▶ Progesterone-only OCPs
- ▶ Progesterone-only injectables
- ▶ Implants
- ▶ Diaphragm

#### **Delay 6 months:**

- ▶ Combined OCPs, injectables
- ▶ Fertility awareness method

### **Advise on When to Return D28**

- ▶ Use chart for advising on postpartum care
- ▶ Encourage woman to bring her partner or family member to at least 1 visit

### **Routine Postpartum Care Visits\_D28<sup>1st</sup> visit (D19) within**

- ▶ 1<sup>st</sup> week, preferably within 2-3 days
- ▶ 2<sup>nd</sup> visit (E2) 4-6 weeks

### **Follow-up Visits for Problems:**

If problem was:	Return in:
▶ Fever	2 days
▶ Lower UTI	2 days
▶ Perineal infection or pain	2 days
▶ Hypertention	1 week
▶ Urinary incontinence	1 week

If problem was:	Return in:
▶ Severe anemia	2 weeks
▶ Postpartum blues	2 weeks
▶ HIV (+)	2 weeks
▶ Moderate anemia	4 weeks
▶ If treated in hospital for complication	not later than 2 weeks

- ▶ Advise the women to bring her HBMR to the HC, even for an emergency visit.

### **Advise on danger signs**

Go to hospital or HC immediately, anytime, urgently if:

- ▶ Vaginal Bleeding 2-3 pads soaked in 20-30 mins after delivery, increases after delivery
- ▶ Convulsion
- ▶ Fast or difficult breathing
- ▶ Fever and too weak to get out of bed
- ▶ Severe abdominal pain

### **Go to Health Center ASAP for the following signs:**

- ▶ Fever
- ▶ Abdominal pain
- ▶ Feels ill
- ▶ Breast swollen, red, tender, sore nipple
- ▶ Urine dribbling or pain on micturition
- ▶ Pain in perineum or draining pus
- ▶ Foul-smelling lochia

### **How to prepare for an Emergency in postpartum**

- ▶ Always have someone near at least 24hrs after delivery
- ▶ Discuss with partner or family member about emergency issues:
  - where to go
  - how to reach the hospital
  - costs involved
  - family and community support
- ▶ Advise the woman to ask for help from the community if needed I 1-3.

## Module 6: Postpartum Care

### Session 1: Post Partum examination of the Mother Up to Six Weeks

- ▶ Always begin with RAM pp E2-E7
- ▶ For examination of the woman on postpartum follow-up or after home delivery, use Postpartum Examination of the Mother (P2)
- ▶ Use 'Respond to Observed Signs of Volunteered Problems' chart if an abnormal sign is identified (E3-E10)
- ▶ Record all findings and treatment given then schedule next visit.
- ▶ For the first and second postpartum visits, during the first week after delivery, use the Postpartum Examination chart (E2)
- ▶ For further advise, use Advise and Counselling Section D26
- ▶ If the woman is HIV Positive, Adolescent or with Special Needs G2-G8, H1-H4

#### Overview

- ▶ Time between delivery of the baby – 6 weeks
- ▶ Complications may usually occur
- ▶ Morbidity & mortality attributed to inadequate knowledge of proper assessment and management while the mother is in the health facility
- ▶ Important role of health providers: prevent such problems to occur

#### Postpartum Care Sessions:

- ▶ Postpartum Examination of the Mother Up to Six Weeks, Postpartum Care
- ▶ Respond to Observed Signs and Volunteered Problems
- ▶ Preventive Measures and Additional Treatments

### Session 1: Postpartum Examination of the Mother Up to Six Weeks (E2)

- ▶ Use this chart for examining the mother after discharge from a facility

- ▶ If she delivers less than 1 week ago without a skilled attendant, use the chart Assess the Mother After Delivery (D21)

#### Ask, Check Record

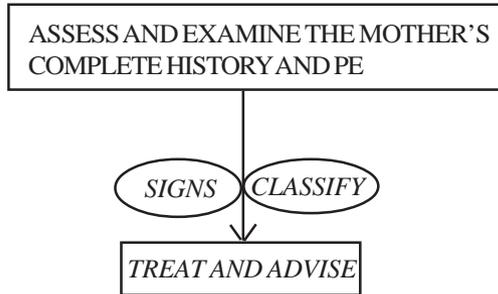
- ▶ When, where delivered
- ▶ How are you feeling?
- ▶ Pain, fever, bleeding since delivery?
- ▶ Hard to void urine?
- ▶ Family Planning?
- ▶ Other concern?
- ▶ Check records: complications, tx during delivery?
- ▶ HIV Status

#### Look, Listen & Feel

- ▶ BP, Temp
- ▶ Feel uterus. Is it hard, round?
- ▶ Look at vulva & perineum for: tear, swelling, pus
- ▶ Look at pad for bleeding and lochia:
  - does it smell?
  - is it profuse?
- ▶ Look for pallor

#### Treat and Advise

- ▶ What to watch for hygiene, counsel on nutrition (D26)
- ▶ Counsel on birth spacing and FP (D27)
- ▶ Iron supply for 3months, compliance (F3)
- ▶ Treatment or prophylaxis due: TTd (F2)
- ▶ Impregnated bed for mother and babyRecord on the mother's HBMR
- ▶ Advise to return within 4-6 weeks



## Module 6: Postpartum Care

### Session 2: Respond to Observed Signs & Volunteered Problems

#### Observed signs & Volunteered problems:

- ▶ Elevated diastolic BP
- ▶ Pallor
- ▶ HIV status
- ▶ Heavy bleeding
- ▶ Fever or foul-smelling lochia
- ▶ Dribbling urine
- ▶ Pus or perineal pain
- ▶ Feeling unhappy or crying easily
- ▶ Vaginal discharge 4 weeks after delivery
- ▶ Breast problem
- ▶ Cough or breathing difficulty
- ▶ Taking anti-tuberculosis drugs
- ▶ Signs suggesting HIV infection

#### Summary

- ▶ Recognize problem
- ▶ Respond to volunteered problem or observed signs
- ▶ Manage properly the problem

## Module 6: Postpartum Care

### Session 3: Preventive Measures & Additional Treatments

#### Contents:

- ▶ Tetanus toxoid (TTd)
- ▶ Vitamin A postpartum
- ▶ Iron and Folic Acid
- ▶ Compliance on Iron treatment
- ▶ Antimalarial treatment and Paracetamol
- ▶ Oral antibiotics
- ▶ Signs of allergy

#### Tetanus toxoid

- ▶ All women, 0.5 ml IM
- ▶ Check TTd status: when last given, which dose
  - if unknown -give TTd 1
  - give TTd 2 in 4 weeks
- ▶ Explain its safe in pregnancy, ADR
- ▶ Advise when is next dose
- ▶ Record on mother's card

#### Tetanus toxoid schedule:

- ▶ At 1<sup>st</sup> contact w/ woman of childbearing age or at 1<sup>st</sup> antenatal care visit, ASAP - TTd1
- ▶ At least 4 weeks after TTd1 — TTd2
- ▶ At least 6 months after TTd2 — TTd3
- ▶ At least 1 year after TTd3 — TTd4
- ▶ At least 1 year after TT4 — TTd5

#### Vitamin A

- ▶ 200,000 IU capsule after delivery or w/in 6 weeks of delivery
- ▶ Helps recovery, good to the baby also
- ▶ Nausea and headache temporary only
- ▶ Do not give capsules with high dose of vitamin A during pregnancy

## Iron & Folic acid

- ▶ All pregnant, postpartum and post-abortion women
- ▶ Give 3 months supply
- ▶ 1 tablet = 60mg iron, 400ug folic acid
- ▶ Motivate compliance

## Antimalarial treatment

- ▶ Give preventive intermittent treatment for falciparum malaria
- ▶ Sulfadoxine-pyrimethamine at the beginning of 2<sup>nd</sup> and 3<sup>rd</sup> trimester to all women according to nat'l policy
- ▶ Check when last dose is given:
  - if no dose in last month, give 3 tablets in clinic
  - ▶ Advise when next dose is due
  - ▶ Monitor baby for jaundice if given just before delivery
  - ▶ Record in home-based record
  - ▶ Sulfadoxine-pyrimethamine
  - ▶ 1 tablet = 500mg sulfadoxine + 25 mg pyrimethamine
    - Second trimester = 3 tablets
    - Third trimester = 3 tablets
  - ▶ Oral anti-malarial treatment

## Paracetamol

- ▶ For severe pain
- ▶ 500 mg
- ▶ 1-2 tabs every 4-6 hrs

## Insecticide-treated bednet

- ▶ Dip in insecticide every 6 months
- ▶ Provide information to help her do this

## Mebendazole

- ▶ Give 500 mg to every woman once in 6 months
- ▶ Do not give in the first trimester

- ▶ Mebendazole 100mg tablet = 5 tablets

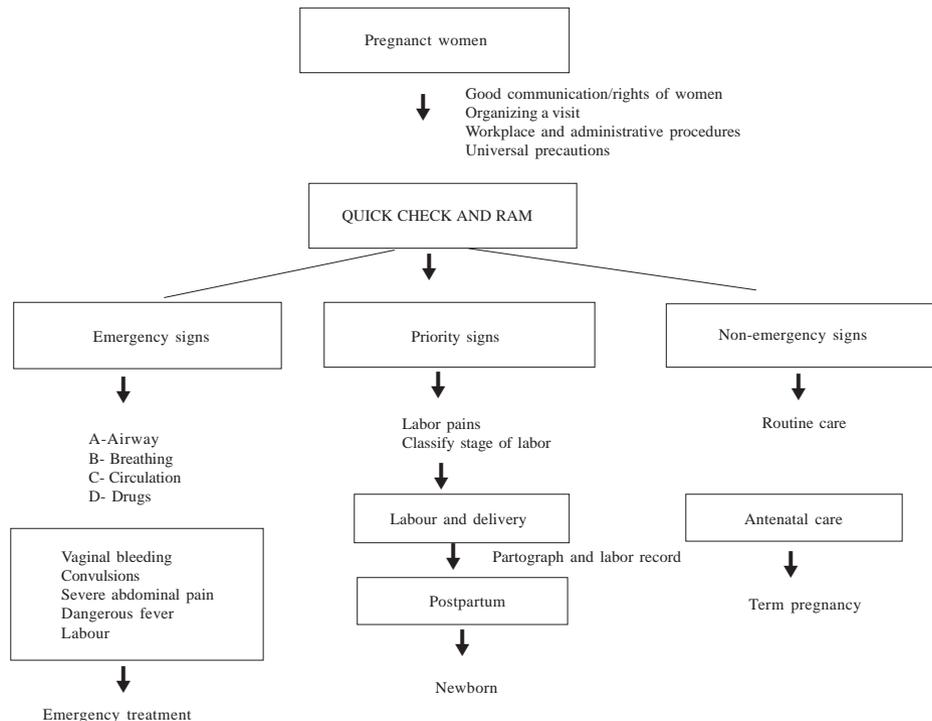
## Summary

### Complete management of a mother by:

- ▶ Giving these preventive measures
- ▶ Treating infectious conditions
- ▶ Recognize and initially manage allergy after giving medications

## Module 6: Postpartum Care

### Session 3: Preventive Measures & Additional Treatments-RAM



## **Module 7: Newborn Care**

### **Session 1: Care of the Newborn Baby at the Time of Birth D11 - Immediate Newborn Care**

#### **Basic Needs of the Newborn at Birth**

- ▶ To breathe normally
- ▶ To be warm
- ▶ To be fed
- ▶ To be protected

#### **Preparing to Meet the Baby's Needs**

- ▶ “Good care of the newborn begins with good preparation”
- ▶ Have clean warm towels/ cloths ready for the newborn (warmth)
- ▶ Have a sterile kit to tie and cut the cord (protection)
- ▶ Keep the delivery room clean and warm (warmth, protection)
- ▶ Keep the mother and baby in skin-to-skin contact from birth to encourage breastfeeding (warmth, feeding)
- ▶ Have resuscitation equipments near the delivery bed (breathing)

#### **Universal Precautions A4**

- ▶ Always remember the importance of observing precautions to help protect the mother and baby and ourselves from infections with bacteria, viruses including HIV
- ▶ Change the gloves. If not possible, wash gloved hands.

#### **Give Immediate Newborn Care J10**

- ▶ Place baby on the mother's abdomen or arms;
- ▶ Note the time of delivery;
- ▶ Dry the baby . Wipe eyes. Discard wet cloth;
- ▶ Assess baby's breathing while drying;
- ▶ Most babies cry at birth and breathe normally.

- ▶ However, a baby may behave in a number of ways after it is born, thus we should be always be prepared for the baby who will need help with its breathing. (Newborn Resuscitation – B11)
- ▶ Clamp and cut the cord
  - put ties tightly around the cord at 2 cm and 5 cm from baby's abdomen;
  - cut between ties with sterile instrument.
  - observe for oozing blood.
- ▶ Leave baby on the mother's chest in skin-to-skin contact;
- ▶ Place identification label;
- ▶ Encourage initiation of breastfeeding (K2);
- ▶ If HIV-positive mother-G7,G8

#### **Care of the Newborn within the first hours of life J19 Permanent surveillance**

- ▶ Never leave the woman and newborn alone;
- ▶ Keep the mother and baby in the delivery room;
- ▶ Record findings, treatments and procedures in the labor record;

#### **Monitor every 15 minutes:**

##### **Baby**

- ▶ Breathing
- ▶ warmth

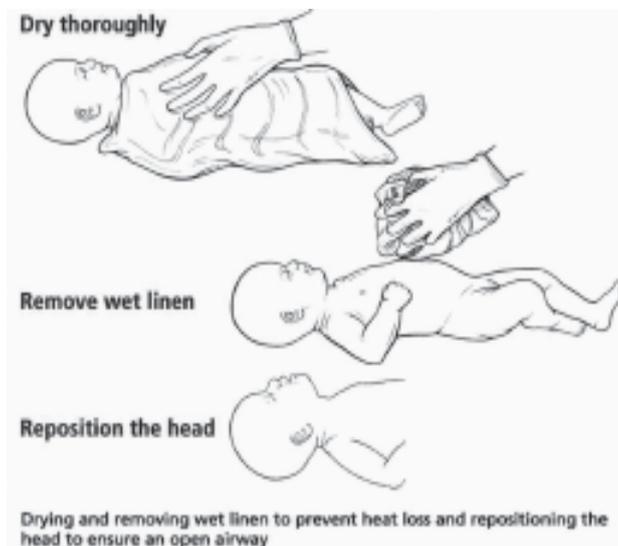
#### **Care of the mother and newborn**

- ▶ Wipe the eyes
- ▶ Apply an eye antimicrobial within 1 hour of birth
  - 1% silver nitrate drops or
  - 2.5% povidone iodine drops or
  - 1% tetracycline ointment.
- ▶ Administer Vitamin K 0.5 -1 mg IM
- ▶ If blood or meconium, wipe off with wet cloth and dry.
- ▶ DO NOT remove vernix or bathe the baby.
- ▶ Keep the baby warm and in skin-to-skin contact with the mother – K9

## Keep the baby warm K9

### At birth and within the first hour(s)

- ▶ Warm delivery room
- ▶ Dry the baby: place the baby on the mother's abdomen or on a warm, clean and dry surface. Dry the whole body and hair thoroughly, with a dry cloth.
- ▶ Skin-to-skin contact: Leave the baby on the mother's abdomen (before cord cut) or chest (after cord cut) after birth for at least 2 hours. Cover the baby with a soft dry cloth.



### Help the mother to initiate breastfeeding within 1 hour, when baby is ready

#### (K2 box 2)

- ▶ Signs of readiness to breastfeed are: baby looking around/moving, mouth open, searching.
- ▶ Check position and attachment at the first feed. Offer to help the mother at any time (K3).
- ▶ Let the baby release the breast by her/himself; then offer the second breast.

- ▶ If unable to initiate breastfeeding, plan for alternative feeding method K5-K8
- ▶ If mother HIV+ and chooses replacement feeding, feed accordingly (G8)
- ▶ If the baby does not feed in 1 hour, examine the baby (J2-J9). If healthy, leave the baby with the mother to try later. Assess in 3 hours, or earlier if the baby is small (J4).
- ▶ If the mother is ill and unable to breastfeed, help her to express breast milk and feed the baby by cup (J4).
- ▶ If mother cannot breastfeed at all, use one of the following options:
  - home-made or commercial formula
  - donated heat-treated breast milk.

### In the first two hours after birth, it is not necessary to:

- ▶ Weigh or measure the baby
- ▶ Bathe the baby
- ▶ Dress the baby
- ▶ Give the baby any other food other than breast milk
- ▶ Give the baby to anyone apart from the mother

### Review

- ▶ Make sure that the delivery area is ready for the mother and baby;
- ▶ Observe universal precautions at all times (protection);
- ▶ Keep the delivery room warm (warmth, protection);
- ▶ Have resuscitation equipment near the delivery bed (breathing);
- ▶ Have clean warm towels/cloths ready for the baby (warmth);
- ▶ Have a sterile kit to tie/clamp and cut the cord;
- ▶ Apply antimicrobial to the eyes (protection);
- ▶ Keeping the mother and baby in skin-to-skin contact encourages early breastfeeding (warmth, feeding).

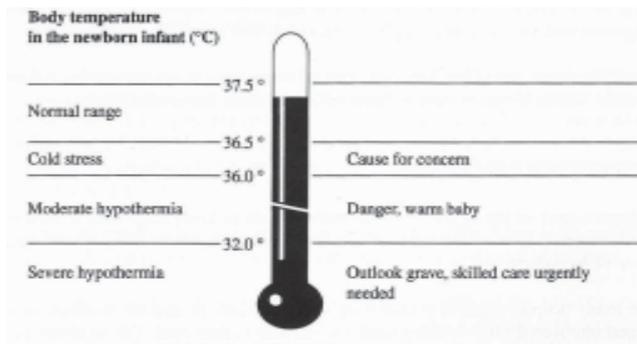


Preventing heat loss at the time of birth:  
drying · wrapping · skin-to-skin · breast-feeding

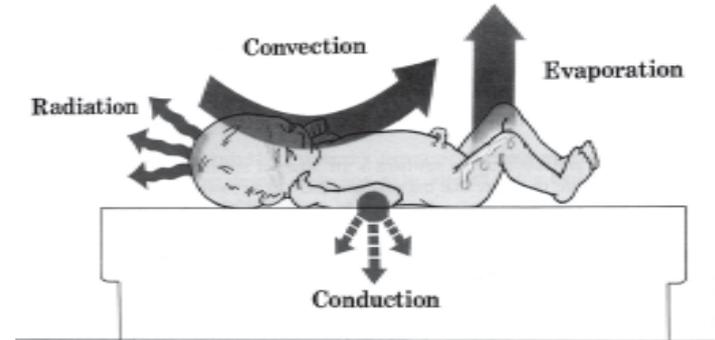
## Module 7: Newborn Care

### Session 1: Care of the Newborn Baby at the Time of Birth D11-Keeping the Baby Warm – K9

What is hypothermia?



Hypothermia in the newborn infant



Four ways a newborn may lose heat to the environment

#### The “Warm Chain”

- ▶ Warm delivery room
- ▶ Immediate drying
- ▶ Skin-to-skin contact
- ▶ Breastfeeding
- ▶ Bathing and weighing postponed
- ▶ Appropriate clothing and bedding
- ▶ Mother and baby together
- ▶ Warm transportation
- ▶ Warm resuscitation
- ▶ Training and awareness

#### Ensure Warmth for the Newborn Baby K9

- ▶ Keep the baby warm
- ▶ Keep a small baby warm
- ▶ Rewarm the baby skin-to-skin

#### Rewarm the baby skin-to-skin

- ▶ Before rewarming, remove the baby’s cold clothing.
- ▶ Place the newborn skin-to-skin on the mother’s chest dressed in a pre-warmed shirt open at the front, a diaper, hat and socks.

- ▶ Cover the infant on the mother's chest with her clothes and an additional (pre-warmed) blanket.
- ▶ Check the temperature every hour until normal.
- ▶ Keep the baby with the mother until the baby's body temperature is in normal range.

### Re-warming a cold baby

- ▶ If the baby is LBW or preterm, encourage the mother to keep the baby in skin-to-skin contact for as long as possible, day and night.
- ▶ Be sure the temperature of the room where the rewarming takes place is at least 25°C.
- ▶ If the baby's temperature is not 36.5°C or more after 2 hours of rewarming, reassess the baby (J2-J7).
- ▶ If referral needed, keep the baby in skin-to-skin position/contact with the mother or other person accompanying the baby.

### Taking a baby's temperature

#### If you have a thermometer:

- ▶ Make sure it is clean. Shake it down so that it reads < 35°C
- ▶ Place the silver/red bulb end of the thermometer under the baby's arm, in the middle of the armpit
- ▶ Gently hold the baby's arm against his body
- ▶ Keep the thermometer in place for 3-5 minutes
- ▶ Remove the thermometer and read the temperature
- ▶ Record the temperature in the baby's notes

#### If you do not have a thermometer:

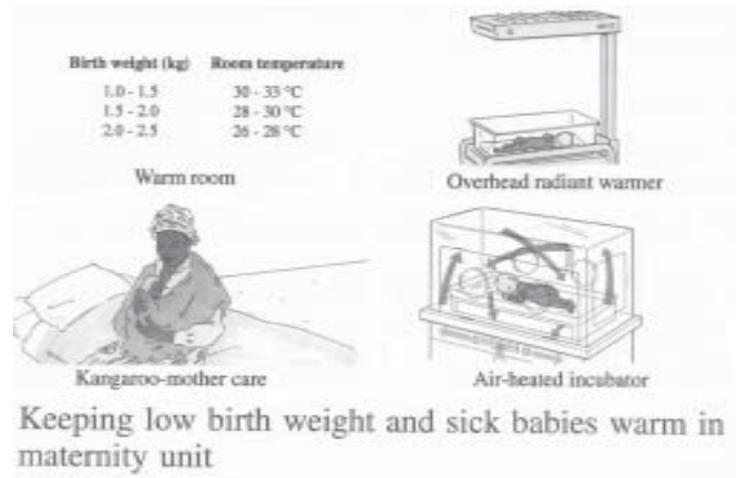
- ▶ Feel the baby's feet.
- ▶ If they are cold to touch, the baby is cold and needs to be warmed
- ▶ If the baby's temperature is < 36°C or >37.5°C, the baby will need to be observed.

### Does a newborn baby's temperature need to be taken routinely by a thermometer?

An accurate temperature is needed

if the baby is:

- ▶ Preterm or low birthweight or sick
- ▶ Admitted to the hospital
- ▶ Suspected of being either hypothermic or hyperthermic
- ▶ Being rewarmed during the management of hypothermia
- ▶ Being cooled down during the management of hyperthermia





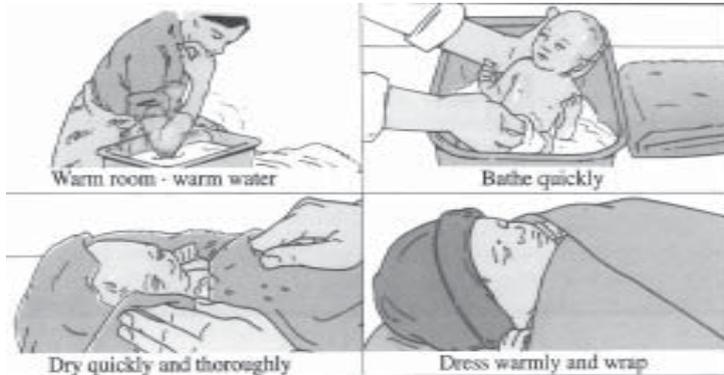
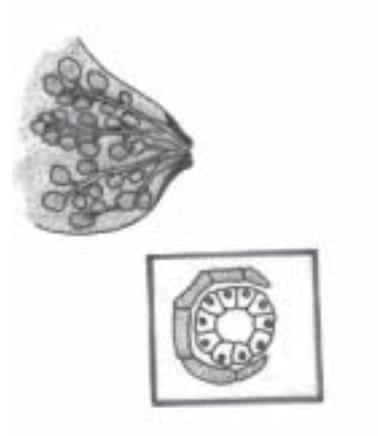
Kangaroo-mother care keeps baby warm, promotes breast-feeding and increases mother's confidence

**Module 7: Newborn Care**  
**Session 1: Care of the Newborn Baby at the Time of Birth-Breastfeeding the Newborn Baby**

**What to teach the mother about breastfeeding:**

- ▶ Correct attachment and positioning (K3box 2)
- ▶ Importance of exclusive breastfeeding (K2 box 1)
- ▶ How to express her milk (K5)
- ▶ How to prevent or treat common problems
- ▶ When to seek help

**Anatomy of the Breast**



Warm room - warm water

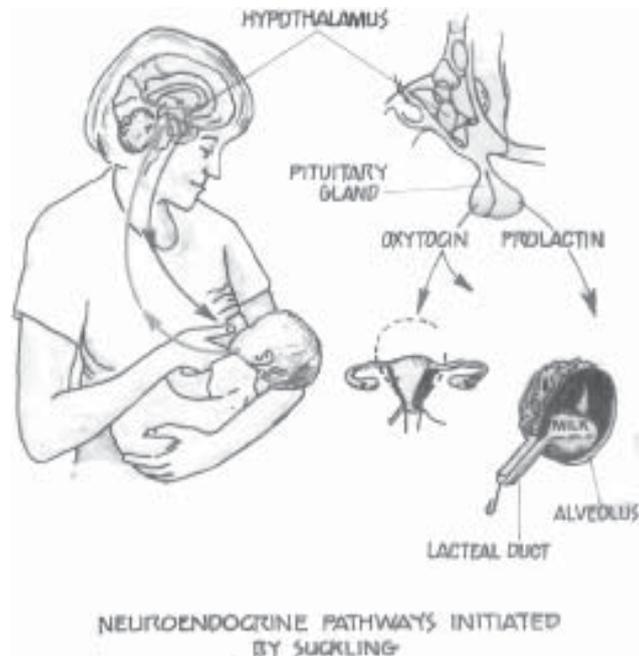
Bathe quickly

Dry quickly and thoroughly

Dress warmly and wrap

Bathing the infant - if his temperature is normal not before 6 hours after birth

## Physiology of breastfeeding



### Key points to good attachment:

- ▶ The baby's mouth is widely open
- ▶ The tongue is far forward in the mouth, and may be seen over the bottom gum
- ▶ The lower lip is turned outwards
- ▶ The chin is touching the breast
- ▶ More areola is visible above the baby's mouth than below it K3 box 2

### For the mother to attach her baby, she should:

- ▶ Touch her baby's lips with her nipple
- ▶ Wait until her baby's mouth is opened widely
- ▶ Move her baby quickly onto the breast, aiming the infant's lower lip well below the nipple

### Problems that may arise if the baby is not well attached to the breast

#### The baby:

- ▶ May cry a lot and be unhappy
- ▶ May be slow to gain weight, or may even lose weight

#### The mother:

- ▶ May get sore/cracked nipples
- ▶ May get very full breasts which feel hard, sometimes they may feel hot and may look red

### Key points to good positioning- p.K3

- ▶ The baby's head and body are in a straight line
- ▶ The baby's face is opposite the nipple and breast
- ▶ The baby's upper lip or nose is opposite the mother's nipple
- ▶ The baby is held as close to the mother's body as possible
- ▶ The baby's whole body is supported if the mother is in a sitting position.

### The baby's first breastfeed

Help the mother to initiate breastfeeding within 1 hour, when the baby is ready.

### Other breastfeeding concerns K8

- ▶ Give special support to the mother who is not breastfeeding ( Mother or baby ill)
- ▶ If the baby does not have a mother
- ▶ Advise the mother who is not breastfeeding at all on how to relieve engorgement ( baby died or stillborn or mother chose replacement feeding)

## Module 7: Newborn Care

### Session 1: Care of the Newborn Baby at the Time of Birth-Alternative Methods of Feeding a Baby

#### Why a baby may not be able to breastfeed

- ▶ Preterm
- ▶ Low birth weight
- ▶ The baby or the mother is ill
- ▶ The baby or mother is referred to another hospital
- ▶ Alternative feeding methods
- ▶ Direct expression of breastmilk
- ▶ Cup feeding
- ▶ Gastric tube
- ▶ Spoon
- ▶ Syringe
- ▶ Breastfeeding supplementer
- ▶ Bottle

#### What are the advantages of direct expression of breastmilk?

- ▶ The mother can do it
- ▶ She can do it anytime and anywhere
- ▶ It does not require the baby to use a lot of energy
- ▶ It encourages skin-to-skin contact between the mother and baby
- ▶ It encourages the baby to use its instinctive responses
- ▶ It can be done before the baby is able to coordinate its swallowing, sucking and breathing.

#### Direct expression of breastmilk into the baby's mouth

- ▶ Hold the baby in skin-to-skin contact, the mouth close to the nipple.
- ▶ Express the breast until some drops of breast milk appear on the nipple.
- ▶ Wait until the baby is alert and opens mouth and eyes, or stimulate the baby lightly to awaken her/him.
- ▶ Let the baby smell and lick the nipple, and attempt to suck.

- ▶ Let some breast milk fall into the baby's mouth.
- ▶ Wait until the baby swallows before expressing more drops of breast milk.
- ▶ After some time, when the baby has had enough, she/he will close her/his mouth and take no more breast milk.
- ▶ Ask the mother to repeat this process every 1-2 hours if the baby is very small (or every 2-3 hours if the baby is not very small).
- ▶ Be flexible at each feed, but make sure the intake is adequate by checking daily weight gain.

#### Why cup feeding?

- ▶ A cup is a simple piece of equipment
- ▶ A cup is easy to clean
- ▶ Simple method of feeding
- ▶ The baby can take what he needs in his own time

#### How to Cup Feed

- ▶ Ask the mother to:
- ▶ Measure the quantity of milk in the cup
- ▶ Hold the baby sitting semi-upright on her lap
- ▶ Hold the cup of milk to the baby's lips:
  - rest cup lightly on lower lip
  - touch edge of cup to outer part of upper lip
  - tip cup so that milk just reaches the baby's lips
  - do not pour the milk into the baby's mouth.
- ▶ When the baby smells the milk, the baby becomes alert, opens mouth and eyes, and starts to feed.
- ▶ The baby will sip or suck the milk into his mouth
- ▶ Preterm /Small babies take milk into their mouth with their tongue using a lapping movement.
- ▶ Preterm babies do not dribble as much as older babies.
- ▶ Baby finishes feeding when mouth closes or when not interested in taking more.

#### Cup Feeding

- If the baby does not take the calculated amount:
- ▶ Feed for a longer time or feed more often

- ▶ Teach the mother to measure the baby's intake over 24 hours, not just at each feed.
- ▶ Feed the baby by cup if the mother is not available to do so.
- ▶ Baby is cup feeding well if required amount of milk is swallowed, spilling little and weight gain is maintained.

### **How to hand express breastmilk**

- ▶ Prepare a clean containers to collect and store the milk. A wide necked jug, jar, bowl or cup can be used.
- ▶ Once expressed, the milk should be stored with a well-fitting lid or cover.
- ▶ Teach the mother to express her milk by herself. **DO NOT** do it for her.

### **How to hand express breastmilk**

Teach the mother how to:

- Wash her hands thoroughly.
- Sit or stand comfortably and hold a clean container underneath her breast.
- Put her first finger and thumb on either side of the areola, behind the nipple ( about 4 cm from the tip of the nipple).
- Compress and release the breast between her finger and thumb.
- Compress in the same way all the way around the breast keeping her fingers the same distance from the nipple

### **How to hand express breastmilk**

- ▶ Express one breast until the milk just drips, then express the other side until the milk just drips.
- ▶ Continue alternating sides for at least 20-30 minutes.

### **If milk does not flow well:**

- ▶ Apply warm compresses to the breast
- ▶ Gently massage the breast

- ▶ Have someone massage her back and neck before expressing.

### **How to hand express breastmilk**

- ▶ Feed the baby by cup immediately. If not, store expressed milk in a cool, clean and safe place.
- ▶ If necessary, repeat the procedure to express breast milk at least 8 times in 24 hours.
- ▶ Express as much as the baby would take or more, every 3 hours.

## Module 7: Newborn Care

### Session 1: Newborn Resuscitation-Neonatal Resuscitation

#### Why learn neonatal resuscitation?

- ▶ Birth asphyxia accounts for 19% of approx. 5 million neonatal deaths that occur each year worldwide (WHO, 1995)
- ▶ Outcomes of more than 1 million newborns per year might be improved by resuscitation techniques

#### Which babies require resuscitation?

- ▶ At least 90 percent newly born babies are vigorous
- ▶ Ten percent require some kind of assistance
- ▶ One percent need resuscitative measures to survive

#### Overview and Principles of Resuscitation

- ▶ Physiologic changes at birth
- ▶ Resuscitation flow diagram
- ▶ Resuscitation risk factors
- ▶ Equipment and personnel needed

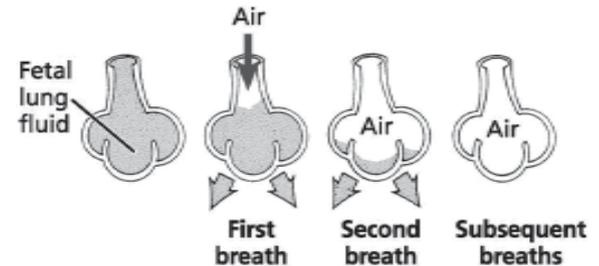
#### Lungs and Circulation

##### In the fetus

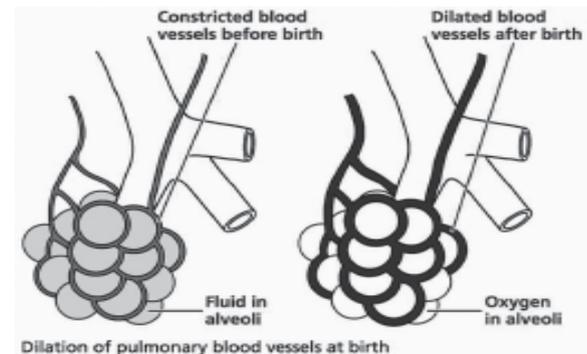
- ▶ In utero, the fetus is dependent on the placenta as the organ of gas exchange
- ▶ Air sacs are filled with fetal lung fluid
- ▶ Arterioles are constricted
- ▶ Pulmonary blood flow is diminished
- ▶ Blood flow is diverted across ductus arteriosus

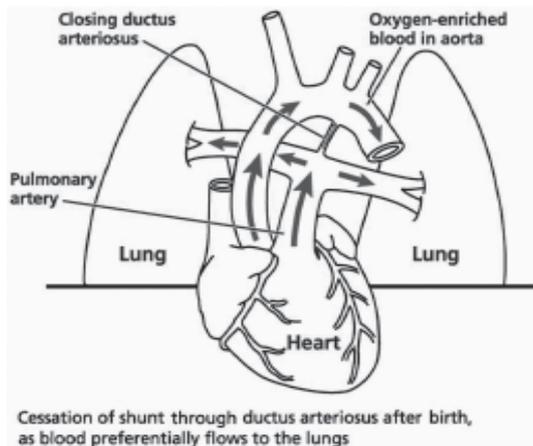
##### After delivery

- ▶ Lungs expand with air
- ▶ Fetal lung fluid leaves alveoli
- ▶ Pulmonary arterioles dilate
- ▶ Pulmonary blood flow increases
- ▶ Blood oxygen levels rise
- ▶ Ductus arteriosus constricts
- ▶ Blood flows through the lungs to pick up oxygen



Fluid replaced by air in alveoli





### Normal Transition

These major changes take place within seconds after birth:

- ▶ Fluid in the alveoli is absorbed
- ▶ Umbilical arteries and vein constrict
- ▶ Blood vessels in lung tissue relax

### Fetal lung fluid clearance

- ▶ Improved with labor before delivery
- ▶ Facilitated with effective initial breaths
- ▶ Impaired by

–Apnea at birth with no lung expansion

–Shallow ineffective respirations

### Pulmonary blood flow

- ▶ Decreases with hypoxemia and acidosis due to vasoconstriction
- ▶ Increases with ventilation, oxygenation, and correction of acidosis

### Cardiac function and compensatory mechanisms in asphyxia

- ▶ Initial response
  - Constriction of vascular beds in lungs, intestines, kidneys, muscle, and skin to redistribute blood flow to heart and brain
- ▶ Late effects
  - Myocardial function may be impaired, cardiac output decreases, and organ damage may occur

### What Can Go Wrong During Transition

- ▶ Insufficient ventilation, airway blockage, or both
- ▶ Excessive blood loss or poor cardiac contractility
- ▶ Sustained constriction of pulmonary arterioles

### Signs of a Compromised Newborn

- ▶ Cyanosis
- ▶ Bradycardia
- ▶ Low blood pressure
- ▶ Depressed respiratory effort
- ▶ Poor muscle tone

### Interruption in Normal Transition: Apnea

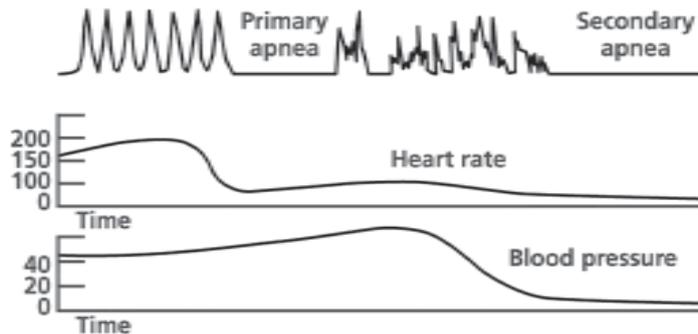
#### Primary apnea

Rapid attempts to breathe

- ▶ Respirations cease
- ▶ Heart rate decreases
- ▶ Blood pressure is usually maintained
- ▶ Responds to stimulation

#### Secondary Apnea

- ▶ Respirations cease
- ▶ Heart rate decreases
- ▶ Blood pressure decreases
- ▶ No response to stimulation



Heart rate and blood pressure changes during apnea

- Provide warmth
- Position; clear airway\* (as necessary)
- Dry, stimulate, reposition
- Give O<sub>2</sub> (as necessary)

A

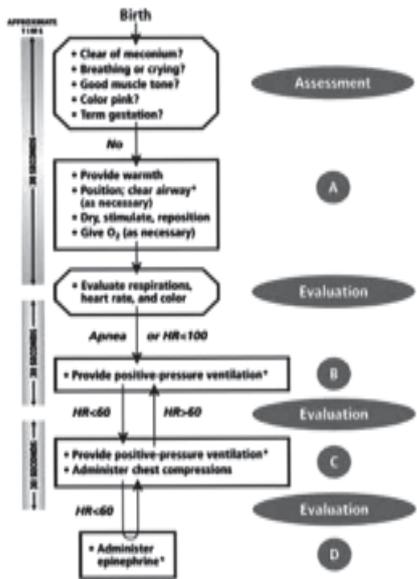
\*Endotracheal intubation may be considered at several steps.

**Provider Responses: Resuscitation Flow Diagram Initial Steps (Block A)**

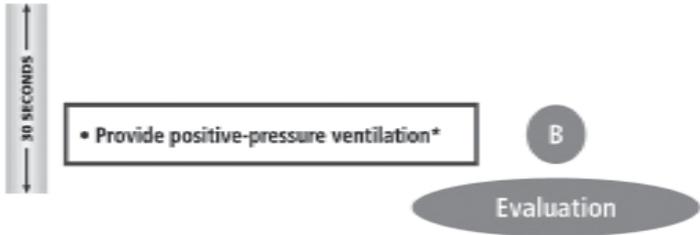
**Evaluation**

After these initial steps, further actions are based on evaluation of:

- ▶ Respiration
- ▶ Heart Rate
- ▶ Color



\*Endotracheal intubation may be considered at several steps.

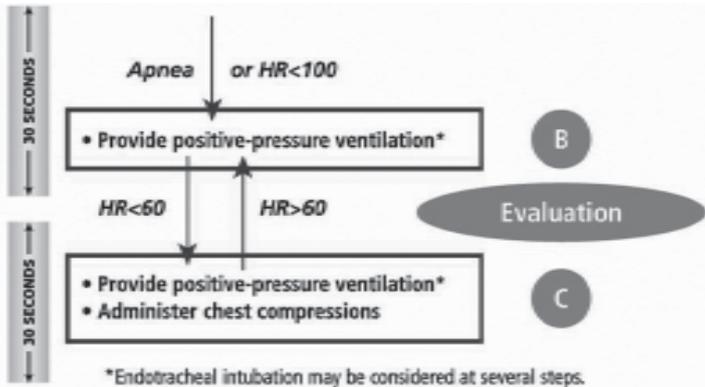


\*Endotracheal intubation may be considered at several steps.

**Breathing (Block B)**

**If Apnea or HR < 100 bpm:**

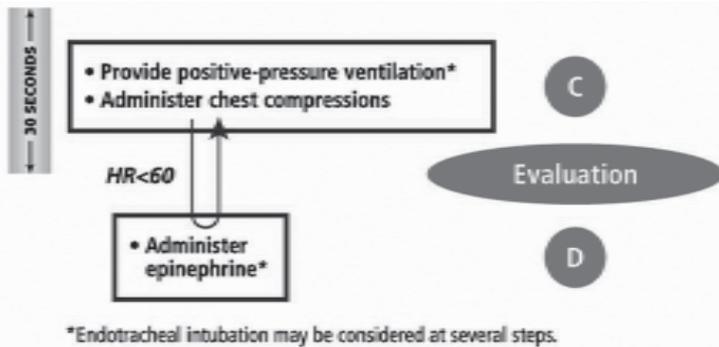
- ▶ Assist newborn by providing positive-pressure ventilation with a bag and mask for 30 seconds.
- ▶ Then, evaluate again



### Circulation (Block C)

#### If HR < 60 bpm despite adequate ventilation:

- ▶ Support circulation by starting chest compressions while continuing ventilation.
- ▶ Then, evaluate again. If heart rate < 60, proceed to D.



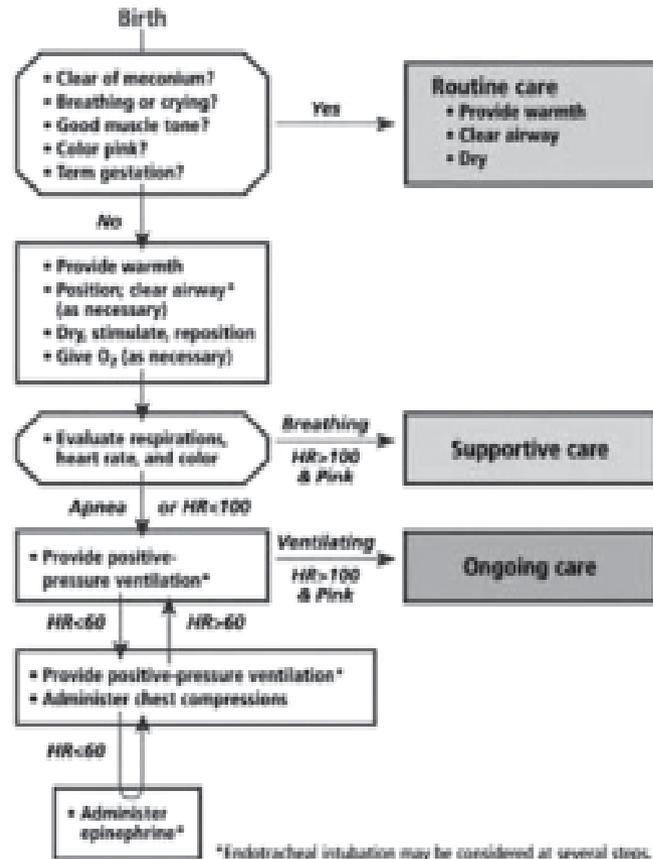
### Drug (Block D)

#### If HR < 60 bpm despite adequate ventilations and chest compressions:

- ▶ Administer epinephrine as ventilation and chest compressions continue

### Important Points in the Neonatal Resuscitation Flow Diagram

- ▶ Heart rate < 60 additional steps needed
- ▶ Heart rate > 60 chest compressions can be stopped
- ▶ Heart rate > 100 positive-pressure ventilation can be stopped
- ▶ Asterisk (\*) endotracheal intubation may be considered at several steps
- ▶ Timeline – 30 seconds if no improvement, then proceed to next step



## Evaluation, Decision and Action Cycle

### Preparation for Resuscitation Personnel and Equipment

- ▶ Trained person to initiate resuscitation at every delivery
- ▶ Recruit additional personnel, if needed for complex delivery
- ▶ Prepare necessary equipment
  - Turn on radiant warmer
  - Check resuscitation equipment

### Preparation for Resuscitation Risk Factors

- ▶ Antepartum factors
- ▶ Intrapartum factors

### Why are Premature Newborns at Higher Risk?

- ▶ Possible surfactant deficiency
- ▶ Increased heat loss, poor temperature control
- ▶ Possible infection
- ▶ Susceptible to intracranial hemorrhage

## Module 7: Newborn Care

### Session 2: Newborn Resuscitation-Initial Steps

#### Decide if resuscitation is needed

- ▶ Open the airway
- ▶ Manage if meconium is present
- ▶ Provide free-flow oxygen

#### Evaluating the Newborn

Immediately after birth, the following questions must be asked:

#### Initial Steps

- ▶ Provide Warmth
- ▶ Position; clear airway (as necessary)
- ▶ Dry, stimulate, reposition
- ▶ Give O<sub>2</sub> (as necessary)

#### Prevent heat loss by

- ▶ Placing newborn under radiant warmer
- ▶ Drying thoroughly
- ▶ Removing wet towel



Radiant warmer for resuscitating newborns

## Preventing Heat Loss

- ▶ Premature newborns
- ▶ Special problems
- Thin skin
- Decreased subcutaneous tissue
- Large surface area
  - ▶ Additional steps
- Raise environment temperature
- Cover with clear plastic sheeting

## Open the airway by

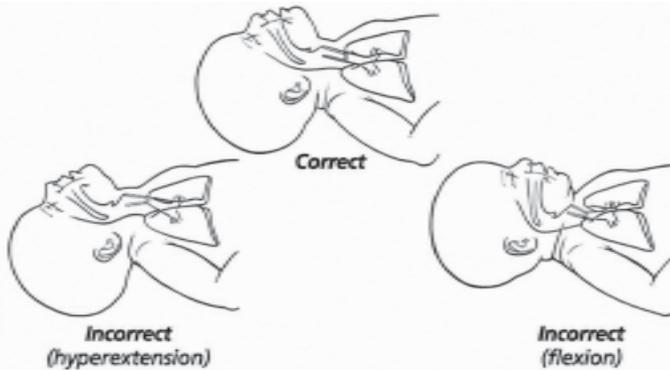
- ▶ Positioning on back or side
- ▶ Slightly extending neck
- ▶ “Sniffing” position
- ▶ Aligning posterior pharynx, larynx and trachea

## Opening the Airway

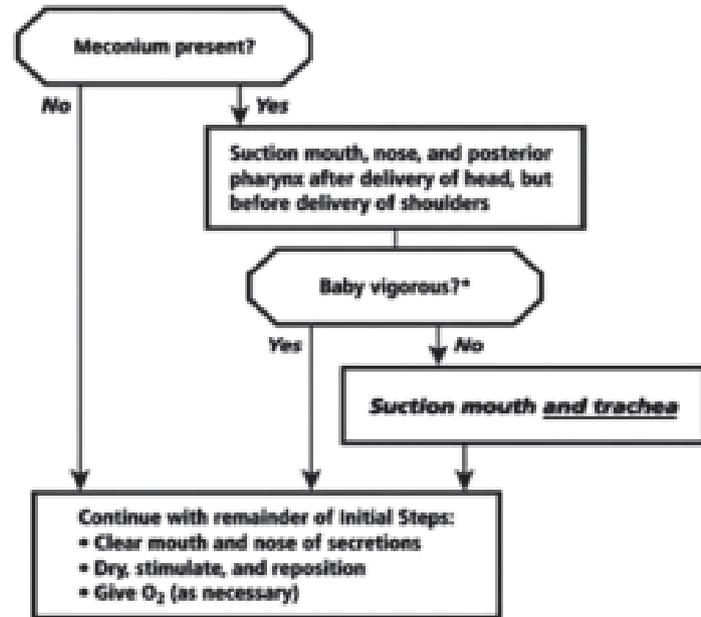
## Meconium Present and Newborn Vigorous

If:

- ▶ Respiratory effort is strong, *and*
- ▶ Muscle tone is good, *and*
- ▶ Heart rate is greater than 100 bpm



Correct and incorrect head positions for resuscitation



\*“Vigorous” is defined as strong respiratory efforts, good muscle tone, and a heart rate greater than 100 bpm.

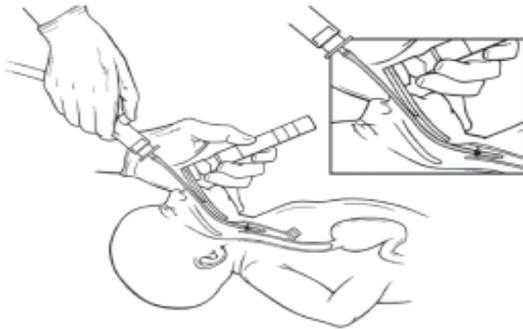
Then:

- ▶ Use bulb syringe or large-bore suction catheter to clear mouth and nose

## Meconium Present and Newborn Not Vigorous

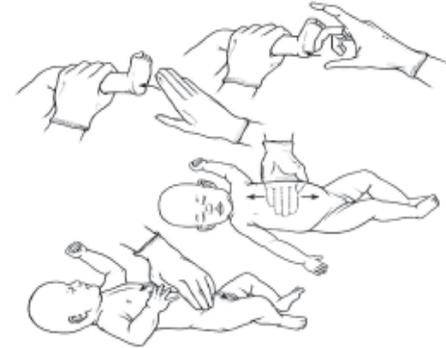
- ▶ Tracheal suction
- ▶ Administer oxygen
- ▶ Insert laryngoscope, use 12F or 14F suction catheter to clear mouth
- ▶ Insert endotracheal tube
- ▶ Attach endotracheal tube to suction source
- ▶ Apply suction as tube is withdrawn
- ▶ Repeat as necessary

## Suctioning Meconium



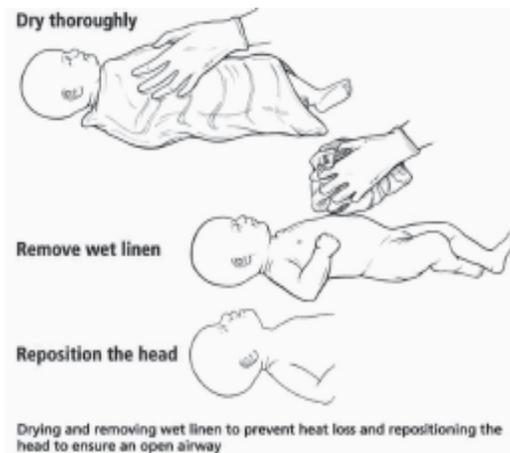
Visualizing the glottis and suctioning meconium from the trachea using a laryngoscope and endotracheal tube

## Tactile Stimulation



Acceptable methods of stimulating a baby to breathe

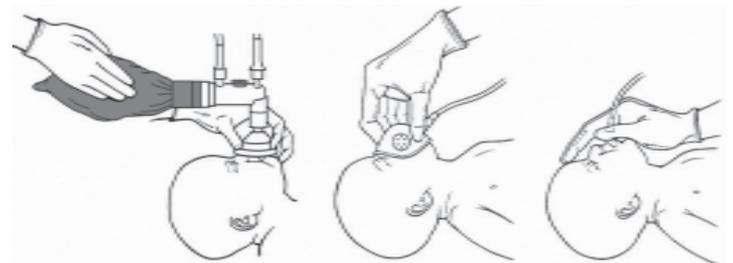
## Stimulate to Breathe, Reposition

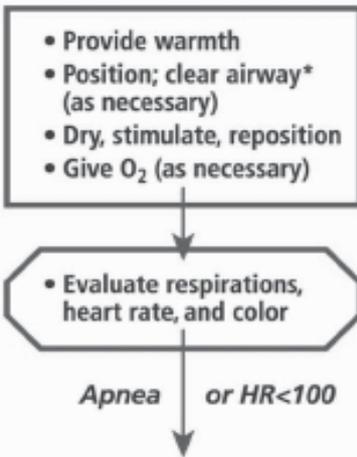


## Potentially Hazardous Forms of Stimulation

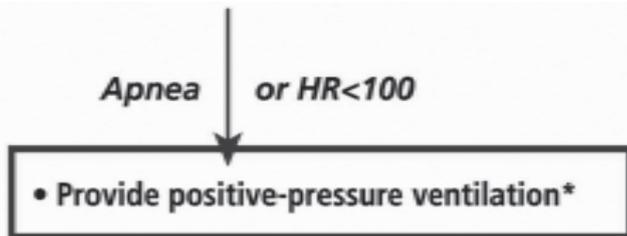
- ▶ Slapping the back
- ▶ Squeezing the rib cage
- ▶ Forcing thighs into abdomen
- ▶ Dilating anal sphincter
- ▶ Hot or cold compresses or baths
- ▶ Shaking

## Free-flow Oxygen





\*Endotracheal intubation may be considered at several steps.



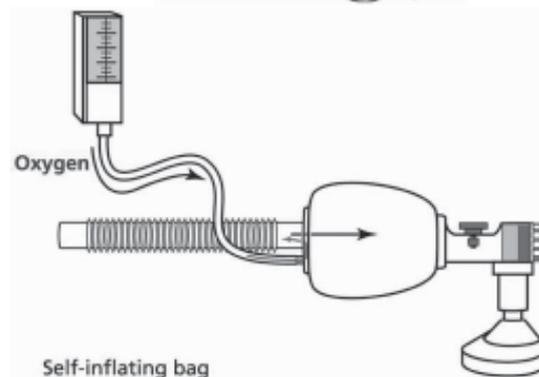
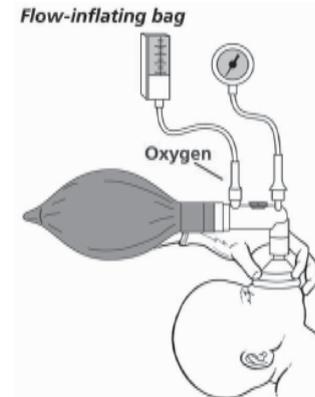
## Module 7: Newborn Care

### Session 2: Newborn Resuscitation- Resuscitation Bag and Mask

#### Use of resuscitation bag and mask

- ▶ When to ventilate
- ▶ Types of resuscitation bags
- ▶ Operation of each type of bag
- ▶ Face-mask placement
- ▶ Troubleshooting resuscitation bags
- ▶ Evaluating ventilation

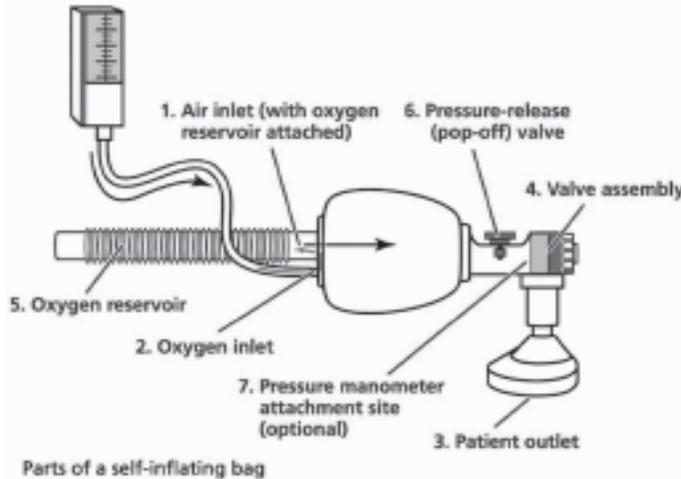
#### Types of Resuscitation Bags



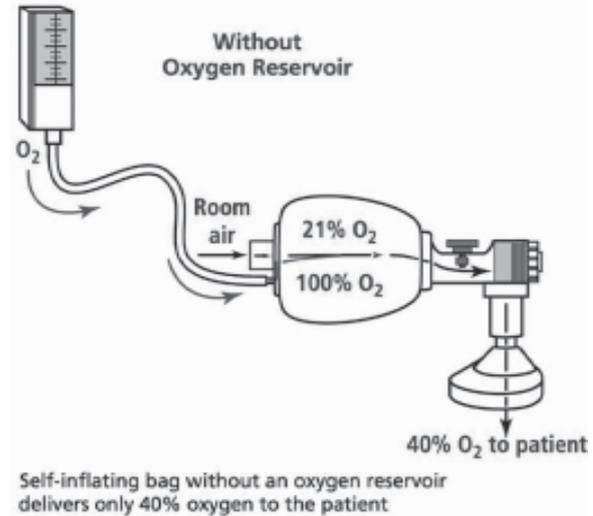
## General Characteristics of Neonatal Resuscitation Bags and Masks

- ▶ Size of bag (200 to 750 mL)
- ▶ Oxygen capability 90%-100%
- ▶ Capable of avoiding excessive pressures
- ▶ Appropriate-sized mask (cushioned, anatomically shaped masks preferred)

## Self-inflating Bag: Basic Parts



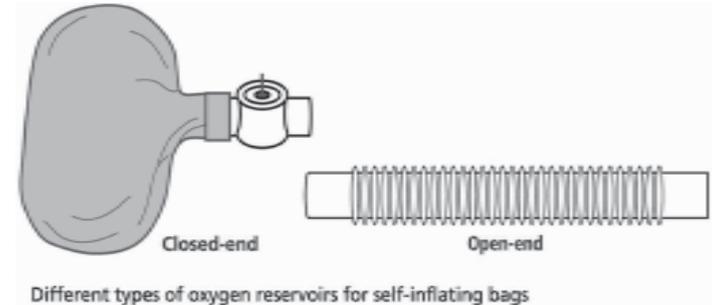
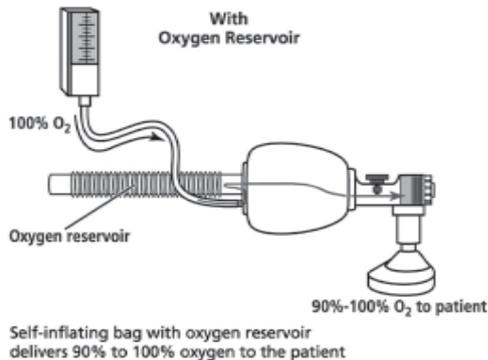
Without reservoir: Delivers only 40% oxygen to the patient  
**Self-inflating Bag**



## Control of Oxygen

With reservoir: 90%-100% oxygen delivered to patient

## Self-inflating Bag Control of Oxygen



## Self-inflating Bag: Types of Oxygen Reservoirs

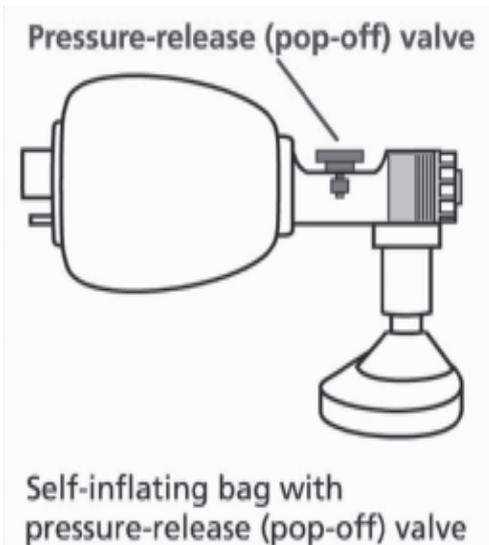
### Self-inflating Bag: Pressure

- ▶ Amount of pressure delivered depends on the following three factors:
- ▶ How hard the bag is squeezed
- ▶ Any leak between mask and newborn's face
- ▶ Set point of pressure-release valve

### Resuscitation Bags:

#### Safety Features

- ▶ Every bag should have at least 1 safety feature to prevent excessive pressure.
- ▶ Pressure manometer and flow-control valve
- ▶ Pressure-release valve



## Self-inflating Bags With Pressure-release Valve Bag and Mask: Equipment

### Masks

#### Rims

- Cushioned
- Non-cushioned

#### Shape

- Round
- Anatomic shape

#### Size

- Small
- Large



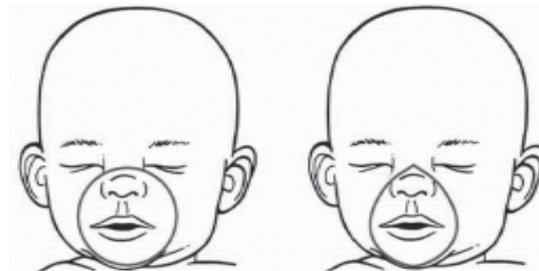
Face masks with cushioned rims

### Mask should cover

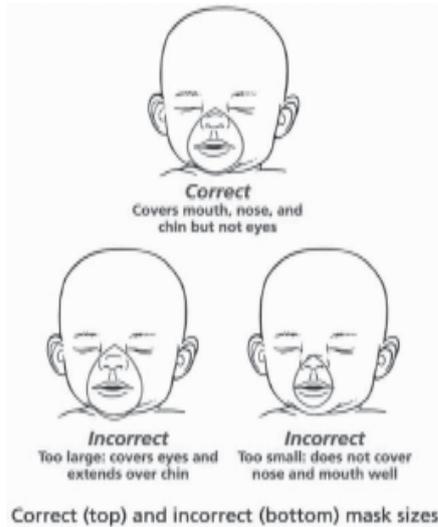
- ▶ Tip of chin
- ▶ Mouth
- ▶ Nose

### Preparation for Resuscitation

- ▶ Assemble equipment
- ▶ Test equipment



Round (left) and anatomically shaped (right) face masks

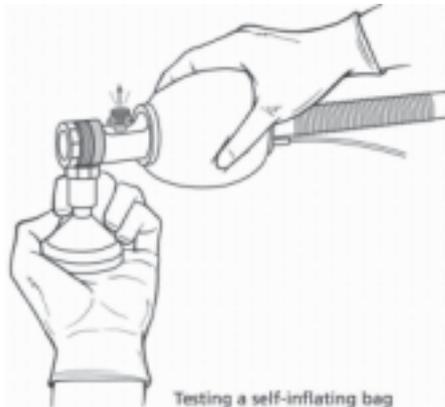


### Testing a Self-inflating Bag

- ▶ Pressure against your hand?
- ▶ Pressure manometer working?
- ▶ Pressure-release valve opens?

### Checklist

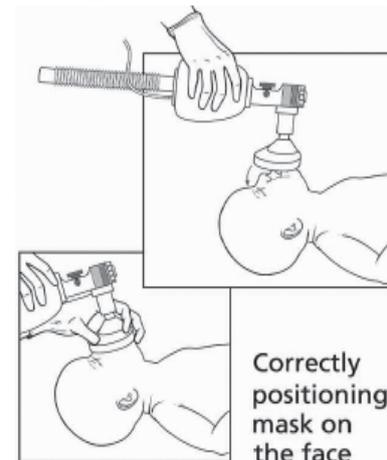
- ▶ Before assisting ventilation with bag,
- ▶ Select appropriate-sized mask



- ▶ Clear airway
- ▶ Position newborn's head
- ▶ Position yourself at the side or head of the baby

### Positioning Bag and Mask on Face

- ▶ Do not jam the mask down on the face
- ▶ Do not allow your fingers or parts of the hands to rest on the newborn's eyes
- ▶ Do not put pressure on the throat (trachea)



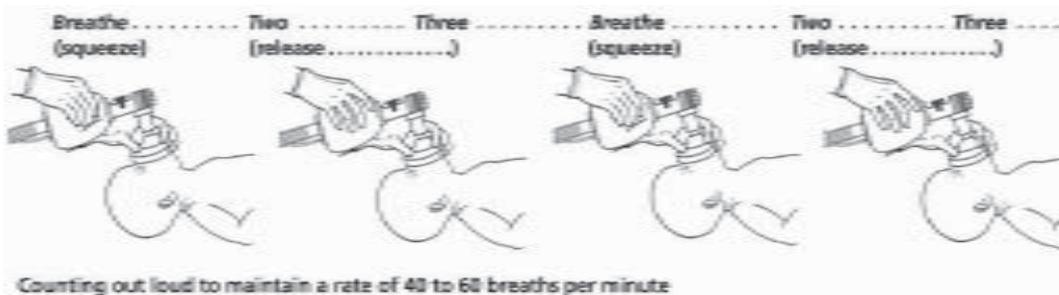
### Face-mask Seal

- ▶ Airtight seal is essential to achieve positive pressure.
- ▶ Tight seal required for flow-inflating bag to inflate
- ▶ Tight seal required to inflate lungs when bag squeezed

### How Hard to Squeeze the Bag

- ▶ Noticeable rise and fall of chest
- ▶ Bilateral breath sounds
- ▶ Improvement of color and heart rate
- ▶ Overinflation of Lungs
- ▶ If the baby appears to be taking a very deep breath,
- ▶ Too much pressure is being used
- ▶ Danger of producing a pneumothorax

Frequency of Ventilation: 40 to 60 breaths per minute



### Chest Not Expanding Adequately

- ▶ Possible causes
- ▶ Seal inadequate
- ▶ Airway blocked
- ▶ Not enough pressure given

### Causes of and Solutions for Inadequate Chest Expansion

Condition	Actions
1. Inadequate seal	Reapply mask to face.
2. Blocked airway	Reposition the head. Check for secretions; Suction if present. Ventilate with newborn's mouth slightly open.
3. Not enough pressure	Increase pressure until there is an easy rise and fall of the chest. Consider endotracheal intubation.
4. Malfunctioning equipment	Check or replace bag.

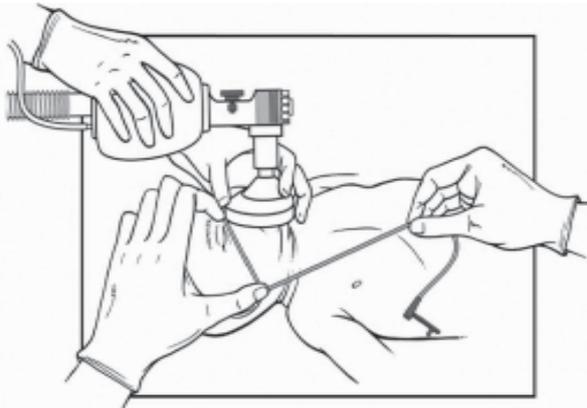
### Signs of Improvement

- ▶ Increasing heart rate
- ▶ Improving color
- ▶ Spontaneous breathing

### Continued Bag-and-Mask Ventilation

- ▶ Orogastric tube should be inserted to relieve gastric distention.
- ▶ Gastric distention may elevate diaphragm, preventing full lung expansion
- ▶ Possible regurgitation and aspiration

### ▶ Insertion of Orogastric Tube Equipment



Measuring the correct distance for inserting an orogastric tube

- ▶ 8F feeding tube
- ▶ 20-mL syringe

### Measuring correct length

### Insertion of Orogastric Tube: Technique

- ▶ Insert through mouth, rather than through nose (resume ventilation)
- ▶ Attach 20-mL syringe and aspirate gently
- ▶ Remove syringe and leave tube end open to air
- ▶ Tape tube to newborn's cheek

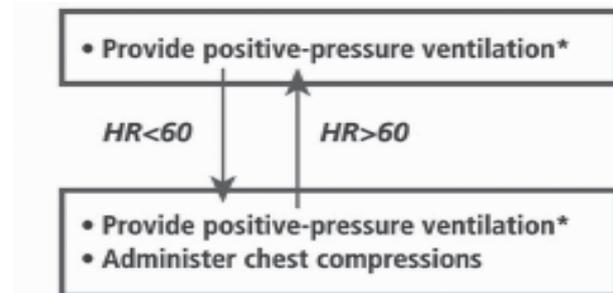
### Newborn Not Improving

- ▶ Check oxygen, bag, seal, and pressure
- ▶ Is chest movement adequate?
- ▶ Is 100% oxygen being administered?

Then

- Consider endotracheal intubation
- Check breath sounds; pneumothorax is possible

### Newborn Not Improving



\*Endotracheal intubation may be considered at several steps.

**Module 7: Newborn Care**  
**Session 2: Newborn Resuscitation-Chest Compressions**

**Chest Compressions**

- ▶ Indications for chest compressions
- ▶ Performance of chest compressions
- ▶ Coordination of chest compressions with positive-pressure ventilation
- ▶ Stopping chest compressions

**Chest Compressions**

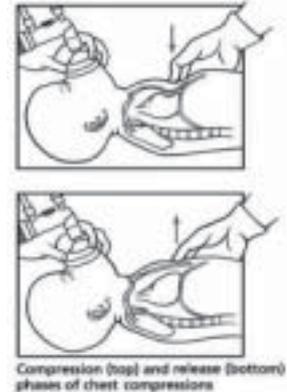
- ▶ Temporarily increase circulation
- ▶ Must be accompanied by ventilation

**Chest Compressions: Indications**

- ▶ HR less than 60 despite 30 seconds of effective positive-pressure ventilation

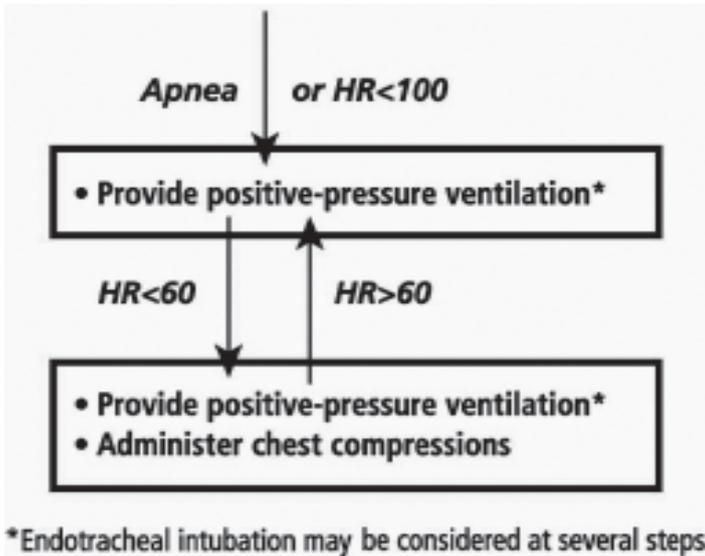
**Chest Compressions:**

- ▶ Compress heart against spine
- ▶ Increase intrathoracic pressure
- ▶ Circulate blood to vital organs



**Chest Compressions:**

- ▶ 2 People Needed
- ▶ One person compresses chest
- ▶ One person continues ventilation



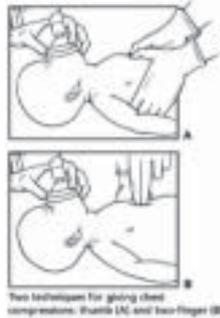
## Comparison of Chest Compression Techniques

### Thumb Technique (*Preferred*)

- Less tiring
- Better control of compression depth

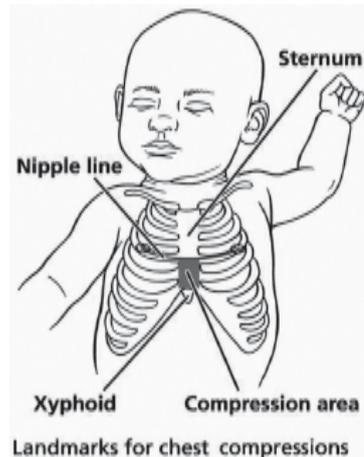
### Two-Finger Technique

- More convenient with only one rescuer
- Better for small hands
- Provides access to umbilicus for medications



### Chest Compressions: Positioning of Thumb or Fingers

- ▶ Apply pressure to lower third of sternum
- ▶ Avoid xyphoid process



### Chest Compressions:

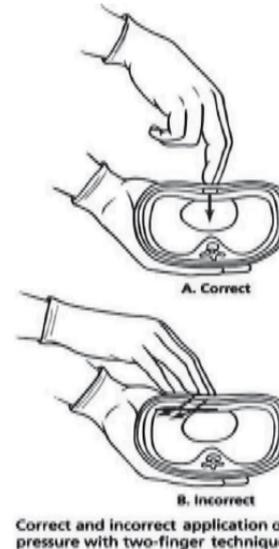
- ▶ Thumb Technique
- ▶ Chest Compressions

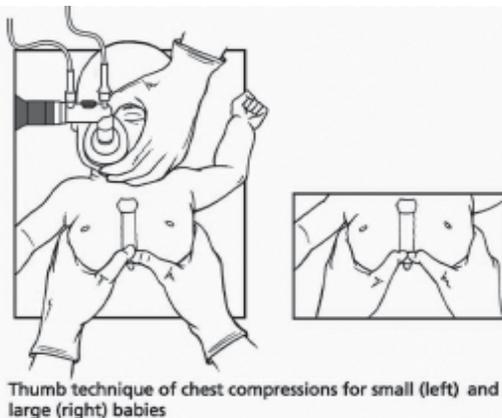
### Thumb technique

- ▶ Pressure must remain on sternum

### Chest Compressions:

- ▶ Two-finger Technique
- Tips of middle finger and index or ring finger of one hand compress sternum-
- Other hand supports back



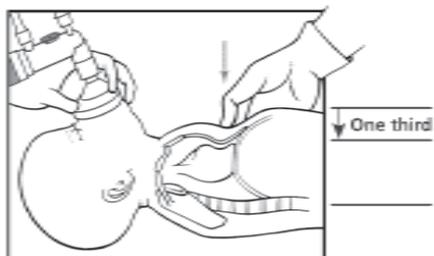


### Chest Compressions:

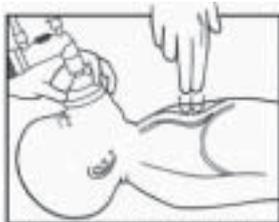
#### Compression Pressure and Depth

- Depress sternum one third of the anterior-posterior diameter of chest
- Duration of downward stroke shorter than duration of release

Compression depth should be approximately one third of the anterior-posterior diameter of the chest.



Correct method of chest compressions (fingers remain in contact with chest on release)



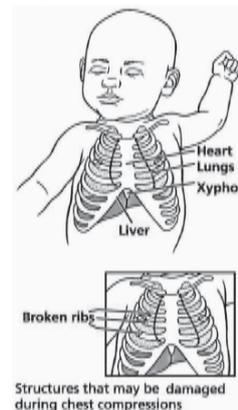
Incorrect method of chest compressions (fingers lose contact with chest on release)

### Potential Complications

- ▶ Laceration of liver
- ▶ Broken ribs

### Coordination With Ventilation

- ▶ A four event cycle should take approximately 2 seconds
- ▶ Approximately 120 “events” per minute (30 breaths and 90 compressions)

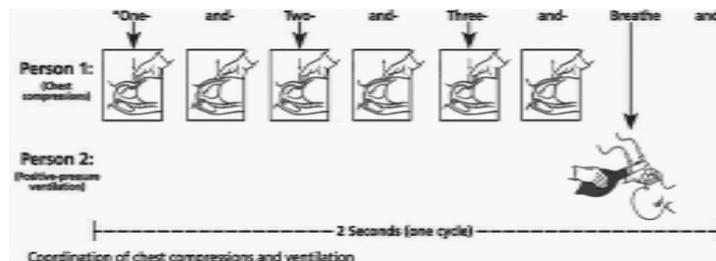


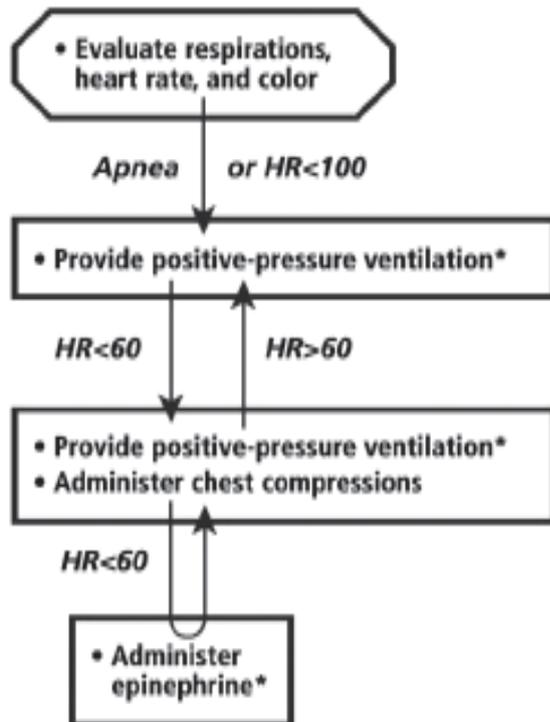
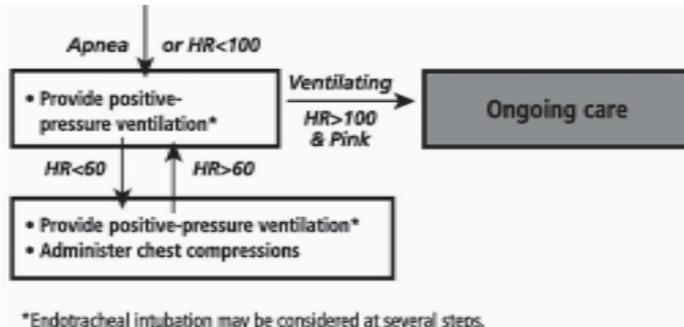
### Stopping Compressions

- ▶ After 30 seconds of compressions and ventilation, stop and check the heart rate for 6 seconds

### Newborn Not Improving

If heart rate less than 60 bpm despite adequate ventilation and chest compressions for 30 seconds, administer epinephrine.





## Module 7: Newborn Care

### Session 2: Newborn Resuscitation-Endotracheal Intubation

#### Indications

- ▶ Equipment preparation
- ▶ Laryngoscope use
- ▶ Determination of tube placement
- ▶ Suctioning meconium from trachea
- ▶ Positive-pressure ventilation via endotracheal tube
- ▶ Meconium present and baby is not vigorous
- ▶ Prolonged positive-pressure ventilation required
- ▶ Bag-and-mask ventilation ineffective
- ▶ Chest compressions necessary
- ▶ Epinephrine administration necessary
- ▶ Special indications: prematurity, surfactant administration, diaphragmatic hernia

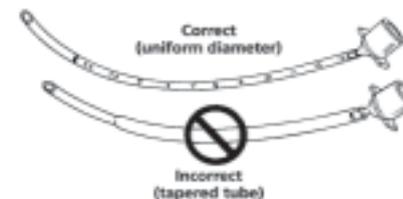
#### Endotracheal Intubation: Equipment and Supplies

- ▶ Equipment should be clean, protected from contamination
- ▶ Sterile disposable endotracheal tubes with uniform diameters preferred

#### Characteristics of Endotracheal Tube

- ▶ Sterile, disposable
- ▶ Uniform diameter
- ▶ Centimeter marks and vocal cord guides helpful
- ▶ Uncuffed

#### Endotracheal Tube:



Endotracheal tubes with uniform diameter are preferred for newborns.

- ▶ Appropriate Size
- ▶ Select tube size based on weight and gestational age
- ▶ Consider shortening tube to 13-15 cm
- ▶ Stylet optional

Tube Size (mm) (inside diameter)	Weight (g)	Gestational Age (wks)
2.5	Below 1,000	Below 28
3.0	1,000-2,000	28-34
3.5	2,000-3,000	34-38
3.5-4.0	Above 3,000	Above 38

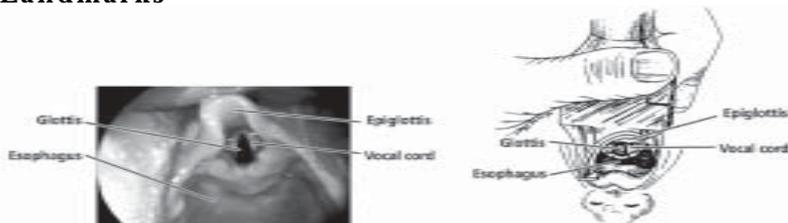
### Preparation of Laryngoscope: Supplies

- ▶ Select blade size
- No 0 for preterm newborns
- No 1 for term newborns
- ▶ Check laryngoscope light
- ▶ Connect suction source to 100 mm Hg
- ▶ Use large suction catheter (greater than or equal to 10F) for secretions
- ▶ Small suction catheter for ET tube

### Preparation for Intubation

- ▶ Prepare resuscitation bag and mask
- ▶ Turn on oxygen
- ▶ Get stethoscope
- ▶ Cut tape or prepare endotracheal tube stabilizer

### Endotracheal Intubation: Anatomic Landmarks



Photograph and drawing of laryngoscopic view of glottis and surrounding structures

### Endotracheal Intubation: Holding the Laryngoscope



Correct hand position when holding a laryngoscope for neonatal intubation

### Endotracheal

- Step 1: Preparation for Insertion
- Step 2: Insert Laryngoscope
- Step 3: Lift Blade
- Step 4: Visualize Landmarks
- Step 5: Inserting Tube
- Step 6: Remove Laryngoscope

Correct — Line of sight clear (tongue will be lifted by laryngoscope blade)



Incorrect — Line of sight obstructed



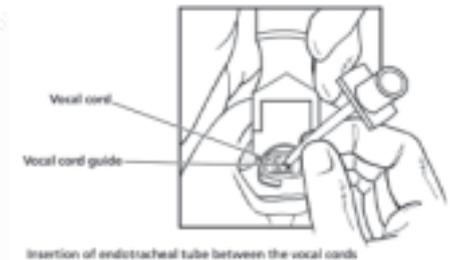
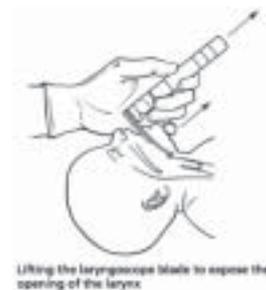
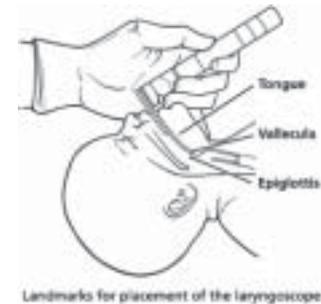
Incorrect — Line of sight obstructed



Correct (top) and incorrect (middle and bottom) positioning for intubation

## Endotracheal Intubation: Checking Tube Position Signs of correct tube position

- ▶ Chest rise with each breath
- ▶ Breath sounds over both lung fields
- ▶ No gastric distention with ventilation
- ▶ Vapor condensing on inside of tube during exhalation



## Suctioning Meconium Via Endotracheal Tube

- ▶ Connect endotracheal tube to meconium aspirator and suction source
- ▶ Occlude suction port to apply suction
- ▶ Gradually withdraw endotracheal tube
- ▶ Repeat intubation and suction as necessary
- ▶ Suction for only 3 to 5 seconds as tube is withdrawn
- ▶ If no meconium is recovered, proceed to resuscitation
- ▶ If meconium is recovered, check heart rate
- ▶ Heart rate OK: Reintubate, suction again if indicated
- ▶ Heart rate decreased: Administer positive-pressure ventilation

- ▶ Carbon dioxide detector will change color (or reads more than 2%-3% during exhalation)

### Tip-to-lip measurement

### Endotracheal Intubation: Checking Tube Position

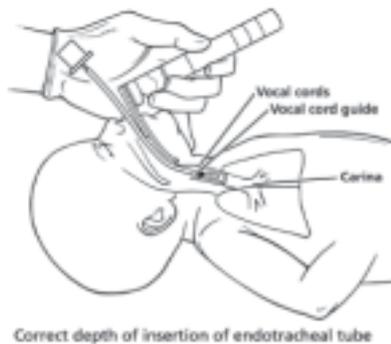
The tube is likely not in trachea if

- ▶ No chest rise
- ▶ No breath sounds over lungs
- ▶ Noises over the stomach
- ▶ No mist in endotracheal tube
- ▶ Abdomen becomes distended
- ▶ Carbon dioxide detector does not indicate exhaled Carbon dioxide
- ▶ Newborn remains cyanotic or bradycardic

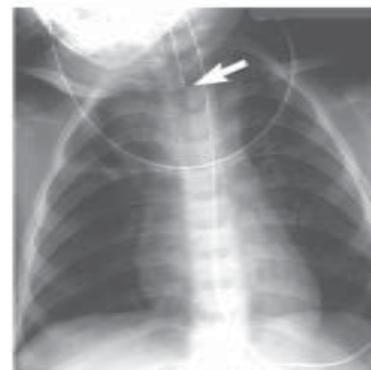
Weight (kg)	Depth of insertion (cm from upper lip)
1*	7
2	8
3	9
4	10

\* Babies weighing less than 750 g may require only 6 cm insertion.

### Tube Location in Trachea



### Endotracheal Intubation: Radiographic Confirmation



Correct placement of endotracheal tube with tip in midtrachea



Incorrect placement of endotracheal tube with tip in right main bronchus. Note collapse of left lung.

## Module 7: Newborn Care

### Session 2: Newborn Resuscitation-Medications

- ▶ Indications
- ▶ Epinephrine administration via
- ▶ Endotracheal tube
- Umbilical vein
- Volume expansion
- ▶ Sodium bicarbonate administration

Heart rate less than 60 after

- ▶ 30 seconds of assisted ventilation and
- ▶ 30 seconds of compressions and assisted ventilation

Total 60 seconds

Note: Epinephrine *not* indicated before adequate ventilation established

#### Epinephrine:

Routes of Administration

- ▶ Endotracheal tube
- ▶ Umbilical vein

#### Epinephrine: Administration

##### Via Endotracheal Tube

- ▶ Give directly into endotracheal tube
- ▶ May use 5F feeding tube
- ▶ Dilution vs flush
- ▶ After instillation, give positive-pressure ventilation

#### Epinephrine: Administration

##### Via Umbilical Vein

- ▶ Placing catheter in umbilical vein
- Preferred route
- 3.5F or 5F end-hole catheter
- Sterile technique
- ▶ Insert 2 to 4 cm
- ▶ Free flow of blood when aspirated
- ▶ Less depth in preterm newborns
- ▶ Insertion in liver may cause damage

#### Epinephrine: Effects Repeated Dosing

- ▶ Increase strength and rate of cardiac contractions
- ▶ Peripheral vasoconstriction
- ▶ May repeat dose every 3 to 5 minutes
- ▶ Consider repeat dose via umbilical vein if first dose given via endotracheal tube

#### Epinephrine: Poor Response (Heart Rate <60 bpm)

##### Recheck effectiveness of

- ▶ Ventilation
- ▶ Chest compressions
- ▶ Endotracheal intubation
- ▶ Epinephrine delivery
- ▶ **Consider possibility of**
- ▶ Hypovolemia
- ▶ Severe metabolic acidosis

#### Poor Response to Epinephrine: Hypovolemia

##### Signs of Hypovolemia

- ▶ Pallor after oxygenation
- ▶ Weak pulses (high or low heart rate)
- ▶ Poor response to resuscitation
- ▶ Low blood pressure/poor perfusion

#### Blood Volume Expansion: Acceptable Solutions

- ▶ Normal Saline
- ▶ Ringer's lactate
- ▶ O-negative blood

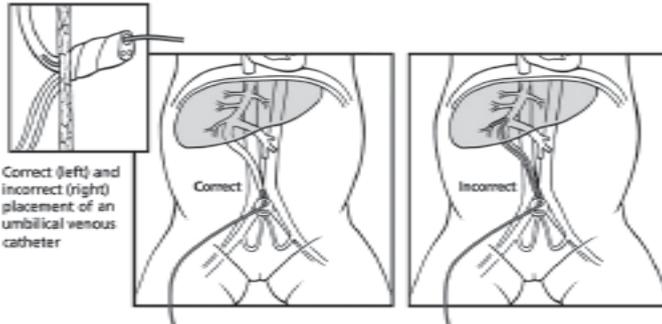
#### Medication: Volume Expanders

##### Expected signs of volume expansion:

- ▶ Blood pressure increases
- ▶ Pulses stronger
- ▶ Pallor lessens

#### Follow up if hypovolemia persists

- ▶ Repeat volume expanders
- ▶ Give sodium bicarbonate for presumed acidosis



### Prolonged Resuscitation: Physiologic Consequences

- ▶ Lactic acid buildup
- ▶ Poor cardiac contractility
- ▶ Decreased pulmonary blood flow

### Metabolic acidosis suspected

- ▶ Sodium bicarbonate administration is controversial
- ▶ Use only after adequate ventilation is established

Recommended concentration =  
1:10,000

Recommended route =  
by endotracheal tube or intravenously

Recommended dose =  
0.1 to 0.3 mL/kg of 1:10,000 solution

Recommended preparation =  
1:10,000 solution in 1-mL syringe

Recommended rate of administration =  
*Rapidly* — as quickly as possible

Recommended solution =  
Normal saline

Recommended dose =  
10 mL/kg

Recommended route =  
Umbilical vein

Recommended preparation =  
Estimated volume drawn into large  
syringe

Recommended rate of administration =  
Over 5 to 10 minutes

### Medication Given: No Improvement

- ▶ Recheck effectiveness of
- ▶ Ventilation
- ▶ Chest compressions
- ▶ Endotracheal intubation
- ▶ Epinephrine delivery

If heart rate is less than 60 or absent:

- ▶ Consider possibility of
  - Hypovolemia
  - Severe metabolic acidosis
  - Pneumothorax
  - Diaphragmatic hernia
  - Congenital Heart Disease
- ▶ Consider discontinuing resuscitation

Recommended dose =  
2 mEq/kg (4 mL/kg of 4.2% solution)

Recommended route =  
Umbilical vein, from which there is good  
blood return

Recommended preparation =  
0.5 mEq/mL (4.2% solution)

Recommended rate of administration =  
*Slowly* — no faster than a rate of  
1 mEq/kg/min

### Special Considerations

- ▶ Special problems that complicate resuscitation
- ▶ Management after resuscitation
- ▶ Ethical consideration
- ▶ Resuscitation beyond newborn period or outside hospital delivery room

### No Improvement After Resuscitation: Categories

- ▶ Failure to begin spontaneous respirations
- ▶ Inadequate ventilation with positive-pressure ventilation
- ▶ Baby remains cyanotic or bradycardic despite good ventilation

### Failure to Initiate Spontaneous Respirations

- ▶ Brain injury (hypoxic ischemic encephalopathy)
- ▶ Sedation secondary to maternal drugs

### Positive-pressure Ventilation Fails to Produce Adequate Ventilation

#### Mechanical blockage of airway

- ▶ Meconium or mucous plug
- ▶ Choanal atresia
- ▶ Airway malformation
- ▶ Other rare conditions

## Naloxone Hydrochloride

Recommended concentration =  
1.0 mg/mL solution

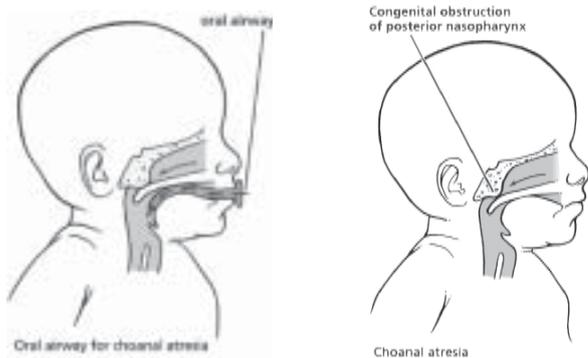
Recommended route =  
Endotracheal or intravenous preferred;  
intramuscular or subcutaneous  
acceptable but delayed onset of action

Recommended dose =  
0.1 mg/kg

### Mechanical Blockage of Airway: Choanal Atresia

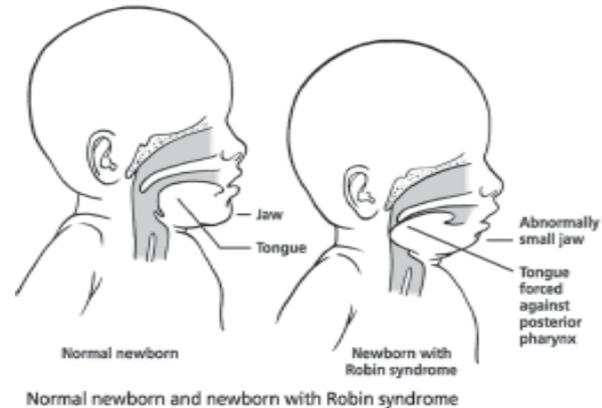
### Mechanical Blockage of Airway: Pharyngeal Airway Malformation

Robin syndrome



### Positive-pressure Ventilation Fails to Produce Adequate Ventilation

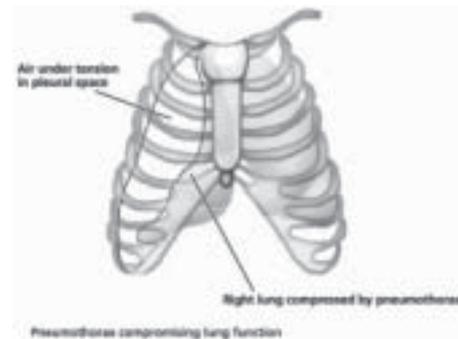
- ▶ Impaired lung function
- ▶ Pneumothorax



- ▶ Pleural effusion
- ▶ Congenital diaphragmatic hernia
- ▶ Pulmonary hypoplasia
- ▶ Extreme prematurity
- ▶ Congenital pneumonia

### Impaired Lung Function: Pneumothorax

### Impaired Lung Function: Congenital Diaphragmatic Hernia



### **Baby Remains Cyanotic or Bradycardic**

- ▶ Ensure chest is moving with ventilation
- ▶ Confirm 100% oxygen is being given
- ▶ Consider congenital heart block or cyanotic heart disease (rare)



Compromised lung function from presence of a congenital diaphragmatic hernia

### **Post-resuscitation Care**

Baby requires

- ▶ Close monitoring
- ▶ Anticipatory care
- ▶ Laboratory studies

### **Post-resuscitation Problems**

- ▶ Pulmonary hypertension
- ▶ Pneumonia, aspiration, or infection
- ▶ Hypotension
- ▶ Fluid management
- ▶ Seizure, apnea
- ▶ Hypoglycemia
- ▶ Feeding problems
- ▶ Temperature management

### **Post-resuscitation Problems: Premature Infants**

- ▶ Temperature management
- ▶ Immature lungs
- ▶ Intracranial hemorrhage

- ▶ Hypoglycemia
- ▶ Necrotizing enterocolitis
- ▶ Oxygen injury

### **Ethical Principles: Starting and Stopping Resuscitation**

- ▶ No different than older child or adult
- ▶ No advantage to delayed, graded, or partial support
- ▶ Support can be withdrawn after initiation
- ▶ Base decision on data (may not be available in delivery room)
- ▶ Communicate with family prior to resuscitation if possible

### **Ethical Decisions: Non-initiation of Resuscitation**

- ▶ Confirmed gestation < 23 weeks or birthweight < 400 grams
- ▶ Anencephaly
- ▶ Confirmed trisomy 13 or 18

### **Ethical Decision: Stopping Resuscitation**

- ▶ Ensure adequate resuscitation efforts
- ▶ May stop after 15 minutes of asystole
- ▶ Ongoing evaluation, discussion with parents and team, if prognosis uncertain

## Module 7: Newborn Care

### Session 3: Examination of the Newborn Baby J2-J8

When should a newborn baby be examined?

#### Examine routinely all babies:

- ▶ within an hour of birth
- ▶ for discharge
- ▶ at routine and follow-up postnatal visits in the 1<sup>st</sup> week of life, and
- ▶ when the mother or provider observes danger signs.

#### Examination Format

- ▶ Ask, Check Record
- ▶ Look, Listen and Feel
- ▶ SIGNS
- ▶ CLASSIFY
- ▶ TREAT AND ADVISE

### Newborn Care Guidelines

#### CASE STUDY

- ▶ Ask, Check Record
- ▶ Look, Listen and Feel
- ▶ SIGNS
- ▶ CLASSIFY
- ▶ TREAT AND ADVISE

## Module 7: Newborn Care

### Session 4: Care of the Newborn Until Discharge from Health Facilities

#### Parent Education

- ▶ Keeping the baby warm
- ▶ Breastfeeding the newborn baby
- ▶ Giving cord care
- ▶ Ensuring hygiene
- ▶ Watching her baby and reporting her concerns
- ▶ Sleeping with her baby
- ▶ Attaching and positioning her baby at the breast

J10

#### Keeping the baby warm

- ▶ In cold climate keep at least an area of the room warm.
- ▶ Newborns need more clothing than other children or adults
- ▶ If cold, put hat on the baby's head. During cold nights
- ▶ cover the baby with an extra blanket.
- ▶ At night, let the baby sleep with the mother or within easy reach to facilitate breastfeeding.
- ▶ DO NOT put the baby on the cold surface
- ▶ DO NOT swaddle the baby (wrap too tightly) because
- ▶ swaddling makes them cold
- ▶ DO NOT leave the baby in direct sun because it may become too hot and dehydrated

#### Giving cord care

- ▶ Wash hands before and after cord care
- ▶ Put nothing on the stump
- ▶ Fold diaper below the stump
- ▶ Keep stump loosely covered with clean clothes
- ▶ If the stump is wet, wash with clean water and soap, dry with clean cloth.

- ▶ If umbilicus is red or draining pus or blood, see the health worker.
- ▶ DO NOT bandage the stump or abdomen
- ▶ DO NOT apply substances or medicines to stump
- ▶ Avoid touching the stump unnecessarily

**Washing the baby**

- ▶ Wash the face, neck and underarms daily
  - ▶ Wash the buttocks when soiled. Dry thoroughly
  - ▶ Bathe when necessary:
- Ensure the room is warm  
 -Use warm water for bathing
- ▶ Thoroughly dry the baby, dress and cover after bath

**Monitoring the Baby**

- ▶ Cold feet
- ▶ Breathing difficulties ("grunting", fast or slow breathing, chest in-drawing)
- ▶ Any bleeding

**Give prescribed treatments according to the schedule**

- ▶ treatments for infections
- ▶ Immunizations

K12 & K13 : "Treat and immunize the baby"

**Discharge examination**

- ▶ Examine every baby before planning to discharge the mother and baby
  - ▶ Tell the mother when to return for
- routine postnatal visit  
 -if danger signs

**Advise when to return with the baby K14**

**Routine Visits**

Postnatal visit  
 -Within the 1st week preferably within 2-3 days  
 Immunization visit  
 (if BCG, OPV-0 and HB-1 given in the 1st week of life)  
 -at age 6

**Follow-up Visits**

If the problem was	Return in
Feeding difficulty	2 days
Red umbilicus	2 days
Skin infection	2 days
Eye infection	2 days

**Follow-up Visits**

If the problem was	Return in
Thrush	2 days
Mother has either breast engorgement or mastitis	2 days
Low birth weight and either first week of life or not gaining weight adequately	7 days

**Follow-up Visits**

If the problem was	Return in
Orphan baby	7 days
INH prophylaxis	14 days
Treated for possible congenital syphilis	14 days
Mother HIV positive	14 days

**Advise the mother to seek care for the baby**

Return or go to the hospital immediately if the baby has:

- ▶ Difficulty breathing
- ▶ convulsions
- ▶ Fever or feels cold
- ▶ Bleeding
- ▶ Has diarrhea
- ▶ not feeding at all

Go to the health center as quickly as possible if the baby has:

- ▶ Difficulty feeding
- ▶ Pus from eyes
- ▶ Skin pustules
- ▶ Yellow skin
- ▶ A cord stump which is red and draining pus
- ▶ Feed less than 5 times in 24 hours
- ▶ Other concern

## **Module 7: Newborn Care**

### **Session 4: The Small Baby**

What do we mean by a “small baby”?

- ▶ Small baby
  - born between 32-36 weeks gestation, or one to two months early, and/or
  - with a birth weight between 1500g and 2500g.
- ▶ Very small baby:
  - A very preterm baby born less than 32 weeks gestation or more than 2 months early, or
  - A baby with birth weight less than 1500 g

**Refer baby urgently to hospital (B14)**

**Ensure extra warmth during referral/transport**

#### **Special needs of a small baby**

- ▶ To breathe normally
- ▶ To be kept warm
- ▶ To be fed
- ▶ To be protected

Newborn examination as in N2-N9

#### **Care of the small baby**

- ▶ Care of the Newborn p.N10
- ▶ Additional care of a small baby (or twin) p.N11

#### **Additional care of a Small Baby (or Twin)**

- ▶ Plan to keep the small baby longer before discharging.
- ▶ Allow visits to the mother and baby.

#### **Additional care of a Small Baby (or Twin)**

- ▶ Give special support for breastfeeding the small baby (or twins) **(B4)**
- ▶ Encourage the mother to breastfeed every 2-3 hours.
- ▶ Assess breastfeeding daily: attachment, suckling, duration and frequency of feeds, and baby satisfaction with the feed **(K3)**

- ▶ If alternative feeding method is used, assess the total daily amount of milk given.
- ▶ Weigh daily and assess weight gain (K7).
- Weigh and assess weight gain B7
- ▶ Weigh the small baby
- ▶ Every day until 3 consecutive times gaining weight (at least 15 g/day).
- ▶ Weekly until 4-6 weeks of age (reached term).
- ▶ Weigh and assess weight gain B7

### **If weighing daily using a precise and accurate scale**

#### **Response to abnormal finding**

- ▶ If the small baby is not suckling effectively and does not have other danger signs, consider alternative feeding methods
- ▶ Teach the mother how to hand express breast milk directly into the baby's mouth
- ▶ Teach the mother to express breast milk and cup feed the baby
- ▶ Determine appropriate amount for daily feeds by age
- ▶ If feeding difficulty persists for 3 days, or weight loss greater than 10% of birth weight and no other problems, refer for breastfeeding counselling and management.

### **Additional care of a Small Baby (or Twin)**

- ▶ Ensure additional warmth for the small baby
- ▶ Ensure the room is very warm (25°-28°C).
- ▶ Teach the mother how to keep the small baby warm in skin-to-skin contact
- ▶ Provide extra blankets for mother and baby.
- ▶ Ensure hygiene
- ▶ **DO NOT** bath the small baby. Wash as needed.

### **Additional care of a Small Baby (or Twin)**

- ▶ Assess the small baby daily
- ▶ Measure temperature
- ▶ Assess breathing (baby must be quiet, not crying): listen for grunting; count breaths per minute, repeat the count if >60 or <30; look for chest indrawing
- ▶ Look for jaundice (first 10 days of life): first 24 hours on the abdomen, then on palms and soles.
- ▶ If difficult to keep body temperature within the normal range (36.5°C to 37.5°C):
- ▶ Keep the baby in skin-to-skin contact with the mother as much as possible
- If body temperature below 36.5° persists for 2 hours despite skin-to-skin contact with mother, assess the baby
- ▶ If breathing difficulty, assess the baby
- ▶ If jaundice, refer the baby for phototherapy.
- ▶ If any maternal concern, assess the baby and respond to the mother.

### **Discharging the small baby**

- ▶ Plan to discharge when:
  - ▶ Breastfeeding well
  - ▶ Gaining weight adequately on 3 consecutive days
  - ▶ Body temperature between 36.5 and 37.5 on 3 consecutive days
  - ▶ Mother able and confident in caring for the baby
  - ▶ No maternal concerns.
  - ▶ Assess the baby for discharge.

## **Module 8: Counseling**

### **Session 1: Basic Facts About Counseling**

#### **Overview**

- ▶ Health workers are expected to be counselors in maternal and newborn care, where the patient has to make choices based on accurate information and in a climate where his/her reproductive rights are respected.
- ▶ It is a service which the health facility should provide.
- ▶ Effective communication ensures that the client can comprehend and act on improving his/her, as well as his/her family's state of health.

#### **Purpose of Counseling**

In maternal and neonatal health counseling serves 3 main purposes:

- ▶ Contributes to the satisfaction of women, their families and communities from the services she/they receive; helps to ensure that people use services appropriately; and, return to use them and recommend them to others
- ▶ Helps to develop skills to enable women and their families to take better care of themselves and their babies
- ▶ Most importantly, it helps to empower women and teach them new skills to help them take action on the decisions they have to make in all aspects of their lives

#### **Principles in Counseling**

- ▶ Total Honesty
- ▶ Confidentiality
- ▶ Non-judgemental

#### **Counseling Skills**

1. Interpersonal communication
2. Emphatic listening
3. Questioning
4. Negotiating
5. Planning
6. Evaluating

#### **Knowledge on:**

- ▶ Maternal and newborn care
- ▶ Basic Information, transmission and management of HIV(Human Immunodeficiency Virus)
- ▶ Family Planning and Modern Method Choices
- ▶ Infant Feeding Choice
- ▶ Adolescent Pregnancy
- ▶ Violence Against Women and Children
- ▶ Institutions, Health programs and projects that may be resources to the client
- ▶ National policies and laws related to the options/methods

#### **Qualities of an Effective Counselor**

##### **Personal Qualities and Attitudes**

- ▶ A desire to work with people
- ▶ Respect for the right & ability of people to make their own decisions
- ▶ Comfort with issues related to human sexuality & the expression of feelings
- ▶ Self-awareness (of one's own biases, expectations, capabilities & limitations)
- ▶ Unbiased attitudes toward various population groups
- ▶ Tolerance for values that differ from one's own
- ▶ Empathy for clients
- ▶ Supportive attitude toward clients
- ▶ Ability to maintain confidentiality
- ▶ Unbiased attitudes/non-judgmental
- ▶ Comfort with issues related to human sexuality & the expression of feelings.
- ▶ Self-awareness (of one's own biases, expectations, capabilities & limitations.)

##### **Six Counselor Task of Counseling Process Model**

1. Initiate counseling relationship
2. Understand counselee concerns emphatically
3. Negotiate counseling objectives
4. Identify plan to meet objectives/achieve outcomes
5. Support the plan
6. Evaluate counseling

## Module 8: Counseling

### Session 2: Applying Counseling Skills

#### HIV / AIDS

- ▶ Caused by a virus called the *Human Immunodeficiency Virus*
- ▶ This virus is spread from person to person through body fluids such as semen, vaginal fluid or blood during unprotected sexual intercourse;
- ▶ HIV-infected blood transfusions or contaminated needles for drug abuse or tattoos.
- ▶ From an infected mother to her child during:
  - pregnancy
  - labour and delivery
  - postpartum through breastfeeding
- ▶ HIV cannot be transmitted through hugging or mosquito bites
- ▶ A special blood test is done to find out if the person is infected with HIV

#### Asymptomatic Carrier

1 month after picking up HIV, flu-like symptoms develop temporarily such as:

- ▶ Fever
- ▶ Sore throat
- ▶ Malaise
- ▶ Muscle aches
- ▶ Rash
- ▶ Large lymph nodes

#### Symptomatic HIV

##### (8-10 years later)

- ▶ Oral and vulvovaginal candidiasis
- ▶ Diarrhea
- ▶ Bacterial infections (skin, upper & lower respiratory tract)
- ▶ Tuberculosis
- ▶ Herpes zoster/simplex
- ▶ Skin infections (Fungal infections)
- ▶ Opportunistic malignancies:
- ▶ Kaposi's sarcoma Lymphoma

#### HIV status in Pregnancy, WHY?

- ▶ Get medical care to prevent associated illnesses
- ▶ Protect sexual partner from infection
- ▶ Make a choice about future pregnancies

#### Counseling

##### Why is HIV/AIDS counseling necessary?

- ▶ Prevent spread of HIV/AIDS
- ▶ Provide emotional support
- ▶ Maximize survival
- ▶ Assist beareavement process
- ▶ Coordinate support resources

##### Who should receive HIV/AIDS counseling?

- ▶ People seeking HIV test
- ▶ People proven HIV positive
- ▶ People diagnosed with AIDS
- ▶ Significant others (family, friends, etc.)
- ▶ Worried well people at high risk for HIV

##### Where can HIV/AIDS counseling be held?

any setting/venues which is comfortable for client to discuss things over in privacy

##### Who should provide HIV/AIDS counseling?

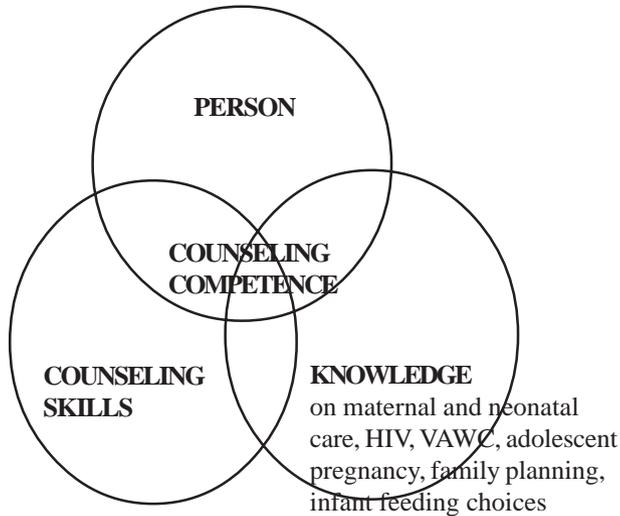
any person can be encouraged and those willing to be trained to provide counseling

##### Need to know about counselling:

- ▶ Essentials of counseling
- ▶ Counseling skills
- ▶ Types of counseling
- ▶ Ethical principles
- ▶ Referral system & network for counselling

##### Types of counseling

- ▶ Primary prevention counseling
- ▶ People at risk for HIV but not known to be infected



- ▶ Highlight and discuss risk behavior of HIV and review ways of managing individual change

### ***Types of counseling***

- ▶ Counseling of HIV testing

#### a. Pretest counseling, *aims*:

- informed consent to procedure
- necessary preparation for (+) result
- provide necessary risk reduction information in acquiring passing the infection

#### b. Post test counseling

- depends on the outcome of test

- ▶ Secondary prevention counseling

- Person/known considered w/ HIV & ways to avoid transmission
- Focus on the need of infected persons to recognize their responsibility for the health & welfare of their lover/spouses
- Discuss the need of current/previous partner of possibility of infection

- Stress that infected persons should NOT donate blood or syringes or piercing equipments
- Address perinatal transmission
- Discourage interruption of pregnancy
- Encourage prevention of future pregnancy

- ▶ Psychosocial support counseling

- HIV infected & persons living w/ them need emotional support
- Supportive counseling to help the person react positively with the problems
- Help live a full & productive life enabling them to resume/assume authority over their lives & decision-making

### **Referral system & Network for Counseling**

- ▶ How to talk about HIV/AIDS
- ▶ Learning to live w/ HIV/AIDS
- ▶ Self Help group
- ▶ Helping care-givers
- ▶ Care-givers/loved ones should be taught to handle the pressures of taking care of HIV/AIDS persons
- ▶ Dealing w/ feelings of loneliness, depression and powerlessness.
- ▶ Reducing stress and avoiding conflicts.
- ▶ Managing the implications of adopting & maintain safer sex behaviors and practices

### **STD Prevention**

- ▶ Abstinence
- ▶ Safe sex practices
- ▶ Stick to one faithful partner
- ▶ Male and female latex Condom correctly STD check up every 6 months if you or your partner have more than one sex partner
- ▶ If STD diagnosed, have complete treatment including partner before resuming sex
- ▶ not share needles for tattooing, body piercing or injecting drugs
- ▶ If pregnant, seek prenatal care for early detection and treatment of STD to prevent transmission to the baby.

## Module 9: Mobilizing Community Support

### Session 1: Establishing Links

#### Community Support

##### Overview

Community support is also vital in addressing maternal and infant morbidities & mortalities. Everyone in the community should be informed and involved in the process of improving the health of their locality.

##### Involving the community in Quality of services

Developing a comprehensive plan (to include community involvement) in support to Maternal & newborn health care

##### Community Linkages

Advantages of working together

- ▶ Collaboration is a difficult challenge but brings many benefits:
- ▶ It increases the knowledge and understanding of what different groups provide
- ▶ It helps to classify roles and avoid duplication of effort and work
- ▶ It helps to clarify roles and avoid duplication of effort and work
- ▶ It leads to a more effective use of resources

Advantages.....

- ▶ Some groups who would not normally see themselves as having a role in maternal and newborn health can see how they might contribute
- ▶ Health problems can be addressed more comprehensively
- ▶ A more comprehensive picture of local needs is drawn up
- ▶ It helps to minimize gaps in provision and provide better targeting of services

- ▶ The same messages and advice are given out rather than conflicting information

##### Ways to work together....

A good *team work* involves:

- ▶ A common task or purpose
- ▶ Understanding of different roles
- ▶ Different expertise for different functions/tasks
- ▶ Skills and personalities complement one another
- ▶ Commitment to achieving functions/tasks
- ▶ A leader to take responsibility & coordinate

*To help you establish linkages with other health care providers & community groups & to establish ways of working with them*

- ▶ Make a list of providers & groups that work in your community
- ▶ Organize a meeting/s where representatives from each of these providers or groups can attend
- ▶ Find out what each of these groups / providers currently do with respect to the care of the woman & newborn during pregnancy, delivery & the postnatal period. Collate this information into a document to be used as a future resource
- ▶ Work out a way to coordinate & unify messages related to the care of the woman & newborn during pregnancy, delivery & the postnatal period. Think about how you might be able to do this in advance:
  - a. You could consider generating the key messages together
  - b. You could provide a list in advance that you discuss at the meeting

*To help you establish linkages with other health care providers & community groups & to establish ways of working with them*

- ▶ Try to keep it simple & focused on the most important messages & information relevant for women in your community

- ▶ Identify the most common health problems related to pregnancy & childbirth in your community & try to find solutions together. Use local morbidity & mortality data to help you.
- ▶ Prepare an action plan defining responsibilities & circulate it to all participants
- ▶ Prepare an action plan defining responsibilities & circulate it to all participants
- ▶ Decide upon a person or group who will be responsible for monitoring how the implementation of the action is occurring

#### **Links with traditional birth attendants and traditional healers:**

- ▶ Include them in your referral system
- ▶ Get them to refer women to you
- ▶ Providing them with feedback on anybody they have referred to you
- ▶ Clarify together what constitutes harmful, harmless or helpful practices
- ▶ Examine what resources you could share

#### **Links with TBAs...**

- ▶ Share with them your knowledge and expertise
- ▶ Work with them to explain the key message of the PCPNC
- ▶ Invite them to participate during meetings that you have for community groups and providers
- ▶ Ask for their help in identifying women who may be at risk
- ▶ Encourage them to encourage all women to deliver with a skilled birth attendant
- ▶ Encourage them to act as labour companions for women
- ▶ Tap them as a valuable source of feedback about the services you provide

# Practicum Phase

SKILLS CHECKLIST FORM-A Medical Doctors				
Name of Participant: _____				
Designation: _____				
Place of Assignment: _____				
Team No. _____				
Skills Requirement	Name of Patient	Diagnosis	Date	Facilitator's Signature
1. IV insertion (10)	1.			
	2.			
	3.			
2. Skin testing (5)	1.			
	2.			
	3.			
3. IV antibiotics	1.			
	2.			
	3.			
4. IM injection of anticonvulsant (Mag SO4) including with monitoring of vital signs (7)	1.			
	2.			
	3.			
5. Oxytocin injection (3)	1.			
	2.			
	3.			
6. Normal spontaneous delivery (5)	1.			
	2.			
	3.			
7. Perineal Repair	1.			
	2.			
	3.			
8. Manual extraction of placenta (not required)	1.			
	2.			
	3.			
9. Recognition of case for assisted delivery (1)	1.			
	2.			
	3.			
10. Removal of retained placenta, dilation & curettage (10)	1.			
	2.			
	3.			
11. Vitamin K injection (1)	1.			
	2.			
	3.			

SKILLS CHECKLIST FORM-B Public Health Nurse				
Name of Participant: _____				
Designation: _____				
Place of Assignment: _____				
Team No. _____				
Skills Requirement	Name of Patient	Diagnosis	Date	Facilitator's Signature
1. IV insertion (10)	1.			
	2.			
	3.			
2. Skin testing (5)	1.			
	2.			
	3.			
3. IV antibiotics	1.			
	2.			
	3.			
4. IM injection of anticonvulsant (Mag SO4) including with monitoring of vital signs (7)	1.			
	2.			
	3.			
6. Oxytocin injection (3)	1.			
	2.			
	3.			
6. Normal spontaneous delivery (5)	1.			
	2.			
	3.			
7. Perineal Repair	1.			
	2.			
	3.			
8. Manual extraction of placenta (not required)	1.			
	2.			
	3.			
9. Recognition of case for assisted delivery (1)	1.			
	2.			
	3.			
10. Removal of retained placenta, dilation & curettage (not required)	1.			
	2.			
	3.			
11. Vitamin K	1.			
	2.			
	3.			

**SKILLS CHECKLIST FORM-C**  
**Rural Health Midwife**

Name of Participant: \_\_\_\_\_  
 Designation: \_\_\_\_\_  
 Place of Assignment: \_\_\_\_\_  
 Team No: \_\_\_\_\_

Skills Requirement	Name of Patient	Diagnosis	Date	Facilitator's Signature
1. IV insertion (10)	1.			
	2.			
	3.			
2. Skin testing (5)	1.			
	2.			
3. IV antibiotics	1.			
	2.			
	3.			
4. IM injection of anticonvulsant (Mag SO4) loading with monitoring of vital signs (3)	1.			
5. Oxytocin injection (3)	1.			
	2.			
	3.			
6. Normal spontaneous delivery (5)	1.			
7. Perineal Repair	1.			
	2.			
	3.			
8. Manual correction of placenta (not required)				
9. Recognition of case for assisted delivery (1)	1.			
10. Removal of retained placenta: dilation & curettage (not required)				

*Legend:*

*Yellow box: Not required*

# Monitoring, Evaluation and Action Plan

## **Skills Training on BEmOC Monitoring Checklist for Implementation of PCPNC Instructions for Monitor**

### **Part 1: Demographic Information:**

This part of the monitoring checklist is self-explanatory and should be completed at the beginning of the monitoring visit.

### **Part 2: Use of the PCPNC:**

#### **(Allow approximately 1 hour to complete Part 2)**

The person conducting the monitoring visit (the monitor) should sit with the health care worker who has been trained to use the PCPNC and ask the relevant questions in this part of the monitoring checklist. For each “NO” response, the monitor should discuss and record the reasons in the “NOTES” column. It will not be necessary to ask all of the questions in this part of the monitoring tool of all health care workers using the PCPNC. For example, a health care worker who provides only antenatal care should only be asked the questions pertaining to the provision of antenatal care. However, questions 3, 3.1, 3.2, 3.3, 4, 5, 5.1, 5.2, 6, 6.1, 6.2, 6.3, 6.4, 6.5 should be asked of all health care workers who are using the PCPNC.

It is important to sit in a quiet room/area while asking the questions, to ensure that the health care worker being interviewed can concentrate on the questions being asked. It

is also important to make sure that the health care worker understands that you are not testing her/his ability to use the PCPNC but, instead, that you are interested in knowing how useful it is as a guide for providing pregnancy, childbirth and newborn care.

### **Part 3: Observations of Clinical Care:**

#### **(Allow approximately half a day to complete Part 3)**

After completing Part 2, the monitor should observe the health care worker while she/he provides clinical care. During these observations, the monitor should compare the care being provided by the health care worker with the corresponding section(s) of the PCPNC. For example, if she is observing care in an antenatal clinic, she should follow the sections on quick check and RAM and antenatal care, as well as the linkages to other relevant sections. Following these observations, further discussion should be held with the health care worker, focusing on any issues and/or problems encountered with respect to using the information in the PCPNC.

If there is more than one health care worker using the PCPNC per facility, more time will be needed to observe them individually. However, if they are working together on the labour and delivery ward, it may be possible to observe several workers at the same time. In addition, you may wish to hold a group discussion following your observations, rather than individual discussions.

**Part 4: Health System Implications:**  
(Allow approximately 30 minutes to complete Part 4)

**Part 5: Summary of Discussion:**  
(Allow approximately 15 minutes to complete Part 5)

The key points from the individual and group discussions should be recorded in this part of the monitoring tool before leaving the health facility where the monitoring activity has taken place.

## Part 1: Demographic Information

Region: \_\_\_\_\_ Province/City/Municipality: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Location/Address: \_\_\_\_\_

Name and Position of Trained Health Staff Interviewed and Observed: \_\_\_\_\_

Date and Time of Monitoring Visit: \_\_\_\_\_

## Part 2: Use of the PCPNC

1. When did you start using the PCPNC?	YES	NO	NOTES
2. Which of the following sections of the PCPNC have you used?			
2.1 Principles of Good Care 2.1.1 Communication (A2) 2.1.2 Workplace & administrative procedures (A3) 2.1.3 Universal precautions and cleanliness (A4) 2.1.4 Organizing a visit (A5)			
2.2 Quick Check, Rapid Assessment and Management of Women of Childbearing Age 2.2.1 Quick check (B2) 2.2.2 Rapid assessment & management (B3-B7)			
2.3 Emergency Treatments for the Woman 2.3.1 Airway, breathing, circulation (B9) 2.3.2 Bleeding (B10-B12) 2.3.3 Eclampsia and pre-eclampsia 2.3.4 Infection (B15) 2.3.5 Malaria (B16) 2.3.6 Urgent referral to hospital (B17) 2.3.7 Essential emergency drugs and supplies for transport and home delivery (B17)			
2.4 Bleeding in Early Pregnancy and Postabortion Care 2.4.1 Examination of the woman (B19) 2.4.2 Preventive measures (B20) 2.4.3 Advise and counsel (B21)			

	YES	NO	NOTES
<b>2.1 Antenatal Care</b>			
2.1.1 Pregnancy status and birth and emergency plan (C2-C6)			
2.1.2 Observed signs and volunteered problems (C7-C11)			
2.1.3 Preventive measures (C12)			
2.1.4 Birth and emergency plan (C13)			
2.1.5 Advise on labour signs, danger signs, emergency preparation, family planning, care in pregnancy, routine and follow-up visits, home delivery (C14-C15)			
<b>2.2 Labour, Delivery and Immediate Postpartum Care</b>			
2.2.1 Examine woman in labour (D2)			
2.2.2 Respond to obstetrical problems in admission (D4-D6)			
2.2.3 Give supportive care throughout labour (D6-D7)			
2.2.4 First stage of labour (D8-D9)			
2.2.5 Second stage of labour (D10-D11)			
2.2.6 Third stage of labour (D12-D13)			
2.2.7 Respond to problems during labour and delivery (D14-D18)			
2.2.8 Care and assessment of mother after delivery (D19-21)			
2.2.9 Respond to problems immediately postpartum (D22-D24)			
2.2.10 Preventive measures (D25)			
2.2.11 Advise on postpartum care, family planning, routine and follow-up visits, danger signs, emergency plan (D26-D28)			
<b>2.3 Postpartum Care</b>			
2.3.1 Postpartum examination (E2)			
2.3.2 Respond to observed signs (E3-E10)			
<b>2.4 Preventive Measures and Additional Treatments for the Woman</b>			
2.4.1 Preventive measures (F2-F4)			
2.4.2 Additional treatments (F5-F6)			
<b>2.5 Inform and Counsel on HIV</b>			
2.5.1 Information and counseling (G2-G5)			
2.5.2 Antiretroviral treatments (G6)			
2.5.3 Counsel on infant feeding (G7-G8)			

	YES	NO	NOTES
<b>2.1 Antenatal Care</b>			
2.1.1 Pregnancy status and birth and emergency plan (C2-C6)			
2.1.2 Observed signs and volunteered problems (C7-C11)			
2.1.3 Preventive measures (C12)			
2.1.4 Birth and emergency plan (C13)			
2.1.5 Advise on labour signs, danger signs, emergency preparation, family planning, care in pregnancy, routine and follow-up visits, home delivery (C14-C15)			
<b>2.2 Labour, Delivery and Immediate Postpartum Care</b>			
2.2.1 Examine woman in labour (D2)			
2.2.2 Respond to obstetrical problems in admission (D4-D5)			
2.2.3 Give supportive care throughout labour (D6-D7)			
2.2.4 First stage of labour (D8-D9)			
2.2.5 Second stage of labour (D10-D11)			
2.2.6 Third stage of labour (D12-D13)			
2.2.7 Respond to problems during labour and delivery (D14-D18)			
2.2.8 Care and assessment of mother after delivery (D19-21)			
2.2.9 Respond to problems immediately postpartum (D22-D24)			
2.2.10 Preventive measures (D25)			
2.2.11 Advise on postpartum care, family planning, routine and follow-up visits, danger signs, emergency plan (D26-D28)			
<b>2.3 Postpartum Care</b>			
2.3.1 Postpartum examination (E2)			
2.3.2 Respond to observed signs (E3-E10)			
<b>2.4 Preventive Measures and Additional Treatments for the Woman</b>			
2.4.1 Preventive measures (F2-F4)			
2.4.2 Additional treatments (F5-F8)			
<b>2.5 Inform and Counsel on HIV</b>			
2.5.1 Information and counseling (G2-G5)			
2.5.2 Antiretroviral treatments (G6)			
2.5.3 Counsel on infant feeding (G7-G8)			

	YES	NO	NOTES
2.1.1 Care after abortion (M5)			
2.1.2 Care of baby after birth (M5)			
2.1.3 Breastfeeding (M7)			
2.1.4 Clean home delivery (M8-M9)			
2.2 Records and Forms			
2.2.1 Referral record (N2)			
2.2.2 Feedback record (N3)			
2.2.3 Partogram and labour record (N4-N8)			
2.2.4 Information form of medical certificate of causes of death (N7)			
1. Did the information in the flow charts in the section(s) you used help you to:			
3.1 Assess the woman and baby?			
3.2 Identify the needs and/or problems of the woman and baby?			
3.3 Provide advice and treatment for the woman and/or baby?			
4. Was the advice and treatment you provided the same as the advice and treatment recommended in the flow charts?			
5. Did you see women with problems that are not included in the PCPNC? (note any additional problems)			
6. When using the PCPNC, do you spend:			
6.1 More time with clients?			
6.2 Less time with clients?			
7. What helped you to remember the information in the section(s) you used (e.g. the questions to be asked, the observations to be made, and the advice and treatment to be provided based on your findings)? (see 6.1 to 6.5 below, but do not read out possible responses)			
6.1 Read the PCPNC before and after work			
6.2 Made cue cards containing reminders			
6.3 Placed copies of flow charts on the wall			
6.4 Consulted the PCPNC between clients			
6.5 Consulted the PCPNC while attending to clients			

### Part 3: Observations of Clinical Care

	YES	NO	NOTES
<b>1. Quick Check and RAM</b> 1.1 Carries out Quick Check as indicated on (E2)  1.2 Conducts RAM, when necessary, as indicated on (E3-E7)  1.3 Provides emergency treatments, when necessary (E8-E17) 1.4 Follows principles of good care (G7-G11) 1.5 Records all details of care accurately			
<b>2. Antenatal Care</b> 2.1 Examines pregnant woman (A2)  2.2 Checks for pre-eclampsia (A3)  2.3 Checks for anaemia (A4)  2.4 Responds to observed signs and volunteered problems (A7-A11)  2.5 Provides preventive measures (A12) (note which preventive measures given)  2.6 Develops birth and emergency plan (A13)  2.7 Advises on labour signs, danger signs and emergency preparation, family planning, nutrition and self care (A14-A16)  2.8 Advises when to return for routine and follow-up visits (A18) 2.9 Follows principles of good care (G7-G11) 2.10 Records all details of care accurately			

<p><b>1. Labour, Delivery &amp; Immediate Postpartum Care</b></p> <p>1.1 Examines woman in labour (D2)</p> <p>1.2 Does vaginal exam, if appropriate (D3)</p> <p>1.3 Decides on stage of labour (D3)</p> <p>1.4 Responds to obstetrical problems on admission (D4-D5)</p> <p>1.5 Gives supportive care throughout labour (D6-D7) (note which aspects of supportive care given)</p> <p>1.6 Monitors labour and records findings on labour record and partogram (D9, R5)</p> <p>1.7 Provides continuous surveillance during first and second stage of labour (D10-D11)</p> <p>1.8 Gives immediate newborn care (D11)</p> <p>1.9 Uses active management of third stage (D12) (if not, note method used to deliver placenta)</p> <p>1.10 Responds to problems during labour and delivery, when necessary (D14-D18)</p> <p>1.11 Assesses mother after delivery of placenta (D21)</p> <p>1.12 Responds to problems immediately postpartum, when necessary (D22-D25)</p> <p>1.13 Provides preventive measures (D25) (note which preventive measures given)</p> <p>1.14 Provides advice and counseling (D26-28)</p> <p>1.15 Follows principles of good care (G7-G11)</p> <p>1.16 Records all details of care accurately</p>			
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<p><b>1. Postpartum Care</b></p> <p>1.1 Examines the mother (P2)</p> <p>1.2 Responds to observed signs and volunteered problems (P3-P10)</p> <p>1.3 Follows principles of good care (G7-G11)</p> <p>1.4 Records all details of care accurately</p>			
<p><b>2. Newborn Care</b></p> <p>2.1 Examines the baby (N2)</p> <p>2.2 Assesses breast feeding (N3)</p> <p>2.3 Checks for special treatment needs (N5)</p> <p>2.4 Checks for signs of jaundice and local infection (N6)</p> <p>2.5 Provides newborn care (N10)</p> <p>2.6 Provides special care if baby is small (N11)</p> <p>2.7 Counsels on breast feeding (B2-B4)</p> <p>2.8 Ensures warmth for the baby and teaches mother (B9)</p> <p>2.9 Provides cord care and ensures hygiene and teaches mother (B10)</p> <p>2.10 Follows principles of good care (G7-G11)</p> <p>2.11 Records all details of care accurately</p>			



# Guide to PowerPoint Presentations

Below are the title of each Module and Session and the corresponding PowerPoint Presentation that can be found inside the compact disk (CD).

<b>Module and Session Title</b>	<b>PowerPoint Presentation</b>
<i><b>Didactic Phase</b></i>	
Module 1, Session 1: BEmOC and the Use of the PCPNC Manual	Module1A, Module1B
Module 2, Session 1: Principles of Good Care	Module2
Module 3, Session 1: Quick Check	Module3A
Module 3, Session 2: Rapid Assessment and Management	Module3B
Module 3, Session 4: Emergency Treatment for the Woman	Module3C, Module3D
Module 4, Session 1 and 2: Process Flow of Antenatal Care	Module4A
Module 5, Session 1: Stages of Labor	Module5A, Module5B, Module5C
Module 5, Session 2: First Stage of Labor	Module5D
Module 5, Session 3: Second Stage of Labor	Module5E
Module 5, Session 4: Third Stage of Labor	Module5F, Module5G
Module 6, Session 1: PostPartum Examination of the Mother up to Six Weeks	Module6A
Module 6, Session 2: Respond to Observed Signs and Volunteered Problems	Module6B
Module 6, Session 3: Preventive Measures and Additional Treatments	Module6C, Module6D

Module 7, Session 1: Newborn Care-Care of the New Born at the Time of Birth	Module7A, Module7B, Module 7C, Module7D
Module 7, Session 2: Newborn Care-Newborn Resuscitation	Module7E, Module7F, Module7G, Module7H, Module7I, Module7J
Module 7, Session 3: Newborn Care-Examination of the Newborn Baby	Module7K
Module 7, Session 4: Care of the Newborn-Small Babies Until Discharge from the Health Facility	Module7L, Module7M
Module 8, Session 1: Basic Facts About Counseling	Module8A
Module 8, Session 2: Applying the Counseling Skills	Module8B
Module 9, Session 1: Establishing Links	Module9A

***Monitoring, Evaluation and Action Plan***

Module 1, Session 1: Monitoring, Evaluation and Action Plan	ModuleMEPA, ModuleMEPB
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# Sample Training Schedule

Time	Agenda Item, Objectives	Exercises/ Activities	Materials
<b>Day 1</b>			
30 min		Registration	Registration Sheet, pen, kits for distribution, name tags
15 min	Opening Ceremony	Prayer National Anthem Welcome Remarks	Philippine Flag
10 min 30 min 10 min 40 min	Module 1 <u>Overview of BEmOC and the PCPNC Manual</u> a. Overview of BemOC b. Use of the PCPNC Manual  <i>To update learners understanding of BEmOC and the importance of PCPNC Manual and its use</i>	Warm-up exercise Lecture-discussion Reinforcement Drill	Metacards, pentel pens, masking tape, board, LCD/OHP, presentation materials and handouts on BEmOC and PCPNC Manual
15 min	<b>BREAK TIME</b>		
10 min 20 min 30 min	Module 2 <u>Principles of Good Care</u> a. Communication b. Workplace and administrative procedures c. Universal precautions and cleanliness d. Organizing a visit  <i>To improve learners' skills in applying the principles of good care</i>	Lecture Workshop Plenary	4 brown papers, pentel pens, masking tape, board, LCD/OHP, PCPNC Guide, handouts and CD/transparencies of presentation materials on the Principles of Good Care
15 min 5 min/20 min	Module 3 <u>Quick Check and Rapid Assessment and Management (RAM)</u> Session 1. Quick check  <i>To enable the learners to identify and prioritize patients from the group</i>	Lecture-discussion Contest/reinforcement	3 big brown papers with headings (SIGN, CLASSIFY and TREAT), metacards with descriptive words, LCD/OHP, chalk and board

60 min	<i>LUNCH BREAK</i>		
20 min 10-30 min	<p>Session 2. Rapid Assessment and Management (RAM)</p> <p><i>To enable the learners to:</i></p> <p><i>a. perform RAM to all women of childbearing, labor and postpartum stages;</i></p> <p><i>b. assess emergency and priority signs, and give appropriate treatment; and</i></p> <p><i>c. refer women to hospital</i></p>	<p>Lecture-discussion</p> <p>Drill on RAM</p>	<p>RAM chart, LCD/OHP, 5 drill exercises, brown papers, pentel pens, masking tape, and board</p>
20 min	<p>Session 3. Referral System</p> <p><i>To enable the learners to refer patients correctly</i></p>	<p>Interactive discussion</p>	<p>Short notes of own experiences, chalk, board, LCD/OHP</p>
30 min 60 -90 min	<p>Session 4. Emergency Treatment for the Woman</p> <p><i>To provide the learners with the opportunity to practice the details on emergency treatment identified during Quick Check and RAM.</i></p>	<p>Lecture-discussion</p> <p>Demonstration/Return Demo</p>	<p>Arm Model, IV Butterfly/Cannula, Chicken Breast, drugs, and supplies</p>
15 min	<i>BREAK TIME</i>		
15 min 30 min 30 min	<p>Module 4</p> <p><u>Antenatal Care</u></p> <p>Session 1. Importance of General Assessment of a Pregnant Woman during a Visit</p> <p><i>To enable the learners to discuss the importance of doing an immediate general assessment of the pregnant woman upon consultation at the facility</i></p>	<p>Drawing</p> <p>Plenary</p> <p>Lecture</p>	<p>Quick Check and RAM Chart, brown paper, pentel pen, masking tape, crayola, board, OHP/LCD and printed materials</p>
<b>Day 2</b>			
15 min	Recapitulation, Question and Answer		

20 min 30-50 min	<p><b>Session 3. Second Stage of Labor</b></p> <p><i>To enable learners to:</i></p> <p>a. describe the course and conduct of normal delivery; and</p> <p>b. review and describe steps in the management of breech delivery, stuck shoulder, multiple fetuses and cord prolapse</p>	<p>Lecture-Discussion</p> <p>Lecture-Demonstration</p>	OHP/LCD, AVP
30 min 30 min 30 min 20 min 15-125 min	<p><b>Session 4. Third Stage of Labor</b></p> <p><i>To enable learners to:</i></p> <p>a. describe steps in the delivery of placenta;</p> <p>b. determine active management of the 3<sup>rd</sup> stage of labor;</p> <p>c. assess and manage the mother during and after the 1<sup>st</sup> hour of complete delivery of the placenta until discharge from the health facility;</p> <p>d. identify and manage problems encountered in the mother immediately postpartum; and</p> <p>e. provide preventive measures to the mother after delivery.</p>	<p>Lecture-Discussion</p> <p>Lecture-Demonstration</p> <p>Case Study</p> <p>Plenary</p> <p>Didactic with Illustrations</p>	AVP, LCD/OHP, PP Form, 2 case studies, brown papers, pastel pens, marking tape and board
<b>Day 3</b>			
15 min	Recapitulation, Question and Answer		
15 min	<p>Module 6</p> <p><u>PostPartum Care</u></p> <p><b>Session 1. PostPartum Examination of the Mother Up to Six Weeks</b></p> <p><i>To enable learners to:</i></p> <p>a. assess and examine the mother after discharge from the facility; and</p> <p>b. conduct complete history and physical examination of a mother after discharge from a facility.</p>	Lecture-Discussion	Examination Chart for mothers after discharge and slides presentation

20 min 25 min 20 min 15-80min	<p>Session 2. Process Flow of Antenatal Care</p> <p><i>To improve the ability of the learners in explaining the process flow of providing quality antenatal care.</i></p>	<p>Lecturette-discussion Reinforcement Role Play Workshop</p>	<p>35 metacards (pink, yellow &amp; green), printed information materials, computerized information materials, slides/diskettes of the topic &amp; mechanics, brown papers, pentel pen, masking tape/paste, board, assorted art papers, 2 scenarios, observation tool, OHP/LCD, Quick Check and RAM Chart, case studies</p>
15 min	<i>working BREAK TIME</i>		
10 min 20-30 min	<p>Session 3. Skills Necessary during Antenatal Care</p> <p><i>To enable learners to perform the procedures and skills correctly and easily</i></p>	<p>Lecture-discussion Demonstration/Return Demo</p>	OHP/LCD
30 min	<p>Module 5 <u>Labor, Delivery and Immediate PostPartum</u> Session 1. Stages of Labor</p> <p><i>To enable the participants to:</i>  <i>a. recognize and assess the woman's and fetal status at the time of admission; and</i>  <i>b. decide stage of labor after complete rapid assessment on admission</i></p>	Lecture-Discussion	LCD/OHP, CD/transparencies of presentation materials, white board marker, board, slides presentation and PCPNC Guide
60 min	<i>LUNCH BREAK</i>		
15 min 30 min 30 min 30 min 10 -115 min	<p>Session 2. First Stage of Labor</p> <p><i>To enable learners to:</i>  <i>a. identify abnormal findings in a woman while assessing pregnancy and fetal status on admission;</i>  <i>b. manage identified abnormal findings in a woman during labor;</i>  <i>c. provide supportive care for a woman in labor; and d. review and develop skills needed while attending to a woman in labor</i></p>	<p>Pre-Test/Game Lecture Case Study Small Group Discussion Plenary</p>	<p>QC and RAM Chart, 4 big cards with letters A-D, prize, OHP/LCD, N4-N5 pages, 2 case studies, Partograph &amp; Labor, record acetate (4 sets), brown paper, pentel pens, masking tape and board</p>
15 min	<i>working BREAK TIME</i>		

10 min 30 min 30 min	<p>Session 2. Respond to Observed Signs or Volunteered Problems</p> <p><i>To enable learners to:</i>  <i>a. differentiate abnormal from normal signs and manage appropriately and accordingly; and</i>  <i>b. recognize volunteered problems of a woman after discharge from a facility and to properly manage them accordingly.</i></p>	Lecture-Discussion Workshop/Pyramiding Critiquing/Plenary	Handouts/PCPNC Manual, OHP/LCD, Chart, paper, pencil, brown paper, pentel pen and masking tape
15 min	<p>Session 3. Preventive Measures and Additional Treatments</p> <p><i>To enable learners to provide preventive measures and additional treatments to a woman after discharge from a facility including immunization, vitamin K, folic acid, mebendazole, antimalaria treatment, etc.</i></p>	Lecture-Discussion	OHP/LCD, handouts and PCPNC Manual
15 min	<b>BREAK TIME</b>		
50 min 10-60 min	<p>Module 7  <u>Newborn Care</u>            Session 1. Care of the Newborn at the Time of Birth</p> <p><i>To enable learners to describe and carry out routine care of the newborn at the time of birth.</i></p>	Interactive Discussion Demonstration	board, chalk, LCD/OHP and undressed doll
60 min	<b>LUNCH BREAK</b>		
60 min 60-120 min	<p>Session 2. Newborn Resuscitation</p> <p><i>To enable learners to:</i>  <i>a. assess and identify newborns needing resuscitation; b. perform resuscitation of the newborn using standard guidelines; and</i>  <i>c. provide after care if a baby requires help with breathing.</i></p>	Lecture-Discussion Lecture-Demonstration	OHP/LCD, PCPNC Manual/Handout, Manikin, self-inflating bag, mask size 0 & 1, suction tube/suction device, 2 towels and clock
15 min	<b>working BREAK TIME</b>		
30 min	Session 3. Examination of the Newborn Baby	Lecture-Discussion	OHP/LCD, 3 case studies, brown papers, pentel pens and masking tape

30 min 15 min 15-60 min	<p>Session 3. Examination of the Newborn Baby</p> <p><i>To enable learners to:</i></p> <p>a. describe and carry out an examination of the baby soon after birth, before discharge from the hospital, during the first week of life at routine, follow-up and sick newborn visit; and</p> <p>b. assess, classify and treat a newborn using the "Examine the Newborn" chart</p>	Lecture-Discussion Workshop Plenary	OHP/LCD, 3 case studies, brown papers, pen/teal pens and masking tape and slide presentation
20 min 40-60 min	<p>Session 4. Care of the Normal and Small Babies Until Discharge from the Health Facility</p> <p><i>To enable learners to describe and carry out the everyday care of the baby.</i></p>	Interactive Discussion Lecture-Demonstration	board, chalk, PCPNC Manual, OHP/LCD and slides
<b>Day 4</b>			
15 min	Recapitulation, Question and Answer		
40 min	<p>Module 8 <b>Counseling</b> Session 1. Basic Facts about Counseling</p> <p><i>To enable learners to:</i></p> <p>a. define counseling and interpersonal communication, and</p> <p>b. discuss principles of counseling and interpersonal communication.</p>	Interactive Discussion	OHP/LCD, slides, mancards, pen/teal pens, masking tape and board
75min	<p>Session 2. Applying the Counseling Skills</p> <p><i>To enable learners to:</i></p> <p>a. demonstrate effective communication skills; and</p> <p>b. demonstrate appropriate counseling techniques in the different maternal health situations.</p>	Lecture-Discussion	OHP/LCD, slides, PCPNC Manual, counseling video, observation tool, board and chalk
15 min	<i>working BREAK TIME</i>		